

Division of Licensing and Protection  
103 South Main Street  
Waterbury, VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 871-3317  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 871-3318

August 5, 2015

Mr. Thomas Rice, Administrator  
Brookside Health And Rehabilitation  
1200 Christian Street  
White River Junction, VT 05001-9267

Dear Mr. Rice:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 8, 2015**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN  
Licensing Chief





DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/08/2015
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NAME OF PROVIDER OR SUPPLIER  BROOKSIDE HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 CHRISTIAN STREET WHITE RIVER JUNCTION, VT 05001
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F 226

Continued From page 1

indicated that Resident #63 had approached Resident #57 and put their hands down the front of the pants of this resident. Per interview on 7/8/15, the Unit Manager stated that they had conducted a reenactment of both of these incidents with staff to determine if any actual inappropriate touching had occurred between Resident #63 and the two other residents.

Per interview on 7/8/15 at 1:10 PM, the Unit Manager stated that the incident involving Resident #4 on 9/29/14 happened in the dining room and observed by an LNA nearby, who intervened in the situation. This incident was documented by a nurse who did not witness the incident, however the note did not reflect that it was reported by the LNA who witnessed this. In the incident documented on 10/18/14, the incident was witnessed by an LNA who also intervened in the situation. The nurse's note was written by a nurse who received the report, however the note did not indicate that it was reported to the nurse by an LNA and not witnessed first hand by the nurse. The Unit Manager stated that based on the angle of the witnesses view and the promptness of the staff intervention, that they determined that Resident #63 was not successful in completing any intended sexual groping of either resident due to staff intervention in both situations. The Director of Nursing and the Unit Manager both confirmed that there were no incident reports written for either incident, and no written staff witness statements gathered during the investigation.

The Director of Nursing stated on 7/8/15, that these incidents were not reported to the state as they were determined to be prevented by the intervention of staff before any inappropriate

F 226

4. Re-educate staff to ensure any abuse investigation interviews are conducted IAW policy. 8/8/15
5. Random weekly audits x4 to ensure continued compliance. 8/8/15
6. Results to be reported to QAA for determination of continued surveillance.
7. Plan completed by 8/8/15. Administrator or designee responsible for implementation

*F226 POC accepted 8/4/15 SDennis RN/PMC*

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F 226 Continued From page 2  
 touching occurred. Per the facility policy for Abuse investigations, the witnesses in an alleged abuse event were to be interviewed separately, and reports of these events will be obtained in writing from any witnesses, signed and dated by them. The Unit Manager confirmed that the policy for investigating an alleged incident of resident to resident abuse was not followed for the incidents on 9/29 and 10/18/14.

F 279 483.20(d), 483.20(k)(1) DEVELOP SS=D COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:  
 Based on staff interviews and record review, the facility failed to develop a comprehensive care

F 226

F 279

F279  
**Disclaimer**  
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1. Resident #61 has been evaluated, no negative outcome as result of this alleged deficient practice bladder evaluations completed, care plan updated by 7/31/15
2. All residents who are incontinent at risk for this alleged deficient practice.
3. Review MDS for any resident who has experienced any loss or deterioration in bladder function by 7/31/15

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F 279	Continued From page 3 plan for 1 of 2 residents in the applicable stage two sample (Resident #61). Findings include:  Per record review, Resident #61 was admitted to the facility in February 2015. His/her 2/3/15 bladder evaluation at the time of admission identified the resident as continent of urine. Per review, the resident's 2/12/15 MDS (Minimum Data Set) identified the resident's bladder function as always continent; however, the MDS showed a decline in bladder continence between 2/12/15 and 5/3/15.  Per review of the Nursing Assistant flow sheets, the resident was identified as having incontinent episodes on 8 of the 15 days that were reviewed for March and incontinent for 15 of 15 days reviewed in April. On 5/5/15 a Bowel and Bladder Assessment identified the resident as being continent 1-2 times daily and needing assistance from 1 person for walking to the BR [bathroom] or transferring to the toilet; mental status was identified as confused, needs verbal and physical prompts and assistance; sometimes mentally aware of toileting needs; and taking 2 or more medications (such as diuretics) that might affect bladder function. The Nursing Assistant flow sheet for June 2015 identified the resident as incontinent on 10 of 15 days reviewed.  On 7/8/15 at 2:39 PM, the Unit Manager (UM) confirmed the above information and confirmed that no care plan had been developed to address the needs of Resident #61 related to urinary incontinence.	F 279	4. Re- evaluate residents found with deterioration, up date or implement care plan. by 8/8/15 5. Re-educate staff the steps required for comprehensive care planning if a resident has a change of condition. .8/8/15 6. Random weekly audits x4 to ensure continued compliance.8/8/15 7. Results to be reported to QAA for determination of continued surveillance. 8. Plan completed by 8/8/15. DNS or designee responsible for implementation  <i>F279 POC accepted 8/4/15 Spennis RUI/Pme</i>	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		

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F 281

Continued From page 4  
 The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:  
 Based on record review and interview, the facility failed to provide services that meet professional standards by failing to follow physician orders in a timely manner for 1 of 24 Residents in the stage 2 sample (Resident #8).

Per record review, Resident #8 had diagnoses of hyperlipidemia (elevated cholesterol level), depression, seizure disorder and other chronic medical health problems. On 1/26/15 the consultant pharmacist notified the facility that the resident had "...standing lab orders including an FLP (Lipid profile) annually, due in August. There are no results for the FLP from this past August ...If the FLP was not obtained in August 2014, could we add it to [his/her] scheduled February labs?" On 2/5/15 the facility obtained a physician order to schedule the FLP annually in February and CBC (Complete blood count) and CMP (comprehensive metabolic profile) biannually in February and August. On 2/20/15 a staff nurse attempted to draw the labs but was not successful. On 3/2/15 another attempt to draw the labs was unsuccessful. On 4/2/15 the Pharmacist again notified the facility that Resident #8 "...was due for some labs to be drawn in February but there were no results in [his/her] chart as of 3/27/15. If the labs were not drawn, please ensure they are scheduled ASAP. [S/he] is due for an FLP, CBC and CMP." On 4/16/15 the CBC and CMP were drawn (2 months past the physician order) but FLP was not obtained. On 5/13/15 the FLP was drawn, over 3

F 281

F281  
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1. Resident #8 evaluated, no negative outcome as result of this alleged deficient practice..
2. All residents who have labs recommended during monthly pharmacy review are at risk for this alleged deficient practice.
3. An audit will be performed to ensure all MD orders have been carried out related to monthly pharmacy recommendation by 8/4/2015.
4. Nursing staff to be re-educated on following md orders, and wht to do if unable to carry them out by 8/8/15

F281 POC accepted 8/4/15 SDennis RJP/PMC

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F 281	Continued From page 5 months past the physician order.  On 7/8/15 at approximately 1:04 PM, the UM confirmed the above information and that the facility did not obtain the resident's FLP and other labs timely following the physician order of 2/5/15. S/he stated that expectations for staff who are unsuccessful in drawing labs would be to re-attempt the blood draw in 1 weeks' time, look for the barriers to obtaining the lab and attempt to correct (by offering the resident more fluids, applying warm compresses to the site or having a more experienced staff member or a hospital lab attempt the blood draw). The UM also confirmed that there was no documentation that the physician had been contacted or a new order obtained when the labs were not drawn in February as ordered.	F 281	5. Random weekly audits x4 to ensure continued compliance. Results to be reported to QAA x3 for determination of compliance. 8/8/15 6. Plan completed by 8/8/15. Director of Nursing or designee responsible for implementation  <i>- accepted 8/4/15</i>	
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide services in accordance with the plan of care for 3 of 24 residents in the stage 2 sample (Resident #78, #19 and #8). Findings include:  1. During observation on 07/06/15 at 11:55 AM Resident #78's feet were dangling in the wheelchair and did not reach the wheelchair's	F 282	<b>F282 Disclaimer</b> The filing of this plan of correction is filed as the facility's does not constitute the fact that deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply the requirements and provide High quality care  1. Resident #78,19,8 has been evaluated, No negative outcome as result of this alleged deficient practice. 2. All residents care planned for splints, Teds, repositioning, and repositioning assistive devices are at risk for being affected by this alleged deficient practice.	

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F 282	<p>Continued From page 6</p> <p>foot rest. Per record review of the MDS [Minimum data set] dated 04/04/15 section for mobility and transfers shows the resident as needing total assistance with staff for all ADLs [activities of daily living] and having limited function of the lower extremities. Review of the care plan directs staff to apply TEDs stockings, float heels, and reposition with body pillow. Per interview and observation with two LNAs at 2:58 PM stated "I don't think [resident] has pillows when [s/he] is in bed and we don't have any splints that I know of". The resident was in bed at this time and there was no pillow for body positioning, TEDs, nor was the heels lifted [floated]. The Unit Manager at 3:04PM confirmed that body pillows and TEDs were not used and the heels were not floated as care planned.</p> <p>In addition, during interview with the Therapy Director at 3:22 PM, s/he said that although there is no diagnosis of contractures, the resident does have limited range and 'firm-end field' shoulders and lower extremities extension, which was based on the assessment. At this time the Therapy Director observed that the resident's foot rests were not supporting the feet. S/he confirmed that the feet were not positioned correctly and said "they [foot rest] must've dropped or [resident] had a change in positioning and/or flexibility".</p> <p>2. Staff failed to provide consistent and accurate skin monitoring for Resident #19 who was identified through hospital data, nursing assessments and a corrected MDS for uicers. The Resident's Braden scale scores dated 05/05/15 through 05/18/15 as a 12 [less than 11 -12 represents high risk of developing skin breakdown] and on 05/30/15 as an 11. Per the</p>	F 282	<ol style="list-style-type: none"> <li>3. Inventory all care plans to residents to ensure residents have devices as per plan of care. 8/8/15</li> <li>4. Nursing staff re-educated for process for care plan implementation of TEDs, splints, and repositioning with and without supportive devices by 8/8/15</li> <li>5. Random weekly audits x4 to ensure continued compliance. Results to be reported to QAA x3 for determination of compliance. Start 8/8/15</li> <li>6. Plan completed by 8/08/14. Director of Nursing or designee responsible for implementation</li> </ol> <p><i>F282 POC accepted 8/14/15 SDennis RHP/MLC</i></p>	

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F 282 Continued From page 7  
 care plan dated 04/27/15, staff were directed to reposition every 2 hours, report skin related concerns to charge nurse, head to toe skin check by the nurse weekly, barrier cream to coccyx and sacrum PRN, moisturizer, float heels, blue booties, pressure reducing cushion to chair and bed to conduct weekly skin checks on Monday. The skin assessments were written as follows:  
 4/27/15: purple right heel and dried red left heel;  
 5/18/15: sores on heels bilateral sutures sites healed no new skin issues;  
 5/25/15: previous sores on bilateral heels, incisions healed;  
 6/1/15: states "eschar continues on both heels" and skin tear right lateral lower leg;  
 6/8/15: 'pink/purple' on both heels and bruise on right lateral eye;  
 6/15/15: bruise right eye, left arm and skin tear right arm;  
 6/22/15: known bruise on face no new issues;  
 6/29/15: known bruise on face no new issues;  
 7/6/15: no new areas.

Per observation and interview with the Licensed Practical Nurse on 07/07/15 at 1:30 PM stated "It [heels] sort of looks like normal to pink skin when I put the skin prep on today", however, at this time the nurse surveyor noted a skin tear just lateral and below the right knee and a quarter sized dark red area on shin with bilateral heels having dried scabbing on left heel and blanchable pink right heel. These areas were not noted on the recent weekly assessment.

Per interview on 07/07/15 at 1:45 PM the charge nurse stated "I can't tell you if the heels were healed or not on any particular date because staff are not correctly documenting the skin". S/he acknowledged that "no new issues" is not a

F 282

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F 282	<p>Continued From page 8</p> <p>correct description for a wound that has no change. S/he confirmed the skin assessments were not done as expected, which should've been thorough and accurate with size, color, drainage, and/or odor for each skin issue.</p> <p>3. Per medical record review, Resident #8 had diagnoses of a left hemiplegia (paralysis of one side of the body) with contractures of his/her left arm and hand. On 7/6-7/8/15 the resident was observed wearing a left elbow brace to position his/her left arm; his/her left hand was held in a closed fist position with no splint in place. When asked, the resident was unable to voluntarily open his/her left hand.</p> <p>On 7/8/15 at 10:14 AM, the facility Rehab Manager stated that the use of a palm protector [a soft splint that provides moisture control and support for a contracted hand] was established for the resident during rehab services from 4/14-5/27/15. Per review of Occupational Therapy (OT) treatment notes, on 4/23/15 the OT assessed the resident's left palm and found it to exhibit a "foul odor and cheesy film." A palm protector was trialed and tolerated by the resident with no signs of irritation. A 5/19/15 OT note documents that the resident had excellent tolerance of the palm protector, there were no signs of irritation from its use. "Pt/caregiver education with unit manager, nurse on the cart, and both day LNAs on the unit for training with wear schedule for palm protector. The individuals trained today demonstrated good understanding of the palm protector and the projected wearing schedule." A 6/12/15 OT-Therapist Progress &amp; Discharge Summary documented that "Discharge instructions are the written wearing schedule for donning the elbow brace (and palm protector per</p>	F 282		

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F 282 Continued From page 9  
 prior therapy track) as well as the instructions to notify nurse if any signs of irritation are visible."

Per 7/8/15 care plan review, the Restorative nursing program care plan stated to "Utilize Splint, AFO, Braces, Etc as Directed by Therapy for RNP." The care plan for Contractures of the Left Arm... and at risk for progression of contractures, stated to "Utilize Braces, Splints, etc as indicated." On 7/8/15 at 10:48 AM, the UM (Unit Manager) confirmed that Resident #8 was not wearing a palm protector and that the care plan related to use of splints was not implemented for this resident. The UM stated that there had been a communication problem between therapy and nursing and use of the palm protector had not been implemented by nursing.

F 309 SS=D 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:  
 Based on observation, interview and record review, the facility failed to assure that services were provided to maintain or attain the highest practicable level of well-being for 2 of 3 applicable residents in the Stage 2 sample with positioning needs. (Resident #78 and #8).

F 282

F 309

F309  
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1. Resident # 78 and 8 evaluated, no negative outcome sustained as result of this alleged deficient practice.
2. All residents who have positioning needs are at risk due to this alleged deficient practice

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(X4) ID PREFIX TAG F 309	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F 309	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 10</p> <p>1. During observation on 07/06/15 at 11:55 AM Resident #78's feet were dangling in the wheelchair and did not reach the wheelchair's foot rest. Per record review of the MDS [Minimum data set] dated 04/04/15 section for mobility and transfers shows the resident as needing total assistance with staff for all ADLs [activities of daily living] and having limited function of the lower extremities. Review of the care plan directs staff to apply TEDs stockings, float heels, and reposition with body pillow. Per interview and observation with two LNAs at 2:58 PM stated "I don't think [resident] has pillows when [s/he] is in bed and we don't have any splints that I know of". The resident was in bed at this time and there was no pillow for body positioning, TEDs, nor was the heels lifted [floated]. The Unit Manager at 3:04PM confirmed that body pillows and TEDs were not used and the heels were not floated as care planned.</p> <p>In addition, during interview with the Therapy Director at 3:22 PM, s/he said that although there is no diagnosis of contractures, the resident does have limited range and 'firm-end field' shoulders and lower extremities extension, which was based on the assessment. At this time the Therapy Director observed that the resident's foot rests were not supporting the feet. S/he confirmed that the feet were not positioned correctly and said "they [foot rest] must've dropped or [resident] had a change in positioning and/or flexibility".</p> <p>2. Per 7/7-7/8/15 medical record review, Resident #8 had diagnoses of left hemiplegia (paralysis of one side of the body) with contractures of his/her left arm and hand. There was a care plan in place</p>	F 309	<ol style="list-style-type: none"> <li>3. Re-evaluate all residents with positioning needs to ensure they are meeting their highest level of function by 8/7/15</li> <li>4. Re-educate Interdisciplinary care staff on their responsibility to provide care that meets the resident highest level of well being by 8/7/15</li> <li>5. Random weekly audits x4 to ensure continued compliance.</li> <li>6. Results to be reported to QAA for determination of continued surveillance.</li> <li>7. Plan completed by 8/7/15. Director of Nursing or designee responsible for implementation</li> </ol> <p>F309 POC accepted 8/14/15 S Dennis RN/AME</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/08/2015
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NAME OF PROVIDER OR SUPPLIER  BROOKSIDE HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 CHRISTIAN STREET WHITE RIVER JUNCTION, VT 05001
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F 309 Continued From page 11  
 for the contractures and the resident was identified as being at risk for contracture progression. Throughout the day on 7/6-7/8/15 Resident #8 was observed wearing a left elbow brace to position his/her left arm; his/her left hand was held in a closed fist position with no splint in place. When asked, the resident was unable to voluntarily open his/her left hand.

On 7/8/15 at 10:14 AM, the facility Rehab Manager stated that the use of a palm protector [a soft splint that provides moisture control and support for a contracted hand] was established for the resident during rehab services from 4/14-5/27/15. Per review of Occupational Therapy (OT) treatment notes, on 4/23/15 the OT assessed the resident's left palm and found it to exhibit a "foul odor and cheesy film." A palm protector was trialed and tolerated by the resident with no signs of irritation. A 5/19/15 OT note documents that the resident had excellent tolerance of the palm protector, there were no signs of irritation from its use. "Pt/caregiver education with unit manager, nurse on the cart, and both day LNAs on the unit for training with wear schedule for palm protector. The individuals trained today demonstrated good understanding of the palm protector and the projected wearing schedule." A 6/12/15 OT-Therapist Progress & Discharge Summary documented that "Discharge instructions are the written wearing schedule for donning the elbow brace (and palm protector per prior therapy track) as well as the instructions to notify nurse if any signs of irritation are visible."

Per 7/8/15 care plan review, the Restorative nursing program care plan stated to "Utilize Splint, AFO, Braces, Etc as Directed by Therapy for RNP." The care plan for Contractures of the

F 309

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OMB NO. 0938-0391

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F 309 Continued From page 12  
Left Arm... and at risk for progression of contractures, stated to "Utilize Braces, Splints, etc as indicated." On 7/8/15 at 10:48 AM, the UM (Unit Manager) confirmed that Resident #8 was not wearing a palm protector for the left hand contracture and that the care plan related to risk for contracture progression was not implemented. The UM stated that there had been a communication problem between therapy and nursing and use of the palm protector had not been implemented by nursing.

F 309

F 313 SS=D 483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION

F 313

To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

This REQUIREMENT is not met as evidenced by:  
Based on interviews and record review there was a failure to ensure, for one applicable resident in the sample, received assistive devices to maintain adequate vision for approximately six weeks. (Resident #80) Findings include:

1. Per interview with spouse on 07/06/15 at 12:19 PM, s/he stated that the eye glasses of Resident #80 "went missing a couple of weeks ago". The spouse further stated that staff were aware but they stated "we don't know [where the

F313  
**Disclaimer**  
The filing of this plan of correction is filed as the facility's does not constitute the fact that deficiencies did in fact exist. This plan of correction is fitted as evidence of the facility's desire to comply the requirements and provide High quality care

1. Resident #80 evaluated and no negative outcome sustained as a result of this alleged deficient practice. .
2. All residents who wear eyeglasses are at risk related to this alleged deficient practice.
3. Staff will check with each resident ascertain if they have any needs to see an optometrist or ophthalmologist. Offer assist to facilitate visit in any way should they wish to go. By 7/31/15

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F 313	<p>Continued From page 13</p> <p>glasses were]" and had not heard back from the staff. The spouse indicated that a replacement pair of glasses would be beneficial as the pair that the resident is currently wearing are "a very old prescription and not sure how well [the resident] could see". In addition, [s/he] stated "I never heard back from them or what they were going to do".</p> <p>Per the incident report dated 05/24/15 states the following "it was reported to this nurse at 1500 that the resident glasses have been missing since this AM. [spouse] aware and wants them replaced". Two daily morning reports on 05/26/15 and 05/27/15 state "missing shoes and pink-purple glasses missing" and "shoes found and [old] brown glasses being used", respectively. No further information and/or resolution was documented in the resident's chart or on the report.</p> <p>Per interview on 07/08/15 at 9:35 AM the Medical Social Worker (MSW) stated that s/he recently talked to the spouse and [spouse] couldn't understand where [the resident's] glasses were. The MSW acknowledged that the spouse did want them replaced but that the the information did not go over to Human Resources, who is the responsible party who would issue a check for replacement cost. The MSW confirmed "it was a glitch" and that an appointment and/or phone call to renew the prescription for eye glasses to the optometrist was not done at that time and the expectation is that this would have been done by nursing. The MSW further said "I guess I need to have a copy for things like this so that it can be handled sooner, which we normally do, but this way we can be assured that it gets done."</p>	F 313	<ol style="list-style-type: none"> <li>4. Re-educate staff on their role for broken eyeglasses. By 8/7/15</li> <li>5. Random weekly audits x4 to ensure continued compliance. Results to be reported to QAA x3 for determination of compliance. 8/8/15</li> <li>6. Plan completed by 8/8/15. Director Social work or designee responsible for implementation</li> </ol> <p><i>F313 POC accepted 8/4/15 SDennis R. Pme</i></p>		

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F 323 F 323 SS=E	<p>Continued From page 14</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by:            Based on observation and staff interview, the facility failed to ensure that the environment was as free of accident hazards as is possible in 13 resident rooms. Findings include:</p> <p>1. Per record review on 7/7/15, a resident in room 26 had a diagnosis of dementia, and has had a number of recent falls, some of which were from bed. Per review of the care plan, the resident was to have a low bed with a fall mat placed next to it when they were in the bed. Per observation on 7/8/15 at 2:40 PM, the bed of the resident had a metal bracket attached to the side of the bed that was at about shoulder level for someone in the bed, as well as a lower piece that protruded near the bottom that was meant to hold the side rail in place. The resident no longer had side rails on the bed, however the metal bracket remained attached to the bed and protruded out about 3 inches from the frame. Upon further investigation and observation, the beds of the other resident in room 26 and in room 27 also had the side rails removed and had a protruding metal bracket remaining in place. These residents were also identified as having dementia and the resident in</p>	F 323 F 323	<p>F323</p> <p><b>Disclaimer</b>            The filling of this plan of correction is filed as the facility's does not constitute the fact that deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply the requirements and provide High quality care</p> <ol style="list-style-type: none"> <li>Side rail brackets that presented an alleged hazard in room 1,10,14,18,25,26,27 have been removed with no negative effects. Radiator covers in room 20 and 24 has been repaired, with no negative outcome. Bed stand in rm 12 has been removed and replaced, without negative outcome. Door frames in rm 2 and 4 have been repaired without negative outcome. Ceiling tile in room 9a replaced without any negative outcome.by 7/29/2015</li> <li>All residents have potential to be effected by this alleged deficient environment.</li> </ol>	

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F 323 Continued From page 15  
 room 27 also had falls from bed documented. Per interview on 7/8/15 at 2:54 PM, the Regional Manager of maintenance and housekeeping services confirmed that housekeeping keeps track of the resident mattresses; however, do not have a process to keep track of removing the metal brackets from a bed if the resident is not utilizing side rails. S/he also acknowledged the concern of the brackets being a potential accident hazard if a resident fell into them or bumped into them, and that they were an unnecessary piece of equipment to have attached to the bed if side rails were not in use.

2. In addition, during the environmental tour on 07/08/15 at 2:45 with the Maintenance Director and Regional Manager the following observations were made and confirmed:

a) Potentially sharp side rail brackets in rooms 25, 26 [2 beds], 27, 18, 14, 10, and 1.  
 b) Room 20 and 24 had metal heating elements [shields] that were broken and exposing sharp edges.  
 c) The bed side stand in room 12 had missing side molding exposing sharp pieces that were then taped with masking tape material.  
 d) The shared bathroom between room 1 & 2 had an exposed sharp wall board.  
 e) Room 2's bathroom door frame had bent and protruding metal on the lower edge.  
 f) Room 4 bathroom's door frame had a sharp edge.  
 g) Room 9A was noted to have water marks on the ceiling and a space between the air conditioner and window leaving an opening for potential insect entry

F 323

3. All bed frames, radiator covers, door frames, bed side stands and ceiling tiles have been checked and changed as need to ensure a safe environment. 8/8/15
4. Staff re- educated to report any potential hazard immediately for repair by 8/8/15
5. Random weekly audits x4 to ensure continued compliance. Results to be reported to QAA x3 for determination of compliance. 8/8/15
6. Plan completed by 8/8/15. Director of Maintenance or designee responsible for implementation

*F323 PDC accepted 8/4/15 SPemisRN/PMC*

F 327 483.25(j) SUFFICIENT FLUID TO MAINTAIN

F 327

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F 327  
 SS=D  
 Continued From page 16  
 HYDRATION

The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.

This REQUIREMENT is not met as evidenced by:  
 Based on observation, record reviews and interviews, the facility failed to provide one of twenty-four residents in the sample (Resident #60) with sufficient fluid intake to maintain proper hydration and health. Findings include:

1. During observation on 07/06/15 at 4:09 PM, Resident #60 presented with clinical signs of possible insufficient fluid intake such as dry skin and lips and the tongue appeared dry and furrowed. In addition, a cup a water was on a high dresser out of reach of the resident. Per record review on 07/07/15, Resident #60 has functional impairments that make it difficult to reach fluids, or communicate fluid needs. The review of the care plan dated 07/28/14 states; "at risk for developing signs and symptoms[s/s] of dehydration related to side effects of anti-psychotic medication, dependence on staff for assistance to eat and drink and diverticulitis". The interventions directed staff to "observe for s/s such as dry mouth, poor skin turgor, furrowed tongue, decreased output, elevated BUN [blood urea nitrogen], report to charge nurse and notify physician as needed [RN], encourage resident to drink all fluids offered, offer fluids of choice and position near resident so that they may drink freely, variety of fluids, monitor labs as ordered and vital signs as indicated, monitor consumption for adequate intake, Registered Dietician [RD] to

F 327

F327  
**Disclaimer**  
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1. Resident #60 has been evaluated and shows no signs of dehydration. No negative outcomes from this alleged deficient practice.
2. All residents whom requires assist with hydration are at risk from this alleged deficient practice..
3. Evaluate all at risk residents to ensure adequate hydration. Intervene as needed.8/4/15
4. Re- educate Interdisciplinary care team members on their role to care out in Hydration policy.8/7/2015
5. Random weekly audits x4 to ensure continued compliance. Results to be reported to QAA x3 for determination of compliance.
6. Plan completed by 8/7/15 Director of Nursing or designee responsible for implementation

F327 POC accepted 8/4/15 SDennisR/K/PMC

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F 327	<p>Continued From page 17 monitor nutritional status".</p> <p>Per a physician order the annual Basic Metabolic panel was completed on 02/19/15 which reflected a nearly double the normal range for BUN at 31mg/dL [normal range =8-18]. A nutritional assessment dated 11/07/13 notes the fluid needs as 1600cc's a day and to advance the mechanical soft diet to Dysphagia 3 diet with finger foods if possible. The RD assessment note dated 02/26/15 states "[s/he] is a very poor drinker, BUN increase as 31 showing poor intakes of fluid, doctor is aware".</p> <p>Review of the Nursing Assistant Flow Sheet for the month of July 2015 presents with an average fluid intake of 650 - 840 cc's a day. The previous three months have approximately the same daily totals. Per interview with a LNA on 07/08/15 at 11:40 AM, s/he stated "we don't really keep track of all [his/her] drinks during the day but I guess [s/he] gets coffee in the morning and maybe some water with medications. We just track what is given during the meals." Per interview on 07/08/14 at 1:34 PM the charge nurse stated "we try to get in at least 1000cc a day with the LNAs tracking that, but nursing should be looking at that." S/he acknowledged "we might have to revise the care plan to see what we can do to make sure [s/he] is getting enough fluids since [the resident] might not drink the recommended amount per day and the LNA sheets are only capturing the meal only drinks". S/he confirmed that there was not a system in place to assure that daily fluid intake totals were reviewed to consistently assure sufficient fluids were given for Resident #60.</p>	F 327		
F 428	483.60(c) DRUG REGIMEN REVIEW, REPORT	F 428		

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F 428  
SS=D

Continued From page 18  
IRREGULAR, ACT ON

The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.

This REQUIREMENT is not met as evidenced by:  
Based on medical record review and staff interview, the facility failed to ensure that the recommendations made by the consultant pharmacist during monthly pharmacy reviews were acted upon in a timely manner for 1 of 24 Residents in the stage 2 sample (Resident #8).

Per record review on 7/7-7/8/15, Resident #8 had diagnoses of hyperlipidemia (elevated cholesterol level), depression, seizure disorder and other chronic medical health problems. On 1/26/15 the consultant pharmacist notified the facility that the resident had "...standing lab orders including an FLP (Lipid profile) annually, due in August. There are no results for the FLP from this past August ...If the FLP was not obtained in August 2014, could we add it to her scheduled February labs?" On 2/5/15 the facility obtained a physician order to schedule the FLP annually in February and CBC (Complete blood count) and CMP (comprehensive metabolic profile) biannually in February and August. On 2/20/15 a staff nurse attempted to draw the labs but was not

F 428

F428  
**Disclaimer**  
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1. Resident #8 lab has been drawn no new orders obtained and has not had any negative outcome as a result of this alleged deficient practice
2. All residents whom have lab recommendations on their monthly Pharmacy medical record review are at risk for this alleged deficient practice.
3. An audit will be performed of any outstanding pharmacy medical record review lab recommendations and addressed immediately with MD.7/31/15
4. MD and staff will re-educate on process for addressing Pharmacy medical record review by 8/7/15

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F 428 Continued From page 19  
 successful. On 3/2/15 another attempt to draw the labs was unsuccessful. On 4/2/15 the Pharmacist again notified the facility that Resident #8 "...was due for some labs to be drawn in February but there were no results in [his/her] chart as of 3/27/15. If the labs were not drawn, please ensure they are scheduled ASAP. [S/he] is due for an FLP, CBC and CMP." On 4/16/15 the CBC and CMP were drawn (2 months past the pharmacist notification) but not the FLP. On 5/13/15 the FLP was drawn, over 3 months past the pharmacist notification.

On 7/8/15 at approximately 1:04 PM, the UM confirmed the above information and that the facility did not obtain the resident's FLP and other labs timely following the pharmacist recommendation. S/he stated that expectations for staff who are unsuccessful in drawing labs would be to reattempt the blood draw in 1 weeks' time, look for the barriers to obtaining the lab and attempt to correct (by offering the resident more fluids, applying warm compresses to the site or having a more experienced staff member or a hospital lab attempt the blood draw). The UM also confirmed that there was no documentation that the physician had been contacted and a new order obtained when the labs were not drawn in February as ordered.  
 (Refer F281)

F 428

5. Random weekly audits x4 to ensure continued compliance. Results to be reported to QAA x3 for determination of compliance. 8/7/15
6. Plan completed by 8/7/15. Director of Nursing or designee responsible for implementation

*F428 POC accepted 8/14/15 SDennis/WPme*