

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

December 28, 2015

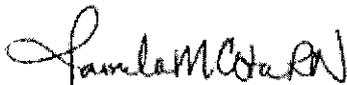
Ms. Meagan Buckley, Administrator  
Burlington Health & Rehab  
300 Pearl Street  
Burlington, VT 05401-8531

Dear Ms. Buckley:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 2, 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



PRINTED: 12/14/2015  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  12/02/2015
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NAME OF PROVIDER OR SUPPLIER  BURLINGTON HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 300 PEARL STREET BURLINGTON, VT 05401
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F 000  F 253 SS=B	<p><b>INITIAL COMMENTS</b></p> <p>The Division of Licensing and Protection conducted an unannounced annual recertification survey 11/30/15 - 12/2/15. The following regulatory deficiencies were identified as a result.</p> <p><b>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</b></p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Findings include:</p> <p>Per observation on 12/1/15, bathroom ceiling intake vents in the following resident rooms were heavily soiled with dust: 501, 502, 507, 508, 509, 510, 514, 519. Additionally, both ceiling intake vents in the shower/tub room were heavily soiled with dust. These observations were confirmed by the Unit Manager on 12/1/15 at 2:50 PM.</p>	F 000  F 253	<p>The following constitutes the facility's response to the findings of the Department of Licensing and Protection and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set for the on the summary statement of deficiencies.</p> <p><b>F253 B 483.15(h)(2)</b></p> <ol style="list-style-type: none"> <li>Residents had no negative effects as a result of this alleged deficient practice</li> <li>Residents residing in the facility have the potential to be affected by this alleged deficient practice.</li> <li>Education will be provided to staff regarding requirements for cleaning bathroom ceiling vents.</li> <li>Random weekly audits will be conducted by the ED or designee to monitor the effectiveness of the plan.</li> <li>The results of the audits will be reported to the QAA committee by the ED or designee monthly x3 months at which time the QAA committee will determine further frequency of the audits.</li> <li>Corrective action to be complete by 1/2/16.</li> </ol> <p><i>F253 POC accepted 12/23/15 RTremblay RN/pmc</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>[Signature]</i>	TITLE Administrator	(X6) DATE 12/22/15
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any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 253	Continued From page 1	F 253		
F 280 SS=D	<p>1</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review, the facility failed to ensure for 1 of 26 residents, Resident #205, had opportunities to participate in planning of care and treatment.</p>	F 280	<p>F280 D 483.20(d), (3), 483.10 (k)(2)</p> <ol style="list-style-type: none"> <li>1. Resident #205 was not negatively affected by the alleged deficient practice.</li> <li>2. Residents residing in the facility have the potential to be affected by the alleged deficient practice.</li> <li>3. Staff education will be provided to social service staff regarding requirements for documentation of care plan meeting held and invitation to resident/family.</li> <li>4. Random weekly auditing will be conducted by DNS or designee to evaluate the effectiveness of the plan.</li> <li>5. The results of the audit will be reported to the QAA committee monthly X3 months at which time the QAA committee will determine the frequency of further auditing.</li> <li>6. Corrective action will be complete by 1/2/16.</li> </ol> <p>F280 POC accepted 12/23/15 RTremblay/pmc</p>	

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F 280	Continued From page 2 Findings include:  Per record review on 12/2/15 at 9:30 AM, the facility did not provide evidence that Resident #205 or his/her family had been informed of quarterly care plan meetings. The quarterly Minimum Data Set (MDS) assessments were completed on 7/31/15 and 10/27/15 and per interview with the social worker at 9:35 AM, the care plan meetings are set up after the MDS is completed. S/he stated that the care plan date is set, the resident and the family are invited to attend and the method of notification for families is by them being called and the resident is verbally told. S/he further stated that there is a signature sheet for those in attendance and a social service progress note is written for each care plan meeting. At 9:45 AM the social worker confirmed that there is no evidence that the care plan meetings occurred and s/he is unable to locate any notes or a signature sheet for Resident #205.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review, the facility failed to provide services that meet professional standards of quality by not following a physician's order for obtaining vital signs for 1 of 26 residents, following the resident's readmission to the facility following a hospital stay (Resident #225). Findings include:	F 281	F281D 483.20(K)(3)(I)  1. Resident # 225 had no negative effects as a result of this alleged deficient practice. 2. Residents requiring monitoring of vital signs have the potential to be affected by this alleged deficient practice. 3. Process for monitoring vital signs reviewed and education provided to licensed nurses.	

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F 281	<p>Continued From page 3</p> <p>Per interview during a facility tour on 11/30/15 at 11:10 AM, Resident #225 reported that s/he does not get much attention from staff and no one checks his/her blood pressures. The resident reported concern that if s/he had another stroke it "would devastate me." Per record review, Resident #225 was readmitted to the facility on 11/4/15 following hospitalization for altered mental status in the setting of emesis and dehydration. S/he has diagnoses of hypertension and multiple strokes with hemiparesis and hemiplegia (muscular weakness and partial paralysis) along with other chronic medical conditions. Physician orders dated 11/4/15 at 14:04 stated, "Vital signs every shift x's 3 days then D/C."</p> <p>Per 12/2/15 at 2:53 PM medical record review, the 4th floor UM (Unit Manager) confirmed that the resident's vital signs (including blood pressure) were taken on 1 shift on 11/4/15; on 2 shifts on 11/5/14 (at 6:30 and 14:37) and on 2 shifts on 11/6/15. Per confirmation with the UM, the resident's vital signs were taken on 5 of the ordered 9 shifts. Later in the day, facility staff showed that Resident #225's physician had taken vital signs on 11/5/15 (there was no time written on the form to indicate if taken during next shift when due).</p>	F 281	<ol style="list-style-type: none"> <li>4. Random weekly audits will be conducted by the DNS or designee to monitor the effectiveness of the plan.</li> <li>5. The results of the audits will be reported to the QAA committee by the DNS or designee monthly x3 months at which time the QAA committee will determine further frequency of the audits.</li> <li>6. Corrective action to be complete by 1/2/16.</li> </ol> <p><i>F281 POC accepted 12/23/15 RTremblay RN/PMC</i></p>	
F 329 SS=D	<p><b>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b></p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of</p>	F 329	<p><b>F329D 483.25(I)</b></p> <ol style="list-style-type: none"> <li>1. Resident # 226 had no negative effects as a result of this alleged deficient practice.</li> <li>2. Residents receiving medication have the potential to be affected by this alleged deficient practice.</li> </ol>	

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F 329	<p>Continued From page 4</p> <p>adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview and record review, the facility failed to ensure that 1 of 6 residents' drug regimen was free from unnecessary drugs. (Resident #226) Findings include:</p> <p>During observation of medication pass on 12/2/15 at 9:14 AM, the Registered Nurse (RN) administered 2 scoops (4 tablespoons) of Metamucil, a psyllium based bulk forming natural fiber for restoring and maintaining regularity to Resident #226. During reconciliation of medications the medical record and the medication administration record indicates that the physician ordered Benefiber 2 scoops (which is equivalent to 4 tablespoons). Per label from the Benefiber, 2 scoops equal 4 tablespoons and</p>	F 329	<ol style="list-style-type: none"> <li>3. Education regarding the rights of medication provided to licensed nurses.</li> <li>4. Random weekly audits will be conducted by the DNS or designee to monitor the effectiveness of the plan.</li> <li>5. The results of the audits will be reported to the QAA committee by the DNS or designee monthly x3 months at which time the QAA committee will determine further frequency of the audits.</li> <li>6. Corrective action to be complete by 1/2/16.</li> </ol> <p><i>F329 POC accepted 12/23/15 RTremblay RJA/PMC</i></p>	

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F 329	Continued From page 5 per label from the Metamucil dosing should be no more than 2 tablespoons. The RN stated that there was no Benefiber on the medication cart and thought that Metamucil and Benefiber were the same. S/he also thought that 2 scoops were the equivalence of a medication cup filled twice. The medication cups are for liquid medications and are equivalent to 2 tablespoons. At 1:58 PM the RN confirmed that the medication that s/he administered and what the physician ordered were not the same and that s/he had administered more than the physioian had ordered.	F 329			
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS  The facility must assist residents in obtaining routine and 24-hour emergency dental care.  A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency	F 411	F411D 483.55(a)  1. Resident # 201 has seen the dentist and adamantly refuses dentures had no negative effects as a result of this alleged deficient practice. 2. Residents with no teeth have the potential to be affected by this alleged deficient practice. 3. Education provided to staff regarding requirements for dental services for those with dentition concerns. 4. Random weekly audits will be conducted by the DNS or designee to monitor the effectiveness of the plan. 5. The results of the audits will be reported to the QAA committee by the DNS or designee monthly x3 months at which time the QAA committee will determine further frequency of the audits.		

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F 411	Continued From page 6 dental services to meet the needs of 1 applicable residents (Resident # 201). Findings include:  Per observation on 11/30/15, Resident # 201 was edentulous (lacking teeth). There is no indication in the clinical record that the resident has been evaluated by a dentist since admission. Per the Registered dietician note on 9/11/14, the resident is at nutritional risk related to dysphagia, edentulous, difficulty feeding self, diuretic use and constipation. Per Interview with the Social Worker (SW), the resident has never had dentures or own teeth at facility. Both the Unit Manager and the SW stated that no one at the facility has asked the resident if he wants dentures. The UM and SW both confirmed resident has not seen a dentist while at facility.	F 411	6. Corrective action to be complete by 1/2/16.  <i>F411 POC accepted 12/23/15 RTremblay/pd/pme</i>	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT 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 record review and staff interview, the facility failed to assure that the consultant pharmacist reports any irregularities to the attending physician and Director of Nursing for 1	F 428 F428D	483.60(c)  1 Resident # 135 had no negative effects as a result of this alleged deficient practice. The resident's physician has added a diagnosis of depression to the problem list. 2 Residents receiving psychotropic medication have the potential to be affected by this alleged deficient practice. 3 Education provided to licensed nurses regarding requirements for appropriate diagnosis for medication use and requirement reviewed with the pharmacist consultant.	

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F 428	Continued From page 7 of 6 residents reviewed for unnecessary medications (Resident #135). Findings include:  Per 12/1-12/2/15 record review for Resident #135, there is no evidence an irregularity was identified and reported by the pharmacist to the Director of Nursing (DON) or physician regarding the indication for use of a psychotropic medication. On 10/23/15, Resident #135 was prescribed Prozac 10mg one time daily by mouth "related to a cognitive communication deficit." According to the manufacturer's indications for use, Prozac is indicated for acute and maintenance treatment of major depressive disorders; acute and maintenance treatment of obsessive compulsive disorders; acute and maintenance treatment of Bulimia Nervosa and acute treatment of panic disorders. Per record review, the pharmacist reviewed the resident's medications on 10/30/15 and checked "no apparent irregularities noted;" on 11/27/15, the pharmacist wrote "on Prozac" but did not note an irregularity. On 12/2/15 the 5th floor unit manager (UM) confirmed that the consultant pharmacist did not report the irregularity related to indication for the use of Prozac.	F 428	4 Random weekly audits will be conducted by the DNS or designee to monitor the effectiveness of the plan.  5 The results of the audits will be reported to the QAA committee by the DNS or designee monthly x3 months at which time the QAA committee will determine further frequency of the audits.  6 Corrective action to be complete by 1/2/16.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	F431D 483.60(b), (d), (e)  1 Residents had no negative effects as a result of this alleged deficient practice. The identified vials were immediately disposed of.  2 Residents newly admitted have the potential to be affected by this alleged deficient practice.	

*F428 POC accepted 12/23/15 RTremblay RN/pme*

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F 431	<p>Continued From page 8</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1978 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected:</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to properly label and store medications on 2 of 4 units. Findings include:</p> <p>1.) On 11/30/15, during observation and review of medication storage on Unit 3, there was one vial of Tuberculin purified derivative that had no date as to when it was opened. The Licensed Practical Nurse (LPN) confirmed at 12:39 PM that the vial was not dated and s/he was unsure when it were last used, but s/he stated that it has been quite a while.</p>	F 431	<p>3 Education provided to licensed nurses regarding requirements for labeling and storage of medications.</p> <p>4 Random weekly audits will be conducted by the DNS or designee to monitor the effectiveness of the plan.</p> <p>5 The results of the audits will be reported to the QAA committee by the DNS or designee monthly x3 months at which time the QAA committee will determine further frequency of the audits.</p> <p>6 Corrective action to be complete by 1/2/16.</p> <p><i>F431 POC accepted 12/23/15 RTremblay RA/pmc</i></p>	
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F 431	Continued From page 9	F 431			
F 441 SS=E	<p>2.) On Unit 5, at 1:07 PM, there was one vial of Tuberculin purified protein derivative that was opened on 10/5/15 and the LPN confirmed at the time of discovery that it was dated as being opened on 10/15/15 and that it should have been discarded by the middle of November. Per manufacturer's guidelines vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if</p>	F 441	<p>441E 483.65</p> <ol style="list-style-type: none"> <li>Residents # 47, #51, #95, #225, # 320 had no negative effects as a result of this alleged deficient practice.</li> <li>Residents residing in the facility have the potential to be affected by this alleged deficient practice.</li> <li>Education provided to staff regarding appropriate infection control procedures to prevent the spread of infection as it relates to linens, nebulizers, Foley catheter drainage bags, and medication administration.</li> <li>Random weekly audits will be conducted by the DNS or designee to monitor the effectiveness of the plan.</li> <li>The results of the audits will be reported to the QAA committee by the DNS or designee monthly x3 months at which time the QAA committee will determine further frequency of the audits.</li> </ol>		

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/02/2015
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NAME OF PROVIDER OR SUPPLIER  BURLINGTON HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 300 PEARL STREET BURLINGTON, VT 05401
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F 441

Continued From page 10  
direct contact will transmit the disease.  
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens  
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:  
Based on observation and staff interview, the facility failed to ensure infection control practices were followed surrounding administration of medications, storage of resident nebulzers for 4 residents, Resident #47, 51, 95 and 225, personal linen for Resident #47 and disposal of urinary drainage bag for Resident # 320.  
Findings include:  
1.) On 11/30/15 at 12:01 PM there was a urinary drainage bag observed lying in the bathroom bathtub for resident #320. The urinary drainage bag had over 200 cc of urine in it and it was uncapped and was not in a plastic bag. Per interview with the Licensed Practical Nurse (LPN) at 12:35 PM, the resident has the drainage bag removed and it is replaced with a leg bag. S/he stated that the urine is emptied out and then the drainage bag is capped and put in a plastic bag. At 4:00 PM, the Licensed Nursing Assistant stated that the urinary drainage bag is to be removed, emptied and the tip covered and then it is placed in a plastic bag. S/he confirmed that this had not happened with this resident's bag

F 441

6. Corrective action to be complete by 1/2/16.

*F441 POC accepted 12/23/15 Rivenbly RN/jmc*

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F 441	<p>Continued From page 11</p> <p>and that it should have been drained and a cap placed on it and that it should have been in a plastic bag.</p> <p>2.) On 12/1/15 at 8:27 AM it was observed that Resident #47 sleeps in a recliner in his/her room and covers with blankets. These blankets were observed lying on the floor behind and beside the recliner. The Resident stated that s/he places them there so s/he can reach them whenever they want them and that s/he does not have any other place to put them except on the floor. The resident also stated that they are only washed once a week when his/her son comes and takes them. The resident received his/her breakfast and assistance with care and at 10:12 AM the Registered Nurse (RN) confirmed that the blankets were on the floor.</p> <p>3.) During observation of medication administration on 12/1/15 at 9:23 AM, the RN used a 30 cc medication dosing cup to scoop ProSource protein supplement for Resident #320, s/he then put the dosing cup into the container of protein supplement and returned the container to the medication cart and then administered the supplement to the resident. The RN did not cleanse his/her hands prior to the preparation of the supplement, nor when scooping from the container. S/he confirmed at 9:35 AM that s/he did not use proper technique for scooping out the powder and that the container is multi-use for many residents and that it is the same scoop for all residents.</p> <p>4.) During interviews with Residents #47, 51 and 95 on 11/30/15 about 12 noon, it was observed that there were uncovered nebulizer mask set ups and there was a small amount of liquid in the</p>	F 441			

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F 441	<p>Continued From page 12</p> <p>reservoir for Resident #95. All of the set ups were on the night stands next to the beds along with other items including mouth wash, papers, towels and food. Observation of the nebulizers on 12/1/15 presented that the set ups were still uncovered and on the night stands. Per interview with the Licensed Practical Nurse (LPN) on 12/1, Resident #47 has nebulizer treatments four times a day and Resident #95 is as needed. Review of the facility policy titled administering Medications through a Small Volume (Handheld) Nebulizer, with the purpose statement: that the purpose of the statement is to safely and aseptically administer aerosolized particles of medication into the resident's airway. Steps in the procedure, #29 states that when equipment is completely dry, store in a plastic bag with the resident's name and the date on it. Per confirmation with the RN on 12/1 at 10:14 AM, at the time of administration of nebulizer to Resident 47, the nebulizer mask was not stored in plastic bag and it was sitting on the night stand. Per interview with the Unit Manager at 3:55 PM, s/he confirmed that the nebulizer masks had not been properly cleaned and stored after use as per the facility policy.</p> <p>5.) During a facility tour on 11/30/15 at 11:10 AM, a nebulizer mouthpiece and medication cup were observed uncovered on Resident # 225's bedside stand; also on the same stand was the nebulizer unit, an adult brief, napkins, mouthwash, a dopp kit and an unwrapped face mask. The resident reported that s/he receives nebulizer treatments as needed. On 12/2/15 at 1:51 PM, the Unit Manager (UM) confirmed that the nebulizer mouthpiece was stored uncovered on the resident's bedside stand at the start of the survey on 11/30/15 and that this was an infection control</p>	F 441		

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F 441	Continued From page 13 issue; s/he reported that the mouthpiece has since been thrown out.	F 441		