

Division of Licensing and Protection  
103 South Main Street, Ladd Hall  
Waterbury VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 241-2345  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 241-2358

January 12, 2011

David Silver, Administrator  
Newport Health Care Center  
148 Prouty Drive  
Newport, VT 05855

Provider ID #:475026

Dear Mr. Silver:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 15, 2010**.

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,



Pamela M. Cota, RN  
Licensing Chief

PC:jl

Enclosure



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

RECEIVED  
Division of

PRINTED: 12/28/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____  Licensing and Protection	JAN 10  <b>12/15/2010</b> (X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER  <b>NEWPORT HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>148 PROUTY DRIVE NEWPORT, VT 05855</b>
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F 000	INITIAL COMMENTS	F 000		
F 159 SS=B	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p>	F 159	<p>An interest bearing account separate from facility bank accounts and exclusively for patient fund balances over \$50.00 has been opened. All patient balances over \$50.00 have been transferred to this interest bearing account. Interest for this account will be allocated to each patient upon payment by the financial institution. The interest allocation will be based upon each patient's daily balance within the interest bearing account. This account will be administered using general accepted accounting principles and there will be no commingling of resident funds with facility funds.</p> <p>When a resident who receives Medicaid benefits has a combined interest bearing and non-interest bearing account balance within \$200.00 or less of the SSI resource limit the facility will issue written notification to the resident/responsible party that the resident may lose eligibility for Medicaid or SSI if the resident's total nonexempt resources exceed</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrator</b>	(X6) DATE <b>01/07/11</b>
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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 other 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 159	Continued From page 1 The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.  The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to assure that resident funds held by the facility were placed in an interest-bearing account. Findings include:  1. Per review of the Personal Funds account for residents on 12/14/10, the account set up with the bank is a non-interest bearing checking account. As of 12/15/10, there were 20 residents that had funds in excess of \$50.00 held by the facility. Per interview on 12/14/10 at 3:45 PM, the Office Managers confirmed that local banks would not set up an interest bearing account for a group of residents, only if they were separated into individual accounts, and they were not receiving any interest for the balances held.	F 159	<b>the SSI resource limit.</b>  <b>Administrator will monitor on a monthly basis.</b>	01/21/11
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		

*Accounted POC  
1/21/11  
J. Cummings*

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F 253	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based upon observation, interview, and record review the facility failed to provide housekeeping and maintenance services to maintain a sanitary and comfortable interior for 2 of 45 residents (Residents #6 and #36) and for 6 shared resident bathrooms (Bathrooms located between room numbers 2 &amp; 4, 7 &amp; 9, and 25 &amp; 27, 20 &amp; 22, 26 &amp; 28, and 30 &amp; 32). Findings include:</p> <p>1. Per observation on 12/14/10 at 9:28 AM of the the shared resident bathroom located between room numbers 25 &amp; 27, the toilet seat riser was soiled with dried feces, the wall behind the toilet was splattered with dried feces, the floor in front of the toilet was spotted with dried feces, a urinal placed on the back of the toilet seat was soiled with dry urine and was not labeled with a resident's name, and the wall switch plate was soiled. In addition, the baseboards in the bathroom were in disrepair and coming loose from the wall. Per record review, the Housekeeping Policies and Procedure states the cleaning schedule for bath and shower rooms on the East and West wings are to be cleaned daily. Per interview on 12/14/10 at 9:33 AM, the Assistant Director of Nursing (ADNS) confirmed the above observations.</p> <p>2. Per observation on 12/14/10 at 9:56 AM Resident #6's bedside commode was soiled with dried feces and not labeled with the resident's name. Per interview on 12/14/10 at 9:56 AM, the ADNS confirmed that Resident #6's bedside commode was soiled with dried feces and was not labeled with the resident's name.</p>	F 253	<p><b>1. The bathrooms have been cleaned and walls, floors and mouldings are being replaced or repaired as needed.</b></p> <p><b>2 &amp; 3. Bedside commodes have been cleaned and labeled with resident's names.</b></p> <p><b>4 &amp; 5. The bathrooms have been cleaned and any necessary repairs will be made.</b></p> <p><b>The housekeeping supervisor on a weekly basis will check and sign off in a log that the bathrooms are clean and in good repair.</b></p> <p><b>An in-service on proper cleaning and labeling of commodes will be held on 01/13/11.</b></p> <p><i>POC accepted 1/12/11 J. Cummings RW</i></p>	02/01/11

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F 253	Continued From page 3  3. Per observation on 12/14/10 at 9:56 AM, Resident #36's bedside commode was soiled around the inside rim with dried feces and was not labeled with the resident's name. Per interview on 12/14/10 at 9:56 AM, the ADNS confirmed that Resident #36's bedside commode was soiled with dried feces and was not labeled with the residents name.  4. Per observation on 12/14/10 at 9:24 AM, the toilet seat was soiled with dried feces in the bathroom shared by the residents in rooms 2 & 4. Additionally, tiles forming a border between the wall and floor were loose and broken. During an interview on 12/14/10 at 9:30 AM, the ADNS confirmed that the toilet seat was soiled with dried feces and the floor border tiles were broken away from the wall in the shared bathroom between rooms 2 & 4.  5. Per observation on 12/14/10 at 9:27 AM, the toilet bowl was soiled with dried feces in the bathroom shared by rooms 7 & 9. In an interview on 12/14/10 at 9:35 AM, the ADNS confirmed that the toilet bowl was soiled with dried feces in the bathroom shared by rooms 7 & 9.  6. Per observation on 12/14/10 at 2:00 PM, the walls and/or baseboards in the following shared bathrooms were scuffed and/or warped; bathrooms between rooms 20 & 22, 26 & 28, and 30 & 32. The ADNS confirmed the above observations at 2:00 PM on 12/14/10.	F 253		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be	F 280	1. The care plans for resident #3 and all residents with indwelling catheters have been revised to include the use of an indwelling catheter.	

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F 280	<p>Continued From page 4</p> <p>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 upon observation, interview, and record review, the facility failed to revise the plan of care for 4 of 12 residents in the Stage 2 sample (Residents # 3, # 51, #15, #25). Findings include:</p> <p>1. Per record review, the care plan for Resident #3 was not revised to include the use of an indwelling urinary (Foley) catheter. Per physician order, written on 10/13/10, "Reinsert Foley catheter and change every 30 days". Per interview on 12/15/10 at 9:14 AM, the Assistant Director of Nursing (ADNS) confirmed the care plan was not revised to include the use of an indwelling Foley catheter.</p> <p>2. Per record review, the care plan for Resident #51 was not revised to reflect a 10/1/10 physician</p>	F 280	<p>2. The care plan for resident #51 has been revised to include Foley catheter to continuous drainage, change Foley catheter monthly (see treatment book for when catheter is due to be changed again) and to change catheter bag weekly on Mondays. All residents who have catheters at this time have had their care plans revised to include the use of an indwelling catheter. Any current resident or new admission that receives an order for an indwelling catheter will have a care plan to reflect the use of an indwelling catheter.</p> <p>3. Resident care plan will include all recent falls and interventions. Riser alarm will be used at all times.</p> <p>4. Resident's care plans will include all recent falls. We have ordered a new mattress and rise alarm system.</p> <p>The DNS will monitor on a monthly basis. Q.A. will monitor on a random basis.</p> <p><i>4/12/11</i> <i>POC accepted J. Cummings RN</i></p>	02/01/11

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F 280	<p>Continued From page 5</p> <p>order for "Foley catheter to CD (continual drainage), change Foley catheter monthly due November 1st, and change catheter bag weekly on Mondays." Per interview on 12/15/10 at 8:48 AM, the ADNS confirmed the care plan was not revised to reflect the 10/1/10 physician order.</p> <p>3. Per record review for Resident #15, who is assessed to be at a high risk for falls, fell on 9/20/10 and 11/14/10 . A nursing note dated 9/20/10 indicated that Resident #15 was found on the floor and stated that s/he "bumped head". A nursing note dated 11/14/10 indicates that Resident #15 was found on the floor near his/her wheelchair and bed and the resident stated s/he hit his/her head. Per review on 12/14/10, the Resident's current care plan does not include these recent falls nor any new interventions to address these falls. Per interview on 12/15/10, the ADNS confirmed that the above falls were not documented as part of the current care plan, nor were any new interventions added to the care plan as a result of the falls.</p> <p>4. Per record review for Resident #25, who is assessed to be at high risk for falls, the resident fell on 8/28/10, 9/5/10, 11/7/10, and 12/2/10. Per review on 12/14/10, nursing notes dated 8/28/10 indicate that the Resident slid from the edge of the bed to the floor, and on 9/5/10 the Resident was found on the floor stating that s/he fell out of bed and hit the right side of the face/head. Mild bruising was noted. A nursing note dated 11/7/10 indicates that the Resident slid off the edge of the bed and sustained a skin tear. A nursing note dated 12/2/10 indicates that Resident #25 again slid from the bed to the floor. Per interview on 12/15/10, the ADNS confirmed that the above falls were not documented as part of the current</p>	F 280		

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F 280	Continued From page 6	F 280		
F 281 SS=D	<p>care plan, nor were any new interventions added to the care plan as a result of the falls.</p> <p><b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b></p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the nursing staff failed to follow professional standards of practice by not documenting the amount of insulin administered by a sliding scale range for 2 of 2 applicable residents (Residents #3, #39) Findings include:</p> <p>1. Per record review on 12/14/10 at 2:05 PM, Resident #3 has an order for a sliding scale range of insulin that is based on the Resident's blood glucose level. Per review of the Medication Administration Record (MAR), the glucose readings and the nurse's initials were recorded at the prescribed times, however there was no documentation as to the number of units of insulin administered to the resident at any of these times. Also, on 12/14/10 at 2:15 PM, upon reviewing Resident #39's MAR, who was identified by staff as another resident who had a sliding scale insulin regime, the documentation was incomplete with regards to the amount of units of insulin administered at each scheduled check. Per interview on 12/14/10 at 2:22 PM, the Assistant Director of Nursing confirmed that the documentation was incomplete as to the amount of insulin administered, and that the expectation was that nurses document the units given at the time of the administration. Refer also to F514.</p>	F 281	<p><b>1. The medication sheets for resident #3 and #38 have been revised to include documentation as to the number of units of insulin the resident receives per sliding scale. All residents with a sliding scale insulin will have the units documented on the medication sheet.</b></p> <p><b>Q.A. will monitor on a monthly basis.</b></p> <p><i>1/12/11 P.O.C. accepted L. Cummings</i></p>	02/01/11

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F 281	Continued From page 7	F 281		
F 315 SS=E	<p>Reference: Complete Guide to Documentation (2008). Wolters Kluwer Health / Lippincott Williams &amp; Wilkins (2nd ed.) Pg 4-5.</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon observation, interview, and record review, the facility failed to ensure that 3 of 3 residents with an indwelling Foley catheter had a valid medical justification for use documented in the resident's record (#1, # 3, #51). Findings include:</p> <p>1. Per record review on 12/15/10, there was no documentation concerning a valid medical justification for use of an indwelling urinary (Foley) catheter for Resident #3 . The Physician order written on 10/13/10 states "Reinsert Foley catheter and change every 30 days". On 12/15/10 at 9:09 AM, the Assistant Director of Nursing (ADNS) confirmed there was no documentation in the record concerning a valid medical justification for use of an indwelling urinary (Foley) catheter for Resident # 3.</p>	F 315	<p>1. M.D. was notified 01/04/11, to get medical documentation for the use of an indwelling catheter. Diagnosis for urinary retention was received 01/06/11. Medical Records Clerk updated computer records to include diagnosis of urinary retention. All residents with an indwelling catheter has updated documentation for use. Any new orders for catheters will have documentation for use. DNS will follow any new orders received for indwelling catheters that documentation is in place for the use of an indwelling catheter.</p> <p>2. M.D. was notified 01/04/11, to get medical documentation for the use of an indwelling catheter. An order was received to discontinue the catheter 01/05/11. The resident has refused to have his catheter removed, even after multiple discussions from nursing. This resident is on comfort care for a terminal illness. M.D. was updated on residents refusal to have catheter removed.</p> <p>3. History was obtained from residents records showing a</p>	

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F 315	Continued From page 8  2. Per record review on 12/15/10, there was no documentation concerning a valid medical justification for use of an indwelling urinary (Foley) catheter for Resident # 51. The Physician order written on 10/1/10 states "Foley catheter to CD (continual drainage), change Foley catheter monthly due November 1st, and change catheter bag weekly on Mondays." Per interview on 12/15/10 at 8:40 AM, the ADNS confirmed that there is no documentation in the record concerning a valid medical justification for use of an indwelling urinary (Foley) catheter for Resident # 51.  3. Per record review on 12/15/10, there was no documentation concerning a valid medical diagnosis to justify the insertion of an indwelling urinary (Foley) catheter for Resident #1. A medical order written on 1/21/04 includes "Foley catheter to CD (continual drainage), #16 Fr (French) 5 cc; change Foley monthly; change bag weekly on Sunday". Per interview at 9:30 AM on 12/15/10, the ADNS confirmed that there was no documentation in the medical record concerning a valid medical diagnosis which would justify the insertion of an indwelling urinary (Foley) catheter for Resident #1.	F 315	<b>problem with urinary retention/ neurogenic bladder. This history was sent to resident's M.D. on 01/05/11 and a diagnosis for neurogenic bladder/urinary retention was received. Medical Records Clerk has updated computer records. All residents with an indwelling catheter has updated documentation for the use of an indwelling catheter. DNS will follow any new order for an indwelling catheter to insure documentation is in place.</b>  <i>POC accepted 1/8/11 J. Cummins</i>	01/07/11
F 329 SS=D	<b>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b>  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 adverse consequences which indicate the dose should be reduced or discontinued; or any	F 329		

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F 329	<p>Continued From page 9 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 record review and confirmed through staff interviews, the facility failed to assure that 1 of 8 residents reviewed (Resident #13) was free from unnecessary drugs. Findings include:</p> <p>1. Per record review on 12/15/10, Resident #13 had allergies to Aspirin and NSAIDs listed in the MD orders. The resident also had medication orders for Ecotrin Aspirin 325 mg (milligrams) once daily, which the resident was receiving. Per interview at 9:25 AM on 12/15/10, the nurse passing medications acknowledged that the resident had an aspirin and NSAID allergy listed on the Med Administration Sheet, was taking Aspirin daily, and that they must not be allergic to the drug since they had been taking it for a long time. Per interview on 12/15/10 at 11:15 AM, the Assistant Director of Nursing confirmed that there was Aspirin and NSAID listed in the resident's</p>	F 329	<p>1. Resident #13's medical records have been updated and the allergy to ASA removed after verification by phone with the resident's M.D. on 12/15/10 that the resident had no allergies to ASA. All resident records are being reviewed for allergies and their records updated with M.D. and pharmacy. Medical Records Clerk will verify with M.D.'s regarding any allergies on any new admission. Pharmacy will address allergies on monthly reviews.</p> <p>DNS will monitor on admission and on a monthly basis.</p> <p>Pharmacy will monitor on a monthly basis.</p> <p><i>1/12/11 P.O. accepted J. Curran</i></p>	02/15/11

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F 329	Continued From page 10 allergies, that the resident was taking the Aspirin daily, and that nursing, the pharmacist doing the monthly reviews, nor the physician had addressed the irregularity in the chart. Per interview by telephone on 12/15/10 at 12:40 PM, the resident's physician confirmed that there was no allergy to Aspirin in the Resident's records, and that it was appropriate for them to be receiving this daily as ordered. Refer also to F428.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure the food in the snack refrigerator was properly labeled with date opened, resident name, and was discarded after three days per facility policy.  Per observation on 12/14/10 at 3:00 PM, the following food items in the snack refrigerator were observed to be either not dated when opened or not labeled with the resident name; one cup of custard was opened but not dated, one sport drink was opened but not dated, 2 bottles of sparkling flavored water were opened but not dated, one orange soda was opened but not	F 371	<b>All opened food and drinks that were not labeled with name and date that were opened were discarded on the day of survey 12/14/10. Dietary will check the regrigerator on a daily basis. All open containers that are not labeled with name, date or have been opened for three (3) days will be discarded.</b>  <b>Dietary supervisor will monitor weekly for compliance.</b>  <i>1/12/11 POC accepted J. Cummings</i>	01/15/11

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F 371	Continued From page 11 labeled with resident name and not dated when opened, one container of apple cider not dated when opened, and one bottle of maple syrup not dated when opened. In addition, there was one jar of four bean salad, which was opened on 9/12/10, approximately 3 months before the date of survey. The above observations were confirmed with the ADNS on 12/14/10 at 3:01 PM.  Per interview on 12/14/10 at 3:14 PM, the Food Services Supervisor confirmed that facility policy is to discard food three days after it has been opened. Per record review on 12/14/10, the facility policy for cleaning the refrigerator states "All foods must be used up with-in (3)days unless quick frozen".	F 371		
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 monthly pharmacy review did not identify an irregularity in the medication regime for 1 of 8 residents (Resident #13). Findings include:  1. Per record review on 12/15/10, Resident #13	F 428	Resident #13's medical records have been updated and the allergy to ASA removed after verification by phone with the resident's M.D. on 12/15/10, that the resident had no allergy to ASA. All resident medical records are being reviewed and allergies are being updated with the M.D. and pharmacy. Medical Records Clerk will verify with M.D. on any new admission regarding their allergies. Pharmacy will address allergies on his monthly reviews.  Q.A. will monitor on a random basis.	02/15/11  <i>1/12/11 POC accepted J. Curran</i>

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F 428	Continued From page 12 had an allergy to Aspirin listed in the Physician's orders, as well as an order to administer Ecotrin 325 mg daily. Per review of all the monthly pharmacy consults in the Resident's record, this was not identified as an irregularity in the medication regime. Per interview on 12/15/10 at 11:20 AM, the Assistant Director of Nursing confirmed that the discrepancy between the allergy listed and the resident's medications ordered had not been identified by the Pharmacist during the monthly review. Refer also to F329.	F 428		
F 431 SS=D	<b>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</b>  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.  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.  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.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431	<b>The outdated Novolog Regular Insulin was discarded on 12/14/10 and reordered. All opened insulins have been checked and are in compliance with the twenty eight (28) day recommendation. There will be an in-service for all nurses on 01/13/11, to discuss the discarding of opened insulin after twenty eight (28) days. A licensed nurse will monitor opened insulin weekly to insure the compliance to the twenty eight (28) day recommendation.</b>	<b>01/15/11</b>  <i>1/12/11 AUC accepted J. Cummings</i>

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F 431	Continued From page 13 Comprehensive Drug Abuse Prevention and Control Act of 1976 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.  This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to assure that medications were discarded after the expiration date. Findings include:  1. Per observation on 12/14/10 at 2:00 PM, the West wing medication cart contained a vial of Novolog Regular Insulin prescribed to Resident #3. The date opened was written on the bottle 11/13/10, and the scheduled discard date listed on the bottle as 12/11/10, 28 days after opening as per facility policy based on pharmacy recommendation. The resident's Medication Administration Record shows that the insulin was ordered twice per day based on a sliding scale, and that the resident had received the insulin for 3 days past the recommended discard date. Per interview on 12/14/10 at 2:00 PM, the nurse working on the wing confirmed that this was the only insulin currently in use for the resident, and that it was administered for 3 days past the discard date written on the bottle. Per interview on 12/14/10 at 2:15 PM, the Assistant Director of Nursing confirmed that it is the responsibility of the nurse administering the insulin to check the discard date on the bottle before each administration.	F 431		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

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F 441 SS=D	Continued From page 14 SPREAD, LINENS  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.  (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.  (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 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.	F 441	There will be an in-service on 01/13/11 to discuss blood glucose checks in regards to infection control. All residents that have blood glucose checks ordered will have it done in their room or another private place. DNS will make random checks at different meal times to monitor that blood glucose checks are not being done in the dining rooms.  <i>1/13/11 POC accepted J. Luning</i>	01/15/11

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F 441	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to assure that Infection Control practices were maintained during a blood glucose monitoring procedure for one resident (Resident #38). Findings include:  1. Per observation on 12/13/10 at 4:45 PM, Resident#38 was seated in the dining room at a table prior to the evening meal. The nurse proceeded to perform a blood glucose test by pricking the Resident's finger while their hand was positioned over the dining room table. Per interview immediately following the procedure at 4:50 PM, the nurse confirmed that the Resident's blood glucose monitoring test was performed in the dining room at the table. Per interview on 12/14/10 at 9:10 AM, the Assistant Director of Nursing confirmed that the facility policy was to check the blood glucose of residents in their room or other private place, and that it was contrary to Blood-Borne Pathogen Infection Control Practices to perform this test at a table where residents eat.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State;	F 514		

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F 514	<p>Continued From page 16 and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain complete clinical records that identify services provided regarding administration of insulin administered by a sliding scale range for 2 of 2 residents (Residents #3, #39) Findings include:</p> <p>1. Per record review on 12/14/10 at 2:05 PM, Resident #3 has an order for a sliding scale range of insulin that is based on the Resident's blood glucose level. Per review of the Medication Administration Record (MAR), the glucose readings and the nurse's initials were recorded at the prescribed times, however, there was no documentation as to the number of units of insulin administered to the resident at any of these times. Also, on 12/14/10 at 2:15 PM, upon reviewing Resident #39's MAR, who was identified by staff as another resident who had a sliding scale insulin regime, the documentation was incomplete with regards to the amount of units of insulin administered at each scheduled check. Per interview on 12/14/10 at 2:22 PM, the Assistant Director of Nursing confirmed that the documentation was incomplete as to the amount of insulin administered, and that the expectation was that nurses document the units given at the time of the administration. Refer also to F281.</p>	F 514	<p><b>The medication sheets on resident #3 and #39 have been revised to include documentation on the number of units of insulin the resident receives per sliding scale. The Medical Records Clerk has added units to the computer to insure that each month units will be on the medication sheets or for any new order for sliding scale. Licensed nurse/team leaders will check all new monthly medication sheets when they come out to insure insulin units are ordered and for any new orders for sliding scale insulins.</b></p> <p><b>Q.A. will do random checks every month.</b></p> <p><i>POC accepted 1/12/11 J. Curry MD</i></p>	02/01/11