



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
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

March 30, 2010

Saza Ahmad, Administrator
Redstone Villa
7 Forest Hill Drive
St Albans, VT 05478

Provider #: 475055

Dear Mr. Ahmad:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 5, 2010**. Please post this document in a prominent place in your facility.

We will 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,

Suzanne Leavitt, RN, MS
Licensing Chief

Enclosure



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

PRINTED: 03/19/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2010
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NAME OF PROVIDER OR SUPPLIER REDSTONE VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 7 FOREST HILL DRIVE ST ALBANS, VT 05478
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F 000	INITIAL COMMENTS An unannounced annual re-certification survey was conducted by the Division of Licensing & Protection on 3/3/10 - 3/5/10.	F 000	Redstone Villa, (the "Provider") submits this plan of correction, (POC), in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed through	F 164	The Provider submits this POC with the intention that it be inadmissible by any third party any civil or criminal action against the Provider or any employee, agent, officer, director or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings, that are relied upon to adversely influence or serve as a basis, in any way, for the selection and / or imposition of future remedies, or for any increase in future remedies, whether any such remedies are imposed by the Centers for Medicare and Medicaid Services ("CMS"), the State of Vermont or any other entity. Any changes to Provider Policy or Procedure should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceedings on that basis. 1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? No Residents were harmed by this alleged deficient practice. Nurse Unit Manager was re-educated regarding Resident Rights. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All Residents have the potential to be affected by this alleged deficient practice.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE ADMINISTRATOR (X5) DATE 03/26/2010

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 164	Continued From page 1 interview, the facility staff failed to assure accomodation for all residents during the administration of an injection to 1 resident in the targeted sample (Resident # 29) in the presence of 12 other residents, during an activity. 1. Per observation during a current events program involving 12 residents in the activity room on 3/4/10 at 9 AM, the Nurse Unit Manager (N.U.M.) came in the room and administered an insulin injection to Resident # 29 in the public setting. The N.U.M. had determined that Resident #29 wanted to receive the injection without moving into a private space, however the dozen other residents were not offered a choice and a number of the residents present had difficulty expressing their thoughts and preferences.	F 164	3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Re-education of Nursing staff on Residents Rights. 4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? Weekly Random audits of Nurses during procedures for compliance with resident rights for 3 months. Results to QA meeting x 90 days. 5. Include dates when a corrective action will be completed. DNS/designee will be responsible for compliance by 3/29/10. <i>DOC complete 3/29/10 B. Bone</i>	03/29/10
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview facility staff failed to assure that dignity and respect were afforded to all residents. Findings include: 1. Per observation on 3/5/10 at 9:50 AM, while seated in the front hall by the nurses station, the Nurse Surveyor overheard an escalating loud voice, using foul language, coming from the direction of the hall by the side exit/kitchen door area. Per interview the Nurse Surveyor	F 241	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? No residents were harmed by this alleged deficient practice. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by this deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The employee was disciplined according to facility code of conduct.	

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F 241	Continued From page 2 approached the two staff members standing in that area and asked what the loud swearing was about and who it was directed to. The staff member stated it pertained to a personal issue at home. During the time the incident occurred, there was a resident in close proximity, seated in a wheelchair by the stairway. Per interview on the afternoon of 3/5/10, the Administrator stated this was not acceptable behavior.	F 241	4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? The District Manager will review employee performance and conduct and will report to Administrator during the weekly visit. 5. Include dates when a corrective action will be completed. District Manager will monitor for ongoing compliance 03/29/10 <i>PDC unpto 3/29/10 B. Home</i>
F 278 SS=B	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? No residents were harmed by this alleged deficient practice. Resident #6,25,29,31,32, and 36 had their MDS reviewed, signed by the appropriate professionals, and printed. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All Resident MDS were audited for compliance. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? MDS Coordinator was re-educated on the need to review, have signed, and print the MDS. 4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? MDS will be audited in conjunction with Care Plan Calendar weekly. Results will be reviewed at QA meeting. 5. Include dates when a corrective action will be completed. DNS/designee will be responsible for compliance by 3/29/10. 03/29/10 <i>PDC unpto 3/29/10 B. Home</i>



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F 278 Continued From page 3

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to assure nursing reviewed and signed comprehensive assessments for 6 of 15 residents in the targeted sample. (Residents # 6, #25, #29, #31, # 32, #36) Findings include:

1. Per record review, the MDS assessments completed in October of 2009 for Residents # 6 and # 32 were not signed as reviewed and complete by the Registered Nurse (R.N.) as required. Per interview on the morning of 3/5/10, the MDS Nurse confirmed during interview these assessments were not reviewed and signed.

2. Per record review, the MDS assessments for Resident #29 (Admission Assessment done 12/7/09), Resident #25 (Quarterly review done 12/21/09), and Resident #36 (Admission Assessment and 2 Medicare required : 5 day, 30 day) were not signed as reviewed and complete by the Registered Nurse or other departments involved in the assessment process as required. Per interview on 3/5/10 at 11:10 AM, the MDS nurse confirmed that the assessments for theses residents were not printed and signed.

3. Per record review, Resident #31's Quarterly MDS assessment, dated 12/17/09, was lacking an RN signature certifying the completeness of the assessment, as well as signatures of all other professionals who participated in the assessment process. This was confirmed by the MDS Coordinator during interview on the afternoon of 3/5/10.

F 279 483.20(d), 483.20(k)(1) DEVELOP

F 278

F 279

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F 279 SS=D	Continued From page 4 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 interview and record review the facility failed to develop a comprehensive care plan that addressed all identified issues and needs for 1 of 15 applicable residents in the targeted sample. (Resident #31). Findings include: Per record review Resident #31, who was identified through the comprehensive admission assessment, with a history of bleeding gums had a care plan that did not address the resident's oral/dental needs. A nurse's note, dated the day of admission on 9/4/09, stated "Hx (history) of	F 279	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident # 31 was not harmed by this deficient practice. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by this alleged deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? MDS and Care Plan coordinator was re-educated on the process for completion of care plans. 4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? RAPS when appropriate will be audited weekly in conjunction with care plans. 5. Include dates when a corrective action will be completed. DNS/designee will be responsible for compliance by 3/29/10. <i>DOC unpt 3/29/10</i> <i>B Bone 185</i>	03/29/10

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F 279	Continued From page 5 gums bleeding uses Orajel." A physician order, also dated 9/4/09, directed staff to administer Orajel every shift prn (as needed). In addition, the comprehensive assessment, dated 9/18/09, identified the resident with bleeding gums secondary to an inability to perform ADLs (Activities of Daily Living). The note further stated that the issue was addressed on the care plan and that the resident would have teeth brushed twice a day and mouth care as needed. During interview, at 2:00 PM on 3/5/10, the nurse Unit Manager stated s/he was aware of the resident's history of oral issues, that the resident's family member had discussed concerns regarding the resident's dental/oral care at care plan meetings and confirmed that the care plan did not address the issue.	F 279		
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 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. 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.	F 280	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice. Care Plan was updated for Resident # 32 with PT recommendation. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents are at risk with this alleged deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Therapy and Care plan Coordinator will be reeducated on process for updating care plans. 4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? Therapy recommendations will be audited 2 times a week for 3 months. Results will be reviewed at QA.	

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F 280	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to revise a care plan for 1 of 15 residents in the targeted sample. (Resident # 32) Findings include: 1. Per record review Resident #32's care plan failed to be revised with Physical Therapy (P.T.) reconditions made on 1/15/10. On 1/10/10 nursing requested a P.T. screen for Resident # 32. On 1/15/10 P.T. evaluated the resident for worsening ambulation and made recommendations that included "2 assist during periods of fatigue or use of a wheelchair." Resident #32's care plan was not revised to include these recommendations. Per interview at 11:15 AM on 3/5/10 the P.T. stated it was nursing staffs responsibility to update the nursing care plan with the recommendations after a P.T. screen was completed.	F 280	5. Include dates when a corrective action will be completed. DNS/designee will be responsible for compliance by 3/29/10. <i>Doc unpt 3/29/10</i> <i>B Home / St</i>	03/29/10
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 observations, record review, and staff interview, the facility failed to provide services in accordance with physician orders and professional standards of nursing practice for two residents in the applicable sample (Residents #18 and #45). Findings include:	F 281	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident # 45 and #18 were not harmed by this alleged deficient practice. Resident # 45 received their medication at 2:56PM on 3/4/10. Resident # 18 can take medications whole in pudding and allergy was addressed with attending Physician.	

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F 281	Continued From page 7 1. Per observation of med pass at 8:00 AM on 3/4/10 the nurse failed to administer a physician ordered medication to Resident #45. Per record review a physician order, dated 3/3/10, stated to administer Xifaxan (an antibiotic) 200 mg (2 tabs) 400 mg po TID (three times a day). Per review of the MAR the medication was to be administered at 8:00 AM, 2:00 PM and 8:00 PM. The medication nurse stated, at that time, that the drug had not been given then, nor had the resident received the 8:00 PM dose on the evening of 3/3/10, because it was not available in the facility. During a subsequent interview, that afternoon at 3:00 PM, the medication nurse stated that the 2:00 PM dose of Xifaxan had also not been administered, again, because the drug was still not available in the facility. Despite the fact that the resident had missed 3 doses of the medication the physician was not notified of the unavailability of the drug until the afternoon of 3/3/10 when the surveyor intervened and informed the nurse Unit Manager of the issue. The Unit Manager, who stated that it is the facility policy to notify the physician if a medication is not available, immediately contacted the physician and received an order to administer the medication when it became available. Per record review a Memo to all Licensed Nurses, dated 4/7/09, stated; "2) If a medication is not available the Pharmacy is to be notified we need the med ASAP. If it will not be delivered within the 1 hour before or 1 hour after, the MD is to be notified and an order is to be received to give med when available or get an order for an alternative med we have available....." In addition, per record review on the morning and	F 281	2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents receiving medications and time released medications have the potential to be affected by this alleged deficient practice. Residents with allergies to medications have the potential to be affected by this alleged deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Nurse was re-educated and written warning given on availability of medications. Nurses were re-educated on procedure for unavailable meds, crushing of meds, and allergies. 4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? Random audits of medication pass will be completed 2 times per week for 3 months. Results will be reviewed at QA meeting. 5. Include dates when a corrective action will be completed. DNS/designee will be responsible for compliance by 3/29/10. <i>POC complete 3/29/10</i> <i>B Kme 18</i>	03/29/10

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F 281	<p>Continued From page 8</p> <p>afternoon of 3/5/10 the 8:00 AM and 2:00 PM doses of Xifaxan had not been given. During interview, at 2:55 PM on 3/5/10, the medication nurse stated that the 2 doses had not been given because the medication was still not available. Per interview, at 3:10 PM on that date, the Unit Manager stated that the medication had arrived at the facility on the evening of 3/4/10 and retrieved it from the medication cart where it had been stored. The medication nurse stated that s/he was not aware the medication was available.</p> <p>During interview, on the afternoon of 3/5/10, the DNS confirmed that the medication was not given in accordance with physician orders and that staff had failed to follow facility policy to notify the MD of the unavailability of the medication.</p> <p>2. During a medication pass observation on 3/05/10 at 2:20 PM, and despite the fact that the MAR stated "Do Not Crush", the nurse crushed a tablet of Carbidopa/Levodopa 50/200 mg. SR, along with other medications that were to be given to Resident #18. Although the physician orders include "May Crush Meds", there was no clarification about crushing the sustained release Carbidopa/ Levodopa. The nurse giving the medication stated that she always crushes this tablet with the others as the resident is unable to swallow whole pills. Per interview on 3/5/10 at 4:15 PM, the charge nurse confirmed that the resident will take the med whole in pudding or applesauce, and it was her expectation that the nurses would not crush this medication without a specific order from the physician to do so.</p> <p>3. Per record review, the Facility failed to clarify a physician order for Resident #18, to administer a medication the resident had been identified as</p>	F 281		

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F 281	Continued From page 9 being allergic to. The most recent physician order directed staff to administer Lorazepam (a benzodiazepine) 0.75 ml (1.5 mg) PO twice a day at 12 PM and Bedtime. There was no evidence that nursing staff clarified with the physician that Lorazepam should be administered, despite that the MAR (Medication Administration Record) identified the resident as being allergic to benzodiazepines. Per interview on 3/5/10 at 8:25 AM, the DNS verified that the facility failed to clarify if Resident #18 should receive Lorazepam 1.5 mg with an allergy to benzodiazepine identified on the MAR, and that the resident did receive Lorazepam 0.75 ml (1.5mg) at 12 PM and Bedtime on 3/1, 3/2, and 3/3/10.	F 281		
F 286 SS=B	Reference: Nettina, S.M., (2006), Lippincott Manual of Nursing Practice, 8th Edition, p 18, Lippincott, Williams & Wilkins, Philadelphia 483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain resident assessments completed within the previous 15 months in the resident's record for 4 of 15 residents in the sample. (#25, #29, #31 and #36). Findings include:	F 286	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? No residents were harmed by this alleged deficient practice. Residents #25, 29, 31, and 36 have MDS available for 15 months where applicable. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? Audit of MDS book to ensure 15 months as applicable are available. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? MDS Coordinator was re-educated on requirement of 15 months availability of MDS.	

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

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F 286	Continued From page 10 1. Per record review, the MDS assessments for Resident #29 (Admission Assessment done 12/7/09), Resident #25 (Quarterly review done 12/21/09), and Resident #36 (Admission Assessment and 2 Medicare required : 5 day, 30 day) were not available in the record. Per interview on 3/5/10 at 11:10 AM, the MDS nurse confirmed that the assessments for these residents were not previously printed and signed and were not available in the resident's active record. 2. Per record review, on the afternoon of 3/5/10, Resident #31's most recent MDS assessment, dated 12/17/09, was not readily available for review in the resident's medical record. During interview, on the afternoon of 3/5/10, the MDS Coordinator confirmed that the MDS assessment had not been printed and made available until requested by the surveyor at that time.	F 286	4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? MDS will be audited per care plan schedule weekly. 5. Include dates when a corrective action will be completed. DNS/designee will be responsible for compliance by 3/29/10. <i>POC aupt 3/29/10</i> <i>B Stone</i>	03/29/10
F 371 SS=D	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 and confirmed through staff interview, the facility failed to assure that frozen foods were stored under sanitary	F 371	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this deficient practice. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? Freezer will be inspected weekly and during food delivery and usage based on dietary standard practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Freezer was immediately emptied out and all unwrapped/unlabeled food discarded. Freezer was then reorganized so that all food will be taken from the right side, and new stock put in on the left using the First in First out Method. All staff was inserviced on the proper handling, storage and rotation of frozen foods.	

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F 371	Continued From page 11 conditions. Findings include: Per observation during the initial kitchen tour, on 3/3/10 at 10:30 AM, both freezers located in the basement area and used for storage of resident foods contained improperly sealed foods that were undated including; a bag of breaded chicken, two large bags of broccoli and a package of toaster waffles. Per interview on 3/3/10 at 10:35 AM, the Food Service Supervisor and the District Manager of Food Service confirmed that these frozen packages of food were undated and not properly sealed.	F 371	4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? District Manager will inspect freezer weekly to make sure that these practices continue to be followed. 5. Include dates when a corrective action will be completed. District Manager will monitor for ongoing compliance <i>POC unmt 3/29/10</i> <i>B Done [Signature]</i>	03/29/10
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced	F 425	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident #45 was not harmed by this deficient practice. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents receiving medications have the potential to be affected by this alleged deficient practice. Re-educated Nurse and written warning given on availability of medications. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Nurse re-educated and written warning given on availability of medications. Nurses were re-educated on procedure for availability of medications. 4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? Random med pass audits will be completed 2 times per week for 3 months. Results to QA meeting. 5. Include dates when a corrective action will be completed. DNS/designee will be responsible for compliance by 3/29/10. <i>POC unmt 3/29/10</i>	03/29/10

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 425	Continued From page 12 by: Based on observation, staff interview and record review the facility failed to assure that physician ordered medications were available or that the physician was notified if medications were not available for 1 patient in the applicable sample. (Resident #45). Findings include: 1. Per observation of med pass at 8:00 AM on 3/4/10 the nurse failed to administer a physician ordered medication to Resident #45. Per record review a physician order, dated 3/3/10, stated to administer Xifaxan (an antibiotic) 200 mg (2 tabs) 400 mg po TID (three times a day). Per review of the MAR the medication was to be administered at 8:00 AM, 2:00 PM and 8:00 PM. The medication nurse stated, at that time, that the drug had not been given then, nor had the resident received the 8:00 PM dose on the evening of 3/3/10, because it was not available in the facility. During a subsequent interview, that afternoon at 3:00 PM, the medication nurse stated that the 2:00 PM dose of Xifaxan had also not been administered, again, because the drug was still not available in the facility. Despite the fact that the resident had missed 3 doses of the medication the physician was not notified of the unavailability of the drug until the afternoon of 3/3/10 when the surveyor intervened and informed the nurse Unit Manager of the issue. The Unit Manager stated that it is the facility policy to notify the physician if a medication is not available, immediately contacted the physician and received an order to administer the medication when it became available. Per record review a Memo to all Licensed Nurses, dated 4/7/09, stated; "2) If a medication is not available the Pharmacy is to be notified we need	F 425			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 425	Continued From page 13 the med ASAP. If it will not be delivered within the 1 hour before or 1 hour after, the MD is to be notified and an order is to be received to give med when available or get an order for an alternative med we have available....." During interview, on the afternoon of 3/5/10, the DNS confirmed that the medication was not given in accordance with physician orders and that staff had failed to follow facility policy to notify the MD of the unavailability of the medication.	F 425		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT 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.	F 441	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? Residents #29 and 36 were not harmed by this deficient practice. Resident # 29 receives injections with nurses wearing gloves. Staff is following infection control guidelines for resident #36. LNA was re-educated on hand washing procedure. Signage was posted on Residents room doors. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by this alleged deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Staff will be re-educated on infection control guidelines. 4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? Random audits of handwashing and injections per infection control guidelines 2 times per week for 3 months. Signage will be monitored on unit rounds. Results to QA meeting. 5. Include dates when a corrective action will be completed. DNS/designee will be responsible for compliance. 03/29/10 by 3/29/10. <i>PDE amount 3/24/10</i> <i>B. Jones 18</i>	

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F 441	<p>Continued From page 14</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview facility staff failed to assure infection control practices were maintained for 2 residents in the total sample. (Resident #29 and #36) Findings include:</p> <ol style="list-style-type: none"> 1. Per observation on 3/3/10 at 11:20 AM, the N.U.M. (Nurse Unit Manager) gave a subcutaneous injection to Resident #29 without wearing gloves. On 3/3/10 at 11:45 AM, the N.U.M. confirmed that s/he had not put on gloves before administering the injection. 2. Per observation at 9 AM on 3/4/2010, during a current events activity held in the activity room with 12 residents present, the N.U.M. came into the room and administered an injection to Resident # 29 without first donning gloves. During a meeting with the Infection Control team on 3/4/10 at approximately 5:30 PM, the Director of Nursing Service (D.N.S.) stated there is an expectation that gloves will be worn during the administration of injections. Per review on the afternoon of 3/4/10 the facilities policies state that gloves will be worn when having direct contact with non-intact skin. This was confirmed by the 	F 441	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	<p>Continued From page 15 DNS on the afternoon of 3/4/10.</p> <p>3. Per observation during the days of survey, there was no signage on rooms identifying the need for Isolation practices for those residents with infectious conditions. Per interview on the afternoon of 3/4/10, during a meeting with the Infection Control Committee, the Nurse Unit Manager (N.U.M.) stated the facility did not use Isolation signage for residents with infectious diseases; rather used Universal Precautions for all residents. The N.U.M. informed the surveyors that the staff informed visitors of isolation procedures when they entered the facility and stated there was a note on the front door, directing visitors to check in at the nurses station. Per observation during the 3 days of survey, there was no note on the front door making this request and surveyors observed numerous visitors enter the facility without first checking in at the desk. Per interview of the Admissions Director on the morning of 3/5/10 stated, "we like for visitors to check in at the front desk, but it doesn't always happen and there is no process in place to assure it will." Per review of the facilities Isolation policy and procedure, and confirmed by the DNS during the Infection Control meeting on 3/4/10, there is an expectation that facility staff will adhere to this policy and utilize signage identifying residents on Isolation.</p> <p>4. On 3/5/10 at 11:55 AM, Resident #36, who has an active contagious infection, was observed sitting in a recliner in their room with a jigsaw puzzle on the bedside table next to the chair. The LNA brought in a lunch tray and set it down on another table while clearing the puzzle pieces off the resident's table with ungloved hands. The</p>	F 441			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	Continued From page 16 LNA then set up the resident's meal, uncovering items. The LNA then exited the room without sanitizing or washing hands, walked downstairs to the kitchen, and waited for the next tray to be handed out. The LNA did not wash or sanitize his/her hands until the surveyor intervened. On 3/5/10 at 12:00 noon, the LNA confirmed that s/he had left the room without cleaning or sanitizing hands, and was about to deliver another meal to a different resident.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain a safe, sanitary and comfortable environment for all residents. Findings include: Per observation during an initial tour of the facility on the morning of 3/3/10 and a tour of the environment on the morning of 3/5/10, accompanied by the Director of Maintenance, the following observations were made: 1. The floor carpeting was bucked in the middle of the foyer area as well as in the hall just outside the tub room creating a potential risk hazard for tripping. 2. There were loose and/or broken metal threshold plates, creating potential trip hazards,	F 465	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? No residents were harmed by this alleged deficient practice. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? Ambulatory residents will potentially be affected by this alleged finding. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? All the problems were corrected upon completion of survey. 4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? Weekly environmental/safety round will be conducted and environmental concern will be addressed by Maintenance. 5. Include dates when a corrective action will be completed. Director of Maintenance will monitor for ongoing compliance. <i>POC unit</i> <i>Bonnie Van 1/8</i>	03/24/10

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F 465	<p>Continued From page 17</p> <p>in the doorway leading from the foyer into the dining room; in the hallway outside the nurse's station leading toward rooms #5-7; in the hallway leading towards rooms #8-11; and in the entryways to rooms #11 and #12. In addition, there was no threshold plate at the entryway to room #14 creating a 1.5 inch floor elevation and trip hazard.</p> <p>3. There was a broken tile in the hearthstone in front of the fireplace located in the foyer on the first floor and a broken floor tile in the door entryway to room #10.</p> <p>4. There were aerosol cans of Betco air freshener accessible to residents stored in the resident bathrooms in hall 1 and 2 as well as in the bathroom of room #10.</p> <p>The loose and/or broken threshold plates in the doorway between the foyer and the dining room as well as in the hallway leading toward rooms #8-11 were repaired on the morning and afternoon of 3/3/10. All observations were confirmed by the Director of Maintenance at the time of tour on the morning of 3/5/10.</p>	F 465			