

Division of Licensing and Protection
103 South Main Street, Ladd Hall
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

November 11, 2014

Mr. John Danforth, Administrator
Redstone Villa
7 Forest Hill Drive
St Albans, VT 05478-1615

Dear Mr. Danforth:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 15, 2014**. Please post this document in a prominent place in your facility.

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

Sincerely,



Pamela M. Cota, RN
Licensing Chief

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

PRINTED: 10/29/2014
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 C 10/15/2014
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS An unannounced onsite recertification survey and a complaint investigation was conducted on 10/13/14 through 10/15/14 by the Division of Licensing and Protection. The findings include the following: 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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to assure that housekeeping services maintained a sanitary interior for 2 of 3 portable privacy curtains. The findings include the following: Per interview on 10/14/14 at approximately 2:15 PM, with a Licensed Nursing Assistant (LNA), s/he was questioned how personal care is provided to residents in rooms without hanging privacy curtains. LNA identified that portable privacy curtains which are located on each floor are utilized to provide privacy during personal care to residents. Per inspection of the portable privacy curtain on the first floor on 10/13/2014 numerous stains of yellow/brown dried liquid was noted over various locations on the vinyl covering. LNA confirms at this time that Housekeeping is responsible for cleaning of the portable privacy curtains. Per interview with the Housekeeping Supervisor	F 000	F253 HOUSEKEEPING & MAINTENANCE SERVICES 1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? All 3 portable privacy curtains were cleaned and sanitized on 10/15/14. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? Residents who have portable privacy screens are at risk 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? Re education of Housekeeping/Laundry staff on routine cleaning and disinfecting of portable privacy screens and re education of LNAS on cleaning privacy screens by 11/15/14. 4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? Executive Director/Designee will audit portable privacy screens 3X per week for 3 months. Results will be reviewed at the quarterly QA meeting. 5. Include dates when a corrective action will be completed. Executive Director will be responsible for monitoring to assure compliance with POC and regulatory requirements by 11/15/14.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 10/20/14
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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.

SCANNED

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F 253	Continued From page 1 on the morning of 10/15/2014, confirmation is made that the Housekeeping Department does not clean the portable privacy curtains. Per inspection of the 2 portable privacy curtains on the 2nd floor, confirmation is made by the Housekeeping Supervisor that one of the 2 portable privacy curtains also has numerous stains of yellow/brown dried liquid over various locations on the vinyl covering. Per interview and observation with the Nursing Home Administrator on the morning of 10/15/2014 confirmation is made that 2 of the 3 portable privacy curtains are stained and unsanitary.	F 253	F253 POC accepted 11/10/14 MDeVitrani RN / PML	
F 278 SS=D	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	F 278	<u>F 278</u> <u>ASSESSMENT/ACCURACY/COORDINATION/CERTIFIED</u> <u>D</u> <u>1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</u> Resident #16 Comprehensive Assessments were modified for 8/4/14, 8/14/14, 8/17/14 on 10/16/14. <u>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?</u> Residents requiring MDS assessments are at risk by this alleged deficient practice. <u>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</u> Re education by the MDS Regional Manager to the MDS coordinator on accuracy of coding was done on 10/16/14.	

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F 278	<p>Continued From page 2 penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure that the comprehensive assessment accurately reflected resident status for 1 resident (R#16) in a Stage 2 sample of 13 who has a pressure ulcer. Findings include:</p> <p>Per record review, Resident #16 was coded in Pressure Ulcer assessments beginning on 8/1/14 until now as having a Stage III area of her coccyx. In MDS (Minimum Data Set - a comprehensive assessment tool) assessments conducted on 8/4, 8/14 and 8/17/14 each assessment coded the Pressure ulcer as a Stage II. Per observation of the every other day dressing change to the pressure ulcer at 2:10 PM on 10/13/14, the resident has a Stage III Pressure Ulcer with undermining on her coccyx. In a staff interview on 10/14/14 at 2:30 PM the Director of Nursing Services (DNS) confirmed that the MDS assessments coded the Stage III Pressure Ulcer as a Stage II.</p>	F 278	<p>4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? MDS Regional Manager/Designee will do random audits of MDS'S weekly for 3 months. Results will be reviewed at quarterly QA meeting.</p> <p>5. Include dates when a corrective action will be completed. Executive Director will be responsible for monitoring to assure compliance with POC and regulatory requirements by 11/15/14.</p> <p>F278 POC accepted 11/10/14 MB/AVANK/NML</p>
F 279 SS=G	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care</p>	F 279	

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F 279	<p>Continued From page 3</p> <p>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.</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to develop, review and revise the comprehensive care plan for 2 of 13 residents (Resident #16 and Resident #41) in the applicable sample. The findings include the following:</p> <ol style="list-style-type: none"> Per staff interview on 10/13/14, Resident #16 has a Stage 3 Pressure Ulcer. Per observation at 2:10 PM on 10/13/14, Resident #16 has a Stage 3 Pressure Ulcer with undermining. Undermining is the destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the skin surface. In a review of the Minimum Data Set (MDS) assessments, the resident was admitted with no pressure ulcers. In an MDS assessment dated 7/24/14 is the first noted Stage 2 Pressure Ulcer. Additional MDS assessments dated 8/4, 8/14, and 8/17/2014 all note a Stage 2 Pressure 	F 279	<p><u>F279 DEVELOP COMPREHENSIVE CARE PLANS</u></p> <p><u>1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</u> Resident #16 Comprehensive care plan for pressure ulcer was reviewed and updated on 10/16/14. Resident #41 care plan for comfort care was updated on 10/14/14. Resident #41 died on 10/14/14.</p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?</u> Resident who are at risk for pressure ulcer development or have pressure ulcers and comfort care orders are at risk by this alleged deficient practice.</p> <p><u>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</u> Re education of all Licensed Nurses and Care plan coordinator on care plan development and revisions will be done by 11/15/14.</p> <p><u>4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</u> DNS/Designee will audit care plans 3X per week for 3 months. Results will be reviewed at the quarterly QA meeting.</p> <p><u>5. Include dates when a corrective action will be completed.</u> DNS will be responsible for monitoring to assure compliance with POC and regulatory requirements by 11/15/14.</p>		

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F 279	<p>Continued From page 4 Ulcer.</p> <p>In a review of assessments, the resident was admitted on 3/21/14 with no pressure ulcers. On 5/7/14 the Comprehensive Nursing Assessment reveals a Stage 1 Pressure Ulcer of the Sacrum. In a paper Pressure Ulcer Record dated 7/17/14, a Stage 2 Pressure Ulcer measuring 4x4 centimeter (cm.) was noted. On 8/1/14 the Pressure Ulcer Record notes a Stage 3 Pressure Ulcer is present and on other skin assessments dated 8/6/14 through 9/18/14 the Pressure Ulcer is recorded as a Stage 3 Pressure Ulcer varying in size from 4x4 cm. to 2.5 x 1.5 cm.</p> <p>In a review of the record the initial comprehensive plan of care did not contain any preventative measures specific to pressure ulcer prevention. On 4/15/14 a reddened area is noted on the care plan and a hydrocolloid dressing placed over the coccyx to be changed every 72 hours. No other interventions specific to pressure ulcer prevention were initiated in the plan of care until the Stage 2 ulcer is noted on 7/17/14 when wound care and an air mattress were initiated. On the Risk factors in the pressure ulcer record initiated 7/17/14 Multiple Sclerosis, Immobility, Poor PO (oral) intake of food and fluids, Resistive to care, Refusal to stay in side lying position are all listed as risk factors.</p> <p>After the Pressure Ulcer was determined to be a Stage 3, the intervention of repositioning every hour and use of a wedge for pressure relief were added as interventions. In an interview on 10/15/14 at 2:45 PM the Director of Nursing Services (DNS) confirmed that new interventions were added to the care plan in response to an increase in the Stage and Size of the pressure</p>	F 279	F279 POC accepted 10/10/14 M. Bertrand RN/PMC		

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F 279	Continued From page 5 ulcer rather than as an initial preventative care plan 2. Per medical record review on 10/14/14 at approximately 3:30 PM, Resident #41 was admitted on 6/10/14 with diagnoses to include Muscle Weakness, Anxiety Disorder, Anaplastic Large Cell Lymphoma Nodes with multiple sites, Hypertension, Thyroid Disorder, Hyperlipidemia and Post Traumatic Stress Disorder. Per Physician orders dated 10/10/14, they direct staff to begin comfort care, discontinue all medications administered by mouth (PO), with the exception of Seroquel as tolerated, to continue fluids as tolerated, administer Ativan Intensol 2 milligrams (mg), 1 mg PO every 2 hours as needed (PRN) for anxiety and/or all hunger and administer Morphine Intensol 20 mg PO every 2 hours PRN for pain and/or respiratory distress. Per interview with the Regional Director of Quality Improvement at approximately 3:30 PM on 10/14/2014 confirmation is made that there is no evidence that the Interdisciplinary Care Plan includes a written plan of care for comfort as prescribed by the physician.	F 279			
F 281 SS=E	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 record review and staff interview, the facility failed to assure that nurses both received and followed valid physician's medical orders for	F 281	<u>F281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</u> <u>1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</u> Resident # 54 received the doses of IV medication, ordered thru 10/17/14. Resident #54 timing of administration was audited and was infused for the proper time thru last dose on 10/17/14. Resident # 8 order obtained and transcribed for oxygen use on 10/14/14.		

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F 281	<p>Continued From page 6</p> <p>2 of 13 residents (Residents #54 and #8). Findings include:</p> <p>1. Per medical record review, Resident #54 was admitted to Redstone Villa from Fletcher Allen Healthcare (FAHC) on 10/3/14 with a primary diagnosis of a respiratory infection. Resident #54 required intravenous (IV) administration of antibiotics for 14 days to treat the infection. During an interview on 10/14/14 at 10:15 AM, the order for additional ordered doses (for three times daily, every 8 hours, over 14 days) was faxed to the CAP Pharmacy. The DNS further related that the pharmacy mistakenly delivered the medication (next due to be given at 12 midnight and 8:00 AM of 10/4/14) to the Revera facility in Rochester, NH. Upon review of the Medication Administration Record (MAR), the Registered Nurse (RN) confirmed that the circled "N/A" for the midnight dose of ceftazidime for 10/4/14 meant that the dose had not been administered. The 8:00 AM dose had been signed off as administered. The RN also showed the pharmacy label to this surveyor. The label stated, "infuse 2 gm (50 mL) over 30 min. at 100 mL/h q8h x 14 d" [2 grams in 50 mL over 30 min. at pump rate of 100 milliliters per hour for 14 days] On 10/14/14 at 3:25 PM, Resident #54 confirmed during an interview with this surveyor that the midnight dose of his/her medication had been missed on the first night after admission.</p> <p>In addition, at 7:36 AM on 10/15/14, Resident #54 stated to this surveyor that last night's midnight antibiotic dose had infused over approximately 10 minutes rather than the usual 30 minutes. The resident was visibly distressed. At approximately 7:40 AM, the surveyor interviewed the LPN (Licensed Practical Nurse) who stated that for the</p>	F 281	<p><u>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?</u> Residents who receive medications and Oxygen are at risk by this alleged deficient practice.</p> <p><u>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</u> Re-in servicing licensed nurses on IV administration, medications not available protocol, and oxygen administration will be done by 11/15/14. Re education of IV administration and IV pump use will be done on a as needed basis.</p> <p><u>4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</u> DNS/Designee will audit 3X per week on IV administration and 3X per week on oxygen administration, and audit 3X per week on meds not available protocol for 3 months. Results will be reviewed at quarterly QA meeting.</p> <p><u>5. Include dates when a corrective action will be completed.</u> DNS will be responsible for monitoring to assure compliance with POC and regulatory requirements by 11/15/14.</p> <p>FBI POC accepted 11/10/14 M. Bertrand RN/PMC</p>	

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F 281	<p>Continued From page 7</p> <p>midnight dose last night, everything seemed fine except that the antibiotic had infused in about 15 minutes [rather than 30 min.]. At 1:15 PM on 10/15/14, the DNS confirmed that, after their internal investigation, it was determined that the LPN had twice primed the intravenous equipment and in an effort to clear air bubbles from the tubing had lost more of the total liquid (50 mL) than usual. Mechanical problems with the pump had been ruled out. There was no evidence of harm to the resident and the physician did not voice concern over the shorter infusion time.</p> <p>Reference: Lippincott Manual of Nursing Practice (9th ed.), Wolters Kluwer Health/Lippincott Williams & Wilkins.</p> <p>2. Per record review on 10/14/14, Resident #8 was re-admitted to the facility on 8/22/14 with diagnoses that included COPD (Chronic Obstructive Pulmonary Disease, a chronic respiratory condition), Congestive Heart Failure, Atrial Fibrillation and other chronic medical conditions. Per observation, on 10/14/14 the resident was receiving oxygen per nasal cannula and reported use as needed for shortness of breath. Per review of the physician orders, there was no order for oxygen, by liters, route (mask or nasal cannula) or frequency for the period 9/14-10/31/14. The above was confirmed by the DNS (Director of Nursing) on 10/14/14 at 10:54 AM. S/he reported that the oxygen order had been missed during reconciliation. The facility completed a physician order for the oxygen at the time of the survey. Per review of the facility policy, Oxygen Administration, under the heading,</p>	F 281		

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F 281 F 314 SS=G	<p>Continued From page 8 . Preparation, states "1. Verify that there is a physician's order for this procedure..."</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews the facility failed to assure that one resident (Resident #16) in a Stage 2 sample of 13 received the necessary treatment and services to prevent the development and worsening of a Pressure Ulcer. Findings include:</p> <p>Per staff interview on 10/13/14 Resident #16 has a Stage 3 Pressure Ulcer. Per observation at 2:10 PM on 10/13/14 Resident #16 has a Stage 3 Pressure Ulcer with undermining. Undermining is the destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the skin surface. In a review of the Minimum Data Set (MDS) assessments, the resident was admitted with no pressure ulcers. In an MDS assessment dated 7/24/14 is the first noted Stage 2 Pressure Ulcer. Additional MDS assessments dated 8/4, 8/14/ and 8/17/2014 all note a Stage 2</p>	F 281 F 314	<p><u>F314 Treatment /svcs to prevent/heel pressure sores</u></p> <p><u>1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</u> Resident pressure sore was evaluated on 10/15/14 by Plastic Surgery at FAH and care plan was updated after visit.</p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?</u> Residents who have the potential for pressure ulcer development or with pressure sores are at risk by this alleged deficient practice.</p> <p><u>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</u> Re education of Licensed Nurses on the pressure ulcer care and prevention by 11/15/14.</p> <p><u>4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</u> DNS/Designee conduct audits at minimum of 3X per week to monitor effectiveness of the plan for 3 months. Results will be reviewed at the quarterly QA meeting.</p> <p><u>5. Include dates when a corrective action will be completed.</u> DNS will be responsible for monitoring to assure compliance with POC and regulatory requirements by 11/15/14..</p>	

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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 C 10/15/2014
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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 314

Continued From page 9
Pressure Ulcer.

In a review of assessments, the resident was admitted on 3/21/14 with no pressure ulcers. On 5/7/14 the Comprehensive Nursing Assessment reveals a Stage 1 Pressure Ulcer of the Sacrum. In a paper Pressure Ulcer Record dated 7/17/14, a Stage 2 Pressure Ulcer measuring 4x4 centimeters (cm.) was noted. On 8/1/14 the Pressure Ulcer Record notes a Stage 3 Pressure Ulcer is present and on other skin assessments dated 8/6/14 through 9/18/14 the Pressure Ulcer is recorded as a Stage 3 Pressure Ulcer varying in size from 4x4 cm. to 2.5 cm x 1.5 cm.

In a review of the record, the initial comprehensive plan of care did not contain any preventative measures specific to pressure ulcer prevention. On 4/15/14 a reddened area is noted on the care plan and a hydrocolloid dressing placed over the coccyx to be changed every 72 hours. No other interventions specific to pressure ulcer prevention were initiated in the plan of care until the Stage 2 ulcer is noted on 7/17/14 when wound care and an air mattress were initiated. On the Risk factors in the pressure ulcer record initiated 7/17/14 Multiple Sclerosis, Immobility, Poor PO (oral) intake of food and fluids, Resistant to care, Refusal to stay in side lying position are all listed as risk factors.

After the Pressure Ulcer was determined to be a Stage 3 the interventions of repositioning every hour and use of a wedge for pressure relief were added. In an interview on 10/15/14 at 2:46 PM the Director of Nursing Service (DNS) confirmed that new interventions were added to the care plan in response to an increase in the stage and size of the pressure ulcer rather than as an initial

F 314

F314 POC accepted 11/10/14 M. Bertrand RN/PRN

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F 314	Continued From page 10 preventative care plan. In staff interviews on 10/13/14 at 2:10 PM the Charge Nurse stated that the resident had not seen a wound nurse, but that s/he had spoken with a representative of 3M (a wound care supply company) who is a wound specialist. She confirmed that the wound specialist had never seen Resident #16's pressure ulcer. In an interview on the afternoon of 10/13/14 the DNS stated that the resident had been seen by the Therapist who is a Certified Wound Specialist and that the Therapist would be in the facility the following day. In an interview on 10/14/14 at 12:45 PM the Occupational Therapist stated that s/he had been trained in Lymphedema care which included wounds. S/he stated that this led to her/his interest in wounds. S/he has worked with several wound nurses and taken some training but is not a Certified Wound Specialist and has not done training specific to pressure ulcers. S/he further stated that s/he has not seen or treated Resident #16's Pressure Ulcer or consulted with nursing staff about the ulcer.	F 314		
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS In record review on 10/15/14, the Licensed Nurse Aide (LNA) Electronic Activities of Daily Living (ADL) record, evidences 31 instances where the turn and reposition care area for each shift was not initialed as being done. In an interview on 10/16/14 at 12:30 PM, the DNS stated that the Electronic flowsheet reflects the standard turning every 2 hours and that there are no special flow sheets for residents who are turned more frequently.	F 328		

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F 328	Continued From page 11 The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328	<p>F328 TREATMENT/CARE FOR SPECIAL NEEDS</p> <p><u>1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</u> Resident # 54 received the ordered IV medication doses thru 10/17/14. Resident # 54 IV medication was instilled for the recommended time thru 10/17/14.</p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?</u> Residents receiving IV medication or fluids are at risk by this alleged deficient practice.</p> <p><u>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</u> Re-in servicing licensed nurses on Meds available protocols and IV administration will be done by 11/15/14.</p> <p><u>4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</u> DNS/Designee will audit IV administration and medication available 3X per week for 3 months. Results will be reviewed at quarterly QA meeting.</p> <p><u>5. Include dates when a corrective action will be completed.</u> DNS will be responsible for monitoring to assure compliance with POC and regulatory requirements by 11/15/14</p>	
	This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to assure that one of 13 residents (Resident #54) in the sample received proper treatment and care for parenteral fluids (Intravenous infusion of fluid with antibiotic). Findings include: 1. Per medical record review, Resident #54 was admitted to Redstone Villa from Fletcher Allen Healthcare (FAHC) on 10/3/14 with a primary diagnosis of a respiratory infection. Resident #54 required intravenous (IV) administration of antibiotics for 14 days to treat the infection. During an interview on 10/14/14 at 10:15 AM, the order for additional ordered doses (for three times daily, every 8 hours, over 14 days) was faxed to the CAP Pharmacy. The DNS further related that the pharmacy mistakenly delivered the medication (next due to be given at 12 midnight and 8:00 AM of 10/4/14) to the Revera facility in Rochester, NH. Upon review of the Medication Administration Record (MAR), the Registered Nurse (RN) confirmed that the circled "N/A" for the midnight dose of ceftazidime for 10/4/14			

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F 328	Continued From page 12 meant that the dose had not been administered. The 8:00 AM dose had been signed off as administered. The RN also showed the pharmacy label to this surveyor. The label stated, "Infuse 2 gm (50 mL) over 30 min. at 100 mL/h q8h x 14 d" [2 grams in 50 mL over 30 min. at pump rate of 100 milliliters per hour for 14 days] On 10/14/14 at 3:25 PM, Resident #54 confirmed during an interview with this surveyor that the midnight dose of his/her medication had been missed on the first night after admission. In addition, at 7:36 AM on 10/15/14, Resident #54 stated to this surveyor that last night's midnight antibiotic dose had infused over approximately 10 minutes rather than the usual 30 minutes. The resident was visibly distressed. At approximately 7:40 AM, the surveyor interviewed the LPN (Licensed Practical Nurse) who stated that for the midnight dose last night, everything seemed fine except that the antibiotic had infused in about 15 minutes [rather than 30 min.]. At 1:15 PM on 10/15/14, the DNS confirmed that, after their internal investigation, it was determined that the LPN had twice primed the intravenous equipment and in an effort to clear air bubbles from the tubing had lost more of the total liquid (50 mL) than usual. Mechanical problems with the pump had been ruled out. There was no evidence of harm to the resident and the physician did not voice concern over the shorter infusion time.	F 328	F328 POC accepted 11/16/14 MBeitrand RNP/PMC	
F 425 SS=D	489.60(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	F 425		

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F 425	<p>Continued From page 13</p> <p>unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of 1 of 13 residents (Resident #54) in the applicable sample. Findings include:</p> <p>1. Per medical record review, Resident #54 was admitted to Redstone Villa from Fletcher Allen Healthcare (FAHC) on 10/3/14 with a primary diagnosis of a respiratory infection. Resident #54 required intravenous administration of antibiotics for 14 days to treat the infection. During an interview on 10/14/14 at 10:15 AM, the Director of Nursing Services (DNS) stated that the first ordered dose of ceftazidime (an antibiotic medication), due to be administered intravenously at 4:00 PM on 10/3/14, had been provided by</p>	F 425	<p>F425 PHARMACEUTICAL SVC- ACCURATE PROCEDURES< RPH</p> <p><u>1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</u> Pharmacy was contacted on 11/4/14 on IV med not delivered timely. Resident received medication doses ordered thru 10/17/14.</p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?</u> Residents receiving medications are at risk by this alleged deficient practice.</p> <p><u>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</u> Re education of all Licensed Nurses on medication available protocol by 11/15/14.</p> <p><u>4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</u> DNS/Designee will audit 3X per week meds available protocol for 3 months. Results will be reviewed at the quarterly QA meeting.</p> <p><u>5. Include dates when a corrective action will be completed.</u> DNS will be responsible for monitoring to assure compliance with POC and regulatory requirements by 11/15/14.</p> <p>F425 POC accepted 11/10/14 M. Barreira R. P. M.</p>	

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F 425	Continued From page 14 FANC. The order for additional ordered doses (for three times daily, every 8 hours, over 14 days) was faxed to the CAP Pharmacy. The DNS further related that the pharmacy mistakenly delivered the medication (next due to be given at 12 midnight and 8:00 AM of 10/4/14) to the Revera facility in Rochester, NH, and was thus not given at midnight. Per the DNS, the dose of intravenous antibiotic due at 8:00 AM on 10/4/14 had been obtained that same morning from Northwestern Medical Center and was administered, then the CAP Pharmacy delivery for subsequent doses. Upon review of the Medication Administration Record (MAR) at 10:40 AM on 10/14/14, the Registered Nurse (RN) confirmed that the circled "N/A" for the midnight dose of ceftazidime for 10/4/14 meant that the dose had not been administered.	F 425		