

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

April 28, 2015

Mr. Marc Hunter, Administrator
Rutland Healthcare And Rehabilitation Center
46 Nichols Street
Rutland, VT 05701-3275

Dear Mr. Hunter:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 11, 2015**. Please post this document in a prominent place in your facility.

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

Sincerely,



Pamela M. Cota, RN
Licensing Chief

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2015
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NAME OF PROVIDER OR SUPPLIER RUTLAND HEALTHCARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 46 NICHOLS STREET RUTLAND, VT 05701
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID 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 on-site re-certification survey was conducted, in conjunction with complaint investigations from 3/9 - 3/11/15, by the Division of Licensing and Protection. There were findings surrounding the re-certification survey.	F 000	The filing of this plan of correction does not constitute an admission of the allegations set forth in the statement of deficiencies. The plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to provide medically related social services for 1 of 23 applicable residents in the Stage 2 sample, Resident #96. The findings include the following: Per medical record review on 3/11/15 at 11:06 AM, progress notes identify that the resident's spouse expired on 2/16/15. Per interview with the Social Services staff confirmation is made that there have been no services provided to Resident #96 to assist with coping with the death of his/her spouse and the resident's inability to be discharged back to the community.	F 250	F-250 Resident #96 the care plan was Updated to identify coping with death of spouse resulting in the inability to discharge back to the community and subsequent medically related support was established with social service. Other residents who experience loss of Spouse have the potential to be affected by the alleged deficient practice. No other residents were negatively impacted by the alleged deficient practice. An audit of residents has been Conducted to ensure that anyone experiencing recent loss of spouse will receive medically related support.	
F 253 SS=D	(See F 309) 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Marc A. Hunter</i>	TITLE ADMINISTRATOR	(X6) DATE 3-30-2015
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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.

F250 - F441 POC accepted 4/11/15 BB/ACU/PML

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F 253	<p>Continued From page 1</p> <p>maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based upon observation and interview, the facility failed to ensure that all resident areas are maintained in good repair, and failed to store resident care equipment in a manner to maintain an orderly living environment. Findings include:</p> <p>1). Per observation on 3/11/15 at 10:00 A.M. an approximately 2 foot section of wallpaper in the archway of facility's 3rd floor North unit was noted to be peeling away vertically from the frame, exposing plaster and dried glue. On the reverse side of the archway, an approximately 1 foot section was peeling away from the wall horizontally. Additionally, there were multiple bubbles in the wallpaper on both sides of the archway where the wallpaper was separating from the wall. Per interview with Maintenance staff on 3/11/15 at 10:10 A.M. the staff member confirmed the condition of the wallpaper on the archway and confirmed that the condition had not been noted or scheduled for repair by the Maintenance department.</p> <p>2). Per observation during the 3 days of the re-certification survey, multiple pieces of resident equipment including wheel chairs, walkers, and patient lifts were observed stored in the 1st floor hallway. Per observation on 3/11/15 at 8:08 A.M. 9 wheelchairs, a lift, and a walker were located on the right side of the 1st floor residents' hallway. Per interview on 3/11/15 at 2:16 P.M. a nurse on the 1st floor confirmed the same equipment had not been used and/or moved that day, with some</p>	F 253	<p>Social service staff will be re-educated on the importance of providing medically related support to attain or maintain the highest practicable well-being of each resident.</p> <p>Administrator or designee will conduct weekly audits x3 to ensure compliance and then monthly x3 with results to be reviewed at QA meeting for further review and recommendations. Date of compliance: 4/8/2015</p> <p>F253 No resident was affected. The wall and wall paper have been repaired. Extra wheel chairs and equipment have been relocated.</p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>An audit of the facility to ensure all Resident areas are in good repair and Maintaining an orderly environment has been conducted.</p>

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F 253	<p>Continued From page 2</p> <p>of the equipment no longer needed for treatment of current residents. Per interview with the Maintenance Director on 3/11/15 at 9:30 A.M., the director confirmed that resident equipment is stored on the right side of the hallway on a regular basis.</p> <p>F 279 483.20(d), 483.20(k)(1) DEVELOP SS=D 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 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 staff interviews and record review, the facility failed to assure that comprehensive care plans were developed for residents with dialysis needs or urinary incontinence for 3 of 23 residents in the Stage 2 sample, Resident #21,</p>	F 253	<p>Maintenance staff will be re-educated on the importance of ensuring all resident areas are in good repair and maintaining an orderly environment.</p> <p>Administrator or designee will conduct weekly audits to ensure compliance x3 weeks and then monthly x3 with results to be reviewed at QA meeting for further review and recommendations. Date of compliance: 4/8/2015</p> <p>F279</p> <p>Resident # 136 died on hospice prior to survey. Resident #21 had diet orders clarified and a care plan was initiated. Resident # 150 has had a care plan developed to address incontinence care needs.</p> <p>Other residents that require dialysis</p>	

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F 279	<p>Continued From page 3 #136 and #150. Findings include:</p> <p>1. Per record review on 03/11/15 Resident #136 failed to have a care plan for urinary incontinence. Resident #136 was admitted on 10/06/14 and an assessment for urinary incontinence was conducted on 10/10/14, which directs staff to conduct a three day continence management diary and complete Urine Incontinent Nursing Intervention. In addition, the admission MDS (minimum data set) and subsequent CAA (Care Area Assessment) was triggered to initiate a care plan but was not found. Per interview on 03/11/14 at 11:20 AM the DNS confirmed a care plan for incontinence was not developed.</p> <p>2. Per record review, Resident #21 is on hemodialysis. S/he has Dialysis 3 times a week for End Stage Renal Disease (ESRD). There is no care plan in the record for nutrition. In an interview with the Registered Dietician (RD) on 3/11/15 at 10:20 am s/he stated that the resident did not "trigger" for a nutrition care plan. S/he stated that if there had been a care plan for nutrition it would not contain specifics of the diet but would simply direct staff to look at the Medication Administration Record (MAR) which would state what diet the resident is on. S/he also stated that this would happen only if the pharmacy has carried it over onto the new MAR, which does not always happen. S/he also stated that LNA's can find specifics of the diet on the meal tray slip.</p> <p>In a review of the meal tray slip it states that the resident is on a Consistent Carb, No Added Salt</p>	F 279	<p>or have incontinence have the potential to be affected by the alleged deficient practice. No other residents were negatively impacted by the alleged deficient practice.</p> <p>An audit of residents with dialysis has been conducted to ensure they have a comprehensive nutrition care plan and residents that experience incontinence have been audited to they have a comprehensive care plan in place to address their incontinence care needs.</p> <p>Nursing staff will be re-educated on the importance of developing a comprehensive care plan that helps the resident attain the highest practicable physical, mental and psychosocial well-being of each resident.</p> <p>DNS or designee will conduct weekly audits x3 to ensure compliance and then monthly x3 with results to be reviewed at QA meeting for further review and recommendations. Date of compliance: 4/8/2015</p>

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F 279 Continued From page 4

diet with 1500 ml Fluids. The restrictions that would be on a renal diet, such as orange juice, spinach, bananas are listed under dislikes and the RD states that is where any dietary restrictions would be listed (as a dislike not a restriction).

In a review of the MAR for March and the most recent signed Physician's Orders for February, signed 2/5/15, the order states "Consistent Carb, Renal Liberalized Diet" and "1L Fluid Restriction". The RD confirmed, in interview on 3/11/15 at 10:45 am, that the MD order states as above. The order does include a liberalized renal diet and does not include a no added salt diet. In an interview on 3/11/15 at 12:10 pm the Unit Manager confirmed that the Physician's order does not match the tray ticket, which states what diet is being provided. S/he stated that the resident was receiving the diet listed on the tray ticket.

3. On 3/10/15 at 2:57 PM, during record review for Resident #150, it was noted that s/he sustained a fall on 1/25/15 that resulted in a fracture, which required hospitalization for surgical repair. Per interview with the Licensed Nursing Assistant (LNA) at this time, the resident was continent prior to the fracture and since return, there has been a cognitive decline and s/he has had more frequent periods of incontinence. The LNA stated that Resident #150 will request to use the toilet, but is frequently incontinent at the time of the request, the LNA also stated that at times the resident denies the need to toilet and that s/he is not wet, but upon

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F 279	Continued From page 5 checking by staff, there is a need for an incontinence change. During interview with the Registered Nurse (RN), on 3/11/15 at 8:23 AM, Resident #150 had a urinary incontinence evaluation done on 2/2/15 that indicates the resident is incontinent. The RN also confirmed that prior to the hospitalization, the resident had intermittent episodes of urinary incontinence and there was no care plan. Further confirmation at this time, from the RN, was that the urinary incontinence had increased and that there was no care plan developed to include his/her urinary incontinence	F 279	
F 280 SS=0	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	F280 Resident # 96 - The care plan was revised to reflect behavior resolved and the discharge planning care plan has been resolved. Resident #130 has had a care plan revision to reflect current weight loss. Resident # 33 has had a revision in care plan to reflect current physician orders to obtain and monitor weight per new physician order.

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F 280	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to ensure that care plans were revised to reflect current status for 3 of 23 applicable residents in the Stage 2 sample. Resident # 96, #130 and Resident #33. The findings include the following: 1. Per medical record review on 3/11/15 at approximately 10 AM, Interdisciplinary Care Plan identifies a focus of physical aggression for Resident #96 as evidenced by hitting her/his spouse dated 12/15/14. The care plan also has a focus of the desire of Resident #96, to return to the community for s/he is at the facility for a short stay rehabilitation plan. Per medical record review of the Minimum Data Set (MDS) dated 12/26/15, Section E0200 evidences that the resident has physical behavioral symptoms directed towards others that occurred 1-3 days a week. Per behavioral monitoring forms there have been no episodes for Resident #96, hitting his/her spouse for the past 3 months. The resident's spouse died on 2/16/15. Per interview with Social Services and the Unit Manager (UM), on 3/11/15 at 11:06 AM, confirmation is made that there is no current plan for discharge since the death of the spouse and there have been no signs of physical aggression since his/her death. 2. Per medical record review on 3/10/15 at 3:21 PM, Nutritional Assessment dated 12/30/14 completed by the Registered Dietician (RD), identifies that Resident #130 has had a weight	F 280	Other residents that require care plan revision to reflect current status have the potential to be affected by the alleged deficient practice. No other residents were negatively impacted by the alleged deficient practice. An audit of residents with resolved behavior has been conducted to ensure they have a care plan revision to reflect their current behavior. Residents that experience weight loss have been audited to ensure they have a revision of care plan to address their care needs related to weight loss. Nursing staff will be re-educated on the importance of revising a care plan to accurately reflect the needs of each resident. DNS or designec will conduct weekly audits x3 to ensure compliance and then monthly x3 with results to be reviewed at QA meeting for further review and recommendations. Date of compliance: 4/8/2015

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F 280 Continued From page 7

loss of 9 pounds over the past 6 months. Initiatives to manage undesired weight loss are to change milk to whole and add extra margarine on trays. Encourage snacks during the day. Monitor effectiveness and weight status. Minimum Data Set (MDS) identifies on 12/27/14 that the resident requires set up help only for meals and has a weight of 127 pounds. Per review of the Interdisciplinary Care Plan dated 12/30/14 identifies a focus of nutritional concern due to varied intake with downward weight trend. Interventions to manage the focus is to notify physician and dietician of any significant weight loss/gain and to monitor changes in nutritional status (changes in intake, ability to feed self, unplanned weight loss/gain).

Per medical record review on 3/10/15, Resident #130 weighs 136 pounds on 6/11/14 and on 1/4/15 resident weighs 121 pounds which is a 15 pound weight loss in 7 months. There is no documented evidence for weights for the months of September, October and November 2014 and February 2015.

Per interview with the UM on 3/10/15 at approximately 4:15 PM, confirmation is made that the care plan has not been revised to reflect the current unplanned weight loss.

3. Record review of Resident #33 on 3/11 /15 at approximately 10 AM, presented that resident has diagnosis of Adult Failure to Thrive and has a physician order to weigh twice a week (Monday and Friday), dated and signed 2/4/15. Diet ordered is for a Dysphagia advanced with

F 280

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F 280 Continued From page 8
beverages in cup with cover and no straw, soup in mug and no oatmeal. The Registered Nurse (RN) confirmed at this time that the physician orders were for Resident #33 to be weighed twice a week.
Care plan written on 10/30/14 to address weights and revised on 1/22/15 to include resident is a nutritional concern due to history of varied intake with weight decline. There is no further revision to include the need for weights to be obtained. Per the Licensed Practical Nurse, the Medication Administration Record is where the revision of the weights needing to be done twice a week is written, but the Licensed Nursing Assistants are aware because they are told by the nurse that the weight needs to be done. The RN confirmed at this time that there is no evidence of the care plan being revised to reflect the current status of Resident #33 regarding the need to obtain and monitor weights twice a week.

F 280

F 281
SS=D 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, and record reviews the facility failed to assure that all services provided for 3 of 23 residents (Residents #21, #33 and #132) in the Stage 2 survey met professional standards of quality. Findings include:

F 281

F281

Resident # 132 – An order for therapy to evaluate and treat was obtained and initiated.
Resident #21 A physician order was

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F 281	<p>Continued From page 9</p> <p>Per an orthopedic evaluation note dated 01/22/15 at 11:30 AM states for the plan as "cortisone injection today into left knee continue PT for left knee and bilateral shoulder f/u PRN [follow up as needed]." Per interview the physical therapist on 03/10/15 at 3:41 PM stated "the process is that the nurse writes the orders and then we follow up, I never got the order." Per interview with the nurse at that time, confirmed that the resident did not receive PT services "because the nurse never wrote a verbal order for it".</p> <p>Also see F-282 and F-310</p> <p>2. Per record review resident #21 is on hemodialysis. S/he has Dialysis 3 times a week for End Stage Renal Disease (ESRD). The facility failed to follow physician's orders in regards to the resident's diet. In a review of the meal tray slip it states that the resident is on a Consistent Carb, No Added Salt diet with 1500 ml Fluids. The restrictions that would be on a renal diet, such as orange juice, spinach, bananas are listed under dislikes and the Registered Dietician states that is where any dietary restrictions would be listed (as a dislike not a restriction). In a review of the MAR (Medication Administration Record) for March and the most recent signed Physician's Orders for February, signed 2/5/15, the order states "Consistent Carb, Renal Liberalized Diet" and "1L Fluid Restriction". The RD confirmed, in interview on 3/11/15 at 10:45 am, that the MD order states as above. The order does include a liberalized renal diet and does not include a no added salt</p>	F 281	<p>obtained and meal slip compared to ensure service provided meets professional standards.</p> <p>Resident # 33 a weight was obtained and orders for weights have been clarified with the physician.</p> <p>Other residents that require orders for consultation with therapy and have specific orders for weights have the potential to be affected by the alleged deficient practice.</p> <p>No other residents were negatively impacted by the alleged deficient practice.</p> <p>An audit of residents with orders to Consult with therapy has been conducted to ensure that services were initiated.</p> <p>An audit of diet orders compared to meal slip has been completed to ensure the correct diet is provided as ordered.</p> <p>Residents with specific orders for weights will be audited to ensure weights are obtained and monitored as ordered.</p> <p>Nursing staff will be re-educated on the importance of providing services to meet the professional standards of quality to meet the needs of each resident.</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2015
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NAME OF PROVIDER OR SUPPLIER RUTLAND HEALTHCARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 46 NICHOLS STREET RUTLAND, VT 05701
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
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F 281 Continued From page 10
diet. When asked why the renal diet may have been discontinued the RD stated that it is difficult for dietary staff to coordinate the restrictions of both a Diabetic and a renal diet and that may have been the reason for discontinuing one. In an interview on 3/11/15 at 11:10 am the Unit Manager confirmed that the diet and fluid restriction currently ordered by the Physician are not being followed.

3. Record review of Resident #33 on 3/11/15 at approximately 10 AM presented that resident has diagnosis of Adult Failure to Thrive and has a physician order to weigh twice a week (Monday and Friday), dated and signed 2/4/15. Diet ordered is for a Dysphagia advanced with beverages in cup with cover and no straw, soup in mug and no oatmeal. The Registered Nurse (RN) confirmed at this time that the physician orders were for Resident #33 to be weighed twice a week. On 3/11/15 at 10:12 AM the RN was unable to determine where the order for weights twice a week came from and stated that it may have been an error. S/he stated that there is no fax, telephone or verbal order to indicate when or who gave the order, but did concur that the physician had signed and dated the monthly orders as being reviewed and current on 2/4/15. There is no evidence that weights were obtained on 2/6, 2/9, 2/13, 2/16, 2/23, 3/2 or 3/9/15. The RN confirmed at 10:12 AM that there was no evidence of the weights being obtained and that the physician order was not being followed.

Reference: Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins.

F 281
DNS or designee will conduct weekly audits x3 to ensure compliance and then monthly x3 with results to be reviewed at QA meeting for further review and recommendations.
Date of compliance:
4/8/2015

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 282 483 20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN
SS=E

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and staff interviews the facility failed to ensure that qualified persons provided treatment/services in accordance with each resident's written plan of care for 5 of 23 applicable residents in the Stage 2 sample for Residents # 130, #132, #162, #88 and #20. The findings include the following:

1. Per record review on 03/11/15, Resident #162 did not receive services according to the plan of care. Resident #162 receives a psychotropic drug Celexa (anti-depressant). Per the initial assessment dated 02/27/15 the resident was noted to be taking antidepressants, which requires care planning. A care plan was developed on 02/28/15 regarding the medication Celexa and directed staff to complete behavior monitoring flow sheet, observe for changes in mental status and functioning level, and a gradual dose reduction and to observe for decline. Review of the MAR (medication administration record) and/or progress notes had no behaviors being monitored. Per interview on 03/10/15 at 4:00 PM the unit manager confirmed that a behavior tracking sheet was not initiated for this resident. Evidence demonstrated that staff did not track the residents behaviors therefore did not follow the care plan.

F 282

F282

Resident # 162 a behavior flow sheet was initiated.
Resident # 132 a new order for therapy to evaluate and treat was obtained.
Resident # 130 Physician order to weigh has been clarified.
Resident #20 physician order for the Supra -pubic catheter have been clarified and treatment sheet to reflect care required.
Resident #88 consents for psychoactive medication was obtained.

Other residents have the potential to be affected by the alleged deficient practice.
No other residents were negatively impacted by the alleged deficient practice.

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F 282 Continued From page 12

2. Resident # 132 did not receive treatment per the plan of care. The care plan dated 11/05/14 for decrease ability to perform Activities of Daily Living (ADL), directs staff among other things to, "please assist the patient in donning bilateral knee braces prior to ambulation [s/he] is independent in donning the bilateral knee braces". Per observation on 03/10/15 the resident was not observed with a knee brace. Per interview with the resident on 03/11/15 at 3:30 PM was unable to state when the brace was last applied. Per interview at 3:40 PM the LNA stated "well I am just a float but I don't think [s/he] uses a brace". The Licensed Nursing Assistant (LNA) stated that information such as the brace would be found on the LNA Walking Rounds sheet. The LNA sheet did not have the information noted. Per interview at 4:44 PM the Unit Manager acknowledged that the brace was on the care plan but that it was omitted on the LNA sheet. S/he confirmed the care plan was not followed as written.

ALSO see F-310

3. Per medical record review on 3/10/15 at 3:21 PM, Nutritional Assessment dated 12/30/14 completed by the Registered Dietician (RD), identifies that Resident #130 has had a weight loss of 9 pounds over the past 6 months. Initiatives to manage undesired weight loss are to change milk to whole and add extra margarine on trays. Encourage snacks during the day. Monitor effectiveness and weight status. Minimum Data Set (MDS) identifies on 12/27/14 that the resident requires set up help only for meals and has a weight of 127 pounds. Per review of the Interdisciplinary Care Plan dated 12/30/14 identifies a focus of nutritional concern due to

F 282

An audit was completed to ensure that residents on a psychoactive med have a behavior flow sheet.
An audit was completed to ensure if a resident has a brace that it is listed on the Kardex to match the plan of care.
An audit to identify physician orders regarding special orders to weigh has been completed.
An audit to ensure residents with Supra pubic catheters have orders in place for care to maintain the catheter.
An audit of residents with orders for Psychoactive meds has been completed to ensure consent has been obtained.

Nursing staff will be re-educated on the importance of ensuring that a qualified person provides treatment and services in accordance with each resident written plan of care.

DNS or designee will conduct weekly audits x3 to ensure

compliance and then monthly x3 with results to be reviewed at QA meeting for further review and recommendations.
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F 282 Continued From page 13
varied intake with downward weight trend. Interventions to manage the focus is to notify physician and dietician of any significant wight loss/gain and to monitor changes in nutritional status (changes in intake, ability to feed self, unplanned weight loss/gain).

Per medical record review on 3/10/15, Resident #130 weighs 136 pounds on 6/11/14 and on 1/4/15 resident weighs 121 pounds which is a 15 pound weight loss in 7 months. There is no documented evidence for weights for the months of September, October and November 2014 and February 2015. Per interview with the UM on 3/10/15 at approximately 4:15 PM, confirmation is made that the care plan has not been followed to manage a significant weight loss/gain.

(See F 325)

F 282

4. Record review of Resident #20 on 3/10/15 at 3:58 PM, the resident has a diagnosis of Urinary Tract Infection (UTI) with Septicemia on 12/22/14 and a Neurogenic bladder. Per Licensed Practical Nurse, the resident has had a supra pubic catheter (cath) in place. There are orders to have drainage bags changed weekly and change the catheter as necessary. Further orders are to irrigate as needed for decreased

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F 282 Continued From page 14
 urinary output, observe for color, odor, sediment and report changes to MD. Leg bag when appropriate, provide privacy bag and encourage resident to consume fluids on meal trays, between meals and nourishments. There is no evidence that the output is recorded, per interview with the Licensed Practical Nurse, at this time, s/he stated that they do not record the output and s/he will look at the drainage bag during the evening. Upon further review of the chart, there is no order for the supra pubic cath and no orders for irrigation. There also was no evidence of a treatment record for March and per the Registered Nurse at 4:25 PM, the treatment record was overlooked. At this time the RN also confirmed that the February treatment record presents that the cath care was not provided 22 out of out of 56 times.

F 282

5. During record review on 3/10/15 at 1:50 PM, Resident #88 presents with a diagnosis of Alzheimer's disease with aggressive behaviors and anxiety state. Medications include: Risperidone 0.25 mg at bedtime, Ativan 1 mg by mouth twice a day and Ativan 1mg/ml topically three times a day as needed (prn) for anxiety and agitation. During the month of March 2015, Resident #88 has received the prn dosing of Ativan. The Registered Nurse (RN) stated at this time that the reasons for administering the prn Ativan is because of screaming at others or kicking doors while exit seeking. Per the Unit Manager, the resident is not able to comprehend what medications s/he takes. The physician responded to request for dose reduction of the Risperidone in January by commenting that the resident can still become quite agitated which can potentially place patient and staff and other

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F 282	Continued From page 15 patients at risk. S/he stated at this time that there was not a signed consent form for the administration of the Ativan gel. On 3/11/15 at 7:16 AM interview with Licensed Practical Nurse (LPN) presented that resident receives Ativan Gel because s/he is very confused, raises fists to others and yells at others and does not redirect and other non-pharmaceutical interventions are effective. S/he further stated that Resident #88 does not refuse his medications and they are crushed and put in pudding. Care plan surrounding the resident's medication is an at risk care plan for complications related to use of psychotropic drugs: Risperidol and Ativan with intervention for behavior monitoring flow sheet, monitor for changes in mental status and functional level and report to physician as indicated and to 'provide informed consent to resident or the healthcare decision maker'. At 7:29 AM, the LPN was not able to produce evidence of a signed consent form for the Ativan Gel and that the care plan reflected that there is to be one on record.	F 282			
F 309	483.25 PROVIDE CARE/SERVICES FOR SS=O: HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced	F 309	F309 Resident # 96 – The care plan was updated and medical social service support was provided to the resident. Resident #21 a care plan was developed to address the dietary needs related to dialysis and physician order for diet and fluid was clarified.		

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F 309	<p>Continued From page 16</p> <p>by: Based on medical record review and staff interview the facility failed to provide necessary care and services for 2 of 23 applicable resident in the Stage 2 sample for Residents #96 and #21 regarding needs surrounding dialysis and regarding lack of services provided when a resident experienced a significant loss. Findings include:</p> <ol style="list-style-type: none"> Per medical record review on 3/11/15 at 11:06 AM, progress notes identify that the resident's spouse expired in 2/16/15. Per interview with the Social Services staff confirmation is made that there have been no services provided to Resident #96 to assist with coping with the death of his/her spouse and the resident's inability to be discharged back to the community. (See F250) Per record review resident #21 is on hemodialysis. S/he has Dialysis 3 times a week for End Stage Renal Disease (ESRD). There is no care plan in the record for nutrition. In an interview with the Registered Dietician (RD) on 3/11/15 at 10:20 am s/he stated that the resident did not "trigger" for a nutrition care plan. S/he stated that if there had been a care plan for nutrition it would not contain specifics of the diet but would simply direct staff to look at the Medication Administration Record (MAR) which would state what diet the resident is on. She stated that this would happen only if the pharmacy has carried it over onto the new MAR, which does not always happen. S/he also stated that LNA's can find specifics of the diet on the 	F 309	<p>Other residents that experience the loss of a spouse or require dialysis have the potential to be affected by the alleged deficient practice. No other residents were negatively impacted by the alleged deficient practice.</p> <p>An audit of residents that have recently Experienced the loss of a spouse has been conducted to ensure they receive medical social service support. An audit was also conducted to ensure all residents on dialysis have a nutrition care plan in place and are following orders for diet and fluids.</p> <p>Social service staff and nursing staff will be re-educated on the importance of providing necessary care and services to help the resident achieve the highest practicable physical, mental and psychosocial wellbeing in accordance with the comprehensive assessment and plan of care.</p> <p>DNS or designee will conduct weekly audits x3 to ensure compliance and then monthly x3 with results to be reviewed at QA meeting for further review and recommendations.</p>

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F 309

Continued From page 17
meal tray slip. The care plan contains a potential for excess fluid section that does not mention any fluid restriction and monitoring Intake and Output has been discontinued as resolved.

In a review of the meal tray slip it states that the resident is on a Consistent Carb, No Added Salt diet with 1500 ml Fluids. The restrictions that would be on a renal diet, such as orange juice, spinach, bananas are listed under dislikes and the RD states that is where any dietary restrictions would be listed (as a dislike not a restriction). This indicates that the dietary restrictions are dislikes and would not direct staff that the resident could not have these items should they request them.

In a review of the MAR for March and the most recent signed Physician's Orders for February, signed 2/5/15, the order states "Consistent Carb, Renal Liberalized Diet" and "1L [1 liter] Fluid Restriction". In a review of fluid intake on the March snack & fluid supplement sheet (which does not include fluids given with medications or when out of the facility) the resident's fluid intake has always been above 1L with the exception of March 5th when s/he was out of the facility on LOA (leave of absence) in the morning.

The RD confirmed, in interview on 3/11/15 at 10:45 am, that the MD order states as above. The order does include a liberalized renal diet and does not include a no added salt diet. When asked why the renal diet may have been discontinued the RD stated that it is difficult for dietary staff to coordinate the restrictions of both a Diabetic and a renal diet and that may have been the reason for discontinuing one. In an interview on 3/11/15 at 11:10 am the Unit

F 309

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F 309	Continued From page 18 Manager confirmed that the diet and fluid restriction currently ordered by the Physician are not being followed.	F 309	F310 Resident # 132 an order was obtained to have therapy re-evaluate and treat as indicated.	
F 310	483.25(a)(1) ADLS DO NOT DECLINE UNLESS SS=D UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to ensure that 1 of 3 applicable residents of the 23 residents in the Stage 2 sample, Resident #132, did not have activities of daily living diminish and/or demonstrate that diminution was unavoidable. Findings include: Record review on 03/10/15 of Resident #132's care plan notes that the resident "demonstrates capacity and motivation to improve function but exhibits or is at risk for decrease ability to perform Activities of Daily Living (ADL), goal has not been met- continue same plan of care". The interventions were noted for 1/4 side rails assist with mobility and promote independence, monitor resident for changes in status that may impact his/her ability to self care, please assist the patient in donning bilateral knee braces prior to ambulation [s/he] is independent in donning the	F 310	Other residents that have the potential to be affected by the alleged deficient practice. No other residents were negatively impacted by the alleged deficient practice. An audit of residents that present a decline in activity of daily living will be screened by therapy to ensure that diminution was unavoidable. Nursing and therapy staff will be re-educated on the importance of ensuring that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate diminution was unavoidable. This includes the ability to bathe, dress, groom, transfer, ambulate, toilet, eat, and use speech, language or other functional communication systems. DNS or designee will conduct weekly audits x3 to ensure compliance and then monthly x3 with results to be reviewed at QA	

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F 310	<p>Continued From page 19</p> <p>bilateral knee braces, monitor pain and medicate as appropriate, assist resident with ambulation/transfer providing standby assist and rolling walker on unit".</p> <p>Per observation on 03/10/16 the resident did not have a knee brace, however the rolling walker was in the room. Per interview with the resident's primary physician on 03/10/15 at 3:14 PM, {Resident} had a lot going on...was pretty sick had...some decline...we have [him/her] on pain meds and meds to increase his/her appetite...we had a consult to ortho...we should get [him/her] moving if we can. Review of the orthopedic progress note of 01/22/15 recommends as a plan - cortisone injection today into left knee continue Physical Therapy (PT) for left knee and bilateral shoulder follow up as necessary (PRN).</p> <p>Per interview with PT on 03/10/15 at 3:41 PM it was stated that 'the process is that the nurse writes the orders and then we follow up, I never got the order'. The PT then stated that the resident was on PT services in October/November 2014 and then "went to restorative and there should be a folder". Per the restorative nursing training program dated November 2014 written by the PT states "please motivate patient to walk with standing assist with 2 wheeled walker from room to 1st north elevator and back. Addendum- assist is donning bilateral knee braces [s/he] is able to independently don knee braces.</p> <p>Per review of the November restorative record dated shows the program started mid month with 6 episodes of 'n/a -activity -"did not occur" and approximately one week of "R - refused". There was no further activity noted for the end of the</p>	F 310	<p>meeting for further review and recommendations. Date of compliance: 4/8/2015</p>

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F 310 Continued From page 20
month. Per review of the progress notes dated November 20th, 23rd and 24th, presents that the resident was experiencing "churning stomach" several periods of "loose stools" and "an increase in dizziness", respectively. The resident was being medicated with promethazine [antiemetic] at that time. Per interview with the Unit Manager at 4:44 PM, s/he stated that "the resident refused the restorative" however acknowledged that the resident was ill at that time, and possibly the reason for refusals. S/he also confirmed that the braces were not applied as care planned and nursing failed to write an order for physical therapy in January 2015. There is no documentation to show refusal of such care and efforts by the facility to counsel and/or offer alternatives to the resident.

ALSO SEE F-281

F 316 483.25(d) NO CATHETER, PREVENT UTI, SS=D RESTORE BLADDER

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.

This REQUIREMENT is not met as evidenced by:
Based on record review and interviews the facility failed to provide services to improve

F 310

F-315
Resident #136 the resident died prior to survey on hospice care.

Other residents who experience incontinence have the potential to be affected by the alleged deficient practice.
No other residents were negatively impacted by the alleged deficient practice.

An audit of residents has been conducted to ensure that anyone triggering for incontinence will have a plan of care based on the assessment.

F 315

Nursing staff will be re-educated on the importance of providing service to improve bladder function or prevent decline for the individual resident based on the assessment.

DNS or designee will conduct weekly audits x3 to ensure compliance and then monthly x3 with results to be reviewed at QA meeting for further review and recommendations.
Date of compliance:
4/8/2015

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F 315 Continued From page 21
and/or prevent decline in bladder function for 1 of 5 applicable residents in the Stage 2 sample of 23, (Resident #136). Findings include:

F 315

Per record review, Resident #136, admitted in October 2014 and discharged on 02/20/15, was noted through nursing progress notes and admission assessments of having urinary incontinence but failed to receive services to prevent or restore normal bladder function as possible. Although a care plan was supposed to be written, as presented by the Care Area Assessment (CAA) during the admission process, no bladder and/or toileting program was initiated for Resident #136. Although a care plan for ADL (activities of daily living) presents an at risk for decreasing ability due to weakness, limited mobility and increased confusion, there are no interventions that address specific and measurable actions for urinary incontinence.

A nursing note of 12/24/14 states, "resident transfers via wheelchair and often self to bed and toilet without requesting assists". The progress note of 12/29/14 states "...[resident] remains incontinent of UA (urine)". Also a 01/05/15 nursing note states "[resident] urinates in [his/her] clothes changes them in [the] room or bathroom and leaves them on the floor". The note of 01/03/15 remarks, "makes [his/her] needs known...[s/he] toilets [him/her] self and when [the] clothes are wet, changes them and leaves them on the room or bathroom floor". LNA staff acknowledged that there was no toilet schedule or other protocols but that 'briefs' were used for this resident. Per interview on 03/11/15 at 11:20 AM the Director of Nursing Service confirmed there was no care plan was initiated for bladder function and stated, "should have been".

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F 315	Continued From page 22 ALSO see F-282	F 315	F-325	
F 325	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to ensure that a resident maintains an acceptable parameter of nutritional status and receives a therapeutic diet when there is a nutritional problem for 1 of 5 applicable residents of 23 in the Stage 2 sample. Resident #130. Findings include: Per medical record review on 3/10/15 at 3:21 PM, Nutritional Assessment dated 12/30/14 completed by the Registered Dietician (RD), identifies that Resident #130 has had a weight loss of 9 pounds over the past 6 months. Initiatives to manage undesired weight loss are to change milk to whole and add extra margarine on trays. Encourage snacks during the day. Monitor effectiveness and weight status. Minimum Data Set (MDS) identifies on 12/27/14 that the resident	F 325	Resident #130 the resident's weight has been verified. Other residents have the potential to be affected by the alleged deficient practice. No other residents were negatively impacted by the alleged deficient practice. An audit was conducted to ensure residents are weighed per policy. Nursing staff will be re-educated on the importance that residents maintain an acceptable parameter of nutritional status such as body weight and protein levels, unless the clinical condition demonstrates this is not possible and receives a therapeutic diet when there is a nutritional problem. DNS or designee will conduct weekly audits x3 to ensure compliance and then monthly x3 with results to be reviewed at QA meeting for further review and recommendations. Date of compliance: 4/8/2015	

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F 325: Continued From page 23
requires set up help only for meals and has a weight of 127 pounds. Per review of the Interdisciplinary Care Plan dated 12/30/14 identifies a focus of nutritional concern due to varied intake with downward weight trend. Interventions to manage the focus is to notify physician and dietician of any significant weight loss/gain and to monitor changes in nutritional status (changes in intake, ability to feed self, unplanned weight loss/gain).

Resident #130 was weighed on 6/11/14 at 136 pounds and on 1/04/15 at 121 pounds which is a 15 pound weight loss in 7 months. There is no documented weights for the months of September, October and November 2014 and February 2015. Request made to nursing staff to weigh the resident today (3/10/15) for the month of March 2015. Unit Manager (UM) returned within a 30 minute period and voiced that the resident weighed 111 pounds which was an additional 10 pound loss in 2 months.

Per interview with the UM on 3/10/15 at approximately 4:15 PM, confirmation is made that the resident was not weighed monthly per policy and was last weighed in January 2015. Therefore the MD and the dietician were not notified of the unplanned weight loss. Confirmation is also made by both the MDS Coordinator and the UM, at this time that the resident has had a significant weight loss that has not been addressed.

Facility policy for Weights and Heights dated as revised on 1/2/14 identifies that weight changes will be reviewed by the licensed nurse for assessment with a significant weight change in one month and six months.

F 325

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F 367 F 367 SS=D	Continued From page 24 483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to assure that the therapeutic diet provided to 1 of 5 applicable residents, of the 23 residents in the Stage 2 sample (Resident #21), was prescribed by the attending physician. Findings include: Per record review resident #21 is on hemodialysis. S/he has Dialysis 3 times a week for End Stage Renal Disease (ESRD). There is no care plan in the record for nutrition. In an interview with the Registered Dietician (RD) on 3/11/15 at 10:20 am s/he stated that the resident did not "trigger" for a nutrition care plan. S/he stated that if there had been a care plan for nutrition it would not contain specifics of the diet but would simply direct staff to look at the Medication Administration Record (MAR) which would state what diet the resident is on. She stated that this would happen only if the pharmacy has carried it over onto the new MAR, which does not always happen. S/he also stated that LNA's can find specifics of the diet on the meal tray slip. The care plan contains a potential for excess fluid section that does not mention any fluid restriction and monitoring Intake and Output has been discontinued as resolved. In a review of the MAR for March and the most recent signed Physician's Orders for February.	F 367 F 367	F-367 Resident #21 the resident's diet was clarified and compared to tray ticket to confirm correct. Other residents who are prescribed a therapeutic diet have the potential to be affected by the alleged deficient practice. No other residents were negatively impacted by the alleged deficient practice. An audit of residents diet order and tray tickets has been completed. Nursing and dietary staff will be educated on the importance of ensuring the correct therapeutic diet be provided. DNS or designee will conduct weekly audits x3 to ensure compliance and then monthly x3 with results to be reviewed at QA meeting for further review and recommendations. Date of compliance: 4/8/2015		

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F 367 Continued From page 25
signed 2/5/15, the order states "Consistent Carb, Renal Liberalized Diet" and "1L [1 liter] Fluid Restriction". In a review of the meal tray slip it states that the resident is on a Consistent Carb, No Added Salt diet with 1500 ml Fluids. The restrictions that would be on a renal diet, such as orange juice, spinach, bananas are listed under dislikes and the RD states that is where any dietary restrictions would be listed (as a dislike not a restriction). In a review of fluid intake on the March snack & fluid supplement sheet (which does not include fluids given with medications or when out of the facility) the resident's fluid intake has always been above 1L with the exception of March 5th when s/he was out of the facility on LOA (leave of absence) in the morning.

F 367

The RD confirmed, in interview on 3/11/15 at 10:45 am, that the MD order states as above. The order does include a liberalized renal diet and does not include a no added salt diet. When asked why the renal diet may have been discontinued the RD stated that it is difficult for dietary staff to coordinate the restrictions of both a Diabetic and a renal diet and that may have been the reason for discontinuing one. In an interview on 3/11/15 at 11:10 am the Unit Manager confirmed that the diet and fluid restriction currently ordered by the Physician are not being followed.

F 431 483.60(b), (d), (e) DRUG RECORDS, SS-E LABEL/STORE DRUGS & BIOLOGICALS

F 431

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

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F 431: Continued From page 26

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 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 observation and staff interview on 3 of 5 units, 3 North, 3 South and First floor, the facility failed to dispose of expired medications and to label according to regulations. Findings include:

1. 3/9/15 at 1:39 PM during review of the medication storage on 3 North, it was discovered

F 431

F431
No resident was affected.
The identified expired medications were disposed of per protocol.

All residents have the potential to be affected by the alleged deficient practice.

An audit of medication storage areas was conducted to ensure no expired medication is present and medications are labeled per regulation.

Nursing staff will be re-educated on the importance of monitoring and ensuring that all medications and biologics used in the facility are labeled in accordance with currently acceptable professional principles, and include the appropriate cautionary instructions and the expiration date when applicable.

DNS or designee will conduct weekly audits to ensure compliance x3 weeks and then monthly x3 with results to be reviewed at QA meeting for further review and recommendations.
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F 431	<p>Continued From page 27</p> <p>that there was a multiple dose vial of Tuberculin PPD in the medication refrigerator that was dated as being opened on 11/7/14. Per the Licensed Practical Nurse (LPN), the PPD is to be discarded after 30 days. S/he confirmed that the date labeled as being opened as 11/7/14 and that it had not been destroyed as per protocol.</p> <p>2. On 3/9/15 at 3:47 PM during review of the medication storage on 3 South, it was discovered that there was a multiple dose vial of Tuberculin PPD in the medication refrigerator that was dated as being opened on 12/20/14. Per the LPN, the PPD is to be discarded after 30 days. S/he confirmed that the date labeled as being opened as 12/20/14 and that it had not been destroyed as per protocol.</p> <p>3. On 3/9/15 at 3:47 PM during review of the medication storage on 3 South, it was discovered that there was a multiple vial dose of Influenza vaccine Aluvia that was opened, but there was no date as to when the vial was opened. Per the LPN, s/he could not confirm the date that the vial had been opened and did not know how long it had been in the refrigerator. Further confirmation from the LPN that the vaccine should not be used without knowing how long it had been opened.</p> <p>4. On 3/9/15 at 3:51 PM during review of the medication storage on the medication cart on 3 South, it was discovered that there was a bottle of Morphine Sulfate (MSO4) oral solution 100mg/ml. The resident that it was designated for expired on 2/19/15. At 3:54 PM the Registered Nurse (RN), controlled substance and narcotics are to be destroyed by the DON and a nurse and they try to do it often. S/he confirmed that it had been an extended period of time since the resident</p>	F 431	

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F 431 Continued From page 28

expired and the medication should have been destroyed. Per review of the facility protocol with the Director of Nursing on 3/11/15 at 12:15 PM, s/he confirmed that the destruction is to be done immediately.

5. On 3/9/15 at 3:51 PM during review of the medication storage on the medication cart on 3 South, it was discovered that there was a (MSO4) 50mg/ml cassette for infusion via infusion pump to be dated as filled on 2/19/15. The resident the medication was designated for expired on 2/19/14. At 3:54 PM the RN, controlled substance and narcotics are to be destroyed by the DON and a nurse and they try to do it often. S/he confirmed that it had been an extended period of time since the resident expired and the medication should have been destroyed. Per review of the facility protocol with the Director of Nursing on 3/11/15 at 12:15 PM, s/he confirmed that the destruction is to be done immediately.

6. On 3/9/15 at 3:51 PM during review of the medication storage on the medication cart on 3 South, it was discovered that there was a MSO4 Hi-concentrate 1mg/ml in 0.9% Sodium Chloride cassette for infusion via infusion pump that had an expiration date of 2/13/15. The resident that it was designated for had expired on 2/7/15. At 3:54 PM the RN, controlled substance and narcotics are to be destroyed by the DON and a nurse and they try to do it often. S/he confirmed that it had been an extended period of time since the resident expired and the medication should have been destroyed. Per review of the facility protocol with the Director of Nursing on 3/11/15 at 12:15 PM, s/he confirmed that the destruction is to be done immediately.

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F 431 Continued From page 29

7. On 3/9/15 at 3:51 PM during review of the medication storage on the medication cart on 3 South, it was discovered that there was a bottle of Roxanol 20mg/ml solution for a resident that had expired on 2/14/15. At 3:54 PM the RN, controlled substance and narcotics are to be destroyed by the DON and a nurse and they try to do it often. S/he confirmed that it had been an extended period of time since the resident expired and the medication should have been destroyed. Per review of the facility protocol with the Director of Nursing on 3/11/15 at 12:15 PM, s/he confirmed that the destruction is to be done immediately.

F 431

8. On 3/9/15 at 5:15 PM during review of medication storage refrigerator on the First floor, it was discovered that there was an opened multi-use bottle of Humalog insulin that did not have a date as to when opened and per confirmation of the nurse, s/he did not know how long the insulin had been in use.

F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

F 441

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

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Continued From page 30
(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.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview the facility failed to implement Infection Prevention measures for one resident [Resident #54] of 23 residents in the sample group. Findings include:

Per record review Resident #54's diagnoses include Chronic Airway Obstruction, with a history of Upper Respiratory Infection in February 2015. Resident #54's treatment includes respiratory inhalers and oxygen for shortness of breath. Per interview on 3/10/15 at 1:00 P.M. Resident #54 reported that s/he uses the oxygen on a nightly basis. Per observation on 3/10/15 at 11:30 A.M.

F 441

F-441
Resident #54 Oxygen cannula tubing, and sterile water container for humidification was replaced.

Other residents who require oxygen have the potential to be affected by the alleged deficient practice.
No other residents were negatively impacted by the alleged deficient practice

An audit of residents has been Conducted to ensure that oxygen Supplies are replaced and dated weekly.

Nursing staff will be re-educated on the importance of checking and replacing oxygen supplies weekly to provide a safe sanitary environment and to help prevent the development and transmission of disease and infection.

DNS or designee will conduct weekly audits x3 to ensure compliance and then monthly x3 with results to be reviewed at QA meeting for further review and recommendations.
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID 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 441	Continued From page 31 the nasal cannula, oxygen tubing, and sterile water container for humidifying the oxygen for Resident #54 were dated 2/24/15. Per interview with the unit's nurse on 3/10/15 at 1:30 P.M., the facility's Infection Prevention protocol for oxygen equipment is to replace the nasal cannula, oxygen tubing, and sterile water container every week and to mark the date on the equipment when it is replaced. The nurse confirmed the data on Resident #54's oxygen equipment was dated 2/24/15 and had not been changed on 3/3/15 of the prior week as per the facility's Infection Prevention protocol, and was due to be changed again on the day of the interview.	F 441		
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