



AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection

103 South Main Street, Ladd Hall

Waterbury VT 05671-2306

<http://www.dail.vermont.gov>

Voice/TTY (802) 241-2345

To Report Adult Abuse: (800) 564-1612

Fax (802) 241-2358

September 1, 2010

Ms. Patricia Russell, Administrator  
Union House Nursing Home  
3086 Glover Street  
Glover, VT 05839

Dear Ms. Russell:

Enclosed is a copy of your acceptable plans of correction for the annual survey conducted on August 4, 2010. 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,

A handwritten signature in cursive script that reads "Pamela M. Cota".

Pamela M. Cota, RN  
Licensing Chief



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

PRINTED: 08/17/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475036</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/04/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNION HOUSE NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3086 GLOVER STREET GLOVER, VT 05839</b>	
(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
F 000	INITIAL COMMENTS	F 000	F 157	
F 157 SS=D	<p>The Division of Licensing and Protection conducted an unannounced on-site annual recertification survey on 8/2/10 - 8/4/10.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 157	<p>NOTIFY OF CHANGES-FAILURE TO INFORM</p> <p>***Immediate correction was accomplished by a mandatory in-service 8/25/10 to inform all staff of revised policy and procedure for reporting any incidents, unplanned/undesirable outcomes.</p> <p>***Measures put into place to ensure deficient practice does not recur are outlined in revised policy and procedure. This addresses identifying, documenting and reporting to MD and required individuals. Areas identified are:</p> <ol style="list-style-type: none"> <li>accidents with or without injury</li> <li>any injury bruise or lesion of known or unknown origin</li> <li>change of status/condition</li> <li>adverse or undesired result of plan of care or MD orders.</li> </ol> <p>A copy of revised Policy and Procedure is attached.</p> <p>***Corrective actions being monitored to ensure deficient practice does not recur:</p> <ol style="list-style-type: none"> <li>The DON will review 24 hour report in morning and reconcile incident reports generated from any unusual occurrence.</li> <li>S/he will also review appropriate plan of care to confirm it was updated or new MD orders implemented.</li> <li>DON reviewing all resident charts to ensure notification practice was followed. Will continue to review on monthly audit, as part of ongoing protocol. Nurses will notify the MD promptly upon identifying issue delineated in items a,b,c and d at top of this page.</li> </ol>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*[Signature]* *[Signature]* *8/26/10*

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 for continued program participation.

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F 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to immediately inform the physician and/or legal representative after 2 applicable residents in the stage 2 sample experienced a significant change in clinical condition or an accident. (Residents #40 &amp; 18) Findings include:</p> <ol style="list-style-type: none"> <li>Per record review on 8/4/10, Resident #40 experienced a fall from a bedside commode after being left unattended on the night of 5/23/10. There was no written evidence that nursing staff had informed the resident's responsible family member and the physician. Review of subsequent nursing progress notes did not include any documentation of notification of the family or the physician. During interview at 1:25 PM the same day, the Director of Nursing Services (DNS) confirmed that there was no incident report found for this fall per the facility's protocol when there has been a resident fall/incident. There is a section on the incident report form to document notification to the MD and the family and there was no documentation found.</li> <li>Per record review on 8/4/10 at 10 AM, nurses failed to notify Resident #18's physician of the resident's complaints of constipation from 5/31/10 through 6/10/10 after discontinuance of a daily laxative on 5/26/10. The resident complained to nurses that she was constipated and was administered a laxative on 3 days during this period. The MD re-ordered the daily laxative on 6/11/10 after nurses conveyed the resident's constipation and request to the MD.</li> <li>Per record review for Resident #18 on 8/4/10</li> </ol>	F 157	<p>d) It is also be the DON's responsibility to initiate any disciplinary action for staff contributing to an incident or charge nurse not following the reporting/investigative process. The above process will be implemented by <u>9/1/10</u>.</p> <p>Resident #18 ***Immediate correction and efforts to prevent recurrence initiated 8/25/10 at mandatory staff meeting. The job description and expectation of the charge nurse role were reviewed and the requirement was highlighted. Nurses were reminded that the MDS coordinator, who does weekly MD rounds with the medical director, keeps a record of any complaints, concerns or specific resident request.</p> <p>The DON continues to monitor for compliance when reviewing 24 hour report, of this and any variance from written guidelines will result in disciplinary action. To ensure this deficient practice does not recur, the DON will include this matter for review on a quarterly basis at the QA meeting, which is attended by a multidisciplinary team and reported to the administrator.</p> <p><i>F157 POC Accepted 8/27/10 R. Tremblay RN K. McCotter RN</i></p>	

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F 157	Continued From page 2 at 9 AM, a nurse failed to notify the physician of a bruise (unknown origin) noted on 6/12/10 at 2235, "L inner foot- dark purple in color....L foot + ankle with 1+ edema, also has purple bruise R shin." The next progress note in the record was dated 6/17/10, 2150 and stated "L ankle remains bruised and sl. swollen". During interview on 8/4/10 at 9:40 AM, the nurse author of both progress notes confirmed that she had not notified the physician of the resident's bruises.	F 157		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to develop a care plan to address the	F 279	<b>F 279 DEVELOP COMPREHENSIVE CARE PLANS</b> Resident #58 was admitted 7/30/10 and care plan was approximately 90 percent completed on first day of survey, Monday August 2, 2010; 3 days after admission.  Per MD order 7/30/10 the unstageable area on the L heel was addressed per nurse contact with MD: the heel protector was implemented, as ordered, by nurse CW but had been sent to be laundered Sunday and had not been replaced yet when visited by surveyor at 8 a.m. on 8/2/10.  ***Immediate correction implemented 8/2/10 by providing for Resident #58 use of molded plastic heel protection that will be cleaned on the unit, not requiring to be sent to laundry.  ***Measures put into place to ensure deficient practice does not recur are: 1) wound care specialist presented overview of physiology of a decubiti and staff reminded that the best practice has always been prevention. 2) Admitting nurse will develop care plan for any and all problems. This	

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F 279	Continued From page 3 needs of 2 of 18 residents in the stage 2 sample (Residents #58, 33). Findings include:  1. Per record review on 8/4/10 at 8:35 AM, there is no care plan to address an unstageable pressure sore for Resident #58. Per record review on 8/4/10, the Resident has an unstageable pressure ulcer on the left heel. The facility Minimum Data Set (MDS) nurse confirmed at 8:41 AM on 8/4/10 that there is no care plan to address the pressure ulcer.  2. Per record review on 8/4/10 at 9:25 AM, there was no care plan to address the activity needs for Resident #33. The Activities Director confirmed that there was no activity care plan in place on 8/4/10 at 9:48 AM. The MDS Nurse stated that all residents should have an activity care plan and that "we just missed this one".	F 279	information will be included on the LNA flow sheet so staff will be aware of required care and safety measures.  The process referenced in # 2 above will be monitored by the nurse who will double check new orders and plan of care prior to cosigning, as addressed on page 6, # 2.  ***Immediate correction accomplished on 8/6/10 by updating care plan to require: a) resident #40 not be left unattended on commode or toilet b) Staff informed of this change in plan of care on 8/6/10 -----SEE page 4 B for continuation----->	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after	F 280	F 280 RIGHT TO PARTICIPATE IN PLANNING CARE AND REVISING CARE PLAN ***Measures implemented for immediate correction of Resident #33 on 8/4/10, after surveyor discovered omission of activity care plan. Activities director will review all other residents to assure compliance.  ***Measures put into place to ensure deficient practice does not recur. Activities Director monitors care planning and addresses with residents and documents activity interest within 24 hours of admission or readmission.  Activity director monitors and confirms this process is maintained on a weekly basis during multi-disciplinary care plan meetings held every Wednesday.	

*F280 POC Accepted 8/27/10  
R. Tremblay RN / P. Mota RN*

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F 279 PAGE 4B CONTINUATION OF PAGE 4

\*\*\*Measures put into place to ensure deficient practice does not recur include a new LNA flow sheet and documentation system that includes specific individualized care needs. The LNAs will have this available as daily reference tool for residents' current care needs. The charge nurse keeps information accurate, current and sufficient to inform all care providers of each resident's needs. This documentation tool was in-serviced 8/25/10 and implemented by 9/1/10.  
\*\*\*Corrective action will be monitored by the charge nurses on daily basis and confirmed accurate as the LNA flow sheet will be replaced each month at the same time the new monthly MAR is processed and replaced. This process requires the nurse to review the prior month and manually create new flow sheets and care guides. MDS coordinator reviews care plans and LNA flow sheets for any changes monthly, to make sure they match, and reports any discrepancies to the DON.

F279 POC Accepted 8/27/10  
R. Tremblay RN / AMCOURN

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F 280	Continued From page 4 each assessment.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that the care plan for 1 of 18 residents in the stage 2 sample was reviewed and updated to reflect the current needs of the resident. (Resident #40) Findings include:  Per record review on 8/4/10 and confirmed during interview with the DNS at 1:25 PM, Resident #40 sustained a fall after being left unsupervised on the bedside commode during the night shift on 5/23/10. The care plan, dated 6/2/10, identified the resident as being at risk for falls related to weakness, chronic vertigo, memory loss, non-ambulatory and need for assistance of 1 for transfers, and was not revised to reflect the fall of 5/23/10. There was no evidence of a review of interventions to address this fall. The DNS confirmed, during the same interview, that the resident should have been supervised while on the commode and the care plan was not updated.	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 observation, staff interview and record review, staff failed to meet professional standards of quality for 1 of 18 residents in the stage 2	F 281	F 281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS ***Immediate correction with Resident #58 and issue of heel protection was addressed by utilizing plastic molded protector that will be cleaned at the bedside and not require being sent to laundry. The heel protector initially place on 7/31/10 required laundering due to being heavily soiled and had not been replaced immediately.  ***Measures put into place to ensure deficient practice does not occur again include: 1) Wound care specialist in-serviced staff relative to decubitus prevention and physiology that leads to decubiti on 8/25/10 at mandatory meeting.		

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F 281	Continued From page 5 sample (Resident #58). Findings include:  Per observation at 8:00 AM on 8/4/10, Resident #58 did not have heel protector on the left heel as ordered by the physician. Per record review on 8/4/10, the Resident has an unstageable pressure ulcer on the left heel. On 8/4/10 at 8:27 AM, a Unit Nurse confirmed that there was no heel protector in place and was unable to locate one in the resident's room.	F 281	2) On 9/1/10 we implemented a mechanism that flags charts that have new orders, see attached procedures. Any nurse receiving an order will flag the resident's chart. Flag will be removed by second nurse who initials new orders and s/he has confirmed all were noted/implemented. This nurse can be MDS coordinator, DON or next shift's charge nurse if the order remains flagged. All new orders must be cosigned within 24 hours. The DON will confirm all flags removed by the next morning when she reviews the 24 hour report and include the findings from these reviews in the quarterly quality assurance reports.		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that 1 applicable resident with a history of falls received adequate supervision to prevent falls. (Resident #40) Findings include:  Per record review and confirmed during interview with the DNS on 8/4/10 at 1:25 PM, Resident #40, who required staff assistance for transfers, had been left unsupervised on the bedside commode after refusing to transfer off with the Licensed Nursing Assistants (LNA)s on 5/23/10 during the night shift. The progress note of 5/23/10, 2315 hours (11:15 PM), stated "LNAs found resident laying on L side on floor....LNAs attempted to	F 323	F281 POC Accepted 8/27/10 R-Tremblay, RN / Amcota RN F 323 FREE OF ACCIDENT HAZARDS AND SUPERVISION PROVIDED TO PREVENT ACCIDENTS ***Immediate correction provided on 8/6/10 by updating care plan and mandatory staff meeting on 8/25/10. This issue is also addressed previously in identified issues in tags F157, F280.  ***Measures put into place to ensure deficient practices does not recur as outlined previously for tags F 157 and F280, but specifically in revised Policy and Procedure for Investigation and Reporting Accidents/Incidents. This policy will be enforced by the DON and included within the quarterly assurance meetings.  F323 POC Accepted 8/27/10 R-Tremblay, RN / Amcota RN		

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F 323	Continued From page 6 transfer resident...resident refusing...call bell within reach...". The resident complained of left knee and left hip pain after the fall. After further assessment, the nurse noted no apparent injuries. The resident had been noted in the evening shift progress note of the same day to require several cues and more assist with "HS care tonight related to confusion". During interview at 1:25 PM on 8/4/10, the DNS confirmed that the resident was non-ambulatory, had periods of confusion and required physical assistance to transfer, and should not have been left unsupervised on the commode. The resident's care plan identified the resident as being at risk for falls and requiring staff assistance for transfers.  In addition, the nurse on duty the night of the fall failed to complete an incident report as is the facility's process after a resident fall or accident per the DNS. The DNS stated that s/he receives copies of all incident reports and tracks residents falls for trends (i.e., time of day, activity etc). When asked for a copy of the incident reporting policy/procedure, the DNS stated that there was no written policy/procedure available.	F 323			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F 371 FOOD PROCUREMENT, STORAGE ***Immediate correction was achieved with the purchase of new replacement thermometer for upstairs food/beverage refrigerator, as well as a new medication refrigerator for the second floor nurse's station. Since 8/24/10 all temperatures have been within the recommended guidelines.		

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F 371	Continued From page 7  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to assure that food was stored under appropriate temperatures, as required. Findings include:  Per observation on 8/2/10 at 11:00 AM, the second floor resident refrigerator's temperature log for July, 2010 was observed to have no entries for July 9, 13, 20, 28, 29, 30, and 31 of 2010. Temperatures were noted to be out of safe food storage range (36-41 degrees Fahrenheit (F)) on the following dates: 30 degrees F on 7/14/10; 42 degrees F on 7/10/10 and 7/12/10; and 44 degrees F on 7/3, 4, 5, 6, 7, and 8 of 2010. There was no temperature log posted for August 2010, and the refrigerator thermometer read 30 degrees F during the 8/2/10 11:00 AM observation. Per interview on 8/2/10 at 11:05 AM, the Director of Nursing (DNS) confirmed the missing entries and out of range temperatures, and stated that staff had not reported the out of range refrigerator temperatures according to facility policy.	F 371	***Measures put into place to ensure deficient practice does not recur are as follows: 1) Thermometers are secured in place to avoid fluctuation in readings. 2) Temperatures previously monitored by LNAs now maintained by the charge nurse and recorded when the narcotic count is done at shift change (i.e. 3 p.m. each day). Fluctuations are reported to the DON and/or maintenance. 3) This new process was in serviced <u>8/25/10</u> . DON will receive/review the logs on a monthly basis and include in the quarterly quality assurance meeting. Variations will be reported to the administrator.  <i>F371 POC Accepted 8/27/10 R. Tremblay RN / Annetta RN</i>	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be	F 431	F 431 DRUG RECORDS, LABEL/STORE DRUGS AND BIOLOGICALS ***Immediate correction of deficient practice includes: a) New thermometers in medication refrigerators in both nursing units	

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475036</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/04/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNION HOUSE NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3086 GLOVER STREET GLOVER, VT 05839</b>	
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F 431	<p>Continued From page 8</p> <p>labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, document review and staff interviews, the facility failed to store medications and biologicals under proper temperature controls and according to the pharmacy's policy and procedure. Findings include:</p> <p>1. Per observation on 8/2/10 at 11:25 AM, the downstairs medication refrigerator registered a temperature of 36 degrees Fahrenheit according to the surveyor's thermometer, and the facility's thermometer on the middle shelf read 37 degrees. The refrigerator contained a variety of</p>	F 431	<p>b) Thermometers placed in fixed positions to avoid fluctuating temperatures</p> <p>c) All temperatures currently within recommended range 36 to 46 degrees</p> <p>d) Medicine refrigerator contains only medications and food/beverage refrigerator contains only food or beverage items</p> <p>e) New small refrigerator for medications on second floor nursing unit, with a built in lock.</p> <p>f) Temperatures previously monitored by LNAs now maintained by the charge nurse and recorded when the narcotic count is done at shift change (i.e. 3 p.m. each day). Fluctuations are reported to the DON and/or maintenance and the administrator.</p> <p>***Measures implemented to ensure deficient practice does not recur:</p> <p>a) LNAs are no longer responsible for monitoring/recording temperatures</p> <p>b) Charge nurse now checking temperatures daily and recording on log kept with narcotic count log.</p> <p>c) The check and recording will be done at 3 p.m. daily. The DON will be getting all logs on every month basis. This change in process is serviced on 8/25/10 and implemented by 9/1/10, and included in the quarterly quality assurance meetings.</p> <p><i>F431 POC Accepted 8/27/10 R-Tremblay RN / Pincoturn</i></p>	

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F 431	<p>Continued From page 9</p> <p>medications including suppositories, IV antibiotics, insulins, and a locked box with controlled medications including Ativan vials. Per review of the temperature logs for July 2010, there were temperatures below the pharmacy recommended range of 36-46 degrees F on nine days. On 7/14, 7/16, 7/17, 7/19, and 7/21, the temperatures recorded were 34 degrees F. On 7/13, the recorded temperature was 35 deg. F. On 7/24, 7/25, and 7/29, the temperature documented was 32 deg. F. There were no temperatures recorded on the log on 7/22, 7/23, 7/26, 7/27, 7/28, 7/30, and 7/31. Per interview on 8/4/10 at 10:45 AM, the Director of Nursing confirmed that there was no documentation that the refrigerator temperature was checked on the days left blank on the log, that some of the other temperatures listed are below the 36-46 degree F range recommended by the pharmacy for storage of these medications, and that there was no documentation to show that staff had reported the out of range temperatures according to facility policy.</p> <p>2. Per observation on 8/2/10 at 11:00 AM, the second floor resident snack refrigerator contained a locked box that held refrigerated medications including vials of injectable Ativan, Bisacodyl suppositories, and unopened boxes of insulin. The temperature log for July 2010 was observed to have no entries for 7/9, 13, 20, 28, 29, 30, and 31 of 2010. Temperature recorded on the log for 7/14/10 read 30 degrees F. There was no temperature log posted for August 2010. The pharmacy policy recommends a range of 36-46 degrees F for the storage of refrigerated medications. The policy also states that medications are not to be stored with resident's</p>	F 431		

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F 431	Continued From page 10 food . Per interview on 8/4/10 at 9:40 AM, the Unit Nurse confirmed that the refrigerator contained resident food items and the facility had been using it for medication storage since their small medication storage refrigerator stopped functioning. Per interview on 8/2/10 at 11:05 AM, the Director of Nursing (DNS) confirmed the missing entries and out of range temperatures, and that staff had not reported the out of range refrigerator temperatures according to facility policy.	F 431		
F 441 SS=D	<b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441	<b>F441 INFECTION CONTROL</b> <b>***Immediate correction of deficient practice includes:</b> a) All signs replaced by signs now directing staff/visitors to nurse for appropriate precaution information. b) Infection control policy has been updated with current information. Signs are to be placed on specific resident's door and not just in near proximity.  #2 Immediate correction of deficient wound care and hand washing practice is addressed with development of new Policy and Procedure for basic dressing changes/wound care (copy attached.) This was in serviced 8/25/10 at mandatory staff meeting. The nurse responsible for this less than optimal care submitted her resignation effective 8/19/10 and in consideration of her general job performance, it was accepted.	

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F 441	<p>Continued From page 11</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to implement infection control procedures and techniques to prevent the spread of infection within the facility regarding 2 applicable resident observations during stage 2 of the survey. (Residents #58 &amp; 33) Findings include:</p> <ol style="list-style-type: none"> <li>Per observations of care for Resident #58 on 8/3/10 at 4:15 PM, accompanied by the Director of Nursing Services (DNS), there was no sign on the resident's door alert visitors to check with the nurse before entering. During interview, the DNS stated that Resident #58, who resides in the room with another resident, is on contact precautions and is currently undergoing antibiotic therapy for treatment of an infection.</li> <li>Per observations of a clean dressing change to 2 separate wounds for Resident #33 on 8/4/10 at 2:25 PM, the nurse failed to change gloves and cleanse hands between soiled and clean procedures. After removing the old dressing for wound #1, the nurse failed to cleanse hands before proceeding with the dressing change. After</li> </ol>	F 441			

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F 441	Continued From page 12 completing the care to wound #1, the nurse indicated she was ready to start the care to wound #2, on a different area of the resident's body. When the surveyor asked if s/he had washed his/her hands, s/he stated s/he had not.	F 441	<p>All nurses were provided a copy of this policy/procedure to read and acknowledge understanding 8/25/10. Nurses will be proficiency checked by the wound nurse, by 9/1/10 monitored by the DON, and no less than _____ annually thereafter. To ensure this deficient practice does not recur the DON will continue to monitor all QA and Infection Control measures on a quarterly basis at the QA meeting, which is a multidisciplinary team.</p> <p>The wound care team, implemented 6/1/10, will continue to meet and develop protocols for Union House. The leader of the team, a certified wound care specialist, led an in-service to educate and update the nursing staff on 8/25/10.</p> <p><i>F441 POC Accepted 8/27/10 R. Tremblay RN / P. Mouton RN</i></p>	

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