

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

February 6, 2015

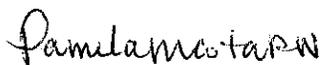
Ms. Meagan Buckley, Administrator  
Burlington Health & Rehab  
300 Pearl Street  
Burlington, VT 05401-8531

Dear Ms. Buckley:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 7, 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

PC:jl

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

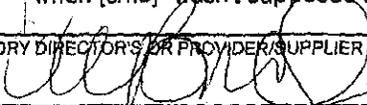
PRINTED: 01/20/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 01/07/2015
NAME OF PROVIDER OR SUPPLIER  BURLINGTON HEALTH & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 300 PEARL STREET BURLINGTON, VT 05401	
(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  An unannounced on-site investigation of 2 entity self-reports and 2 complaints concerning resident rights and quality of care and was conducted by the Division of Licensing and Protection on 1/6/15-1/7/15. The following regulatory violations were identified:	F 000	The following constitutes the facility's response to the findings of the Department of Licensing and Protection and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statement of deficiencies.	
F 223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION  The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.  The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.  This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record and facility investigation review, the facility failed to ensure that 1 of 3 applicable residents was free from verbal and mental abuse (Resident #1). The findings include: Per 1/6-1/7/15 review of the facility internal investigation dated 12/15/14, Resident #1 reported to an Ombudsman (on 12/10/14) that a staff Licensed Practical Nurse (LPN) said to [Resident #1], "What the f--- are you doing up here?" relative to the resident going up to the 5th floor from the 4th floor of the building. This incident was witnessed by a staff Licensed Nursing Assistant (LNA) who in a written statement, wrote that the LPN "repeatedly harassed" [Resident #1] about being on the floor when [s/he] "wasn't supposed to be." The LNA	F 223	<b>F223 483.13(b), 483.13(c)(1)(i)</b>  1. Resident #1 is psychosocially stable. The employee no longer works in facility as a result of this alleged deficient practice. 2. All Residents have the potential to be affected by this alleged deficient practice. 3. All employees receive mandatory education regarding abuse reporting requirements upon hire. 4. Re-Education will be provided to staff regarding abuse reporting requirements. 5. Random interviews will be conducted weekly for staff and residents by the DNS or designee to monitor the effectiveness of the plan.	

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

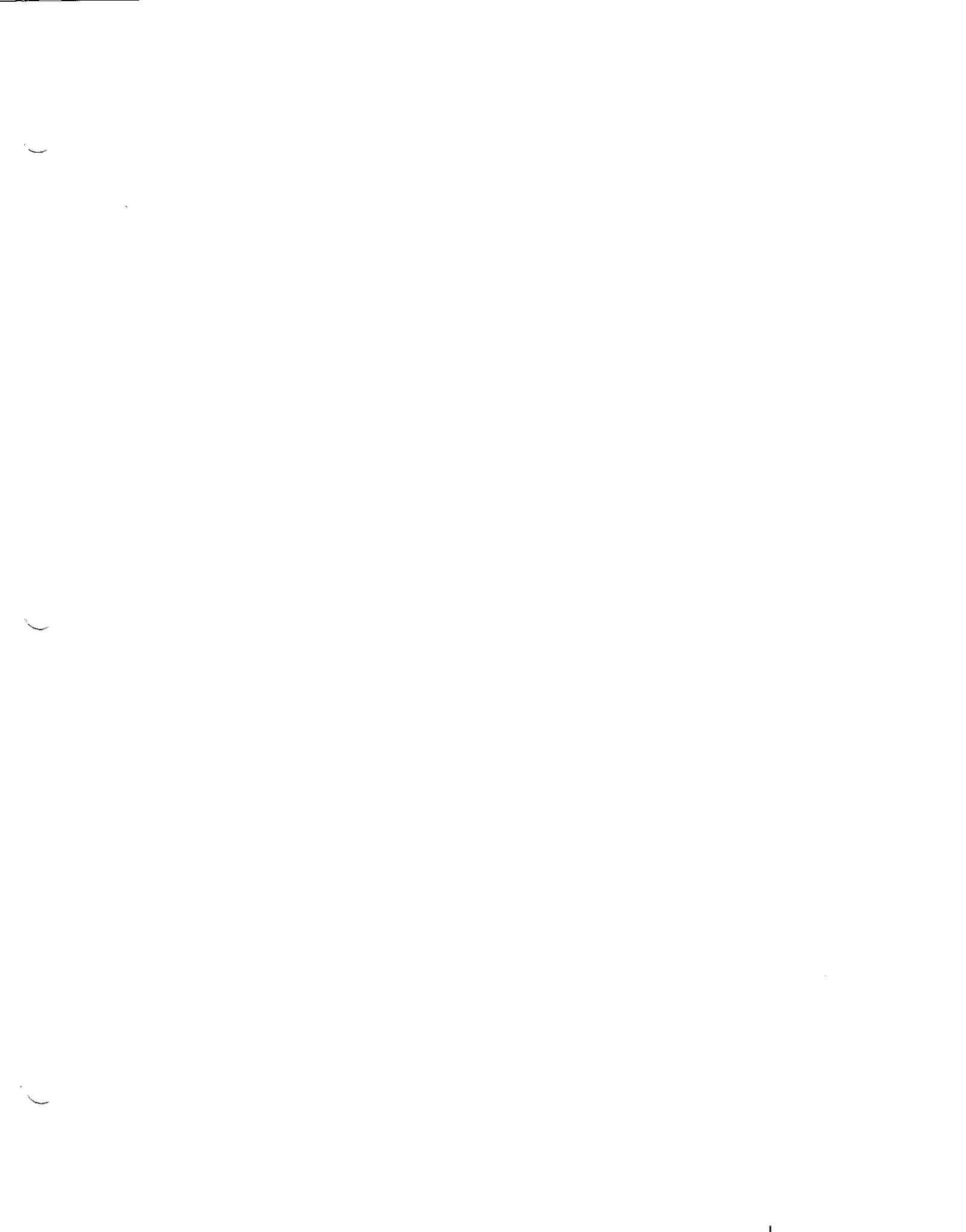
TITLE

(X6) DATE



Executive Director 01/30/15

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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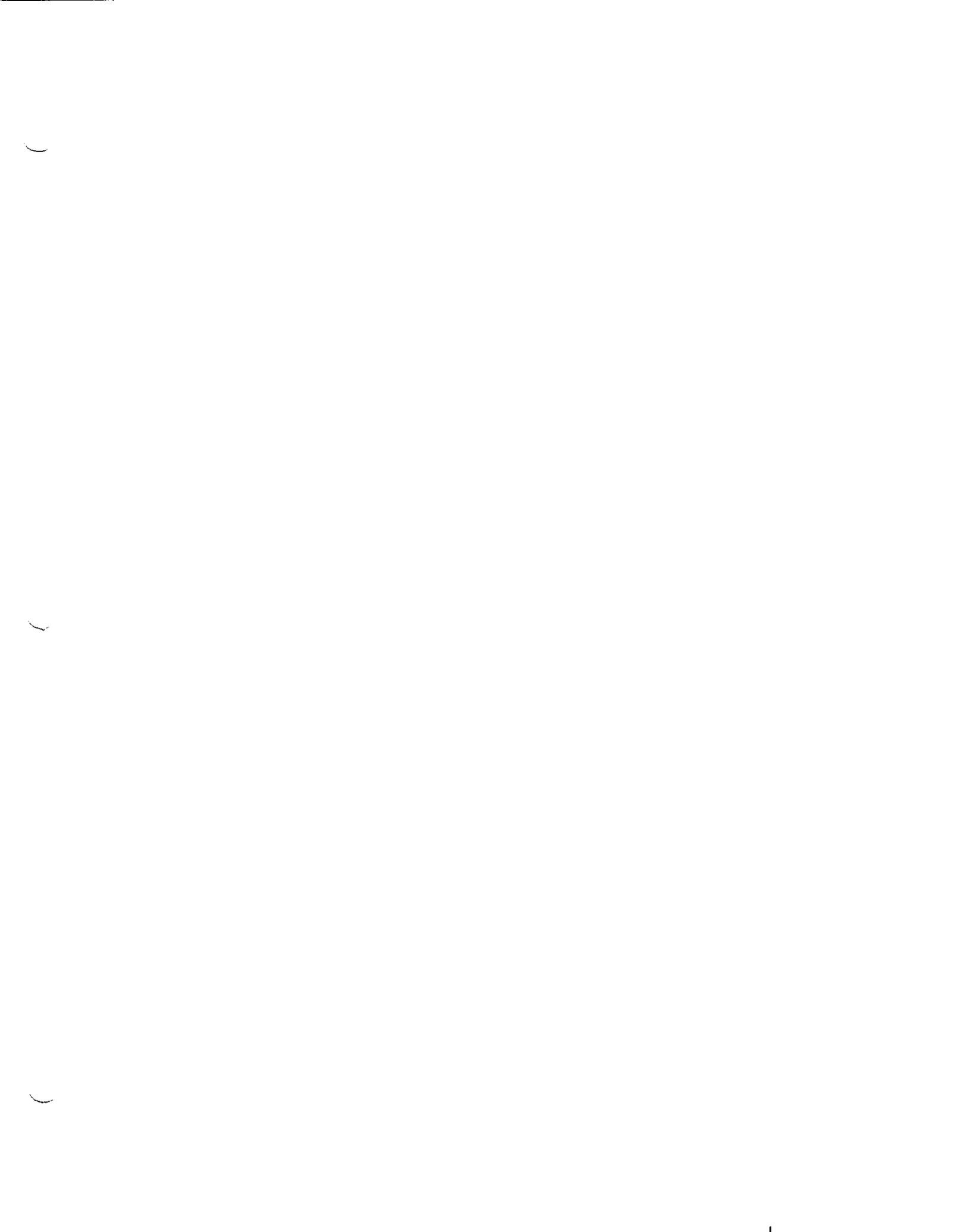
F 223	<p>Continued From page 1.</p> <p>wrote that on 12/4/14, Resident #1 told the LPN that the [Unit Manager] said that [s/he] was allowed to be [on the 5th floor]. After s/he said that, [the LPN] said to [him/herself] "[s/he's] not supposed to f---ing be up here." "What [the LPN] didn't realize is that [s/he] said it loud enough for me and [Resident #1] both to hear." When interviewed by phone by the Director of Nursing Services (DNS) and the 4th floor UM on 12/11/14, the LNA stated that it "slipped [his/her] mind and [s/he] had forgotten to talk to us about this matter."</p> <p>In an interview on 1/6/15 at 12:08 PM, Resident #1 stated that the above LPN "scared the sh-t out of me." S/he "was mean"... would say "go back downstairs, you don't belong here." S/he "made me feel unwanted and bad"...and "more paranoid." "I felt scared to come upstairs"... s/he [the LPN] "swore when other people could not hear" ...s/he "was careful."</p> <p>Per 1/6-1/7/15 review, Resident #1 was interviewed by a Resident and Family Services staff member on 12/10/14 and reported feeling "fearful and intimidated" by the above LPN and described him/her as having a "bad temper with a bossy and controlling approach" and generally makes [him/her] "feel uncomfortable" ...S/he "does not feel comfortable having [him/her] as [his/her] nurse."</p> <p>Per review of the facility policy, Reporting Abuse to Facility Management (Revised June 2004), page B-20, section 7. b. states "Verbal abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability."</p> <p>On 1/6/15 at approximately 2:54 PM, the facility</p>	F 223	<p>6. The results of the audits will be reported to the QAA committee by the DNS or designee monthly x3 months at which time the QAA committee will determine further frequency of the audits.</p> <p>7. Corrective action to be complete by 2/3/2015.</p> <p><i>F223 POC accepted 2/3/15 SDennis APP/PMU</i></p>	
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F 223	Continued From page 2 assistant administrator confirmed the above information from the investigative report and confirmed the definition of verbal abuse from the facility policy. On 1/6/15 at an interview beginning at 8:40 AM, the facility Director of Nursing (DNS) confirmed that the above mentioned LPN was suspended following the abuse allegations and his/her employment was terminated once the investigation was completed. S/he reported that the facility plans to report the LPN to the Board of Nursing. (Refer F225)	F 223			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged	F 225	<b>F225 483.13(c)(1)(ii)-(iii), (c)(2)-(4)</b>  1. Resident #1 is psychosocially stable. The employee no longer works in facility as a result of the alleged deficient practice. 2. All Residents have the potential to be affected by the alleged deficient practice. 3. All employees receive mandatory education regarding Abuse and Abuse Reporting upon hire. 4. Re-Education on abuse and abuse reporting requirements will be provided to all staff. 5. Random interviews will be conducted weekly for staff and residents by DNS or designee to evaluate the effectiveness of the plan.		



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NAME OF PROVIDER OR SUPPLIER

**BURLINGTON HEALTH & REHAB**

STREET ADDRESS, CITY, STATE, ZIP CODE

**300 PEARL STREET  
BURLINGTON, VT 05401**

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F 225	<p>Continued From page 3</p> <p>violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record and facility investigation review, the facility failed to ensure that all alleged violations involving mistreatment, neglect or abuse are reported immediately to the facility administrator for 1 of 3 applicable residents (Resident #1). The findings include: Per 1/6-1/7/15 review of the facility internal investigation dated 12/15/14, Resident #1 reported to an Ombudsman (on 12/10/14) that a staff Licensed Practical Nurse (LPN) said to [Resident #1], "What the f--- are you doing up here?" relative to the resident going up to the 5th floor from the 4th floor of the building. This incident was witnessed by a staff Licensed Nursing Assistant (LNA) who in a written statement, wrote that the LPN "repeatedly harassed" [Resident #1] about being on the floor when [s/he] "wasn't supposed to be." The LNA wrote that on 12/4/14, Resident #1 told the LPN that the [Unit Manager] said that [s/he] was allowed to be [on the 5th floor]. After s/he said that, [the LPN] said to [him/herself] "[s/he's] not supposed to f---ing be up here." "What [the LPN]</p>	F 225	<p>6. The results of the audit will be reported to the QAA committee monthly X3 months at which time the QAA committee will determine the frequency of further auditing.</p> <p>7. Corrective action will be complete by 2/3/15.</p> <p><i>F225 POC accepted 2/5/15 S Dennis APRN / PML</i></p>	

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F 225	Continued From page 4 didn't realize is that [s/he] said it loud enough for me and [Resident #1] both to hear." When interviewed by phone by the Director of Nursing Services (DNS) and the 4th floor UM on 12/11/14, the LNA stated that it "slipped [his/her] mind and [s/he] had forgotten to talk to us about this matter." Per review of the facility policy, Reporting Abuse to Facility Management (Revised June 2004), "It is the responsibility of our employees, facility consultants, attending physicians, family members, visitors, etc., to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of an unknown source, and theft or misappropriation of resident property to facility management." On 1/6/15 at approximately 2:54 PM, the facility assistant administrator confirmed the above information from the investigative report and policy and stated that the LNA should have reported the incident between the staff LPN and Resident #1 immediately to the facility administration. S/he reported that the LNA was disciplined and reeducated about Abuse and Neglect and reporting requirements once the facility became aware of the allegations. (Refer F 223)	F 225		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by:	F 241	<b>F241 483.15(a)</b>  1. Resident #1 is psychosocially stable and the employee no longer works in the facility as a result of this alleged deficient practice.  2. All Residents have the potential to be affected by the alleged deficient practice.	



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F 241	<p>Continued From page 5</p> <p>Based on resident and staff interview and record and investigative report review, the facility failed to promote care for 1 of 3 applicable residents in the sample in a manner and environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality (Resident #1). The findings include:</p> <p>Per 1/6-1/7/15 review of the facility internal investigation dated 12/15/14, Resident #1 reported to an Ombudsman (on 12/10/14) that a staff Licensed Practical Nurse (LPN) said to [Resident #1], "What the f--- are you doing up here?" relative to the resident going up to the 5th floor from the 4th floor of the building. This incident was witnessed by a staff Licensed Nursing Assistant (LNA) who in a written statement, wrote that the LPN "repeatedly harassed" [Resident #1] about being on the floor when [s/he] "wasn't supposed to be." The LNA wrote that on 12/4/14, Resident #1 told the LPN that the [Unit Manager] said that [s/he] was allowed to be [on the 5th floor]. After s/he said that, [the LPN] said to [him/herself] "[s/he's] not supposed to f---ing be up here." "What [the LPN] didn't realize is that [s/he] said it loud enough for me and [Resident #1] both to hear." When interviewed by phone by the Director of Nursing Services (DNS) and the 4th floor UM on 12/11/14, the LNA stated that it "slipped [his/her] mind and [s/he] had forgotten to talk to us about this matter."</p> <p>In an interview on 1/6/15 at 12:08 PM, Resident #1 stated that the above LPN "scared the sh-t out of me." S/he "was mean" ...would say "go back downstairs, you don't belong here." S/he "made me feel unwanted and bad" ...and "more paranoid." "I felt scared to come upstairs"... s/he [the LPN] "swore when other people could not</p>	F 241	<ol style="list-style-type: none"> <li>3. All employees received mandatory education regarding Resident Rights upon hire.</li> <li>4. Re-Education will be provided to staff regarding Resident's Rights.</li> <li>5. Random interviews will be conducted for staff and residents by DNS or designee to evaluate the effectiveness of the plan.</li> <li>6. The results of the audit will be reported to the QAA committee monthly X3 months at which time the QAA committee will determine the frequency of further auditing.</li> <li>7. Corrective action will be complete by 2/3/15.</li> </ol> <p>F241 POC accepted 2/3/15 SDennis AP/PMU</p>	
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F 241	<p>Continued From page 6</p> <p>hear" ...s/he "was careful."</p> <p>Resident #1 also reported that s/he preferred to spend time on the 5th floor where s/he felt more comfortable as s/he had been temporarily relocated to the 4th floor while his/her room on the 5th floor was being renovated.</p> <p>Per interview on 1/6/15 at approximately 10:40 AM, the 5th floor UM confirmed Resident #1 liked being on the 5th floor and confirmed that s/he had told Resident #1 that s/he could come up to the unit to watch TV. The UM also reported that Resident #1 was relocated back to the 5th floor sooner than originally planned as the resident did not do well with the relocation to the 4th floor and reported weight loss. The UM reported that s/he did not witness the LPN act in a way that was disrespectful of residents, but stated that this LPN "followed the rules ...did not bend them for anyone."</p> <p>Per 1/6-1/7/15 review, the facility's Nursing Home Resident's Rights states that "Residents have the right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility." Additionally, You [the resident] have the right to be treated with dignity and respect. The facility has an obligation to treat [you as] an individual and consider your individual needs and preferences and make reasonable accommodations of these needs and preferences."</p> <p>On 1/7/15 during an interview at approximately 12:25 PM, the Social Services supervisor confirmed the Resident Rights information listed above and confirmed that the comments by the LPN [related to Resident #1 being on the 5th floor</p>	F 241		

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F 241	Continued From page 7 unit) could be a dignity issue for Resident #1.	F 241			
F 329 SS=D	(Refer F223, F225) 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that 1 of 4 applicable residents in the survey sample was free from unnecessary drugs (Resident #2). Findings	F 329	<b>F329 483.25(I)</b>  1. Resident #2 was not affected by the alleged deficient practice. 2. Residents receiving medication have the potential to be affected by the alleged deficient practice. 3. Education will be provided to licensed nurses regarding follow up process for recommendations made by referred physicians. 4. Random weekly auditing will be conducted by DNS or designee to evaluate the effectiveness of the plan. 5. The results of the audit will be reported to the QAA committee monthly X3 months at which time the QAA committee will determine the frequency of further auditing. 6. Corrective action will be complete by 2/3/15.  <i>F329 POC accepted 2/5/15 Dennis Appen AM</i>		



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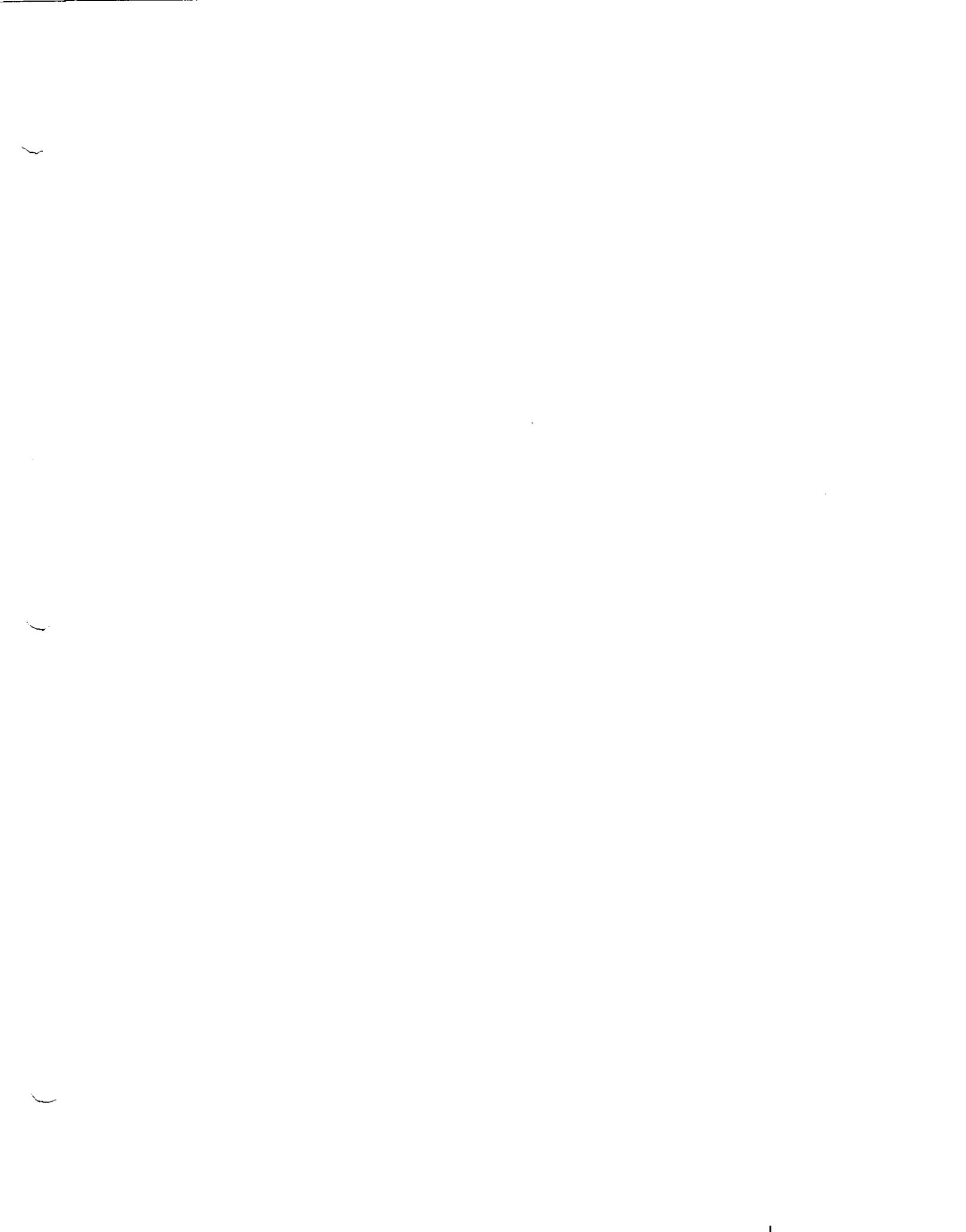
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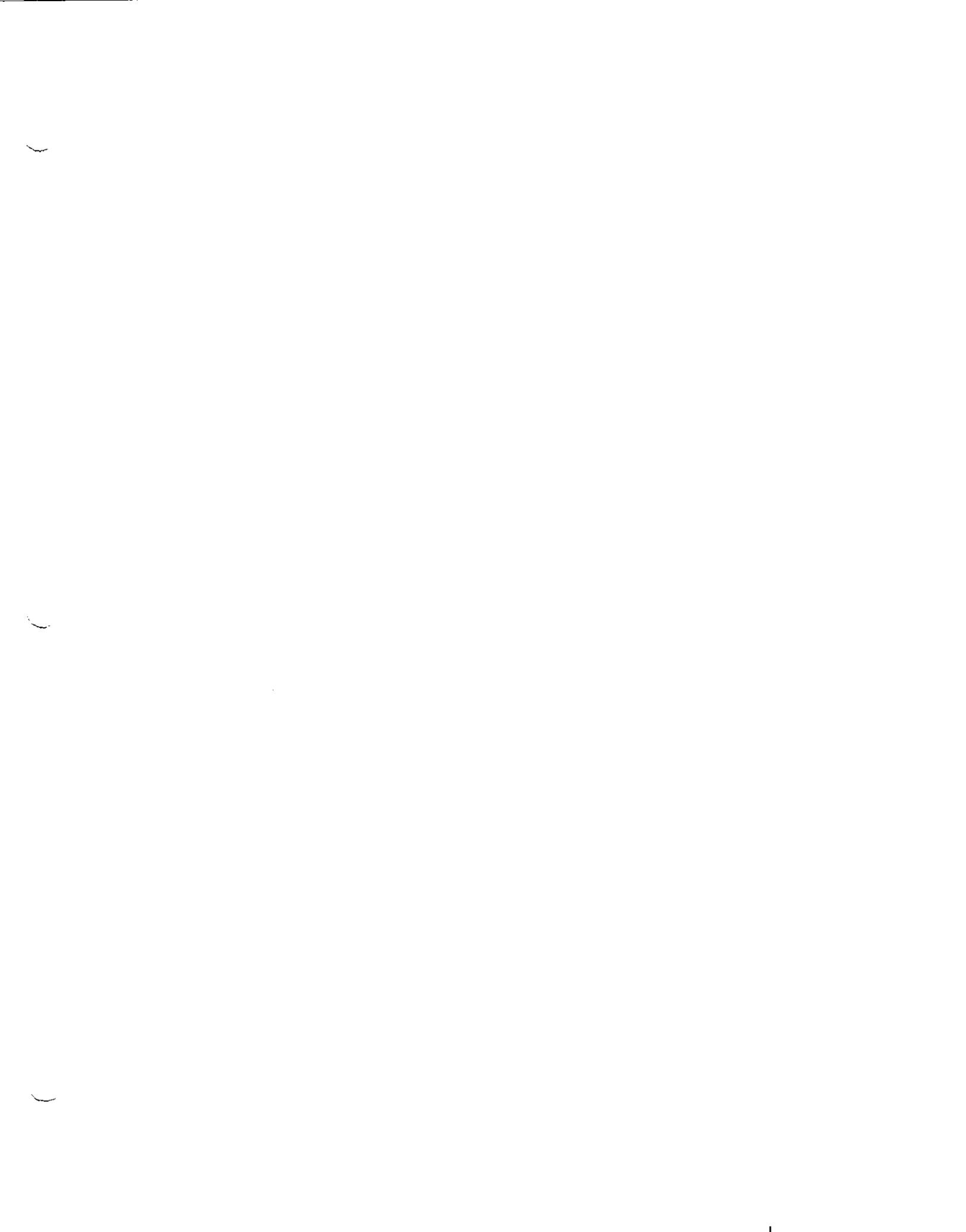
F 329	<p>Continued From page 8 include:</p> <p>Per 1/6-1/7/15 medical record review, Resident #2 was seen by an outpatient psychiatrist on 12/1/14; at the visit, the psychiatrist gave the resident a handwritten copy of medical recommendations to give to the facility. On 12/4/14 the psychiatrist faxed the completed 12/1/14 consult note to the facility. On the consult note, the psychiatrist wrote an order to "Discontinue AM Seroquel [an anti-psychotic medication] and if tolerated D/C Seroquel in 2 weeks." On 12/30/14, Resident #2 was seen for his/her next psychiatric consult visit and the psychiatrist wrote "uncertain why dose [Seroquel] was not reduced last month" and under plan, repeated recommendation to "D/C AM Seroquel and if tolerated, D/C HS Seroquel in 2 weeks."</p> <p>Per interview with the 5th floor Unit Manager (UM) on 1/6/15 between 3-4 PM, s/he reported that when residents are seen in consult or when a consult note is received per fax, the note is brought to the attention of the nurse on the resident's unit. The nurse reads the note, signs to indicate that it was read; if there are recommendations, the nurse is expected to call the attending physician to see if s/he agrees with the consult recommendations; if the physician agrees, new orders are written for physician signature and the new order is implemented.</p> <p>The UM confirmed that a staff nurse signed the faxed 12/1/14 psychiatric consult note but there is no evidence that the primary physician was notified of the recommendation for a gradual dose reduction (GDR) of the resident's Seroquel until 12/30/14 when the physician was contacted by a staff Registered Nurse; the physician then</p>	F 329		
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STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/07/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>BURLINGTON HEALTH &amp; REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 PEARL STREET BURLINGTON, VT 05401</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 329	Continued From page 9 approved the GDR. The UM confirmed that Resident #2's physician was not notified in a timely manner about the psychiatrist's recommendation and his/her Seroquel dose was not reduced for approximately 1 month from the time of the psychiatrist's recommendation. (Refer F428)	F 329		
F 428 SS=D	<b>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</b>  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assure that the consultant pharmacist reports any irregularities to the attending physician and Director of Nursing for 1 of 4 applicable residents reviewed during the survey (Resident #2). Findings include:  Per 1/6-1/7/15 medical record review, for Resident #2 there is no evidence a medication irregularity was reported by the pharmacist to the physician or to the Director of Nursing (DNS) regarding the facility acting on the recommendation made by a psychiatrist consultant on December 1, 2014 that Resident #2	F 428	<b>F428 483.60(c)</b>  1. Resident #2 was not affected by the alleged deficient practice. 2. Residents receiving medications have the potential to be affected by the alleged deficient practice. 3. Review requirements of Drug Regimen Review with pharmacist consultant. 4. Random weekly auditing will be conducted by DNS or designee to evaluate the effectiveness of the plan. 5. The results of the audit will be reported to the QAA committee monthly X3 months at which time the QAA committee will determine the frequency of further auditing. 6. Corrective action will be complete by 2/3/15.  <i>F428 POC accepted 2/5/15 sDennis APPH/pme</i>	



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F 428	<p>Continued From page 10</p> <p>trial a Gradual Dose Reduction (GDR) of his/her anti-psychotic medication.</p> <p>Per interview with the 5th floor Unit Manager (UM) on 1/6/15 at approximately 3:09 PM, Resident #2 was seen by an outpatient psychiatrist on 12/1/14. The psychiatrist gave the resident a handwritten copy of medical recommendations to give to the facility on 12/1/14 and on 12/4/14 faxed the completed 12/1/14 consult note to the facility. On the consult note, the psychiatrist wrote an order to "Discontinue AM Seroquel [an anti-psychotic medication] and if tolerated D/C [discontinue] Seroquel in 2 weeks." Pharmacy notes indicate that the pharmacist reviewed the resident's medical record on 12/28/14 and failed to alert the facility that the psychiatrist's recommendation to reduce the Seroquel dose had not been acted on. Resident #2 was seen for his/her next psychiatric consult visit on 12/30/14 and the psychiatrist wrote "uncertain why dose [Seroquel] was not reduced last month" and under plan, repeated recommendation to "D/C AM Seroquel and if tolerated, D/C HS [bedtime] Seroquel in 2 weeks."</p> <p>On 1/6/15 at approximately 3:09 PM, the UM confirmed the above information and confirmed that the consultant pharmacist would be expected to identify and report medication irregularities to the facility and primary physician to act upon and this had not happened.</p>	F 428		
F 516 SS=E	<p>(Refer F329)</p> <p>483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS</p> <p>A facility may not release information that is resident-identifiable to the public.</p>	F 516	<p><b>F516 483.75(l)(3), 48320(f)(5)</b></p> <p>1. No Resident was affected by the alleged deficient practice.</p>	



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F 516	<p>Continued From page 11</p> <p>The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>The facility must safeguard clinical record information against loss, destruction, or unauthorized use.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure that resident clinical records were stored in safe and secure manner that prevented unauthorized access. This had the potential to affect the confidentiality of medical information for residents living on the 5th floor unit. Findings include:</p> <p>On 1/7/15 at approximately 1:34 PM, a Unit 5 staff LPN reported that residents residing on the unit use the "Cubby Room" to make phone calls in privacy and/or to have a space for private visits. The nurse reported that there are no restrictions on the use of the room by the residents who wish to access the unit's portable phone (which is stored and charged in the room) or use the space for visits. Per interviews during the survey, both Resident #1 and Resident #2 reported using the space for private phone calls or visits without a staff person present in the room.</p> <p>Per observation with the 5th floor Unit Manager (UM) on 1/7/15 at approximately 1:47 PM, the</p>	F 516	<ol style="list-style-type: none"> <li>2. All Residents have the potential to be affected by the alleged deficient practice.</li> <li>3. Medical records were removed from the "cubby".</li> <li>4. Education will be provided to staff and medical record personnel regarding safeguarding of clinical records.</li> <li>5. Random weekly observations will be conducted by DNS or designee to evaluate the effectiveness of the plan.</li> <li>6. The results of the observations will be reported to the QAA committee monthly X3 months at which time the QAA committee will determine the frequency of further auditing.</li> <li>7. Corrective action will be complete by 2/3/15.</li> </ol> <p><i>F516 POC accepted 2/3/15 SDennis APR 1 PM</i></p>	



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F 516	<p>Continued From page 12</p> <p>cubby room (a space that is not within direct view from the nurse's station) contained 2 unlocked file cabinets and 9 unsecured cardboard storage boxes. Per observation and confirmed by the UM, thinned, overflow and past medical records for the resident's living on the unit that did not fit in their medical binders was stored in the files/boxes. The medical records were not secured and the room was unlocked.</p> <p>Per 1/7/15 review, the facility's policy titled, Release of Information (revised April 2010) states under Policy Interpretation and Implementation, section 5. "Access to the resident's medical records will be limited to the staff and consultants providing services to the resident. 6. Resident records, whether medical, financial, or social in nature, are safeguarded to protect the confidentiality of the information... 7. Closed or thinned medical records are maintained in the Medical Records Department and are available only to authorized personnel. Authorized personnel include, but are not necessarily limited to: a. Nursing Personnel; b. Physicians; c. Consultants; d. Support Services (i.e., Dietary, Activities, Social, etc.); e. Administration; f. Government Agencies; and/or g. Resident/Representative (Sponsor).</p> <p>The policy titled Location of Medical Records (Revised April 2010) states under Policy Interpretation and Implementation, section 2. "Medical records are stored in a locked room and protected from fire, water damage, insects and theft."</p> <p>On 1/7/15 at approximately 3:05 PM, the facility's assistant administrator confirmed that the above are the current policies re medical record storage</p>	F 516			



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F 516	Continued From page 13 and safekeeping. On 1/7/15 at approximately 1:47 PM, the 5th floor UM confirmed that the Cubby Room was unlocked and records in the room were not stored in a secure manner that prevented access by unauthorized personnel.	F 516			

