

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

January 25, 2012

Ms. Ursula Margazano, Administrator
Burlington Health & Rehab
300 Pearl Street
Burlington, VT 05401

Provider #: 475014

Dear Ms. Margazano:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **December 21, 2011**. 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, MS
Licensing Chief

PC:ne

Enclosure



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

PRINTED: 01/05/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/21/2011
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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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(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 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon observation, interview, and record review, the facility failed to provide care in a manner that maintains or enhances each resident's dignity and respect for 1 resident [Resident #19] of the sample group by leaving the resident wet with urine for 45 minutes after treating the visibly incontinent resident. The findings include:</p> <p>1. Per observation on 12/19/11 at 4:35 P.M. a Licensed Practical Nurse [LPN] performed a blood glucose check on Resident #19 by pricking the finger and drawing a drop of blood for testing, and administered 2 oral medications while the resident was lying in the bed with visibly wet shirt and pants and a strong urine odor in the room. The LPN left the resident's room without asking if the resident needed assistance and did not ask any other staff member to change the resident's wet clothes. Per record review, Resident #19's Admission Assessment on 4/27/06: "incontinent</p>	F 241	<p>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.</p> <p>The facility maintains that it promotes care for the residents in a manner and in an environment that maintains each resident's dignity and respect.</p> <p>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice? : Resident # 19 suffered no negative outcomes from this alleged deficient practice. Resident # 19 needs were addressed and incontinence protocol was reviewed with nursing on the unit. DNS, SDC, Nurse Mnger, &or Designee</p>	12/22/2011

POC ACCEPTED FOR F241
Susan J Emman RN
1/19/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 1/16/2012
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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.

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F 241	Continued From page 1 at times, difficulty stopping flow." Per record review, Resident #19's Care Area Assessment Summary on 10/12/11 - "urinary incontinence: frequently incontinent, extensive assistance." Per staff interview on 12/19/11 at 5:18 P.M. a Licensed Nursing Assistant in Resident #19's room stated h/she "was there just for showers" and Resident #19 had declined a shower. Per staff interview on 12/19/11 at 5:20 P.M. the Unit Manager [UM] confirmed Resident #19's room had an obvious urine odor and the resident was visibly wet on his/her shirt and pants. The UM confirmed it was her expectation that staff should have recognized the resident was wet with urine and his/her clothes needed to be and should have been changed immediately.	F 241	How will the facility identify other residents having the potential to be affected by the same deficient practice? : All incontinent residents are potentially affected by this alleged deficient practice What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? : Nursing re-educated regarding incontinence care and nursing rounds. DNS, SDC, &/or designee	On-going
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	F 279	How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? : 5 random audits per Unit of nursing rounds including incontinence for 4 weeks with results reported at Action Team and QA Meetings with changes made as appropriate. DNS, ADNS &/or designee	1/20/2012 1/16/12 On-going

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F 279	Continued From page 3 environment as much as possible, room change related to unable to sleep with roommate, encourage to express feelings, assess for isolation, invite to meals, involve family/significant other in resident plans". Per a social service interdisciplinary note of 12/05/11, specific interventions were noted, indicating the resident ambulates independently, utilizes baby stroller for assistance, likes to carry baby doll, resident uses communication board, and has a trach (tracheostomy). In addition, per the social service (SS) admission screen (11/15/11) the SS note states "family is not involved and the significant other died 4 years ago". Per interview on 12/21/11 at 10:30 AM, Social Service confirmed that the care plan did not reflect information accurately, the interventions were not comprehensively specific to provide care for this resident and the Preadmission Screening and Resident review (PASRR) was not completed.	F 279	What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? : Nursing and Social Service staff re-educated re: the development of comprehensive care plans. DNS, SDC, &/or designee	1/20/12
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	F 280	How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? : Initial audit of all residents with psychological diagnosis and use of psychotropic medications. 4 times per week the 24 hr report will be reviewed in Clinical stand-up meeting for accuracy and changes in care plans related to behaviors and psychotropic medication use with results reported at Action Team and QA Meetings with changes made as appropriate. DNS, ADNS &/or designee	1/20/2012 On-going

POC accepted for F279
Jan J. Emmons RN
1/19/12

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F 280	<p>Continued From page 4</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview the facility failed to ensure that the plan of care was revised and updated to accurately reflect the current behavior and medication status for one (#119) of 19 stage two sampled residents' care plans reviewed. Findings include:</p> <p>Per clinical record review on 12/20/11, Resident #119 was admitted on 03/05/11 with diagnoses of traumatic brain injury and behaviors with psychotic features. The plan of care indicated the Resident has called 911 several times to report a headache and to get assistance with intrusive Residents who wander into Resident #119's personal space. The plan of care for alteration in mood and behaviors indicated Resident #119 has daily outbursts that include being constantly on the move in a wheelchair, talking non stop with disconnected thought processes, talking loudly and inappropriately at times, and when extremely agitated, will attempt to grab objects and throw them. The interventions include the use of anti-psychotic medication twice daily for behavior lability. The plan of care did not indicate a preoccupation with money, frequent reports of stolen items or money, and accusations of staff</p>	F 280	<p>The facility maintains that the comprehensive care plans are updated and revised reflecting current behaviors and medications.</p> <p>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice? : Resident #119 has had no negative outcomes from this alleged deficient practice. Resident #119 continues at an optimal level of function without the use of psychotropic medications. Care plans were updated and revised to reflect her current behaviors. The use of anti-psychotic medication was resolved on the care plan. DNS, ADNS, SOC &/or designee</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice? : All residents with psychological diagnosis / behaviors are potentially affected</p>	<p>1/17/2012 On-going</p> <p>On-going</p>

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F 280	Continued From page 5 and residents stealing money or personal belongings. Review of the medication orders for December 2011 revealed no anti-psychotic medications. Review of the monthly pharmacy reviews for 2011 revealed a notation by the pharmacist on 04/28/11 that the anti-psychotic medication had been discontinued. Interview of the two Social Service staff on 12/20/11 at 3:00 P.M. revealed that Resident #119 was obsessed with money, removing the monthly allowance from the personal fund account the day it was available and refusing to secure it. They stated that Resident #119 is forgetful, misplaces the funds gives it to others to do shopping or run errands and often accuses others of stealing. Interview of the Licensed Practical Nurse caring for Resident #119 on 12/21/11 at 9:12 A.M., revealed that the Resident often comes out of the room on a rampage stating that things are stolen. The nurse confirmed on 12/21/11 at 2:30 P.M., during follow up interview, that the plan of care did not indicate the Resident displayed an obsession with money, frequently reported money stolen or refused to secure personal funds. The nurse also confirmed that the Resident has not taken anti-psychotic medication for several months and the plan of care continued to reflect this intervention.	F 280	What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? : Nurses and Social Service staff will be re-educated re: revising / updating care plans that reflect current behaviors and medications. DNS, ADNS, SDC &/or designee	1/20/2012
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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	F 282	How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? : 4 times per week the 24 hr report will be reviewed in Clinical stand-up meeting for accuracy and changes in care plans related to behaviors and psychotropic medication use with results reported at Action Team and QA Meetings with changes made as appropriate DNS, ADNS, &/or design	1/20/2012 On-going

Poc accepted F-280
Susan J. Emmons RN
1/19/12

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F 282	Continued From page 7 12/20/11 at 5:00 PM the Unit Manager confirmed the resident did not receive appropriate treatment and services as care planned.	F 282	<p>How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? : Initial audit of all residents on a functional maintenance program. 5 random audits per week / Unit Xs 4 weeks of residents with orthotic devices or maintenance programs with results reported at Action Team and QA Meetings with changes made as appropriate DNS, ADNS, SDC &/or design</p> <p><i>POC accepted F 282 Susan S. Emmons RN</i></p>	1/20/2012
F 309 SS=D	<p>Refer also to F318 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon observation, interview, and record review, the facility failed to provide the necessary care and services to attain or maintain the highest practical physical well being in accordance with the comprehensive assessment and plan of care regarding a resident who receives dialysis for 1 of 19 total stage 2 residents [Resident #168]. Findings include:</p> <p>1. Per record review Resident #168 active diagnosis list includes End Stage Renal Disease, Acute Kidney Failure, Chronic Renal failure. Per record review Resident #168's Care Plan, revised 8/31/11, states: Alteration in Elimination- interventions: monitor for any changes in elimination pattern; increased incontinence, decreased or increased output. Per record review Resident #168's Care Plan, revised 9/1/11 states: End Stage Renal Disease- Fluid restriction- 1500</p>	F 309		<p>The facility maintains that it provides the necessary care and services to attain or maintain the highest practicable physical well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice? : Resident #168 was not negatively affected by this alleged deficient practice. DNS, ADNS, Unit Mngr &/or designee</p>

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F 309	<p>Continued From page 8</p> <p>milliliters per day. Document compliance. Monitor urinary output. Attend dialysis without complications. Per staff interview with Unit Manager [UM] on 12/21/11 at 8:50 A.M., Licensed Nurses Aides [LNA] record Resident #168's oral intake and output [via bladder or bowel] during each shift daily in the LNA book and transfer this information to a computer. The Nurses take the information from the LNA book and transfer it to Resident #168's Treatment Book. Per interview with the LNA, LNA's estimate the amount of output in Resident #168's incontinence briefs and convert it to milliliters [ml's] then record it. "it depends on the person [LNA] if they write 'N/A' [not applicable] or estimate an amount" [in ml's].</p> <p>Per record review for 12/9/11 the LNA book recorded an output of 960 ml's versus 600 ml's in the Nurses Treatment Book. On 12/10/11 the LNA book recorded 480 ml's output for the first shift versus the Treatment Book which was blank. On the next shift the LNA book recorded 'N/A' versus the Treatment Book which recorded 'x5' [voided 5 times] with no amount noted. On 12/18/11 and 12/20/11 there were no entries in the Treatment Book. Per interview with staff Licensed Practical Nurse on 12/20/11 at 4:00 P.M. the nurses can obtain the LNA documentation through the computer, but the facility was in process of switching over to computers and h/she didn't "know how you get it from there". Per interview with the UM it is h/her expectation that Resident #168's I&O are documented each shift by both the LNA's in the LNA book and by Nurses in the Treatment Book in a consistent format and that the recorded amounts match. The UM confirmed there was</p>	F 309	<p>How will the facility identify other residents having the potential to be affected by the same deficient practice? : All dialysis residents are potentially affected by this alleged deficient practice.</p> <p>What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? : Nurses will be re-educated re: dialysis communication book. Documentation procedure re: I & O modified and nurses re-educated about updated procedure. DNS, ADNS, SDC &/or designee</p> <p>How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? : 5 random audits of Communication book accuracy and I & O documentation will be completed per week x 4 week results reported at Action Team and QA Meetings with changes made as appropriate. DNS, ADNS, Unit Mngr &/or designee</p> <p><i>POC F 309 accepted Susan S. Emmons, RN 1/19/12</i></p>	<p>On-going</p> <p>1/20/2012 On-going</p> <p>1/20/2012</p>
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F 309	<p>Continued From page 9 incomplete and missing data on the above mentioned dates, and that Resident #168's Intake and Output was not being monitored.</p> <p>2. Per record review Resident #168's Care Plan- At Risk for Weight Loss states to "monitor and document weight at dialysis". Per record review, Physician Orders state Dialysis 3 times weekly, Vital signs post dialysis. Per interview with the UM on 12/21/11 at 8:50 A.M. Vital signs for Resident #168 [blood pressure, temperature, heart rate, respirations] and weight before and after dialysis are done by the dialysis center and recorded in Resident #168's Dialysis Book for review upon return to the facility. If the vital signs and weights are not available, the facility can call the dialysis center for them. Per record review Resident #168 underwent dialysis on December 2, 5, 7, 9, 12, 14, 16, 19, 2011. Per record review, the Dialysis Book on 12/2/11 has no vital signs or weights recorded. On 12/7, no weights recorded. On 12/14 there is a handwritten note "can't find book" and no vital signs or weights recorded. On 12/16 there are no vital signs or weights recorded, and on 12/19/11 no weights recorded.</p> <p>Per staff interview with Unit Manager [UM] on 12/21/11 at 8:50 A.M. the UM confirmed there were missing vital signs and weights for the above mentioned dates, and there was no documentation that staff had called the facility for the information. UM confirmed it is clinically important to monitor Intake and Output [I&O] and weights of a dialysis patient, and without the information that was missing from the Resident #168's Dialysis Book, the resident's vital signs and weight could not be accurately monitored per</p>	F 309		

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F 318	Continued From page 11 window sill behind cards and objects. Per interview at that time the LNA stated that s/he "has not seen the sling since [the resident] came to the unit" on 12/09/11 and although the LNA stated s/he does not perform the exercises as noted on the paper, s/he "does ROM during care". Per record review the Resident was admitted for rehabilitation after a CVA (stroke). The care plan for alteration in function related to left hemiplegia dated 09/27/11 directs staff to help the resident to bath self, dress upper & lower, feed self with 1 assist, consult w/ PT/OT PRN, do not allow resident to become frustrated or to escalate, provide hands on assist PRN, implement consistent routines and allow time to complete tasks, provide positive feedback and re-enforce for all activities attempted, provide resident with adaptive equipment & support PRN. The LNA care plan directs staff to apply the sling during transfers and the hand splint should be applied from 9- 11 AM and 2-4 PM and during the night as tolerated. There was no updated care plan for PROM [passive range of motion] noted. Per interview on 12/20/11 at 2:00 PM the PT Director confirmed the resident did not receive appropriate treatment and services.	F 318	How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? : Initial audit of all residents on a functional maintenance program. 5 random audits per week Xs 4 weeks of documentation of ROM programs with results reported at Action Team and QA Meetings with changes made as appropriate. DNS, ADNS, SDC &/or design	1/20/2012
F 323 SS=D	Refer also to F282. 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.	F 323	POC F 318 accepted Susan J. Emmerson RN 1/19/12	

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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
F 323	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to assure the resident environment was maintained in a manner that was as free of accident hazards as possible. (Residents #151 and # 49) Findings include: 1. During interview, at 4:30 PM on 12/19/11, Resident #151, who occupied room #212 on the short term Rehab (Rehabilitation) Unit throughout his/her stay, stated that s/he had utilized the "grab bar" in the bathroom to stand up from the commode and that it was "very loose". During a tour of the physical environment, with the Maintenance Director, at 1:00 PM on 12/21/11, the towel rack bar on the bathroom wall in room #212 was very loosely attached creating a potential for the bar to fall if a resident attempted to utilize the bar as a grab bar to assist in standing. The Maintenance Director confirmed, at the time of observation, that the bar was a towel rack, not a grab bar, and it was not securely attached. S/he stated that grab bars are not utilized unless a request is made by Rehab Therapy to install one. During interview, at 2:10 PM on 12/21/11, the Director of Rehab Therapy confirmed that grab bars are not generally utilized for resident use in the bathrooms on the Rehab Unit, but that residents are educated in the use of the alternate adaptive equipment that is available in the bathrooms to assist them when standing from the commode. 2. Per record review, Resident #49's Care Plan dated 11/18/11 states "at risk for falls related to:	F 323	The facility maintains that it provides an environment that is as free of accidents as much as possible. How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice? : Resident # 151 and # 49 had no negative outcomes from this alleged deficient practice. Room 212 towel bar was tightened. DNS, ADNS, SDC &/or designee How will the facility identify other residents having the potential to be affected by the same deficient practice? : All residents are potentially affected by this alleged deficient practice.	1/20/2012 On-going

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PRINTED: 01/06/2012
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 13</p> <p>psychotropic drug use, history of falls, impaired physical performance, balance, mobility, constant writhing in chair. Utilize alarms at all times while up and in bed." Per record review, the Fall Risk evaluation dated 10/10/11 indicated the resident is at high risk for falls. Per record review, Nursing Notes dated 10/7/11 states Resident # 49 "has [his/her] lower extremities moving frequently, unaware that it will lead to fall. Resident was sitting in Dining Room. I witnessed resident slide to floor." Nursing Notes dated 10/10/11 state "wiggled forward in wheelchair and slid to floor". Nursing Notes Monthly note dated 12/13/11 states "resident very active when in wheelchair and bed". Per record review of the unit's Alarm Check book, it states to "Check alarm at beginning and end of shift. Initial that it is on and functioning". Per record review there were no alarm checks initialed for Resident #49 for the start or end of 3:00 P.M. to 11:00 P.M. shifts for Dec. 1- 18, 2011, and no checks initialed for the end of 7:00 A.M. to 3:00 P.M. shift signed for the same dates.</p> <p>Per record review of the unit's Alarm On Shift Change sheet, there were no checks or initials for 3:00 P.M. on 12/18-12/20, 2011, or 12/12 & 12/11, 2011. Per staff interview with Licensed Practical Nurse [LPN #1] and a Licensed Nursing Assistant [LNA] on 12/20/11 at 4:20 P.M. the Alarm Check book would be the only place to document if alarm checks were done. Both LPN #1 and LNA confirmed there were no alarm checks done for Resident #49 on 3:00 P.M. to 11:00 P.M. shifts for December 2011 or October 2011, no alarm checks done on 7:00 A.M.- 3:00 P.M. shift for October 2011, and gaps in documenting alarm checks on all shifts for</p>	F 323	<p>What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? :</p> <p>Maintenance completed at check of all towel bars and specified as a part of the Preventative Maint Program. Nurses will be re-educated re: documentation of alarm function / placement and physical plant round checks. DNS, ADNS, SDC, Maintenance, &/or designee</p> <p>How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? :</p> <p>5 random audits per week per unit Xs 4 weeks of documentation completion. DNS, ADNS, SDC &/or design</p> <p><i>POC F323 accepted Susan J. Emmens RN 1/19/12</i></p>	<p>1/20/2012</p> <p>1/20/2012</p>

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F 323	Continued From page 14 September 2011. Per staff interview with LPN #2 on 12/21/11 at 9:00 A.M. h/she will do alarm checks but the checks are not documented. Per interview on 12/21/11 at 9:00 A.M. the Unit Manager [UM] stated it was h/her expectation that all alarm check documentation should be consistent and complete, and there should be no blank spaces on the alarm checks. UM confirmed there was no documentation demonstrating that Resident #49's alarm was on and functioning at all times while up and in bed per the resident's Care Plan.	F 323		
F 332 NS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and interview, the facility failed to ensure that medications were administered with an error rate of less than five percent. Three medication errors were observed (involving Residents #35, #2, #182) out of 56 opportunities, resulting in an error rate of 5.357%. Findings include: 1. During observation of the medication administration for Resident #35 on 12/20/11 at 8:30 A.M., the medications were administered at the breakfast table, with the Resident's permission, during the meal. Seven medications were administered, including omeprazole (an acid reducer) 20 milligrams. Review of the Nursing 2011 Drug Handbook available at the nurses	F 332	The facility maintains that it ensures that residents receive medications with limited error rates. How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice? : Residents #35, #2, and #182 had no negative outcomes from this alleged deficient practice. Resident #2 incident report completed and physician notified. Resident #35 clarification on MAR re: time parameter of administration. Resident #182 nurse re-educated regarding asking for assistance when running late with medication administration. Nurses involved with medication administration error will perform competencies successfully X 3 approaches. DNS, ADNS, SDC &/or designee	1/20/2012

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F 353	<p>Continued From page 16</p> <p>provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident interview and record review the facility failed to assure the ongoing and consistent availability of staff to answer call lights and respond to residents requests for assistance in a timely manner for 3 of 3 residents in the targeted sample. (Residents #44, #61 and #54). Findings include:</p> <p>1. Per interview on 12/19/11 at 10:29 AM, Resident #54 who needs total assistance stated to the nurse surveyor that s/he has to "wait sometimes almost an hour to get up out of bed in the morning" after calling for assistance. Per interview with Resident #44 who needs extensive</p>	F 353	<p>The facility maintains that it ensures sufficient nursing and related services to attain and maintain the well-being of the residents.</p> <p>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice? : Residents # 44, 54, and 61 had no negative outcomes from this alleged deficient practice. Nursing staff re-educated re: call bell policy and acceptable response time. DNS, ADNS, SDC &/or designee</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice? : All residents are potentially affected.</p> <p>What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? : Nursing staff will be re-educated re: call bell system / equipment usage and call bell response expectations. DNS, ADNS, SDC &/or designee</p>	<p>1/20/2012</p> <p>On-going</p> <p>12/20/2012</p>
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F 353	Continued From page 17 assistance for all personal needs on 12/19/11 at 9:30 AM the stated to the nurse surveyor "staff are doing the best they can but there is not enough help, I need 2 staff and sometimes I wait hours for a response after using the call bell". Per interview on 12/19/11 at 1:37 PM, Resident #61 stated "I Have to wait a while, sometimes they come in turn off the bell saying they need to get help and then don't come back". Per interview on 12/20/11 at 1:30 PM, the DNS stated that if a call bell is not answered within 5 minutes the pager will beep again and after 10 minutes all staff, including the nurse's beeper will go off again with the expectation that staff respond within 10 minutes to all call lights. Per review on 12/20/11 at 2:45 PM of SMARTcare, audits which show the room location, when the call bell was initiated and the response time, indicated that residents #54, 61 and #44 waited, on several occasions, greater than 10 minutes. Resident #54 on 12/08/11 at 10:18 AM waited 38 minutes, on 12/14/11 at 8:44 PM - 18 minutes, on 12/15/11 at 7:18 PM - 23 minutes, on 12/16/11 at 1:23 PM and 5:52 PM - 16 minutes, on 12/17/11 at 3:43 PM - 18 minutes and on 12/17/11 at 4:39 PM - 33 minutes. Resident #44 on 12/10/11 at 6:17 PM waited 42 minutes, on 12/10/ 11 at 11:14 PM - 16 minutes, on 12/11/11 at 4:58 PM - 40 minutes and on 12/11 11 at 5:47 PM - 16 minutes. Resident #61 on 12/12/11 at 8 AM waited 28 minutes, on 12/13/11 at 2:26 PM - 27 minutes, on 12/14/11 at 7:11 PM & 7:48 PM - 15 & 41 minutes respectively and on 12/15/11 at 6:40 PM - 25 minutes. Per interview on 12/20/11 at 3:00 PM the DNS	F 353	How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? : Initial audit of all call bell equipment to ensure function and nursing staff understanding. 5 daily audits per week X 4 weeks of call bell response outcomes to ensure 90% success in response of 15 mins or below with results reported at Action Team and QA Meetings with changes made as appropriate. DNS, ADNS, SDC &/or design	12/22/2012
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F 353 POC accepted
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1/19/12

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F 353	Continued From page 18 and Administrator confirmed, staff didn't answer the call bells within a timely manner to meet resident's needs.	F 353		