



**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

July 15, 2010

Ms. Leslie Whittington, Administrator  
Gill Odd Fellows Home  
8 Gill Terrace  
Ludlow, VT 05149

Dear Ms. Whittington:

Enclosed is a copy of your acceptable plans of correction for the annual survey conducted on June 22, 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 "Suzanne E. Leavitt RN, MS".

Suzanne Leavitt, RN, MS  
Assistant Director



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

PRINTED: 07/06/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/22/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GILL ODD FELLOWS HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8 GILL TERRACE LUDLOW, VT 05149</b>
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F 000	INITIAL COMMENTS	F 000	F 157 What was done for this resident?	
F 157 SS=D	<p>An unannounced onsite recertification survey was conducted by the Division of Licensing and Protection on 6/21/10-6/22/10.</p> <p><b>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</b></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>Resident #24 received first aid. Resident was not in pain, as evidenced by pain assessment. Neuro vital signs were within normal range. Speech and orientation were at baseline per nurse's note. What was done to identify if other residents were at risk? Reviewed fall log to determine no other residents at risk. What systematic changes were put in place to avoid further occurrences? In-service conducted with staff to review fall protocol. What will be done to measure compliance? The fall log will be monitored weekly by the DNS/designee and chart audit to follow to ensure compliance. Results will be brought to CQI monthly x3 months.</p> <p>Date of completion 7/16/10</p> <p>POC Accepted 7/15/10 <i>[Signature]</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>[Signature]</i>	TITLE  <b>CNHA</b>	(X6) DATE  <b>7-14-2010</b>
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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 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the physician immediately of an accident with injury for 1 of 3 residents in the targeted sample (Resident #24). Findings include:</p> <p>1. Per record review, Resident #24 had an unwitnessed fall on 5/15/10 at 3:35 AM. The nurse's note stated that the resident was on the floor holding a hand over a visible lump on the head, complaining of pain. The note stated that the resident's speech was altered from usual, and a neurological assessment revealed that the pupils were unequal. The Resident's family representative and the physician were not notified of the fall with injury resulting until 11:00 AM on 5/15/10. Per interview on 6/22/10 at 2:20 PM, the night shift nurse who discovered that the resident had fallen, and the day shift nurse who came on at 6:00 AM both confirmed that the family and the physician were not notified of the incident until approximately seven and a half hours later.</p>	F 157	<p><del>F 248 What was done for this resident? Resident #34 behavior plan put in place to address residents frequent change of preferences to ensure her enjoyment and feelings of self value. What was done to identify if other residents were at risk? Reviewed other residents with diagnosis of psychosis, depressive disorder with Parkinsonism to ensure behavioral care plan in place. What systematic changes were put in place to avoid further occurrence? Residents with diagnosis of psychosis, depressive disorder with Parkinsonism will have a recreational behavioral care plan put in place. What will be done to measure compliance? Recreational Assistant Director will report results to IDT quarterly and IDT will make any recommendations based on results.</del></p>	
F 248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and record review, the facility failed to provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment,</p>	F 248	<p><del>F 248 What was done for this resident? Resident #34 behavior plan put in place to address residents frequent change of preferences to ensure her enjoyment and feelings of self value. What was done to identify if other residents were at risk? Reviewed other residents with diagnosis of psychosis, depressive disorder with Parkinsonism to ensure behavioral care plan in place. What systematic changes were put in place to avoid further occurrence? Residents with diagnosis of psychosis, depressive disorder with Parkinsonism will have a recreational behavioral care plan put in place. What will be done to measure compliance? Recreational Assistant Director will report results to IDT quarterly and IDT will make any recommendations based on results.</del></p> <p><i>see addendum</i></p>	

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F 248	Continued From page 2 the interests of each resident for 1 of 4 residents in the targeted sample (Resident #34). Findings include:  1. Per resident interview on 6/21/10 at 10:05 AM, Resident #34 states that "I have nothing to do. They don't have anything I like to do." Per record review on 6/22/10 the resident's current Activities Care Plan states that the "resident will continue to make choices regarding ADLs (Activities of Daily Living)" and does not indicate individualized activities to offer the resident, or specific interventions and goals. Interview with the Activities Director on 6/22/10 at 9:58 AM confirmed that the current Activities Care Plan does not list individualized activities, approaches, or goals for the resident. These findings were confirmed with the DON (Director of Nurses) on 6/22/10 at 2:35 PM.	F 248	<del>This will be monitored by CQI quarterly x3. Date of completion 7/16/10</del>	See addendum
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	F 279	F 279 What was done for this resident? Resident #34 behavior plan put in place to address residents frequent change of preferences to ensure her enjoyment and feelings of self value. What was done to identify if other residents were at risk? Reviewed other residents with diagnosis of psychosis, depressive disorder with Parkinsonism to ensure behavioral care plan in place. What systematic changes were put in place to avoid further occurrence? Residents with diagnosis of psychosis, depressive disorder with Parkinsonism will have a recreational behavioral care plan put in place.	

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F 279	<p>Continued From page 3</p> <p>due to the resident's exercise of rights under §483.10; including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and record review, the facility failed to use the results of the assessment to develop a comprehensive care plan that includes measurable objectives and appropriate goals to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being for 1 of 21 residents in the stage 2 sample (Resident #34). Findings include:</p> <p>1. Per resident interview on 6/21/10 at 10:05 AM, Resident #34 states that "I have nothing to do. They don't have anything I like to do." Per record review on 6/22/10 the resident's current Activities Care Plan states that the "resident will continue to make choices regarding ADLs (Activities of Daily Living)" and does not indicate individualized activities to offer the resident, or specific interventions and goals. During an interview on 6/22/10 at 9:58 AM, the Activities Director confirmed that the current Activities Care Plan does not list individualized activities, approaches, or goals for the resident. These findings were confirmed with the DON on 6/22/10 at 2:35 PM.</p>	F 279	<p>What will be done to measure compliance? Recreational Assistant Director will report results to IDT quarterly and IDT will make any recommendations based on results. This will be monitored by CQI quarterly x3. Date of completion 7/16/10 POC Accepted 7/15/10 <i>Amotarn</i></p>	
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p>	F 280	<p>F 280 What was done for this resident? Resident #22 was not receiving Coumadin. Resident was not at risk for any negative outcomes. Care Plan updated to reflect current status. What was done to identify if other residents' were at risk? MDS Coordinator will audit 5 random charts with care plans for accuracy. What systematic changes were put in place to avoid further occurrences? 672 reviewed and initialed with DNS/designee monthly.</p>	

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F 280	<p>Continued From page 4</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment, prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that the plan of care was revised to reflect current status for 3 of 21 residents in the stage 2 sample (Residents #22, #24, #25). Findings include:</p> <p>1. Per record review, Resident #22 had been on anti-coagulant therapy, and had a plan of care dated 5/2/09 to address the goals and interventions associated with the use of Coumadin. Per review of the Nurse's Progress Notes and MD orders, the resident was discontinued from the Coumadin therapy on November 20, 2009. The Plan of Care updated/reviewed on 1/20/10, and most recently on 3/18/10, still had an active page indicating the resident was on anti-coagulant therapy. Per interview on 6/22/10 at 1:20 PM, the Assistant Director of Nursing confirmed that the plan of care had not been revised to reflect the</p>	F 280	<p>What will be done to measure compliance? 672 will be brought to CQI quarterly for review. What was done for this resident? Resident # 24 Care plan was updated to reflect current status. What was done to identify if other residents' were at risk? The fall log reviewed for the last 3 months to ensure care plans reflected falls and updated to reflect status. What systematic changes were put in place to avoid further occurrences? The fall log will be monitored weekly by the MDS coordinator to ensure care plans reflect falls. What will be done to measure compliance? The fall log will be brought to CQI for review monthly x 3 months.</p>	

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F 280	Continued From page 5 discontinuation of the anti-coagulant.  2. Per record review, Resident #24 had a history of multiple falls since their admission in January 2010. Per review of the plan of care for this resident, only some of the falls were listed. The resident had a fall on 3/18/10, 6/6/10, and on 6/8/10 documented in the Nurse Progress Notes. These three falls were not recorded on the resident's Plan of Care, and there were no updates to reflect any new interventions to reduce the potential for further falls. Per interview on 6/22/10 at 1:20 PM, the Assistant Director of Nursing confirmed that the care plan was not revised to reflect all the actual falls sustained by the resident, and no further interventions were added to help prevent falls for this resident.  3. Per record review and confirmed by staff interview, the plan of care for Resident #25 around nutrition was not revised to reflect a change in diet consistency or a discontinuation of a nutritional supplement. The current nutrition plan of care states that Resident #25 receives a nutritional supplement and states that the Resident's diet order is for thin liquids. Per review of the current signed physician orders for Resident #25 and the current MAR (Medication Administration Record), the Resident is not currently receiving a nutritional supplement, and the current diet order is for nectar thick liquids. During an interview on 6/22/10 at 2:15 PM, the DON (Director of Nurses) confirmed that the plan of care was not revised to reflect the discontinuation of the nutritional supplement or the change in diet consistency.	F 280	What was done for this resident? Resident # 25 Weight is still above Ideal BMI. The residents care plan was updated to reflect current weight loss plan. What was done to identify if other residents' were at risk? Registered Dietician (RD) reviewed all residents with weight loss plans to ensure care plans updated to reflect current status. What systematic changes were put in place to avoid further occurrences? A communication form will be put in RD mailbox with every diet order change and every supplement change. In-service will be provided to all staff. What will be done to measure compliance? RD will have all communication forms dated and initialed after she updates the care plan to reflect changes. These		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281			

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F 281	<p>Continued From page 6</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to provide services in accordance with professional standards for 3 of 21 residents in the stage 2 sample (Residents #29, #17, and #45). Findings include:</p> <p>1. Per record review on 6/22/10, staff failed to implement the 3/10/10 pharmacist recommendation signed by the physician for Resident #29 to change the indication for Nefazodone from osteoarthritis to depression. Per record review on 6/22/10, the Physician Order Sheet for 6/1/10 through 6/30/10 did not reflect the 3/11/10 pharmacist's recommendation signed by the physician. Per review of the Medication Administration Review (MAR) on 6/22/10, Resident #29 received Nefazodone 50 mg tablet 3 tabs (150 mg) PO (by mouth) every AM from 6/1/10 to 6/22/10. Per interview on 6/22/10 at 2:50 PM, the Director of Nursing (DON) confirmed staff failed to implement the pharmacist's recommendation signed by the physician to change the indication for Nefazodone from osteoarthritis to depression.</p> <p>2. Per record review on 6/22/10, staff failed to implement the 6/3/10 physician order for Resident #17 for Prilosec OTC (over the counter) 2 tabs 20 mg orally twice daily for Gastric Esophageal Reflux Disease (GERD). Per review of the Medication Administration Record (MAR) on 6/22/10, Resident #17 received Prilosec OTC 20 mg 2 tabs once per day from 6/4/10 to 6/21/10.</p>	F 281	<p>communication slips will be monitored by the DNS/designee. These forms will be reviewed at CQI monthly x 3 months.</p> <p>Date of completion 7/16/10 POC Accepted 7/15/10 P.M. O'CONNOR</p> <p>F 281 What was done for this resident? Resident # 29 no negative outcome determined to be related to not having correct diagnosis in the black box warning, as it was listed on the bottom of the MAR and the physician orders, which were signed by the physician. Residents MAR updated to reflect indication for use which had previously been updated to depression from physician. What was done to identify if other residents were at risk? Monthly change over audit done by DNS/ADNS.</p>	

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F 281	Continued From page 7 On 6/22/10 at 8:25 AM, the DON confirmed that Resident #17 received Prilosec 20 mg 2 tabs once per day instead of twice per day from 6/4/10 to 6/21/10.	F 281	What systematic changes were put in place to avoid further occurrences? Changeover to be completed by 2 nurses and all orders to be co-signed by 2 <sup>nd</sup> nurse. In-service provided. What will be done to measure compliance? DNS/Designee will do 5 chart audits monthly x 3 months and bring those results to CQI. What was done for this resident? Resident # 17 was assessed, responsible party and physician were notified.. What was done to identify if other residents were at risk? Monthly change over audit done by DNS/ADNS. What systematic changes were put in place to avoid further occurrences? Changeover to be completed by 2 nurses and all orders to be co-signed by 2 <sup>nd</sup> nurse. In-service provided.	
F 325 SS=D	3. Per record review on 6/22/10 at 10:35 AM, the facility did not provide a physical therapy evaluation and treatment for Resident #45 as indicated by a physician's order dated 4/16/10 and signed by the physician on 4/29/10. The DON confirmed at 11:25 A.M. on 6/22/10 that there was an order for a physical therapy evaluation and treatment and that there was no documentation in the clinical record that the evaluation had been completed. Per a telephone interview with the Physical Therapist At 12:42 PM on 6/22/10, sh/e confirmed that the evaluation and treatment had not been done. <b>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</b>  Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325		

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F 325	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that 2 of 3 residents in the targeted sample are free from unplanned, avoidable significant weight loss (Residents #25, #40). Findings include:</p> <p>1. Per record review and confirmed by staff interview, Resident #25, who is dependent on full staff assistance for meals, had a significant, avoidable weight loss of 7% in one month, from 4/15/10 to 5/13/10. The resident was not identified in the nutrition notes to be on a planned weight loss program. The last nutritional assessment, completed and signed by the Registered Dietician (RD) on 3/31/10, states "weight is decreased slightly...continue current plan for now." There were no further nutrition notes or assessments in the medical record.</p> <p>Per review of the Consultant Dietician Reports from April 2010 to present, which are submitted to the DON on a weekly basis, but not part of the resident's medical record, the RD identified a 6.6 lb (pound) weight loss for Resident #25 on 5/12/10 and requested that staff re-weigh the resident. The re-weigh was completed, and was consistent with the 5/12/10 weight. The next week, the report dated 5/19/10 states again to re-weigh Resident #25, which was completed, and the RD notes an 8 lb weight loss. There was no further mention of Resident #25 in the Consultant Dietician Reports after the 5/19/10 report, and no evidence of any assessments, follow-up, or interventions completed in the medical record.</p>	F 325	<p>What will be done to measure compliance? DNS/Designee will do 5 chart audits monthly x 3 months and bring those results to CQI. What was done for this resident? Resident # 45 was offered therapy and declined. What was done to identify if other residents were at risk? PT reviewed all screen received in the last 30 days to ensure follow through with orders. What systematic changes were put in place to avoid future occurrences? PT has a new checklist form to use to ensure compliance with all physician orders. What will be done to measure compliance? PT will submit monthly the checklist form for CQI to review monthly x 3 months to ensure compliance. Date of completion 7/16/10 <i>POC Accepted 7/15/10 P. Mcotarn</i></p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  GILL ODD FELLOWS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 8 GILL TERRACE LUDLOW, VT 05149		
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F 325	Continued From page 9 Per review of the current physician orders and MAR for Resident #25, there are no dietary supplements ordered for or received by the resident. The current plan of care for Resident #25 does not address actual significant weight loss, and the nutrition plan of care does not reflect the current diet or current interventions (Refer to F280). Per review of Nurses' Notes and Physician Progress Notes, there is no evidence that the physician was notified of the significant weight loss. During an interview on 6/22/10 at 2:15 PM, the DON confirmed that the significant weight loss was identified by the RD and confirmed the lack of assessment, follow-up, or interventions related to the weight loss. Per record review and staff interview on 6/22/10, Resident #40, who has a care plan dated 3/24/10 stating that s/he needs to be fed by staff, had an unplanned significant weight loss of 10.5% of his/her body weight over a six month period. Per review of the Vital Signs and Weight Records, on 12/20/2009 Resident #40 weighed 171.8 and on 6/20/10 Resident #40 weighed 153.8 lbs. Per review of a Nutrition Assessment dated 3/24/10, the Resident was assessed as "Weight stable. Skin intact", and the plan was to "Provide routine care. Continue to monitor tolerance of current diet/liquid intake". There was no evidence in the medical record that weight loss was part of the plan of care for Resident #40.  Per interview on 6/22/10, the Director of Nurses confirmed that there was no evidence in the medical record that the significant weight loss was expected or planned for.	F 325	F 325 What was done for this resident? Residents #25 and # 40 are both still above IBM. Residents care plans were updated to reflect current weight loss plans. What was done to identify if other residents are at risk? RD will review all care plans triggered for weight loss in the last 3 months. What systematic changes were put in place to avoid further occurrences? MDS coordinator will present RD with MDS QI tool of all weight losses monthly. What will be done to measure compliance? RD will hand in monthly x 3 months all weigh issues to CQI with interventions/POC.  Date of completion 7/16/10 <i>POC Accepted 7/16/10 AmcotarN</i>		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS  The facility must develop policies and procedures	F 334			

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F 334	<p>Continued From page 10 that ensure that –</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that –</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse</p>	F 334	<p>F334 What was done for this resident?</p> <p>Resident and/or responsible party received education on immunizations.</p> <p>What was done to identify if other residents were at risk?</p> <p>Chart audit done on all present residents.</p> <p>What systematic changes were put in place to avoid further occurrences?</p> <p>Consents will be put in admission package and then will be placed in resident's medical record. All consents have been sent to families of those residents who cannot make decisions for themselves.</p> <p>What will be done to measure compliance?</p> <p>Monthly audit will be done on all new admits by the DNS/designee and results will be brought to CQI x 3 months.</p> <p>Date of completion 7/16/10</p> <p><i>PDC Accepted 7/15/10 Pmatar RN</i></p>	

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F 334	<p>Continued From page 11 immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to obtain informed consent to ensure that before offering influenza immunizations, each resident or each resident's legal representative received education regarding the benefits and side effects of the immunization. Findings include:</p> <p>1. On 6/22/10 a random record review was conducted for residents who had received influenza immunizations for the 2009-2010 flu season. There was no evidence that any of the long term care residents or their legal representatives had received education regarding</p>	F 334	<p>F431 What was done for this resident? Ensured that these expired products were not used on residents. What was done to identify if other residents were at risk? Checked dates on medications in medication cart, medication fridge and med/supply storage room to ensure no other expired products. What systematic changes were put in place to avoid further occurrences? Nurse assigned monthly to do audit of medication carts, medication fridges and med/storage room for any expired medications or any medical related equipment. What will be done to measure compliance? Checklist will be handed monthly to the DNS who will bring to CQI monthly x 3 months for review. Date of completion 7/16/10 POC Accepted 7/16/10 <i>AMC/ARW</i></p>		

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F 334	Continued From page 12 the risks/benefits of the flu vaccine before they were immunized. On 6/22/10 at 3 p.m. the ADON (Assistant Director of Nursing) confirmed that informed consent was not obtained for any long term care residents present at the facility before the 2009-2010 flu season.	F 334	F 502 What was done for this resident? Ensured that these expired products were not used on residents.	
F 431 SS=D	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 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 431	What was done to identify if other residents were at risk? Checked dates on medications in medication cart, medication fridge and med/supply storage room to ensure no other expired products. What systematic changes were put in place to avoid further occurrences? Nurse assigned monthly to do audit of medication carts, medication fridges and med/storage room for any expired medications or any medical related equipment. What will be done to measure compliance? Checklist will be handed monthly to the DNS who will bring to CQI monthly x 3 months for review.  Date of completion 7/16/10  POC Accepted 7/15/10 P. Maturin	

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F 431	Continued From page 13 be readily detected.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure that all medications stored in the medication refrigerator were within the expiration dates. Findings include:  1. Per observation on 6/21/10 during a check on drug and biologic storage at the facility, there were two items in the medication refrigerator in the nurse's station that were stored beyond the expiration date. A box of medicated hemorrhoid treatment pads had an expiration date of October 2007, and a bag of Promethazine suppositories had an expiration date of February 1, 2010. These observations were confirmed with the Assistant Director of Nursing on 6/21/10 at 12:15 PM.	F 431		
F 502 SS=E	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY  The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure the quality of laboratory testing equipment. Findings include:  1. Per observation on 6/21/10 at 12:15 PM, the medication refrigerator contained a box of test	F 502		

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F 502	<p>Continued From page 14</p> <p>strips to perform a PT/INR blood test that had an expiration date of July 30, 2009. Per interview on 6/21/10 at 12:30 PM, the Assistant Director of Nursing and the Ward Clerk who monitors the lab equipment stock confirmed that the test strips were stored beyond the expiration date.</p> <p>2. Per observation on 6/21/10 at 12:25 PM during inspection of the medication/supply storage room, there were glass blood specimen tubes that were stored beyond the expiration date. There were five green top blood sample tubes (used for Basic Metabolic Panel analysis) in the tray used by the nurses for venipuncture, and in the cabinet used to store the back-up was the remainder of the box which had an expiration date of May 2010. Also stored in the cabinet was an unopened box of orange top blood sample tubes (used for drug and alcohol screening) that were expired April 2010. Per interview on 6/21/10 at 12:30 PM, the Ward Clerk and the Assistant Director of Nursing confirmed that these items were stored beyond their expiration dates.</p>	F 502		

# Addendum

F248

What was accomplished for this resident.

The Recreation Care Plan for Resident # 34 was reviewed and revised to include individual recreational choices.

What accomplished to determine if other residents were at risk.

Recreational Plans for residents with Self directed recreational pursuits were reviewed and revised as appropriate to include individualized recreational choices.

What systematic changes were accomplished

To ensure future compliance.

A separate recreational binder will

Be created to include all residents with self directed Recreational pursuits.

This binder will include a plan and a list

Of individual preferences for recreational

Plans for each resident.

This binder will be reviewed quarterly

By the Interdisciplinary Team to ensure

That each residents recreational needs are being met.

What was accomplished to monitor ongoing compliance.

Recreation staff will review results with the

Quality assurance  
committee at least  
Quarterly for one year.  
The Recreation Department  
and the  
Interdisciplinary Team will  
be responsible  
For this Plan.

Completion Date is 7/16/10. (Per telephone discussion w/ Leslie Whittington, ADM  
at 2:20 pm on 7/15/10.

POC Accepted 7/15/10 AmotARN