

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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475042 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 04/07/2010 |
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| NAME OF PROVIDER OR SUPPLIER MAPLE LANE NURSING HOME | STREET ADDRESS, CITY, STATE, ZIP CODE 60 MAPLE LANE BARTON, VT 05822 |
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| F 000 | <p>INITIAL COMMENTS</p> <p>An unannounced on-site recertification survey was conducted by the Division of Licensing and Protection on April 5-7, 2010. The following deficiencies were identified.</p> <p>F 164 SS=E 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p> | F 000 | <p>F 164: Please see attached Plan of Correction</p> | 5/14/10 |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Francis E. Cheney III</i> | TITLE <i>Adm</i> | (X6) DATE <i>4/30/10</i> |
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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 164 | Continued From page 1 Based on observation and staff interview, the facility failed to maintain the privacy and confidentiality of eight residents in the sample. (Residents #20, #22, #30, #41, #45, #66, #64, #36) Findings include: 1. Per observation on 4/7/10 at 9:45 AM, eight resident charts were observed laid out on the unoccupied bed in the room of Resident #45. Per observation between 9:45 and 10:10 AM, there were no staff in the room supervising the resident's medical records. Per interview on 4/7/10 at 10:15 AM, the nurse who placed the records in the room confirmed that they were left in the room unattended, stated that they needed a place for the physician to see these residents privately, and that the resident who occupies that room is usually not in there during the day, and did not mind. Per interview on 4/7/10 at 10:20 AM, the nurse manager confirmed that the records were left unwatched in the resident's room in preparation for physician visits. Also per interview at this time, the nurse manager acknowledged that the use of the room would not allow the occupying resident access to the room while the physician was seeing other residents. | F 164 | | | |
| 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. | F 279 | | Please see attached 5/14/10 Plan of Correction | |

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F 279: Continued From page 2

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview the facility failed to develop a comprehensive care plan for 1 applicable resident in the targeted sample. (Resident #18) Findings include:

1. Per record review on 04/07/10 for Resident # 18, the Behavior Care plan addresses general behavior issues for residents with Alzheimer's but not specific areas such as resisting care. The MDS (Minimum Data Set) Annual Assessment dated 02/11/10 identified the resident as "resistance to care", as well as Nursing notes and Physician's Progress notes. A Behavior Intervention flowsheet in the chart records incidences of behaviors however its use is for all residents receiving psychoactive medications and not specifically for being resistive to care. Per interview on 04/07/10 at 11:45 A.M., 2 LNA's confirmed the Resident to be resistive to care, especially in the evening. Per interview on 04/07/10 at 2:30 P.M. the DNS confirmed a failure to develop a comprehensive care plan to address interventions, measurable objectives or goals for the resident's resistive behaviors.

F 280: 483.20(d)(3), 483.10(k)(2) RIGHT TO

F 280: Please See attached Plan of Correction 5/14/10

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| F 280 SS=E | <p>Continued From page 3</p> <p>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> <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 record review, and interview the facility failed to revise care plans for 4 of 30 residents in the targeted sample. (Residents # 68, #32, #82 & # 37) Findings include:</p> <p>1. Per record review on 4/6/10 - 4/7/10 of Resident's #68 and #32 medical records, the care plans did not reflect current care and services. During record review for Resident #68 & #32, who need assistance in all areas of grooming, dressing and care, the Activities of Daily Living (ADL's) care plans did not direct staff regarding footwear preferences and</p> | F 280 | | |
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F 280 Continued From page 4
 resident/family choices. Per observation throughout the days of survey, Resident #68 and Resident # 32 were observed ambulating in stocking feet only. Per interview, staff stated that it was the Resident's choice to wear only socks. Per interview on 4/7/10 at 10:30 A.M. the DNS confirmed that the care plan was not revised to reflect the current choices for foot wear for both Residents..

2. Per record review on 4/7/10, Residents #37 and #82 have care plans that identified each resident as a fall risk, and contained appropriate interventions to help prevent falls. Per record review of Resident #82, actual falls were documented in the nurse's notes on 3/3/10 (minor bruising to knee) on 3/24/10 and 4/5/ 10 with no injuries resulting. The care plan did not contain updates to reflect any of these falls. Per review of the record of Resident #37, there was a nurse's note documenting an unwitnessed fall out of bed on 4/5/10, where the resident was found next to the bed lying on the floor mat. This incident was not updated on the care plan. Per interview on 4/7/10 at 11:45 PM, the unit manager confirmed that updates to reflect actual falls for these residents were not recorded on the plan of care.

F 323 483.25(h) FREE OF ACCIDENT
 SS=E 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 280

F 323

*Please see attached
 Plan of Correction 5/14/10*

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PRINTED: 04/20/2010
FORM APPROVED
OMB NO. 0938-0391

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F 323 Continued From page 5
This REQUIREMENT is not met as evidenced by:
Based on observation and interview the Facility failed to ensure that the Resident's environment remains as free of accident hazards as is possible. Findings include:

1. Per observations during the tour of the special care unit on 04/05/07 at 10:15 A.M. and throughout the day, the housekeeping closet on the East wing, which contained cleaning solutions, was consistently unlocked. The tub room's tub was filled with water and no staff nearby. The maintenance's door, which contained solutions, tools etc., was unlocked and accessible to wandering residents. Per interview early in the afternoon LNA staff confirmed that baths were given in the morning and the water should have been drained. Per interview at 3:15 PM, maintenance staff confirmed the maintenance door was not locked during the day and should have been.
Per a subsequent environmental tour on 04/07/10 it was determined that the Facilities's water temperatures were not monitored for a 5 month period. The log book's last temperature was recorded in Nov. 2009. The Maintenance Director stated that the plumber was working on the heating system and also replaced valves during this period so 'thought that the temperature were "o.k". because of the new valves and heating system'.
Per interview at 10:30 A.M. on 04/07/10, the Maintenance Director confirmed the environment was not free of potential accident hazards.

F 334 483.25(n) INFLUENZA AND PNEUMOCOCCAL SS=C IMMUNIZATIONS

The facility must develop policies and procedures

F 323

F 334 Please See attached Plan of Correction 4/7/10

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| F 334 | Continued From page 6 that ensure that – (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; (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; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, 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 influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (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; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse | F 334 | | |

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| F 334 | Continued From page 7 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. This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to meet the requirement that formal policies and procedures be in place for the administration and education of preventive immunizations to residents. The findings include: During an interview with the facility administrator on the morning of 04/06/2010, h/she reported that the facility has no current policy or procedure for influenza/ pneumococcal vaccine administration. The administrator stated the facility followed standing medical orders for immunizations and provided residents and | F 334 | | | |

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F 334 Continued From page 8
families with annual educational materials from the Vermont Department of Health, but had not developed their own immunization policies or procedures.

F 334

F 371 483.35(j) FOOD PROCURE, SS=E STORE/PREPARE/SERVE - SANITARY

F 371

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

Please See Attached Plan of Correction 5/14/10

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to adhere to accepted standards of safe food handling, storing and sanitation practices. Findings include:

1. During the initial Kitchen tour on 04/05/10 at 10:15 A.M. the following was observed:
 - a) There was an accumulation of dust and cobwebs on the refrigerators, on pipes on the ceiling above food prep areas and on a stationary fan.
 - b) The temperature on the thermometer in the reach- in refrigerator that stores milk was noted at 48 degrees
 - c) A box of frozen pizza pockets was stored directly on the walk-in freezers floor.

On a follow up visit at 3:00 P.M. on the same day, the following was noted;

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| F 371 | Continued From page 9 a) The reach-in refrigerator's temperature was 48 degrees b) A mop and bucket with cleaning solution was stored in the dry food storage area. | F 371 |
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Per a subsequent follow-up visit on 04/06/10 at 9:00 A.M., the reach-in refrigerator's temperature was noted at 46 degrees. Kitchen staff interview stated that they had been using the refrigerator all morning for breakfast. A second thermometer was placed inside the refrigerator and the refrigerator was not opened for 1 hour. Per re-visit to the kitchen at 10: 00 A.M. the reach -in refrigerator's 2 thermometers temperature were 42 and 44 degrees. In addition the mop and bucket with cleaning solution was noted to still be in the dry food storage area.

Per interviews during the tours and on 04/06 10, the Food Services Director confirmed the above findings.

Maple Lane Nursing Home
Plan of correction
Survey 4/17/10

1) F164 Privacy of Records

- 1) In order to address those residents found to be affected by this deficient practice the records in question were removed from the room immediately and the staff member who had left them unattended was counseled by the Nursing Supervisor regarding proper safeguarding of clinical records.
- 2) All residents of the facility have the potential to be affected by deficient practice. In order to ensure that the deficient practice does not recur we will accomplish the following:
 - 1) An in-service will be held 4/29/10 and 5/6/10 for all nursing staff addressing the residents right to privacy in care and facility protocols for safe guarding clinical records. Frank Cheney, Administrator will present these in-services.
 - 2) The facility has identified private usable space on all of our units to be used when conducting doctor rounds.
- 3) Our Quality Assurance program will monitor the effectiveness of our corrective action. Our Social Service Director will conduct Observation Rounds designed to measure staff performance in the area of the residents right to privacy in care. These reviews will be completed daily for one week, weekly for one month then quarterly there after to ensure on going compliance.

Frank Cheney, Administrator will be responsible for the correction of this deficiency.

Completed Date: ~~5/14/10~~ 5/11/10 AMMENDED 5-5-10 WITH FRANK CHENEY
mH

5/5/10 POC ACCEPTED AS AMMENDED Margant Higgins RN 28895

2) F279 Comprehensive Care Plans

- 1) Resident #18's plan of care has been reviewed and updated by our SNU Nursing Supervisor to include proper identification and direction regarding resident 18's "resistance to care".
- 2) All residents of the facility who are "resistant to care" have the potential to be affected by this deficient practice. Our Nursing Supervisors will review the Plans of Care of all residents who exhibit this behavior. The residents care plans will be updated where indicated to ensure proper care planning relating to "resistance to care".

3) In order to prevent the deficient practice from recurring we will accomplish the following:

1) An in-service will be held for all nursing staff on 4/29/10 and 5/6/10. Topic will include the importance of accurate care planning, inter facility communication of current changing resident care needs and review of resident that are resistive to care. The Administrator and DNS will present this in-service.

2) We will add a review of care planning requirements relating specifically to residents who are "resistive to care" to our existing monthly Fall/Bruise Committee agenda.

4) Our Quality Assurance program will monitor the effectiveness of our corrective actions. Our Clinical Supervisors will conduct resident reviews on a weekly basis for one month of a sampling of residents who have exhibited aggressive/ resistive behaviors during care to ensure that the deficient practice does not recur. Findings will be reported to our Quality Assurance Committee.

Our DNS will be responsible for the correction of this deficiency.

Completion Date: ~~5/14/10~~ 5/11/10 AMMENDED 5/5/10 WITH FRANK CHENEY MA

5/5/10 POC ACCEPTED AS AMMENDED Margaret Wygant RN 28895

3) 280 Right to Participate in Care Planning

1) The plan of care for resident #68, 32, 82, 37 have been reviewed by our Clinical Supervisor and updated where indicated to ensure that their plans of care reflect current care and provided services to help prevent falls.

2) All residents of the facility who are at risk for falls have the potential to be affected by the deficient practice. In order to ensure that the deficient practice does not recur we will accomplish the following corrective action:

A) Our Nursing Supervisors will review the plans of care of all residents at risk for falls and update them where indicated to provide care planning that reflects accurate and current care requirements and interventions for each resident.

B) We will hold an in-service for all nursing staff on 4/29/10 and 5/6/10 to address current resident care planning to prevent falls, staff communication relating to changing resident needs, and the importance of keeping care plans current

C) Our care planning philosophy in the area of falls will be adjusted to recognize the need for the staff to be aware of a recent history of falls.

3) Our Quality Assurance Program will monitor the effectiveness of our corrective action. Nursing Supervisors will conduct resident reviews of a sampling of residents who are at risk for falls on a weekly basis for one month then on a monthly basis through our fall committee there after. Findings will be reported to our QA committee.

Our DNS will be responsible for the correction of this deficiency.

Completion Date: ~~5/14/10~~ 5/11/10 AMMENDED 5/5/10 WITH FRANK CHENEY
MH

5/5/10 POC ACCEPTED AS AMMENDED Margaret Nigamo RN 28895

4) F323 Accident Hazards

At the time of survey there were no residents affected by the deficient practice. However all residents of the facility have the potential to be affected by noncompliance in this area.

In order to ensure that the deficient practice does not recur we will accomplish the following corrective actions:

- A) Weekly water temperature monitoring has been reestablished by our maintenance director.
- B) Locks will be installed on all of our Century Tub doors and these doors will be locked when the Century Tubs contain water and are unattended.
- C) A door lock which locks automatically will be installed on the SNU housekeeping storage area found to be an issue during survey.
- D) The maintenance door has been relocked permanently.
- E) We will hold in-services on 4/29/2010 and 5/6/2010 for all staff to address proper understanding of safety protocols within the facility. Frank Cheney, Administrator will present this in-service.
- F) Our Quality Assurance program will monitor the effectiveness of our corrective action. Our Maintenance Supervisor will complete observation rounds designed to verify on going compliance relating to the protection of residents from hazards. These reviews will occur daily for two weeks then weekly for one month and quarterly after that. Findings will be reported to the Administrator.

Frank Cheney, Administrator will be responsible for the correction of those deficiencies.

Completion Date: ~~5/14/2010~~ 5/11/10 AMMENDED 5/5/10 WITH FRANK CHENEY
MH
5/5/10 POC ACCEPTED AS AMMENDED Margaret Nigamo RN 28895

5) F334 Influenza and Pneumococcal

All residents of the facility had the potential of being affected by the deficient practice. Our existing protocol was written into a formal policy and procedure during our 4/7/10 survey. The policy was found to be acceptable and has been formally instituted as facility practice (policies attached). Our DNS will monitor proper staff implementation of this policy on a monthly basis and report any findings to the Administrator and our Quality Assurance Committee.

The DNS is responsible for the correction of this deficient practice.

Completion Date: 4/7/2010

5/5/10 POC ACCEPTED Margaret Hyjms RN 28895
6) F371 Food-store/prepare/serve-sanitary

All residents of the facility have the potential of being affected by this deficient practice. We will accomplish the following corrective action to ensure that the deficient practice does not recur:

A) The accumulation of dust on the refrigerator and pipes above food prep areas was cleaned and has been specifically added to our daily cleaning schedule.

B) The reach in refrigerator was service on 4/7/10 and is keeping temperature with acceptable limits.

C) The frozen pizza pockets were removed from the floor of our freezer. We also addressed the issue of the mop/water within our dry storage area. THE MOP WAS REMOVED AND IS BEING STORED IN A DIRTY UTILITY ROOM.

D) An in-service will be held on 5/4/10 for all dietary staff. Topics to be covered will include but be limited to acceptable food storage temperature, proper food storage, daily cleaning responsibilities, and protocols. Debbie Hamel, Dietary Supervisor will present this in-service.

E) In order to ensure ongoing compliance our Quality Assurance Committee will monitor the effectiveness of our corrective action. Our Dietary Supervisor will inspect the kitchen, evaluating staff performance regarding the provision of service in a sanitary environment. These inspections will occur daily for one week, weekly for three weeks, then monthly there after. Findings will be reported to our Quality Assurance Committee.

Frank Cheney, Administrator is responsible for the correction of this deficiency.

Completion Date: ~~5/14/10~~ 5/11/10 AMMENDED 5/5/10 WITH FRANK CHENEY
5/5/10 POC ACCEPTED AS AMMENDED Margaret Hyjms RN 28895

Frank Cheney III

4/30/10

TC 5-5-10 ADDENDUM - CONVERSATION OF FRANK CHENEY

**Policies and Procedures
Maple Lane Nursing Home
Immunizations: Pneumococcal vaccinations of
Residents and Staff**

Guideline:

The Advisory Committee on Immunization Practices recommends vaccinating persons who are at high risk for serious complications from pneumococcal pneumonia, including those 65 years of age and older, and all residents of nursing homes.

Recognizing the major impact and mortality of influenza disease on residents of nursing homes and the effectiveness of vaccines preventing illness, hospitalization and death, this facility has adopted the following policy statements:

1. All residents of our facility should receive the pneumococcal if they are 65 years and older or younger than 65 years and have underlying health issues that are associated with increased susceptibility to infection or increased risk for serious disease and its complications.
2. Re- vaccination with the pneumococcal vaccine if 5 or more years have passed since the previous dose and the person was less than 65 years at the time of previous dose.
3. These vaccines may be administered by any appropriately qualified personnel who are following facility procedures, without the need for an individual physician evaluation or order.

Documentation of vaccinated residents as well as those residents who refused or did not get vaccinated will be recorded on the resident immunization sheet in their record.

Administration Procedure:

- A. Each resident's pneumococcal immunization status will be determined upon admission or soon afterwards, and will be documented in the resident's medical record. Current residents will have their immunization status determined by reviewing available past and present records
- B. All resident's with undocumented or unknown pneumococcal vaccination status will be offered the vaccine.
- C. Informed consent in form of written information and discussion regarding the risk and benefits of the vaccination (this may be with the resident's authorized representative when appropriate. Signed consent will be kept in the resident record).

- D. Residents and staff may refuse vaccination. Vaccination refusal will be documented on the immunization record.
- E. Ensure that the current year's influenza vaccine is used. Discard old vaccine.
- F. Vaccine will be administered per Standing Orders: Administer influenza vaccine to all residents and staff who meet criteria. Any large muscle may be used as an injection site (e.g., deltoid or quadriceps).
- G. Vaccine **should not** be administered to residents and staff who are allergic to chicken eggs, the vaccine, or any of the vaccine's components.
- H. Check body temperatures before giving the vaccine. Anyone who is febrile (above baseline temperature, often 101 degrees or higher) or being treated for an infection will not receive the vaccine until he/she has recovered.
- I. Document and administration of the vaccine, including injection site, in the medical record (e.g., medication sheet, nurse's notes, immunization record, or progress sheet) of staff immunization record. Submit immunization information to state entity, as required.
- J. The vaccination may be given at the same time or at any time before or after a dose of pneumococcal vaccine (PPV23). If given at the same time as the PPV, the influenza vaccine must be given in a separate body site, using a different syringe.
- K. An epinephrine injection 1:1000 will be kept on hand for severe allergic reactions (i.e., anaphylaxis). Should anaphylaxis occur, standing emergency treatment procedures followed, and the event reported to the Vaccine Adverse Events Reporting System at 1-800-822-7967 or at <http://www.vaers.org>

**POLICIES AND PROCEDURES
MAPLE LANE NURSING HOME
IMMUNIZATIONS: SEASONAL/H1N1 INFLUENZA VACCINATIONS OF
RESIDENTS AND STAFF**

GUIDELINES:

The Advisory Committee on Immunization Practices recommends vaccinating persons who are at high risks for serious complications from influenza, including those 50 years of age and older, who are residents of nursing homes. The Association for Professionals in Infection Control, the Centers for Disease Control and Prevention, the Immunization Action Coalition and the National Foundation for Infectious Disease all recommend that health care workers be immunized as well, because they work in close contact with residents.

Recognizing the major impact and mortality of influenza disease on residents of nursing homes and the effectiveness of vaccines preventing illness, hospitalization and death, this facility has adopted the following policy statements:

1. All residents and staff of our facility should receive the influenza vaccine annually, unless there is a documented contradiction or informed refusal.
2. These vaccines may be administered by any appropriately qualified personnel who are following facility procedures, (without the need for an individual physician evaluation order.)

Every year, a log will be maintained documenting how many people (resident and staff) received the vaccine, as well as numbers who refused or who did not get the vaccinated.

ADDENDUM - THIS PORTION OF
POLICY WILL BE REMOVED - STANDING
ORDER ADDRESSED IN SEC F PG 2 -

DISCUSSED
WITH FRANK
CHENEY
M HIGGINS
RN

Administration Procedures:

- A. Current and newly admitted residents and staff will be offered the influenza vaccine each year during flu season (sept-march).
- B. Each resident's immunization status will be determined prior to vaccination, and will be documented in the resident's medical record.
- C. Informed consent in form of written information and discussion regarding the risk and benefits of the vaccination will occur prior to vaccination each year. In the case of residents informed consent may be procured with their authorized representative when appropriate. A signed consent form will be kept with the resident record.

- D. Residents may refuse vaccination.
- E. Check to make sure that the current pneumococcal vaccine vials have not expired. Discard old vaccine.
- F. Vaccine will be administered per Standing Orders: Administer pneumococcal vaccine to all residents who meet vaccination criteria. Any large muscle may be used as an injection site (e.g., deltoid or quadriceps).
- G. Vaccine **should not** be administered to residents and staff who are allergic to the vaccine, or any of the vaccine's components.
- H. Check body temperature before giving the vaccine. Anyone who is febrile (above baseline temperature, often 101 degrees or higher) or being treated for an infection **will not** receive the vaccine until he/she had recovered.
- I. Document the administration of the vaccine, including injection site, in the medical record (e.g., medication sheet, nurse's notes, immunization record, or progress sheet) of staff immunization record. Submit immunization information to state entity, as required
- J. The vaccine may be given at the same time or at any time before or after a dose of influenza vaccine. There are no minimal interval requirements between doses of the flu vaccine and PPV. If given at the same time as the influenza, the pneumococcal vaccine must be given in a separate body site, using a different syringe.
- K. An epinephrine injection 1:1000 will be kept on hand for severe allergic reactions (i.e., anaphylaxis). Should anaphylaxis occur, standing emergency treatment procedures followed, and the event reported to the Vaccine Adverse Events Reporting System at 1-800-822-7967 or at <http://www.vaers.org>.