

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

PRINTED: 01/31/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/21/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>NEWPORT HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>148 PROUTY DRIVE NEWPORT, VT 05855</b>
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F 000 INITIAL COMMENTS

F 000

A recertification survey was conducted onsite at the Facility from 1/19/2010 through 1/21/2010.

F 272 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS

F 272

**In the past residents on psychotropic medications were only documented on when a behavior occurred.**

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

**All residents that are receiving psychotropic medications will be assessed daily and nurses will document weekly and PRN on behavior for continued use of psychotropic medications. MDS coordinator will monitor on a weekly basis.**

A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following:  
 Identification and demographic information;  
 Customary routine;  
 Cognitive patterns;  
 Communication;  
 Vision;  
 Mood and behavior patterns;  
 Psychosocial well-being;  
 Physical functioning and structural problems;  
 Continence;  
 Disease diagnosis and health conditions;  
 Dental and nutritional status;  
 Skin conditions;  
 Activity pursuit;  
 Medications;  
 Special treatments and procedures;  
 Discharge potential;  
 Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and  
 Documentation of participation in assessment.

2-5-10

This REQUIREMENT is not met as evidenced by:

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

TITLE

(X6) DATE



**Administrator**

**02/10/10**

deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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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<p>F 000 INITIAL COMMENTS</p> <p>A recertification survey was conducted onsite at the Facility from 1/19/2010 through 1/21/2010.</p> <p>F 272 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS</p> <p>SS=D</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following:          Identification and demographic information;          Customary routine;          Cognitive patterns;          Communication;          Vision;          Mood and behavior patterns;          Psychosocial well-being;          Physical functioning and structural problems;          Continence;          Disease diagnosis and health conditions;          Dental and nutritional status;          Skin conditions;          Activity pursuit;          Medications;          Special treatments and procedures;          Discharge potential;          Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and          Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by:</p>		<p>F 000</p> <p>F 272</p>	<p>In the past residents on psychotropic medications were only documented on when a behavior occurred.</p> <p>All residents that are receiving psychotropic medications will be assessed daily and nurses will document weekly and PRN on behavior for continued use of psychotropic medications. MDS coordinator will monitor on a weekly basis.</p>	<p>2-5-10</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  	TITLE  <b>Administrator</b>	(X6) DATE
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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.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # <b>475026</b>	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: <b>1/21/2010</b>
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 514	<p><b>483.75(1)(1) CLINICAL RECORDS</b></p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to maintain clinical records were complete and readily accessible for each resident for 2 of 24 applicable resident reviews. (Resident #56 and #6) Findings include:</p> <ol style="list-style-type: none"> <li>1. Per closed record review on 1/21/10, there was no initial care plan found in the Resident #56's record. During interview the same day, the MDS nurse confirmed that she could not locate any care plan for this record.</li> <li>2. Per record review on 01/21/10 it was noted that there were 2 incorrect diagnoses for Resident # 6 listed on the MDS as well as the MD orders and Medication Administration record (MAR). The indication for use of Gabapentin was listed as nephritis and the resident has neuritis. Also, the indication for the use of an as needed (prn) nitroglycerine was listed as Multiple Sclerosis (MS) and the resident does not have MS. This was confirmed during interview with the MDS nurse on 01/21/10.</li> </ol> <p><b>F 514</b></p> <ol style="list-style-type: none"> <li>1. <b>Clinical records will contain sufficient information to identify the resident. The initial care plan for resident #56 was found and is part of his closed chart.</b></li> <li>2. <b>The (2) incorrect diagnoses for resident #6 has been corrected, also the indications for use of a PRN was corrected.</b></li> </ol> <p><b>A nurse will be assigned to monitor the MAR/physician's orders, MDS on a monthly basis to assure that all routine/PRN meds have the appropriate diagnosis for use.</b></p> <p><b>QA will monitor for accuracy on a random basis and report to QA Committee.</b></p>		

FEB 11 2010

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The above isolated deficiencies pose no actual harm to the residents

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F 272	<p>Continued From page 1</p> <p>Based on staff interview and record review, the facility failed to assure that the use of psychotropic medications was reassessed for 1 applicable resident in the sample of 24. (Resident #12) Findings include:</p> <p>Per record review and confirmed during staff interview with the Assistant Director of Nursing Services (ADNS) on the morning of 1/21/10, Resident #12 receives an antianxiety medication twice daily and there has been no reassessment of the use of the medication to ascertain it's effectiveness and need for continued use. Since mid November, 2009, there have been only 2 nursing notes regarding resident behaviors.</p> <p>F 279: 483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS</p> <p>SS=D</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>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).</p>	F 272	<p>1. Care plans for resident #12 and #56 for psychotropic medications has been addressed. All residents on psychotropic medications will have a care plan addressing use, monitoring, side affects of the medication. ADON will monitor on a weekly basis.</p> <p>2. Resident #38's care plan has been revised to reflect a stage 4 pressure ulcer with measurable goals and objectives. All residents with a pressure ulcer will have a care plan with measurable goals and objectives and accurately reflects the ulcer. ADON will monitor on a weekly basis.</p> <p style="text-align: right;">3-1-10</p>

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F 279	Continued From page 2  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, for 3 of 24 residents in the applicable sample, the care plans failed to address all of the resident's identified needs, including measurable goals and specific interventions to direct care. (Residents #12, 38 & 56) Findings include:  1. Per record reviews on 1/21/10, there were no care plans to address the use of psychotropic medications for Residents #12 and # 56. The residents required care plans for the use of antianxiety, antipsychotic and antidepressant medications, including monitoring for effectiveness and for possible adverse side effects. These omissions were confirmed during interview with the ADNS at 9:55 AM on 1/21/10. 2. Per record review on 1/21/10, the care plan for pressure ulcers did not contain measurable goals and objectives to comprehensively address a stage 4 pressure ulcer for Resident #38. During a 5:35 PM interview with the Unit Nurse, the nurse confirmed that the existing care plan did not accurately reflect the Resident's current condition and that there was no other care plan to do so.	F 279			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS  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	F 280	Resident #38's care plan has been revised to reflect an increase in pressure ulcer stage. Any resident with a pressure ulcer will have a care plan that accurately reflects the pressure ulcer stage.  ADON will monitor on a weekly basis.	3-1-10	

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F 280	<p>Continued From page 3</p> <p>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 observation, interview and record review, the facility failed to revise care plans for 2 residents in the applicable sample ( Residents #38, 44). Findings include:</p> <p>1. Per record review on 1/21/10, the care plan for pressure ulcers for Resident #38 was not revised to reflect an increase in pressure ulcer stage. A Physical Therapy assessment dated 12/22/09 stated that the Resident had a stage 4 pressure ulcer with visible bone. This was confirmed by both the Unit Nurse and the ADNS ( Assistant Director of Nursing Services) on 1/21/10.</p> <p>Per record review and staff interview, the facility failed to revise the care plan for resident #44 regarding use of psychotropic medications. Seroquel was ordered for resident # 44 on 11/30/2009 and the care plan has not been changed to reflect addition of medication nor what side effects to monitor for while on the medication. This was confirmed by ADNS on 01/21/2010 at 1:30 PM</p>	F 280	<p><b>Resident #44's care plan has been revised to address the use of psychotropic medications and the side effects to monitor.</b></p> <p><b>All residents who require the use of psychotropic medications will have a care plan to reflect the use and side effects of psychotropic medications.</b></p> <p><b>ADON will monitor on a weekly basis.</b></p>	3-1-10

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F 281 SS=D	<p>483.20(k)(3)(i) COMPREHENSIVE CARE PLANS</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 on staff interview and record review, nursing staff failed to consistently maintain professional standards of nursing practice regarding medication transcription and pressure sore management for 3 of 24 residents in the phase 2 sample. (Residents #51, 6 &amp; 27)) Findings include:</p> <ol style="list-style-type: none"> <li>1. Per record review on 1/20/10, a transcription error was noted for 1 medication for Resident #51. The physician order was for Lovenox, which is only given per the injectable route, subcutaneous inj. (SC) and it was written on the Medication Administration Record (MAR) and the signed physician orders as 'PO' (by mouth). The error was confirmed with the Registered Nurse (RN) at 5:20 PM the same day.</li> <li>2. Per record review on 01/21/2010, it was noted that Resident #6 was admitted to the facility on 12/22/2009 with a pressure ulcer on his/her right heel. The physician orders were for the staff to measure the ulcer every 3 days. There is only evidence of one wound measurement having been completed since admission and that is on 01/07/2010. This was confirmed by the Charge Nurse on 01/21/2010 at 2:20 PM.</li> <li>3. During medication administration on 01/20/2010 and record review for medication reconciliation, it was noted that Resident #27 had Vit B-12 100 mcg. ordered in November 2009 but had been receiving Vit B-12, 1000 mcg. since the</li> </ol>	F 281	<p>1. Resident #51 Lovenox order on the MAR has been changed to reflect correct route from P.O. to S.C. The medication was given S.C.</p> <p>There will be an in-service on 2-15-10 for all RN/LPN's regarding checking physicians orders against the MAR/treatment sheet. All meds will be checked against physicians orders when received from pharmacy. Each nurse will sign off meds she has checked in. A nurse will check monthly the new MAR and treatment sheet against the physicians orders.</p> <p>ADON will randomly check M.D. orders with the MAR/treatment sheet to assure compliance.</p> <p>2. Resident #6's pressure ulcer is now being measured and documented every 3 days as ordered by her physician. The wound sheet has been updated to reflect this. There will be an in-service on 2-18-10 for all RN/LPN's on documentation and follow orders for measurements and status of wound. Wound sheets will be used for any ulcer or wound.</p> <p>ADON will monitor on a weekly basis. 3-1-10</p>

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F 281	Continued From page 5 admission date. The pharmacist originally sent the wrong dose to the facility and the staff administered the incorrect dose daily despite a discrepancy between the identifying information on the medication card and what was transcribed on the MAR. This was confirmed by both the nursing staff and the pharmacist on 01/20/2010	F 281	3. The M.D. was notified when the error in dosage was discovered for resident #27. The pharmacy delivered Vitamin B12 1000 mcg p.o. instead of M.D. order of Vitamin B12 100 mcg p.o. The M.D. changed the	3-1-10
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  This REQUIREMENT is not met as evidenced by: Based on staff interview and closed record review, staff failed to show evidence of monitoring	F 329	Resident #56 was discharged on October of 2009, therefore we are unable to update the documentation. To prevent lack of documentation to show effectiveness and potential adverse side effects of antipsychotic medications there will be an in-service for all RN/LPN's regarding documentation. Weekly documentation will be done on residents receiving psychotropic medications to include side effects and behaviors.  MDS coordinator will monitor on a weekly basis. In-service will be	2-5-10

F 281 - continued

order when notified to Vitamin B12 1000 mcg p.o.

Pharmacy was also notified of the medication error.

There will be an in-service on \_\_\_\_\_ for all RN/LPN's regarding checking medications against the MAR and M.D. orders. Nurses will check all meds delivered from the pharmacy against the M.D. orders and sign that this was done.

Monthly MAR/treatment sheets will be checked against M.D.D orders by a designated nurse.

ADON and MDS coordinator will monitor for compliance.

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F 329	Continued From page 6 for effectiveness and adverse side effects for the use of psychotropic medications for 1 applicable resident in the sample. (Resident #56) Findings include:  Per review of Resident #56's closed record and confirmed during interview with the Minimum Data Set (MDS) and the ADNS on the morning of 1/21/10, there was no evidence of monitoring for effectiveness and potential adverse side effects of Seroquel, an antipsychotic medication administered daily. The ADNS stated that the facility no longer uses behavior monitoring flow sheets and per review, the nurses progress notes did not address these issues.	F 329		2-5-10
F 364 SS=D	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by: Based upon resident interview and observation, the facility failed to ensure that 2 of 40 residents received food at the proper temperature to ensure the resident's satisfaction. (#26, #50). Findings include:  1. Per resident interview on 1/19/10 at 4:41 PM, resident #26 stated the potatoes were served lukewarm at the noon meal on 1/19/10.  2. Per resident interview on 1/19/10 at 5:37 PM, resident #50 stated the potatoes were served cold at the noon meal on 1/19/10.	F 364	1. Dietary supervisor will monitor food temperatures daily to ensure all residents are receiving a hot and satisfactory meal. Dietary supervisor will take random temperatures upon the serving floor to ensure all residents meals are hot and to their satisfaction. Dietary supervisor will once a week go from room to room and interview residents about the meals and follow up on any complaints to ensure satisfaction of all the residents are met. All foods served will be of nutritive value and appearance. The food served will be palatable, attractive and a proper temperature.  2. There will be containers of water put into the steam table under food items to maintain	

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F 364 Continued From page 7

3. Per observations in the serving area on 1/19/10 at 11:50 AM, cooked breaded chicken breasts were being held at unsafe temperatures (below 140 degrees for hot foods). The chicken breast in the steam table was 138 degrees Fahrenheit (F) when measured. Per interview and observation, the steam table was not operating properly according to directions and was not hot enough to keep the cooked breasts at the appropriate temp. (There was no water in the compartment). A bowl of mashed potatoes, from the previous day, was sitting on the counter and the temperature was measured at 82 degrees F. The cook stated that during the meal service, they would heat the potatoes to order as needed. Safe food handling practices dictate that prepared foods should be brought up to appropriate, safe temperature (over 140) and held at that temperature until served.

F 371 483.35(j) SANITARY CONDITIONS  
SS=F

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

This REQUIREMENT is not met as evidenced by:  
Based on observations and staff interviews, the facility failed to assure that Dietary Services staff consistently stored and prepared foods under sanitary conditions and in accordance with safe

F 364 safe serving temperatures. All foods being held in the steam table will be held at appropriate temperatures. This will be monitored by dietary supervisor on a daily basis to ensure all foods are at a safe temperature. Any and all left over foods used for the residents as an alternate to the menu will either be reheated and stored in the steam table or if for one (1) or (2) residents they shall remain in refrigerator until such time they are needed and at that time they will be taken from the refrigerator and heated to safe temperature and served immediately. No foods will be held on counters for any reason. *2-17-10*

F 371 When wall mounted fan near food service area is not in use and has been removed for the season the louver will be cleaned, covered and sealed by maintenance. Dietary staff will keep this area cleaned on a weekly cleaning schedule. Dietary supervisor will monitor and check on a weekly basis to ensure compliance. The frayed and soiled carpet on door frame to the dish room will be replaced with a washable vinyl covering. The dietary supervisor will monitor on a regular basis to ensure this is kept clean and in sanitary condition. The vinyl floor covering on a platform where

F364 - continued

To further maintain all foods at the proper temperature new dishes are being purchaed that will retain heat more effectively. A new procedure for serving all trays quickly and efficiently has been developed.

This will be monitored by DNS, ADON and dietary supervisor.

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NAME OF PROVIDER OR SUPPLIER  NEWPORT HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 148 PROUTY DRIVE NEWPORT, VT 05855		
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F 371	<p>Continued From page 8</p> <p>food handling practices. Findings include:</p> <p>Per observations of the kitchen during the initial tour on 1/19/10 at 11:18 AM, the following dietary issues were found:</p> <p>a. A wall mounted fan located near the food service area was soiled with a layer of dust. There was ripped linoleum/vinyl flooring covering a platform where food containers were stored. Frayed and heavily soiled carpeting covered the door frame sides on entrance to the dish machine room.</p> <p>b. There was a container of applesauce mixture in the walk-in cooler dated 1/12/10. Per interview the Food Service Director stated that prepared perishable items should be disposed of after the 3rd day. There was no written policy to direct staff regarding this policy/procedure.</p> <p>c. Per observations in the serving area on 1/19/10 at 11:50 AM, cooked breaded chicken breasts were being held at unsafe temperatures (below 140 degrees for hot foods). The chicken breast in the steam table was 138 degrees Fahrenheit (F) when measured. Per interview and observation, the steam table was not operating properly according to directions and was not hot enough to keep the cooked breasts at the appropriate temp. (There was no water in the compartment). A bowl of mashed potato from the previous day was sitting on the counter and the temperature was measured at 82 degrees F. The cook stated that during the meal service, they would heat the potatoes to order as needed. Safe food handling practices dictate that prepared foods should be brought up to appropriate, safe temperature (over 140) and held at that temperature until served.</p> <p>d. The manual counter mounted can opener was visibly soiled.</p>	F 371	<p>food is stored will be replaced by maintenance. Dietary supervisor will monitor on a weekly basis.</p> <p>All perishable foods will be dated and disposed of after (3) days. This will be checked daily by head cook and dietary supervisor to ensure no foods are more than (3) days old. A written policy will be put into place.</p> <p>There will be containers of water put into the steam table under food items to maintain safe serving temperatures. All foods being held in the steam table will be held at appropriate temperatures. This will be monitored by dietary supervisor on a daily basis.</p> <p>The manual counter mounted can opener will be removed and washed in dishwasher after use. Each staff member will be responsible for keeping this clean on each shift. Dietary supervisor will inspect this daily to ensure this is kept clean.</p>	2-17-10

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F 431 SS=D	<p><b>483.60(b), (d), (e) PHARMACY SERVICES</b></p> <p>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.</p> <p>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.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and confirmed through staff interview, the facility failed to assure that</p>	F 431	<p><b>The three expired multi-dose vials in the medication refrigerator were destroyed immediately.</b></p> <p><b>There will be an in-service for all RN/LPN's regarding destroying outdated medications on 2-15-10</b> One nurse will be assigned to monitor on a weekly basis that all meds in medication refrigerator are current and any out dated have been properly disposed.</p> <p><b>ADON will make random checks to assure compliance.</b></p>	2-16-10

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F 431	Continued From page 10 drugs and biologicals were not kept beyond the expiration dates. Findings include:  1. Per observation on 1/20/10 at 2:15 PM of the medication refrigerator within the med storage room, there were 3 items that were found to be expired or beyond the recommended discard date. An opened and partially used multi-dose vial of Tetanus/Diphtheria/ Pertussis vaccine had an expiration date of November 30, 2009; an opened, partially used multi-dose vial of Pneumovax vaccine was found to have an expiration date of November 29, 2009; and a vial of Lantus Insulin that was dated by staff as opened on 12/13/09, with a discard date of 1/25/10 also written on the label. The insulin vial had been in use daily for 42 days, which is 14 days over the manufacturer's and Pharmacist's recommendation of 28 days in use before discarding. Per interview on 1/20/10 at 2:30 PM, the charge nurse stated that the medications were either outdated or labeled incorrectly and still in use past the discard date.	F 431	
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION  The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that staff washes or sanitized hands after each direct resident contact. Findings include:	F 444	There will be an in-service with all licensed nursing personnel on 2-25-10 on infection control e.g proper handwashing (washing hands between contacting each resident). Supervisory nurses, dietary supervisor, QA on a random basis will monitor LNA's.  2-25-10

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F 444 Continued From page 11  
Per observation of the noon meal on 1/19/10 at 12:29 PM, a Licensed Nursing Assistant (LNA) did not wash or sanitize his/her hands between resident contact. The LNA was feeding a Resident, paused to brush hair off his/her face and then proceeded to feed another resident, touching the resident's face. This observation was confirmed by the LNA at 1:08 PM on 1/19/10. On 1/20/10 at 1:13 PM, the Director of Nursing Services (DNS) stated that staff are expected to sanitize hands between resident contacts.

F 444

F 463 483.70(f) RESIDENT CALL SYSTEM  
SS=D  
The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.

F 463

**Maintenance immediately had the call lights in room 10 working. A weekly check of all call lights will be done by maintenance and a log maintained. Staff and residents will continue to report to maintenance when call lights are not functional.**

This REQUIREMENT is not met as evidenced by:  
Based on observation and interview, the facility failed to ensure that all resident call bells were properly functioning. Findings include:

**Maintenance supervisor and ADON will monitor on a weekly basis.**

2-3-10

1. Per observation on 1/19/10 at 2:46 PM, both call lights in room #10 were not functional. This was confirmed by a Licensed Nursing Assistant on 1/19/10 at 2:49 PM. Per interview on 1/21/10 at 9:20 AM, the Maintenance Director stated there was no regular check done to see if all call lights were functional, either in resident rooms or common bathing and toilet facility areas. Maintenance relies on reports from staff or residents to be alerted when call lights are not functional.

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