

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

August 11, 2009

Patricia Russell, Administrator
Union House Nursing Home
3086 Glover Street
Glover, VT 05839

Provider #: 475036

Dear Ms. Russell:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 8, 2009**. Please post this document in a prominent place in your facility.

We will 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,



Suzanne Leavitt, RN, MS
Licensing Chief

Enclosure



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

PRINTED: 07/21/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/08/2009
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NAME OF PROVIDER OR SUPPLIER UNION HOUSE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3086 GLOVER STREET GLOVER, VT 05839
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F 000

INITIAL COMMENTS

An annual recertification survey and a complaint investigation were conducted by The Division of Licensing & Protection on 7/6/09 -7/8/09.

F 157
SS=D

483.10(b)(11) NOTIFICATION OF CHANGES

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).

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.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced

F 000

F157 NOTIFICATION OF CHANGES

I. Resident 2
IMMEDIATE CORRECTION ADDRESSING RESIDENT 2 AFFECTED BY DEFICIENT PRACTICE

F 157

Doctor was notified by Director of Nursing to order supplement on July 7, 2009. Doctor ordered health shake supplement three times a day with snack. Resident began receiving supplement on July 8 at 10 a.m. snack time.

MEASURES PUT INTO PLACE TO ENSURE DEFICIENT PRACTICE DOES NOT OCCUR AGAIN

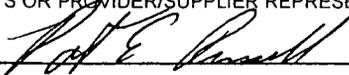
Protocol reviewed with nursing staff 7/15* and 7/22/09** on notifying doctor about any other resident who has had a weight loss of +/- three pounds to be evaluated for supplement order.

To avoid future breaks in the line of communication, consulting registered dietician instructed to include all written communication about residents in Dietician Notes Book, especially those dietary communications recorded on small notes.

CORRECTIVE ACTIONS BEING MONITORED TO ENSURE DEFICIENT PRACTICE WILL NOT OCCUR

Charge nurses will review resident weight logs weekly to determine if doctor needs to be notified on a resident's gain or loss of weight. Charge nurses are responsible for notifying physician for diet change orders. Charge nurses will also notify DNS on weekly basis of change in diet orders.

Monthly, Director of Nursing will monitor weight changes of +/- three pounds. Quarterly, Quality Assurance Committee will monitor weight changes of +/- three pounds.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 7/27/09
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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

Continued From page 1

by:
Based on record review and interviews, the facility failed to notify the physician of a significant weight loss and missed therapeutic treatments for 2 of 5 applicable residents (Residents #2 & #16). Findings include:

1. Per record review on 7/8/09, Resident #2 had a weight loss of 11 lbs during a 38 day period. Per review of the nursing notes for the period 5/28/09 and 7/8/09 there was no documentation that the physician had been notified of the resident's weight loss. In addition, the Dietician had made a written recommendation on 6/8/09 to contact the physician to request an order for supplements (Health Shakes between meals) as verified by her carbon copy of the form. Per interview on 7/7/09 at 3:48 p.m. the DNS confirmed that the physician had not been notified of the weight loss and the Dietician's written recommendation. The DNS also verified that the facility failed to follow their own policy & procedure about notifying the physician of a weight loss or gain of +/- 3 lbs. Also see Tags F325
2. Per observation of a medication administration on 7/6/09 at 4:30 p.m. the staff nurse did not administer Biotene (a mouthwash treatment to be done prior to meals) as ordered by the physician for Resident # 16. During the medication reconciliation with the medical chart and MAR, on 7/5/09 & 7/6/09 for breakfast & lunch there was no documentation as being done. Per interview on 7/7/09 at 9:45 a.m. the charge nurse confirmed that he/she had not given the treatment the previous 2 days (total of 4 missed treatments) as ordered by the physician and failed to notify the physician that the pharmacy did not deliver

F 157

2. Resident 16
IMMEDIATE CORRECTION ADDRESSING RESIDENT 16 AFFECTED BY DEFICIENT PRACTICE
Physician was notified and Biotene was ordered from the pharmacy and delivered July 7. Resident 16 received a treatment of Biotene before lunch on this date. When asked about whether we should have an alternative mouthwash available, physician further stated, "No alternative, symptomatic Rx availability, not med error. Pending availability, keep water/ice at bedside." (See F 157 #1 attached)

MEASURES PUT INTO PLACE TO ENSURE DEFICIENT PRACTICE DOES NOT OCCUR AGAIN
As a result of an internal investigation of this incident, we determined that the registered nurse who discovered the Biotene was gone was a new hire not fully trained on how to obtain additional supplies and notify Physician if unavailable. She had worked 7 days of her training period at the time of survey. (See F 157 # 2 attached) On 7/15/09, we have completed her counseling and training on replenishing medications and supplies and she attended inservice on notification protocols.

Speech therapist who asked for Biotene prescriptions has inserviced QA Committee and charge nurses on the rationale behind the use of mouthwash, to further reinforce importance of keeping supply available. (See attached F 157 # 3)

Nurses meeting held 7/15 and LNA meeting 7/22 to review notification protocols.

CORRECTIVE ACTIONS BEING MONITORED TO ENSURE DEFICIENT PRACTICE WILL NOT OCCUR

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F 157 Continued From page 2
the mouthwash or request another treatment modality. Also see tag F-281

F 240 483.15 QUALITY OF LIFE
SS=D
A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview the Facility failed to assure comfortable water temperatures for 1 applicable resident in the sample. (Resident #3) Findings include:

1. Based on observation on 7/7/09 at 11:00 a.m. the bathtub's water did not reach optimal bathing temperature as the temperature gauge was broken. The Licensed Nursing Assistant (LNA) tested the water with the LNA's elbow and stated that it felt "alright" and "the temperature should be around 100 - 105 degrees F". Per the surveyor's request, a thermometer was placed in the water, which read 97.2 degrees F. The LNA then stated that the water would be too cold for Resident #3 who is unable to speak for her/him self. Per interview later in the day, the Maintenance Director confirmed that the water gauge was broken and that no system had been put in place to assure safe and comfortable water temperatures for a comfortable bathing experience.

F 157 Director of Nursing monitoring RN in question's performance daily during her probationary period, and continuing to review facility's policies and procedures with her.

F 240 Director of Nursing conducting random, unannounced reviews of med passes, to confirm doctor is notified when medication is needed.

Resignation of Director of Nursing accepted, effective when new director is fully oriented to take over. Will share the position with new Director of Nursing until that time.

July 9, 2009 new Director of Nursing attended orientation and briefing on survey; began full time training 7/27/09. Transition between Directors of Nursing will be fully phased in over the next 15-45 days. (See F 157 # 4)

T.C. 8/11/09 DAS will monitor for compliance

F157 PAC accepted with addendum 8/11/09 May 2009, RN

Resident 3
F 240 QUALITY OF LIFE
IMMEDIATE CORRECTION ADDRESSING RESIDENT 3 AFFECTED BY DEFICIENT PRACTICE
In tub portable thermometers were purchased and installed 7/7/09, to serve as backup. (See F 240 # 1 attached).

LNAs inserviced 7/22/09** on importance of functioning temperature gauges

F 241
MEASURES PUT INTO PLACE TO ENSURE DEFICIENT PRACTICE DOES NOT OCCUR AGAIN
Permanent gauges purchased through Fred's Plumbing and Heating, 7/7/09. Second floor unit installed that

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F 241 Continued From page 3
enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, for 1 applicable resident in the sample, nursing staff failed to provide care in a manner that maintained the resident's dignity and respect (Resident #10). Findings include:

1. Per observation on 7/6/09 at 11:45 a.m. Resident #10 received an injectable medication, while eating in the small dining room at a table with 3 other residents, without permission or being removed to another area for privacy. Per interview on 7/7/09 at 10:00 a.m. the Director of Nursing (DNS) confirmed that the expectation and policy is to ask permission and/or shield the resident from the other resident's view.

F 278 483.20(g) - (j) RESIDENT ASSESSMENT
SS=C

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and

F 241

day, with instock gauge. First floor gauge ordered 7/7/09, to be installed upon delivery. (See F 240 # 2 attached) All nursing staff will be inserviced on gauges at TBA time.

CORRECTIVE ACTIONS BEING MONITORED TO ENSURE DEFICIENT PRACTICE WILL NOT OCCUR

Maintenance monitoring both tubs on weekly monitoring sheet and reporting to quality assurance committee and administration upon completion. (See F 240 # 3 attached)

Use and importance of functioning temperature gauges reinforced with all new LNA hires as part of formal orientation.

T.C. 8/11/09 DNS will monitor for compliance.

F240 POC accepted with addendum 8/11/09

F 278 **F 241 DIGNITY**

IMMEDIATE CORRECTION ADDRESSING RESIDENT 10 AFFECTED BY DEFICIENT PRACTICE

Director of Nursing met with nursing staff, 7/15/09* with nurses and 7/22/09** with LNAs, to discuss dignity issues specific to medication pass.

Same new per diem registered nurse identified in F 157 here. She had worked a total of 7 days of her training period at the time of survey. July 7 she was counseled by the Director of Nursing and refreshed on medication passes and patient dignity.

Discussions held with alert diabetic residents about proper administration of insulin injections.

F241

MEASURES PUT INTO PLACE TO ENSURE
DEFICIENT PRACTICE DOES NOT OCCUR
AGAIN

Director of Nursing met with all nursing staff, 7/15/09*
with nurses and 7/22/09** with LNAs, to discuss
dignity issues to be included with med pass assessment.

Same per diem registered nurse identified in F 157
identified here. July 7 she was counseled by the
Director of Nursing and refreshed on and observed
completing medication passes that assure patient
dignity. She attended the 7/15/09* nurses meeting. We
continue to work with her closely during this
probationary period, to orient and train her on patient
dignity and facility protocols. Director of Nursing
reviewed Medication Administration Policy with her,
highlighting item 20. (See F 241 # 1 attached)

Reviewed employment policies, with focus on
scheduling fewer per diem nurses and increasing
permanent nursing staff coverage.

Advertised and interviewed for permanent nursing
staff, Barton Chronicle, 7/15/09.

July 25, 2009, one per diem LPN dismissed. Fulltime
LPN interviewed and hired, starting 8/18/09.

Director of nursing randomly monitoring medication
passes. Inservice on diabetes management conducted
for nursing staff 7/24/09 at 3 p.m. by Director of
Nursing, with some med passes tested. (See F 241 # 2
attached) *monitor insulin settings*

In service scheduled with Marvin Lang, Registered
Pharmacist for 8/26/09 on diabetes management, with
focus on short acting insulin. (See F 241 # 3 attached)

F241 cmt.

CORRECTIVE ACTIONS BEING MONITORED TO ENSURE DEFICIENT PRACTICE WILL NOT OCCUR

Weekly chart audits conducted for one month by Director of Nursing to assure this error does not occur, then monthly for three more months.

Monthly, QA Committee will continue to review medication passes and address errors.

Results of audits to assure compliance

Residents 1-6, 10-14

F 278 RESIDENT ASSESSMENT

An RN (Director of Nursing) does conduct a complete comprehensive assessment on each resident, assisted by the appropriate department heads that represent each area of care. The RN signs and dates the form to certify that the assessment is completed. Each individual who completes his/her portion of the MDS also signs and dates to certify the accuracy of their section of the assessment s/he is responsible for. Upon completion and signing of the assessment, the MDS coordinator inputs them into the computer.

The original signed MDS will continue to be filed in our overflow backup chart, in the nurses station, for each resident's record.

IMMEDIATE CORRECTION ADDRESSING RESIDENTS 1-6, 10-14 AFFECTED BY DEFICIENT PRACTICE

By 7/27/09, computer generated copies of residents' MDSs (group identified as well as remainder of census) were reviewed, signed, and dated by all department heads responsible for their specific areas. Director of nursing also reviewed, signed and dated all MDSs, to further assure accuracy. (See attached face sheets F 278 # 1 [original and computer generated] for residents in question, to confirm MDSs had been signed upon completion.)

cont. next page

T.C. 8/11/09

DNS will monitor for compliance

F241 POC accepted 8/11/09 (Mary Bolt)

per T.C. Adm. Pat Russell

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F 278	<p>Continued From page 4</p> <p>false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview the Facility failed to have a Registered Nurse (RN) and the individuals who completed portions of the Minimal Data Set (MDS), sign and date the MDS to assure accuracy for all residents in the sample. (Residents #1-6 & #10-14). Findings include:</p> <p>1. Per record review of Residents #1-6, #10-14's medical charts during the three days of survey, the completed MDS's were not signed and dated by the RN or other individuals who completed the assessment. Per interview on 7/7/09 at 10:00 a.m. the DNS confirmed that the MDS coordinator types the names of the personnel who attend the care conference, however it is not signed by the RN and others to assure accuracy when it is finished</p>	F 278	<p>These copies were then placed in the resident charts, a protocol that has been immediately added to our existing protocol for handling of patient assessments.</p> <p><i>Previously, this printed copy was included in the resident charts, sans signatures. The original MDS and signatures was kept in our overflow backup file for each resident's record.</i></p> <p>MEASURES PUT INTO PLACE TO ENSURE DEFICIENT PRACTICE DOES NOT OCCUR AGAIN</p> <p>The MDS coordinator will continue to be responsible for the signing of both the original and the copy of the MDS. Signatures and dates will be reviewed and confirmed after each weekly care plan meeting, by Director of Nursing and MDS coordinator. The Director of Nurses will include this review as part of her monthly chart audits, to report at scheduled Quality Assurance meetings.</p> <p>CORRECTIVE ACTIONS BEING MONITORED TO ENSURE DEFICIENT PRACTICE WILL NOT OCCUR.</p> <p>Effective 7/23/09, the MDS coordinator now brings the printed assessment to the Director of Nursing and department heads that completed their portion of the minimal data set, for review, signature and date, to assure accuracy prior to the document becoming part of the resident's chart.</p> <p><i>T.C. 8/11/09 DNS will monitor for compliance</i></p> <p>Residents 6,12,14,15 and 16</p> <p>F 281 COMPREHENSIVE CARE PLANS</p>	
F 281 SS=E	<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>	F 281	<p>IMMEDIATE CORRECTION ADDRESSING</p> <p>RESIDENT 15 AFFECTED BY DEFICIENT PRACTICE</p> <p>1. For Resident 15</p> <p>Director of Nursing met with same new per diem registered nurse identified in F 157 deficiency. She had worked a total of 7 days of her training period at</p>	

F 278 POC accepted with standards 8/11/09 May Kelly POC

F 278

T.C. 8/11/09 DNS will monitor for compliance

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F 281 Continued From page 5
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to assure that professional standards of care and quality were met for 5 of 10 residents (Resident's # 6, 12, 14, 15 & 16) Findings include:

1. During the observation of medication administration on 7/6/09 at 11:45 the staff nurse failed to administer a short-acting insulin prior to the noon meal for Resident #15, whose blood sugar (BS) level was 169. Per review of the medication administration record (MAR), the physician order is for Novolin R U-100 injection, sliding scale BS > 151 AC (before meals) and HS (at hour of sleep). In addition, per the MAR and the Blood Sugar Flowsheet, from 6/27/09 through 7/6/09 no insulin was documented as being administered when the BS was greater than 151. Per interview on 7/7/09 at 10:00 a.m. the DNS confirmed that the staff nurse failed to follow physician's orders.
2. Per observation of a medication administration on 7/6/09 at 4:30 p.m. the staff nurse did not administer Biotene (a mouthwash treatment to be done prior to meals) as ordered by the physician for Resident # 16. During the medication reconciliation with the medical chart and MAR additional treatments were documented as not being done. Per interview on 7/7/09 at 9:45 a.m. the charge nurse confirmed that he/she had not given the treatment the previous 2 days (total of 4 missed treatments) as ordered by the physician. Also see tag F-175
3. Per record review on 7/8/09 for Resident #14 staff failed to administer pain medication per the

F 281
the time of survey. July 7 she was counseled and refreshed on short acting insulin. She attended the 7/15/09* nurses meeting, which addressed the same subject. We continue to work with her closely during this probationary period, to orient and train her on patient dignity and facility protocols.

MEASURES PUT INTO PLACE TO ENSURE DEFICIENT PRACTICE DOES NOT OCCUR AGAIN
Director of Nursing met with nursing staff 7/15/09*, to discuss administering short-acting insulin and the vital need to document all medication passes.

Director of nursing randomly monitoring medication passes.

Inservice on diabetes management conducted for nursing staff 7/24/09 at 3 p.m. by Director of Nursing, and will be offered individually to nurses as they come on duty.

Inservice scheduled with Registered Pharmacist for 8/26/09 on diabetes management, with focus on short acting insulin. (See F 281 # 1 attached)

CORRECTIVE ACTIONS BEING MONITORED TO ENSURE DEFICIENT PRACTICE WILL NOT OCCUR
Weekly chart audits conducted for one month by Director of Nursing to assure this error does not re-occur, then monthly for three more months.

Monthly QA Committee will continue to review medication passes and address errors.

2. Resident 16 (Biotene pass) See F 157, POC on same matter

3. Resident 14 (No Tylenol)

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F 281 Continued From page 6
physician's order. A nursing note dated 5/5/09 during the 11-7 shift noted the resident to be 'yelling and screaming at 4 a.m....complaining of pain, explained no pain med ordered' Per the physician's standing order Tylenol medication can be given as needed (PRN) for pain in addition to the scheduled Tylenol every 8 hours not to exceed 4 GM/day.
Per interview on 7/8/09 at 1:00 p.m. the DNS confirmed that nursing did not follow physician's orders.

4. Per observation of med pass, at 8:55 AM on 7/7/09, Nurse #1 left medications, including tablets of; Aspirin 81 mg, Clozapine 25mg, Multivitamins, Docusate Sodium and Senna, unsecured and unsupervised on top of the medication cart, located in the hall and in full visual view of anyone passing by, while s/he entered a resident room to administer medications. In addition, during administration of an IM medication, at 10:47 AM that morning Nurse #1 carried a syringe containing medication, with the needle uncovered and exposed, from the med cart in the hall, passing other staff and a resident, and into a resident's room. After administration of the medication, s/he again carried the contaminated needle, uncapped, into the hall to dispose of in a sharps container. During interview at the time of each of the respective observations, Nurse #1 stated that s/he did not realize medications had been left unsecured on top of the med cart. The nurse also confirmed that s/he had carried the syringe with needle uncovered and stated that although the needles utilized by the facility could be retracted into the syringe to avoid accidental needle sticks s/he was not aware of how to retract the needle. Per interview, on the morning of 7/8/09, the DNS

T.C.

8/11/09 DNS will monitor for compliance

F 281 IMMEDIATE CORRECTION ADDRESSING RESIDENT 14 AFFECTED BY DEFICIENT PRACTICE
As Resident 14 was a short term rehab resident discharged May 6, 2009, no correction was possible.

MEASURES PUT INTO PLACE TO ENSURE DEFICIENT PRACTICE DOES NOT OCCUR AGAIN
Director of Nursing will completed a review by 7/31/09 of each patient's chart to confirm Physician's standing order for pain medication for those who are and are not allergic to Tylenol are dated, specified and signed. All resident charts will be reviewed, to ascertain that the amount of pain medication in the standing order is recorded.

RN in question counseled and re-educated on following physician's orders.

New Director of Nursing will refresh and reinforce the use of the Pain Scale at a Nurses' Meeting, 2 p.m., August 5, 2009. (see attached)

CORRECTIVE ACTIONS BEING MONITORED TO ENSURE DEFICIENT PRACTICE WILL NOT OCCUR
Quality assurance committee to review use of Pain Scale by charge nurses whenever a patient chart is being reviewed.

4. Nurse 1 Prepouring Medications
~~IMMEDIATE CORRECTION ADDRESSING RESIDENT AFFECTED BY DEFICIENT PRACTICE~~
Per diem LPN disciplined and re-educated on not pre-pouring medications and/or leaving any medicines on the cart. (See F 281 # 3 attached)

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F 281	<p>Continued From page 7</p> <p>stated that s/he was aware of an issue with Nurse #1 leaving medications on top of the med cart and that during a facility medication administration audit review, completed by the DNS within the past month, Nurse #1 had left medications unsecured and unsupervised on top of the medication cart on a least one occasion.</p> <p>5. Per record review staff failed to clarify the code status for resident #6, who was readmitted to the facility on 5/5/09 following a stay at the hospital. Discharge orders, dated 5/5/09, as well as the resident's most recent care plan stated that the resident's code status was to be DNR/DNI (Do Not Resuscitate/Do Not Intubate). However, the Special Interest Sheet, located in the MAR (Medication Administration Record) and the most current physician orders, dated 6/30/09, identified the resident's code status as "Full Code". During interview, on the morning of 7/8/09, the unit Charge Nurse stated it was not clear whether the resident was to be a Full Code or a DNR/DNI. The DNS stated, during interview on the afternoon of 7/8/09, that s/he had determined, via phone conversation with the resident's family that afternoon, that the resident's code status should be DNR/DNI. The DNS also confirmed that staff should have clarified the resident's code status with the physician.</p> <p>6. Per record review on 7/8/09 at 10:45 a.m., facility staff failed to clarify an insulin order for</p>	F 281	<p>MEASURES PUT INTO PLACE TO ENSURE DEFICIENT PRACTICE DOES NOT OCCUR AGAIN</p> <p>July 15 nurses meeting, Director of Nursing reviewed the importance of NOT prepouring any medications, nor leaving the cart unattended with any drugs on top. Nurses reminded of the gravity of such a practice, and that it is unacceptable, outdated practice at Union House.</p> <p>CORRECTIVE ACTIONS BEING MONITORED TO ENSURE DEFICIENT PRACTICE WILL NOT OCCUR</p> <p>Per diem LPN being monitored on unannounced basis by Director of Nursing. If prepouring is observed, will result in immediate dismissal.</p> <p>5. Resident 6 DNR/DRI</p> <p>IMMEDIATE CORRECTION ADDRESSING RESIDENT 6 AFFECTED BY DEFICIENT PRACTICE</p> <p>July 8, 2009 Director of Nursing called the family and updated the resident's code status and documented in chart to indicate DNR/DNI. Resident's code status updated by the Physician, 7/14/09.</p> <p>MEASURES PUT INTO PLACE TO ENSURE DEFICIENT PRACTICE DOES NOT OCCUR AGAIN</p> <p>All residents' code status to be monitored and reviewed by Physician on all admissions and readmissions.</p>	
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	<p>Resident # 12 On 5/19/09 an insulin order was changed by the physician, without any parameters instructing when nursing staff should 'hold' (or omit) a dose of insulin. Between 5/19/09 and 7/8/09 insulin had been 'held' for finger stick blood sugars below 150 for a total of 15 times. Per interview on 7/8/09 at 11:42 a.m. with the</p>		<p>All residents current code status reviewed by new Director of Nursing shall clarify any changes in code status with Physician before 7/30/09.</p> <p>Long term care ombudsman conducting an Advanced Directives program at 2 p.m. 7/30/09. Residents will</p>	
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F281 cont.

be encouraged to attend who may like to create or alter their planning. (See F 281 # 4 attached)

Universal COLST form adopted 7/27/09 for all admissions, replacing existing forms. (See F 281 # 5 attached)

At 7/15/09* nurses meeting, Director of Nursing emphasized and discussed the importance of staff clarifying a resident's code status with the Physician, particularly when the resident is being readmitted following a hospital stay.

CORRECTIVE ACTIONS BEING MONITORED TO ENSURE DEFICIENT PRACTICE WILL NOT OCCUR

Code status to be evaluated at all MDS sessions. The Director of Nursing will review these MDSs for accuracy related to code status.

6. Resident 12 holding insulin

IMMEDIATE CORRECTION ADDRESSING RESIDENT AFFECTED BY DEFICIENT PRACTICE

At 12 noon 7/8/09 Director of Nursing received a written order for Resident 12 from covering Physician, to hold the insulin for blood sugars under 150.

MEASURES PUT INTO PLACE TO ENSURE DEFICIENT PRACTICE DOES NOT OCCUR AGAIN

Charge nurses inserviced 7/15/09* on the importance of remaining fully current on physician orders.

Any nurse receiving a verbal order from the physician ~~convert this order into a telephone order and implement~~ the change.

CORRECTIVE ACTIONS BEING MONITORED TO ENSURE DEFICIENT PRACTICE WILL NOT OCCUR

T.C.

8/11/09 DNS will monitor for compliance

POC accepted per addendum 8/11/09

May Bolte, RN

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F 281 Continued From page 8
Director of Nursing Services (DNS) he/she confirmed that although the physician did not include written parameters for holding the insulin in the 5/19/09 order he/she had given the DNS a verbal order.

On 7/8/09 at 12 noon the DNS obtained a written order from the covering physician to hold the insulin for blood sugars below 150.

F 325 483.25(i) NUTRITION
SS=D

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.

This REQUIREMENT is not met as evidenced by:

Based on record review, observation and interview, the the facility failed to ensure that resident maintained acceptable nutritional status as evidenced by significant weight loss for 1 of 5 applicable residents. (Res.#2). Findings include:

1. Per record review on 07/08/09, the weight log for Resident #2 indicated weight loss of 11 pounds during a 28-day period (5/28/09 (admission) through 6/29/09). Per the weight log flow sheet, on 5/28/09 (admission), Resident # 2 weighed 134 lbs., one month later on 6/29/09 he/she weighed 124.5 lbs., and on 7/5/09 was 123 lbs.. The resident continued to lose weight

F 281
Ongoing weekly chart audits of diabetics identified as affected by this order will be reviewed weekly by the Director of Nursing and MDS coordinator and quarterly by the QA Committee.

*F 281 POC accepted with addendum 8/11/09
Resident 2
May Batta, RN*
F 325 NUTRITION
See F 157, POC on same matter plus addendum below:

*F 325 T.C. 8/11/09
RD and NSG will monitor on weekly basis and instituting corrective plans to address weight change (+/-) 3 lbs per policy
N/S/DNS will (audit) 11 records weekly
To ensure compliance results will be presented at QA.*

*DNS will monitor POC for compliance
F 325 POC accepted with addendum 8/11/09. May Batta, RN*

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F 325 Continued From page 9
as evidenced by the weight log for the week of 07/05/09 which reported a weight loss of an additional 0.5 pounds. No nutritional assessment or evaluation was noted in the medical chart for this resident nor was the recommendation that had been made by the dietician on 06/04/09 for "between-meal supplements" implemented. The charge nurse and DON confirmed on 7/7/09 at 3:38 PM that there was no evidence in the record of nutritional assessments, evaluations or the recommendations by the dietician was implemented. This tag cross-cited at F157.

F 334 SS=C 483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION
The facility must develop policies and procedures 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

F 325

F 334
Residents 1, 3, 5, 12 and 13
F 334 INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION
IMMEDIATE CORRECTION ADDRESSING RESIDENT AFFECTED BY DEFICIENT PRACTICE
Care plans of Residents 1,3,5,12,13 reviewed. All five were vaccinated for the 2008-2009 season. (See F 334 #1 attached) All other residents were also reviewed, and the following immunized.

MEASURES PUT INTO PLACE TO ENSURE DEFICIENT PRACTICE DOES NOT OCCUR AGAIN
Influenza and Pneumococcal consent forms are signed upon admission and part of the permanent patient record. The consent specifically states it is an ongoing, annually administered immunization. (See F 334 # 2 attached)

Letters will be sent each year, prior to the beginning of Flu Season, to residents (residing longer than the one year initial consent, signed on admission) families and/or guardians, educating them about strains of flu and about the availability of immunizations. (See F 334 #3 attached) Residents, families and their guardians will be required to resign a consent on a yearly basis.

CORRECTIVE ACTIONS BEING MONITORED TO ENSURE DEFICIENT PRACTICE WILL NOT OCCUR

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F 334	<p>Continued From page 10</p> <p>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 immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, 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 pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(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>	F 334	<p><i>K.C. 8/11/09</i></p> <p><i>F334 - Checklist for all residents for flu and pneumococcal vaccines will be reviewed by DNS,</i></p> <p><i>DNS will monitor for compliance. Results reviewed at QA committee</i></p> <p><i>F334 POC accepted with addendums 8/11/09</i></p> <p><i>Wing Bath, MW</i></p>	
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F 334	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to obtain informed consent and provide education regarding benefits and potential side effects of the influenza vaccine to residents or their legal representatives each time a vaccine is offered for 5 of 10 residents. (Res #1, #3, #5, #12, and #13). Findings include: 1. Per record review during 3 days of survey, Residents #1, 3, 5, 12 & 13 who have been residing in the facility for greater than 1 flu season had consent forms dated several years old. Per interview on 7/8/09 at 9:00 a.m., the DNS confirmed that informed consent and education to residents or legal representatives were not obtained each time a vaccine was offered.	F 334	Resident Council meeting in August to include educational discussion of immunizations. Dr. Marie Fatigati has been invited to attend the meeting. Materials received from the Vermont Health Department on flu will continue to be posted prior to immunization availability for residents, families and/or guardians to read. <i>E 334 PC accepted 8/11/09 Mary Baker, RN</i> Residents 6 and 12 F 386 PHYSICIAN VISITS IMMEDIATE CORRECTION ADDRESSING RESIDENT 6 AND 12 AFFECTED BY DEFICIENT PRACTICE On the afternoon of 7/8/09, the Director of Nursing corrected Resident 6's chart, adding most current code status, per family's telephone directive and Resident 12's chart, adding Physician's most current verbal insulin order, with parameter's for dosages.	
F 386 SS=D	483.40(b) PHYSICIAN VISITS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the physician failed to review the total program of care during the most recent visit for each of the respective 2 of 10 residents in the sample. (Residents #6 and #12). Findings include:	F 386	MEASURES PUT INTO PLACE TO ENSURE DEFICIENT PRACTICE DOES NOT OCCUR AGAIN An internal investigation was conducted, and we determined we had accepted a letter of resignation from the re-admitting RN, 6/25/09. CORRECTIVE ACTIONS BEING MONITORED TO ENSURE DEFICIENT PRACTICE WILL NOT OCCUR Director of Nursing and/or MDS Coordinator will review all resident admissions and re-admissions to assure orders are updated on chart. Physician will not be faxed admission/readmissions until orders have been reviewed and transcribed by two nurses, per facility policy. Resident 6	

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F 386 Continued From page 12

1. Per record review the physician for Resident #6 failed to review all printed orders for accuracy prior to signing during the most recent physician visit. The resident, whose medical decisions had been made by a family member, had a physician order, dated 5/5/09 for a DNR/DNI (Do Not Resuscitate/Do Not Intubate). The most current physician orders, dated 6/30/09, and printed by the pharmacy stated that the resident was a "Full Code" and should be transported to the hospital. During interview, on the morning of 7/8/09, the charge nurse was unable to determine which order was accurate. During interview on the afternoon of 7/8/09, the DNS stated that per instructions of the resident's family, obtained by phone at that time, the order should read DNR/DNI.

F 386 *P.C. 8/11/09
DNS will report results of audit to QA committee
DNS will permit for compliance.
F386 POC accepted with addendum 8/11/09
Mary Bolth, RN*

F 444 483.65(b)(3) PREVENTING SPREAD OF INFECTION
SS=D

The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.

F 444

F 444 PREVENTING SPREAD OF INFECTION IMMEDIATE CORRECTION ADDRESSING RESIDENT 6 AFFECTED BY DEFICIENT PRACTICE

A hand sanitizer pump bottle and gloves will be available at the bedside of residents with infections, to be used by nursing staff.

This REQUIREMENT is not met as evidenced

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F 444 Continued From page 13
by:
Based on observation and staff interview staff failed to utilize appropriate hand hygiene during the provision of direct care for 1 resident in the applicable sample. (Resident #6). Findings include:

During observation of personal care for Resident #6, on the afternoon of 7/6/09, the staff member providing the care failed to change gloves or sanitize/wash hands between a contaminated and clean procedure. After cleansing the resident the staff member applied cream and powder to the peri area and then, while wearing the same contaminated gloves, touched the resident's back and hips during the process of positioning the resident on his/her side. During interview, on the afternoon of 7/8/09, the DNS stated that staff should change gloves and sanitize or wash hands between contaminated and clean procedures.

(daily currently)

F 444
MEASURES PUT INTO PLACE TO ENSURE DEFICIENT PRACTICE DOES NOT OCCUR AGAIN
LNA Meeting held 7/22/09**, with Director of Nursing demonstrating proper infection control technique.

Director of Nursing met with LNA cited for failure to use appropriate hand hygiene and re-educated her on procedures. (See F 444 # 1 attached)

CORRECTIVE ACTIONS BEING MONITORED TO ENSURE DEFICIENT PRACTICE WILL NOT OCCUR

Director of Nursing and charge nurses will observe LNAs at random to insure proper handling and treatments, to assure the prevention of the spread of infection.

Resident units for those with infections will be set up properly with sanitizer, gloves and disposal container and protocol followed.

* 7/15/09 attendance sheet attached, referencing F 157,240,241,281
** 7/22/09 attendance sheet attached, referencing F 157 and 241
*** 7/24/09 attendance sheet attached, referencing F 241 and 281

*DNS will report results of random observations of hand hygiene to QA Committee monthly.
DNS will monitor for compliance*

F444 PAR accepted with addendum 8/11/09. May Balth, RN