

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

October 13, 2016

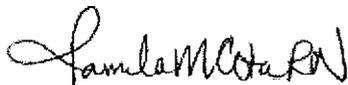
Mr. Richard Morley, Administrator
Woodridge Nursing Home
P.O. Box 550
Barre, VT 05641-0550

Dear Mr. Morley:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 31, 2016**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN
Licensing Chief

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

OCT 11 2016 PRINTED: 09/23/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475045	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/31/2016
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NAME OF PROVIDER OR SUPPLIER WOODRIDGE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE P.O. BOX 550 BARRE, VT 05641
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000		
F 247 SS=B	<p>An unannounced, on-site recertification survey was conducted by the Division of Licensing and Protection between Aug. 29-Aug. 31, 2016. The following regulatory deficiencies were identified:</p> <p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE</p> <p>A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide written notification regarding a change of roommates for 1 applicable resident in the Stage 2 sample of 14, Resident #187. Findings include:</p> <p>Resident #187 stated during the Stage 1 interview process that s/he had not been notified whenever s/he received a new roommate. On 8/30/16 at 3:19 PM, during an interview with social services, s/he stated that there are several ways that residents are notified of changes in their rooms or roommates. S/he further stated that written notification is given if a room change is to occur, but only verbal notification is given when a roommate change is made and documentation is made in the record to indicate they were notified and that Resident #187 was verbally notified.</p> <p>Per interview with Resident #187 on 8/30/16, s/he stated that there were a couple of roommate changes and social services confirmed this at</p>	F 247	<p>The Social Worker had discussed with resident #187 that she would be receiving a new roommate and the resident was agreeable, however the Social Worker did not document that conversation.</p> <p>Education was conducted by the Director of Nursing Services with all the Social Services and Admission staff regarding the need to discuss any roommate changes with a resident, and to document such conversation.</p> <p>Random audits will be completed on 5 residents with roommate changes, per week for 4 weeks, then monthly for 3 months. Audit results will be reported to the QAPI Committee, and monitored by the Administrator/Administrator In-Training and corrective action taken, as needed, based upon performance.</p> <p><i>F247 POC accepted 10/13/16 G Coleman Rdl/Dna</i></p>	10/7/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Administrator / V.P. Support Services</i>	(X6) DATE <i>10/4/16</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 247 F 252 SS=E	<p>Continued From page 1</p> <p>3:26 PM. Per record review at 3:34 PM, there is no evidence that Resident #187 was informed of roommate changes and confirmation was made by the social worker at this time that there is no evidence of notification.</p> <p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on the dining observations on 8/29/2016 at both the noon and evening meals, and based on staff and resident interviews, the facility failed to provide a comfortable, homelike environment in 1 of 4 dining rooms by not providing a psychosocial environment or person-centered care that emphasizes relationships, or that welcomes each resident, making him or her comfortable (Maple Grove).</p> <p>Per observation of the dining experience on Maple Grove at 11:50 am on 8/29/2016, the dining room is small and contains 5 tables at which 13 residents are seated. Staff are delivering trays and assisting residents with meal set-ups. Residents are continually moved in and out of the dining room, until all 31 of the residents who eat or are fed in the dining room have eaten. As soon as they are done eating they are removed from the room. There is minimal opportunity to engage in social</p>	F 252	<p>All residents are potentially affected by this practice.</p> <p>Additional dining space has been identified and will be designed to be more comfortable and homelike for dining. All residents will be re-assessed for the assistance needed and their preferred meal times, at a minimum of quarterly or if their condition changes.</p> <p>Staff Education will occur regarding the importance of social interaction during meals, seating residents comfortably in the dining room, and ensuring that residents who require assistance, receive it in a timely manner during their dining experience.</p> <p>Unit Director or designee will ensure that audits will be completed on 10 residents weekly for 4 weeks, then monthly for 3 months. Audits will ensure that residents are eating their meals in a safe, clean, comfortable and homelike environment. Audit results will be reported to the QAPI Committee, and monitored by the Administrator/Administrator In-Training and corrective action taken, as needed, based upon performance.</p> <p><i>F252 PDC accepted 10/13/16 G.Coleman RN/PMU</i></p>	11/02/16

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F 252	<p>Continued From page 2</p> <p>interactions with others. Residents are in wheel chairs, geri chairs or ambulatory with or without canes or walkers. Since the dining area is small, residents who are at the table need to be moved out of the way to make room for the new ones coming in or leaving the room.</p> <p>Two residents are seated at a half-table that faces out of the dining room, away from the rest of the people who are eating. Resident #128 has his/ her food in front of him/ her and is observed not making any attempts to eat from the beginning of the observation at 11:50 am to 12:25 am. Staff confirm during interview at 12:30 pm that Resident # 128 has not yet touched his/ her food and that after the other residents are finished eating, s/he will be moved to another table and given assistance. The staff brought a new tray to him/ her at 12:49 pm, after the surveyor mentioned the length of time (nearly 1 hour after this resident is first observed sitting in front of his/her food). Resident #163 is seen outside the dining room between 11:35 am and 12:50 pm, nodding that s/he had not yet eaten. Resident # 163 was seated here to wait to go into the dining room when there would be room at one of the tables. Staff indicate, during interview at 12:45 pm that Resident # 163 has already eaten. Confirming that s/he had, in fact not eaten, Resident # 163 is ushered into the dining room for lunch, at 12:50 pm, one of the last to be served. Resident # 163 is later observed at the evening meal being one of the first to be served a tray (between 4:50 and 5:00 PM)</p> <p>Unit direct care staff confirm during interview on 8/29/2016 at 5:00 PM that there isn't enough room in the dining area for all the residents to eat</p>	F 252		

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F 252	Continued From page 3 together and that the residents are served depending on how the trays are put on the carts by the kitchen staff, not using resident preference.	F 252	Resident #113 was weighed on 8/30 when identified by surveyors that monthly weight was overdue.	
F 281 SS=E	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</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, the facility failed to follow the written physician orders for 3 of 14 residents in the Stage 2 sample, Resident #113, 215 and 218. Findings include:</p> <p>1.) Resident #113 was admitted to the facility with a diagnosis of Congestive Heart Failure (CHF) and per interview with the Registered Nurse (RN) on Maple Grove, the resident has had a diet change to Consistent Carbohydrates to decrease caloric intake secondary to overeating. There is a physician order, dated 5/2/16, to weigh at the same time of day and record monthly. The Registered Nurse (RN) stated on 8/30/16 at 10:30 AM that the resident is on comfort care and his/her weights had been discontinued. After reviewing the record with this surveyor at 10:40 AM, s/he confirmed that the last weight obtained was 6/14/16 and that the resident is to be weighed monthly according to the physician orders and confirmed that it has not been done.</p>	F 281	<p>Resident #218 PICC dressing was changed on 8/30.</p> <p>Resident # 215 had the heel booties applied during the survey, when identified by the surveyor.</p> <p>A process will be established to ensure consistent implementation of physician orders, that will ensure that all orders are fully transcribed to the MAR, TAR, POC, and Task List as appropriate.</p> <p>Staff education will be provided regarding the process of completely and accurately transcribing and verifying orders.</p> <p>The DNS or designee will ensure random Audits will be completed on 10 charts per week for 4 weeks, then monthly for 3 months, to ensure that all orders are completely and accurately transcribed.</p> <p>Audit results will be reported to the QAPI Committee, and monitored by the Administrator/Administrator In-Training and corrective action taken, as needed, based upon performance.</p> <p><i>F281 POC accepted 10/13/16 G. Coleman/PRC</i></p>	11/02/16

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F 281	<p>Continued From page 4</p> <p>on 8/30/16 at 9:36 AM, the Licensed Practical Nurse commented that the Peripherally Inserted Central Catheter (PICC) dressing for Resident #218 was last changed on 8/18/16 and stated that it was overdue to be changed. Per interview with the RN on 8/30/16 at 10:10 AM, s/he stated that per facility policy, the PICC dressing are changed weekly. Review of the policy for PICC line dressing changes are to be done every 7 days and as needed if soiled, wet or non-occlusive. Resident was admitted to the facility 8/23/16 with the physician orders to change PICC dressing per protocol. Further review of the medical record did not provide evidence that the order was transferred to the medication administration record or to the treatment administration record. The RN unit manager confirmed at 10:10 AM that the physician order had not been followed.</p> <p>3.) Resident #215 was admitted to the facility with a diabetic ulceration of the left metatarsal and his/her Braden scale assessment was 15, which indicates risk for skin breakdown. An order written 8/18/16 indicates that the resident is to wear heel booties at all times and to keep heels elevated off the bed. Per observation of Resident #215 on 8/30 and 8/31/16, the resident was not wearing heel booties, and per interview with Resident #215's spouse at 10:56 AM, who visits almost daily from about 9:00 AM to 5:30 PM, s/he states sometimes the staff put on the heel bootie and sometimes they don't. There also was only one heel bootie located in the room. The RN unit manager confirmed on 8/31/16 at 11:02 AM that the resident wasn't wearing heel booties and confirmed that the resident's heels were not elevated off the bed.</p>	F 281		

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F 281 F 282 SS=D	<p>Continued From page 5</p> <p>S/he further stated that s/he was unaware of the order and the orders had not been followed.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide care and services in accordance with the resident's written care of plan for 1 of 14 residents in the Stage 2 sample, Resident #113. Findings include:</p> <p>Resident #113 was admitted to the facility with a diagnosis of Congestive Heart Failure (CHF) and per interview with the Registered Nurse (RN) on Maple Grove, the resident has had a diet change to Consistent Carbohydrates to decrease caloric intake secondary to overeating. Record review on 8/30/16 presents that s/he has a care plan dated 6/22/16 that the resident has unplanned/unexpected weight gain related to edema and overeating. There is also a physician order, dated 5/2/16, to weigh at the same time of day and record monthly. The resident's care plan presents that the resident is to be weighed monthly. The Registered Nurse (RN) stated on 8/30/16 at 10:30 AM that the resident is on comfort care and his/her weights had been discontinued. After reviewing the record with this surveyor at 10:40 AM, s/he confirmed that the last weight obtained was 6/14/16 and that the</p>	F 282	<p>Resident #113 was weighed on 8/30 when noted by surveyors.</p> <p>A process will be established to ensure consistent implementation of physician orders.</p> <p>Staff education of all RNs and LPNs will be provided regarding the process of accurately following physician orders as written.</p> <p>DNS or designee will ensure random audits will be completed on 10 charts per week, for 4 weeks, then monthly for 3 months, to ensure that all weight orders are followed as written.</p> <p>Audit results will be reported to the QAPI Committee, and monitored by the Administrator/Administrator In-Training and corrective action taken, as needed, based upon performance.</p> <p><i>FABZ POC accepted 10/13/16 Goleman RN/pme</i></p>	11/02/16

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F 282 F 353 SS=E	<p>Continued From page 6 resident is to be weighed monthly according to the physician orders and confirmed that it has not been done.</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to have sufficient nursing staff to provide nursing and related services to maintain the highest practicable physical, mental, and psychosocial well-being of each resident on 2 of 3 units (Maple Grove and Spruce). The findings include:</p>	F 353	<p>Staffing levels are reviewed daily to ensure that resident needs and acuity are met, according to resident care plan and facility needs/operations. Staffing adjustments are made on as-needed basis.</p> <p>Walkie-talkies were purchased for use by nursing staff, to enhance communication among nursing staff and responding to call lights in a timely manner.</p> <p>An assessment of the Activities Program will be completed by the Management Team to identify opportunities to increase our activities and programs throughout the facility.</p> <p>This assessment will include actions to address any weaknesses and/or opportunities identified.</p>	11/02/16

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F 353	Continued From page 7 1. Per observation on the Spruce unit, at 4:15 PM of 8/30/16, the surveyor noted, while seated in the nurses' station, that the call system sounded for room 126 for over 7 minutes. Upon observation of room 126 at the far end of the hall, Resident # 181 was seen seated, and s/he asked the surveyor for assistance to use the rest room. The surveyor agreed to find staff to assist Resident #181. The surveyor was unable to locate any staff while looking down each hall from the center circle. While glancing toward room 126, the surveyor observed a person walking into the room. The call light was then turned off. The surveyor walked back to room 126 and spoke with the person who identified as a family member. At this time, approximately 4:18 PM (10 minutes from initial call), Resident #181 was seen standing up to a walker device, and asked the surveyor if a staff person had been found. The family member appeared to be assisting by moving items out of the path of Resident #181. The surveyor returned to the hall and found a Licensed Practical Nurse (LPN) assisting another resident, and informed the LPN that a family member was assisting Resident #181. The LPN assisted Resident #181 at that time. At 4:35 PM the surveyor informed the Registered Nurse (RN) of the above observation. The RN confirmed that 5 Licensed Nurse Assistants (LNA) were assigned to Spruce unit for this evening shift, and that the LPN was covering that hallway and part of another. The RN stated that the 5 LNA staff must have been either in rooms assisting residents or assisting residents to the dining room for supper. At 4:45 PM the LPN confirmed that none of the 5 LNA staff had been available to assist Resident #181.	F 353	Education for staff will include the importance of toileting residents regularly, especially prior to meal times, and the importance of answering call lights in a timely manner. Non-nursing staff will be educated on the expectation that they answer call lights as well, when in resident care areas, and what tasks that they can and cannot do for the residents. Unit Directors or designees will ensure random audits will be conducted on the resident call light system to identify peak times and average call response times. Audit results will be reported to the QAPI Committee, and monitored by the Administrator/Administrator In-Training and corrective action taken, as needed, based upon performance.	

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F 353	<p>Continued From page 8</p> <p>Per medical record review, Resident #181 requires assistance of 1 staff and a walker for safe transfer and toileting due to high risk for falls. The care plan indicated that Resident #181 should be assisted to toilet every 2 hours and as needed.</p> <p>2. Per observation on 8/30/2016 from 3:55 pm to 4:40 pm, 9 residents were brought to the common area on Spruce and left sitting in their wheelchairs. Only 1 resident was engaged in conversation or activity; 2 were taken away and replaced with 2 others. According to a roster matrix, printed on 8/29/2016, there are 48 residents on Spruce, 42 of whom are identified as being incontinent and 17 who have behavior issues. There are 44 residents on Maple and 41 of those are identified as being incontinent, and 29 have behavior issues. Care plans indicate that residents are either offered toileting or are changed and have incontinence care every 2 hours. The residents who were seated in the common area at 4:00 pm were taken to the main dining room for the evening meal at 4:40 pm. No one seated was observed to be asked if they needed to go to the bathroom prior to the meal. From observation on 8/29/2016, the meals take more than an hour, and no one is observed being asked if they need toileting or being checked to see if they are incontinent.</p> <p>3. Per observation of the dining experience on Maple Grove at 11:50 am on 8/29/2016, the dining room is small and contains 5 tables at which 13 residents are seated. Staff are delivering trays and assisting residents with meal set-ups. Residents are continually moved in and</p>	F 353	Education for staff will include the importance of toileting residents regularly, especially prior to meal times.	11/02/16

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F 353	<p>Continued From page 9</p> <p>out of the dining room, until all 31 of the residents who eat or are fed in the dining room have eaten. As soon as they are done eating they are removed from the room. There is minimal opportunity to engage in social interactions with others. Residents are in wheel chairs, geri chairs or ambulatory with or without canes or walkers. Since the dining area is small, residents who are at the table need to be moved out of the way to make room for the new ones coming in or leaving the room.</p> <p>Two residents are seated at a half-table that faces out of the dining room, away from the rest of the people who are eating. Resident #128 has his/ her food in front of him/ her and is observed not making any attempts to eat from the beginning of the observation at 11:50 am to 12:25 am. Staff confirm during interview at 12:30 pm that Resident # 128 has not yet touched his/ her food and that after the other residents are finished eating, s/he will be moved to another table and given assistance. The staff brought a new tray to him/ her at 12:49 pm, after the surveyor mentioned the length of time (nearly 1 hour after this resident is first observed sitting in front of his/her food). Resident #163 is seen outside the dining room between 11:35 am and 12:50 pm, nodding that s/he had not yet eaten. Resident # 163 was seated here to wait to go into the dining room when there would be room at one of the tables. Staff indicate, during interview at 12:45 pm that Resident # 163 has already eaten. Confirming that s/he had, in fact not eaten, Resident # 163 is ushered into the dining room for lunch, at 12:50 pm, one of the last to be served. Resident # 163 is later observed at the evening meal being one of the first to be</p>	F 353	<p>Additional dining space has been identified and will be designed to be more comfortable and homelike for dining. All residents will be re-assessed for the assistance needed and their preferred meal times, at a minimum of quarterly or if their condition changes.</p> <p>Staff Education will occur regarding the importance of social interaction during meals, seating residents comfortably in the dining room, and ensuring that residents who require assistance, receive it in a timely manner during their dining experience.</p> <p>Audits will be completed by the Unit Director or designee on 10 residents weekly for 4 weeks, then monthly for 3 months. Audits will ensure that residents are eating their meals in a safe, clean, comfortable and homelike environment. Audit results will be reported to the QAPI Committee, and monitored by the Administrator/Administrator In-Training and corrective action taken, as needed, based upon performance.</p> <p><i>F353 PDC accepted 10/13/16 G Coleman Pd / PML</i></p>	

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NAME OF PROVIDER OR SUPPLIER WOODRIDGE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE P.O. BOX 550 BARRE, VT 05641		
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F 353	Continued From page 10 served a tray (between 4:50 and 5:00 PM) Unit direct care staff confirm during interview on 8/29/2016 at 5:00 PM that there isn't enough room in the dining area for all the residents to eat together and that the residents are served depending on how the trays are put on the carts by the kitchen staff.				
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 431			

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F 431	<p>Continued From page 11</p> <p>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 staff interview the facility failed to maintain a system for reconciling of controlled substances for Resident #7 and medication labeling for 1 of 7 residents was incorrect, Resident #46. Findings include:</p> <p>1.) During observation of the medication storage unit on Evergreen, it was found that the emergency kit had one drawer that had been compromised on 8/24/16 and was not resealed. Per interview with the Licensed Practical Nurse (LPN) on 08/29/16 at 12:13 PM, drawer 3 was not sealed and was last utilized on 8/24/16. Drawer #3 is labeled to contain psychotropic medications (medications used to treat mental illness or distress) and the LPN stated that the protocol is to fax the paper, located in the drawer, that indicates what medication was removed, when and for whom, to the pharmacy as soon as the drawer is opened. S/he further stated at this time that the drawer is to have a replacement lock tie applied and confirmed that neither of these things had been done. Per interview with the Director of Nursing Service (DNS) on 8/31/16 at 8:35 AM, there is the potential for drug diversion if the medications in the emergency kit's unlocked drawers are not being accounted for each shift. Per interview with the pharmacist on 8/31/16 at 9:33 AM, the</p>	F 431	The contracted pharmacy has updated the procedure for emergency boxes to ensure that there is a mechanism to identify when a box has been opened and used and how the pharmacy will replace those boxes.	11/02/16	

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F 431	<p>Continued From page 12</p> <p>pharmacist delivery driver is to check the emergency boxes at the time of each delivery to ensure there is no need for replacement and confirmed that this had not been done or the unlocked drawer would have been discovered before 8/29/16.</p> <p>2.) During observation of medication administration on 8/29/16 at 4:26 PM, Potassium Chloride Extended Release 20 meq (milliequivalent) 1 (one) capsule was administered to Resident #46, the label on the packaging stated to give 2 (two) capsules. Reconciliation of the medications against the physician orders indicate to administer 1 capsule. The Licensed Practical Nurse confirmed at the time of administration that the label was incorrect regarding the dosage to be administered.</p> <p>3.) On 8/29/16 at 12:52 PM, a review of the system for counting and reconciliation of controlled substances produced that the controlled substance inventory book on cart #2, page 94 indicated that there were 5 (five) Morphine Sulfate (MSO4) multi-vial dose bottles that were received from the pharmacy on 6/14/16 for Resident #7, but when reviewing the medications in the secured box for controlled substances, there was no evidence of MSO4 for Resident #7. The Registered Nurse (RN) stated that the medication had not been discontinued and was unsure of where the MSO4 was, s/he stated that the resident had been transferred to another room on 7/9/16 and his medications were transferred to cart #3, but after searching cart #3, s/he reported that 'it wasn't there'. The RN Unit Manager was notified at this time and stated that the medication should have been</p>	F 431	<p>A process will be established to utilize cautionary instructions for dose changes. Labels will be placed on the medication blister packs when a change in dosing has been ordered, which will state "dose change – see MAR".</p> <p>The controlled substance policy will be revised to include a change in process regarding the controlled substance count procedure. This change ensures that all nurses complete the reconciliation on the index list with the medications under lock and key.</p> <p>The contracted pharmacy will be providing a secured controlled substance storage area in the med room.</p> <p>A facility change to support this process is the implementation of a badge-reader system on all medication rooms for additional safety.</p>	<p>11/02/16</p> <p>11/02/16</p>

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F 431	Continued From page 13 counted at the end of each shift. Review of the inventory of the controlled substance book presents as blank and the RN stated that when a medication is received on the unit a page number is placed on the packaging and during count, the package is referred to and the nurses will look at the page number indicated to do the count. After a second search, the MSO4 was located on cart #3. Each cart has its own individual controlled substance book and the medication was listed in both books and there is no documentation in the cart #2 book that the medication had been transferred and during shift count, the nurses were counting that the medication was on cart #2, they were also counting that the MSO4 for resident #7 was on cart #3. Per interview with the DNS on 8/31/16 at 8:35 AM, s/he stated that the pharmacist has been doing some education regarding proper usage of the controlled substance record and it has been recognized that there is opportunity for drug diversion with the current system.	F 431	RN and LPN education will be provided to include the process for securing and utilizing the emergency medication boxes, the procedure for dose changes and placing the alert labels on the medication packs, as well as the new storage system for controlled substances. Random audits will be completed by the DNS or designee to ensure the security of the emergency medication boxes, the labeling of meds with a dose change, and the security of controlled substances weekly for 4 weeks, then monthly for 3 months. Audit results will be reported to the QAPI Committee, and monitored by the Administrator/Administrator In-Training and corrective action taken, as needed, based upon performance	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and		F431 POC accepted 10/13/16 G Coleman R/1/one	

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F 441	<p>Continued From page 14</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to insure a sanitary environment for 4 of 4 applicable residents reviewed, Residents #44, 215, 500 and 501. Findings include: 1.) During the initial tour of the facility, Residents #44, 215, 500 and 501 were observed to have nebulizer machines (used for respiratory inhalation treatments) at the bedsides, they also were observed to have nebulizer masks that were without protective coverings, lying on the night stands. The night stands for each of the residents contained other items for personal</p>	F 441	<p>Nebulizer masks are now stored in a plastic bag with the resident's name on it and stored in the resident room.</p> <p>A policy will be created which will address the use of nebulizers within the facility. Education will occur for RNs, LPNs and LNAs regarding the policy and proper infection control practices (which will include treatment, cleaning and storage).</p> <p>Targeted audits will be completed by the DON or designee on those residents using nebulizers. Audits will be completed weekly for 4 weeks, then monthly for 3 months to ensure compliance with nebulizer use policy.</p>	11/02/16

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F 441	<p>Continued From page 15</p> <p>usage, such as hairbrushes, toothbrush, powders or lotions. On 8/30/16, Residents #44, 215, and 501 were observed to continue to have their nebulizer on the night stand and Resident #500's nebulizer mask was draped over the headboard of the bed. Per interview with a Registered Nurse (RN) on 8/30/16 at 8:48 AM, the protocol for care of the nebulizer masks is to place them in a plastic bag in between usage. On 8/30/16 at 11:35 AM, Resident #215 was observed using the nebulizer mask for an inhalation treatment and after completion, the nurse put the nebulizer on the nightstand. The RN, Unit Manager accompanied me to the rooms for Residents 44, 215, 500 and 501 and confirmed at 11:48 AM that the protocol for infection control was not followed regarding the bagging of the nebulizer masks.</p> <p>2.) During observation of medication administration on 8/30/16 at 9:04 AM, the RN retrieved 2 (two) scoops of protein powder from a container by taking the scoop with an ungloved hand, pouring it into the cup and then replacing the scoop in the container, placed the cover back on the container and then placed the container back into the medication cart. The RN confirmed at 9:07 AM, that s/he did not have gloves on when s/he handled the scoop and that the container of protein powder has the potential to be used for many residents and by many different nurses.</p>	F 441	<p>Single-dose servings of protein supplements have been ordered and will replace the multiple -dose containers. This will eliminate this infection control concern.</p> <p><i>F441 POC accepted 10/13/16 G.Coleman RN/AME</i></p>	10/7/16