

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

November 23, 2016

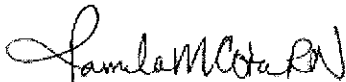
Ms. Meagan Buckley, Administrator
Burlington Health & Rehab
300 Pearl Street
Burlington, VT 05401-8531

Dear Ms. Buckley:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 26, 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

PRINTED: 11/08/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/26/2016
NAME OF PROVIDER OR SUPPLIER BURLINGTON HEALTH & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 300 PEARL STREET BURLINGTON, VT 05401		
(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
F 000	INITIAL COMMENTS An unannounced onsite recertification survey, as well as the investigation of 2 self-reports and 1 complaint, were completed by the Division of Licensing and Protection from 10/24-26/16. There were no regulatory violations identified related to the allegations in the 2 self-reports. There were regulatory violations identified in the survey and related to allegations in the complaint with findings as follows.	F 000			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that nursing staff met professional standards of nursing practice regarding failure to follow physician orders for the administration of an anticoagulant medication and for obtaining monitoring labs for 1 of 26 residents (Resident #112). Findings include: Per record review, nursing staff failed to accurately enter new physician verbal orders for PT/INR (anticoagulant monitoring labs) and changes in Coumadin dosage in the EMR (Electronic Medical Record) resulting in labs not being done per orders and errors in Coumadin administration. (Coumadin is an anticoagulant medication which can have side effects that increase bleeding risk). Per review of Resident #112's nursing progress notes, on 9/20/16 Registered Nurse (RN) staff	F 281	1. Resident # 112 no longer resides in the facility. 2. Residents requiring monitoring of PT/INR have the potential to be affected by this alleged deficient practice. 3. Education provided to licensed nursing staff regarding Transcribing orders as it relates to PT/INR monitoring. 4. An audit of residents requiring PT/INR monitoring conducted to ensure orders properly transcribed for PT/INR monitoring. 5. Weekly audits will be conducted by DNS or designee to monitor the effectiveness of the plan. 6. The results of the audit will be reported to the QAA committee by the DNS or designee monthly X 3 months at which time the QAA committee will determine further frequency of the audits.		

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

TITLE

(X6) DATE

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 281	<p>Continued From page 1</p> <p>documented that the hospital lab called to report a critical PT/INR result of 65.3/5.6; an on call physician was contacted and ordered staff to hold Coumadin for the night. Orders were obtained to redraw the PT/INR on 9/21/16. Per the Coumadin Anticoagulation Record, the 9/21/16 PT/INR was 76.3/6.4 (continued critically elevated with increased risk for bleeding); nursing progress notes document orders to discontinue Coumadin; a verbal order states next PT/INR is due on Friday, 9/23/16. There is no evidence that a PT/INR was done on 9/23/16; the next documented PT/INR was on 9/26/16 (3 days late; result: 22.1/1.8).</p> <p>On 10/10/16 the resident's PT/INR was 45.0/3.7 (elevated); a verbal order states to recheck PT/INR on 10/14/16, hold Coumadin today, change Coumadin dosage to 0.5 mg on Monday and Wednesday; continue Coumadin 1 mg all other days. There is no evidence that a PT/INR was done on 10/14/16; the next documented PT/INR was done on 10/19/16 (5 days late) and the result was 46.1/3.8 (continued elevated). Per review of the MAR (Medication Administration Record), the resident also continued to receive Coumadin 1 mg daily instead of the reduced dose of 0.5 mg on 10/12/16 and 10/17/16 (Wednesday and Monday) as ordered on 10/10/16.</p> <p>On 10/25/16 at approximately 1:50 PM, the facility UM (Unit Manager) confirmed that the physician verbal orders documented on the Coumadin Anticoagulation Record did not get transcribed to EMR orders or to the MAR for implementation, resulting in labs not being done as ordered and errors in Coumadin</p>	F 281	<p>6. Corrective action to be completed by November 26, 2016.</p> <p><i>F281 POC accepted 11/22/16 JHsmarkn/pmc</i></p>		

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F 281	Continued From page 2 administration. The UM confirmed there were issues with the process of transcribing verbal orders into the EMR. The errors placed the resident at additional risk for adverse side effects including bleeding. (Refer to 282, 329, 333, 514)	F 281			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to implement the care plan for 2 of 26 applicable residents (Resident #259 and #112) . Findings include: 1. Per record review, Resident #259 was not weighed per the care plan or given nutritional supplements as recommended by the facility Registered Dietician (RD). Resident #259 sustained a 24 pound, or 12.6 % weight loss between 7/18/16 (215 lb)- 10/13/16 (191 lb). Resident #259 was weighed on 10/25/16 and weight had decreased to 175 pounds. Per an RD assessment on 10/14/16, Resident #259 has not been eating well since his/her admission here and is at nutritional risk. Resident #259 requires increased nutrient needs to help with wound healing. A recommendation for House Supplements twice a day (BID) was made by the RD on 10/14/16. Review of the Medication Administration Record (MAR) indicates Resident	F 282	1. Resident #259 receiving supplements and weights as ordered, #112 no longer resides in th facility. 2. Residents receiving anticoagulant therapy and at nutritional risk have the potential to be affecte by the alleged deficient practice. 3. Education provided to licensed nursing staff regarding care plan implementation as it relates to weights, supplements, and anticoagulant therapy. 4. Weekly audits will be conducted by DNS or designee to monitor the effectiveness of the plan 5. The results of the audit will be reported to the QAA committee by the DNS or designee monthl X 3 months at which time the QAA committee w determine further frequency of the audits. 6. Corrective action to be completed by November 26, 2016. <i>F282 POC accepted 11/22/16 JHsmcrRN PMU</i>		

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F 282	<p>Continued From page 3</p> <p>#259 has not received supplements as of 10/25/16. Additionally, the nutrition care plan has an intervention for weekly weights and BID supplements. It is facility policy to do weekly weights for the 1st 4 weeks following admission. Review of the clinical record indicates weight has not been done since 10/13/16. The Unit Manager (UM) confirmed that weights should be indicated on the MAR and confirmed that they were not on the MAR, and that weights had not been done weekly as per policy and the care plan. The UM also confirmed that he/she did not receive the RD recommendation regarding supplements until 10/22/16 and that the supplements had yet to be started as of 10/25/16.</p> <p>2. Per record review, the care plan for Resident #112 related to "...risk for injury or complications related to the use of anticoagulation therapy" (initiated on 10/5/16) was not followed related to the resident's "anticoagulant" being "given as ordered" and "labs [obtained] as ordered."</p> <p>Per review of the Resident #112's Coumadin Anticoagulation Record, on 10/10/16 the resident's PT/INR was 45.0/3.7 (elevated); a verbal order states to recheck PT/INR on 10/14/16, hold Coumadin today, change Coumadin dosage to 0.5 mg on Monday and Wednesday; continue Coumadin 1 mg all other days. There is no evidence that a PT/INR was done on 10/14/16 per orders; the next documented PT/INR was done on 10/19/16 (5 days late) and the result was 46.1/3.8 (continued elevated). Per review of the MAR (Medication Administration Record), the resident also continued to receive Coumadin 1 mg daily instead of the reduced dose of 0.5 mg on</p>	F 282			

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F 282	Continued From page 4 10/12/16 and 10/17/16 (Wednesday and Monday) as per the 10/10/16 physician order. On 10/25/16 beginning at approximately 1:50 PM, the facility UM (Unit Manager) confirmed that the physician verbal orders documented on the Coumadin Anticoagulation Record did not get transcribed to EMR orders or to the MAR for implementation resulting in labs not being done as ordered and errors in Coumadin administration. The UM confirmed that the care plan for anticoagulant risk was not followed. (Refer to 281, 329, 333, 514)	F 282			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE 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 staff interview and record review, the facility failed to ensure that 1 of 26 applicable residents (Resident # 259) received a therapeutic diet when there is a nutritional problem. Findings include:	F 325	1. Resident #259 receiving supplements and weights as ordered. 2. Residents at risk for weight loss have the potential to be affected by the alleged deficient practice. 3. Education provided to staff regarding weight management and nutritional supplements. 4. Weekly audits will be conducted by DNS or designee to monitor the effectiveness of the pla 5. The results of the audit will be reported to the QAA committee by the DNS or designee month X 3 months at which time the QAA committee w determine further frequency of the audits. 6. Corrective action to be completed by November 26, 2016. F325 POC accepted 11/22/16 JHosmerRN/pmc		

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F 325	Continued From page 5 Per record review, Resident # 259 was not weighed per the care plan or given nutritional supplements as recommended by the facility Registered Dietician (RD). Resident # 259 sustained a 24 pound, or 12.6% weight loss between 7/18/16 (215 lb)- 10/13/16 (191 lb). Resident #259 was weighed on 10/25/16 and weight had decreased to 175 pounds. Per an RD assessment on 10/14/16, Resident #259 has not been eating well since his/her admission here and is at nutritional risk. Resident #259 requires increased nutrient needs to help with wound healing. A recommendation for House Supplements twice a day (BID) was made by the RD on 10/14/16. Review of the Medication Administration Record (MAR) indicates Resident #259 has not received supplements as of 10/25/16. Additionally, the nutrition care plan has an intervention for weekly weights and BID supplements. It is facility policy to do weekly weights for the first 4 weeks following admission. Review of the clinical record indicates weight has not been done since 10/13/16. The Unit Manager (UM) confirmed that weights should be indicated on the MAR, and confirmed that they were not on the MAR, and that weights had not been done weekly as per policy and the care plan. The UM also confirmed that h/she did not receive the RD recommendation of 10/14/16 regarding supplements until 10/22/16, and that the supplements had yet to be started as of 10/25/16.	F 325			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM 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	F 329	1. Resident #112 no longer resides in the facility 2. Residents on anticoagulant therapy have the potential to be affected by the alleged deficient practice.		

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F 329	<p>Continued From page 6</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that each resident's drug regimen is free from unnecessary medications, drugs given in excessive dose or without adequate monitoring, for 1 of 26 residents (Resident #112). Findings include:</p> <p>Per record review, Resident #112 was on physician ordered Coumadin. Coumadin is an anticoagulant medication which can have dangerous side effects that increase bleeding risk. Per review, Resident #112 did not consistently receive PT/INR monitoring labs per</p>	F 329	<p>3. Education provided to licensed nursing staff regarding PT/INR monitoring for Anticoagulant dosing.</p> <p>4. Weekly audits will be conducted by DNS or designee to monitor the effectiveness of the plan</p> <p>5. The results of the audit will be reported to the QAA committee by the DNS or designee monthly X 3 months at which time the QAA committee will determine further frequency of the audits.</p> <p>6. Corrective action to be completed by November 26, 2016.</p> <p><i>P329 POC accepted 11/22/16 JHsmar/pal/muc</i></p>		

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F 329	<p>Continued From page 7</p> <p>physician orders and received an excessive dose of Coumadin when nursing staff failed to accurately enter new orders for PT/INR labs and changes in Coumadin dosage in the EMR (Electronic Medical Record).</p> <p>Per review of Resident #112's nursing progress notes, on 9/20/16 Registered Nurse (RN) staff documented that the hospital lab called to report a critical PT/INR result of 65.3/5.6; an on call physician was contacted and ordered staff to hold Coumadin for the night. Orders were obtained to redraw the PT/INR on 9/21/16. Per the Coumadin Anticoagulation Record, the 9/21/16 PT/INR was 76.3/6.4 (continued critically elevated with increased risk for bleeding); nursing progress notes document orders to discontinue Coumadin; a verbal order states next PT/INR is due on Friday, 9/23/16. There is no evidence that a PT/INR was done on 9/23/16; the next documented PT/INR was on 9/26/16 (3 days late; result: 22.1/1.8).</p> <p>On 10/10/16 the resident's PT/INR was 45.0/3.7 (elevated); a verbal order stated to recheck PT/INR on 10/14/16, hold Coumadin today, change Coumadin dosage to 0.5 mg on Monday and Wednesday; continue Coumadin 1 mg all other days. There is no evidence that a PT/INR was done on 10/14/16; the next documented PT/INR was done on 10/19/16 (5 days late) and the result was 46.1/3.8 (continued elevated). Per review of the MAR (Medication Administration Record), the resident also continued to receive Coumadin 1 mg daily instead of the reduced dose of 0.5 mg on 10/12/16 and 10/17/16 (Wednesday and Monday) as ordered on 10/10/16.</p>	F 329			

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F 329	Continued From page 8	F 329			
F 333 SS=D	<p>On 10/25/16 at approximately 1:50 PM, the facility UM (Unit Manager) confirmed that the physician verbal orders documented on the Coumadin Anticoagulation Record did not get transcribed to EMR orders or to the MAR for implementation resulting in monitoring labs not being done as ordered and a higher dose of Coumadin being administered to the resident than ordered. The errors placed the resident at additional risk for adverse side effects including bleeding. (Refer to 281, 282, 333, 514)</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that residents are free of any significant medication errors for 1 of 26 residents (Resident #112). Findings include:</p> <p>Per record review, nursing staff failed to enter a new physician verbal order for a Coumadin dose reduction in the EMR (Electronic Medical Record) following an elevated PT/INR (anticoagulant monitoring lab) which resulted in a significant medication error. (Coumadin is an anticoagulant medication which can have dangerous side effects that increase bleeding risk).</p> <p>Per review of the Coumadin Anticoagulation</p>	F 333	<p>1. Resident #112 no longer resides in the facility</p> <p>2. Residents receiving medication have the potential to be affected by the alleged deficient practice.</p> <p>3. Education provided to staff regarding order transcription for Anticoagulant dosing.</p> <p>4. Weekly audits will be conducted by DNS or designee to monitor the effectiveness of the plan</p> <p>5. The results of the audit will be reported to the QAA committee by the DNS or designee monthly X 3 months at which time the QAA committee will determine further frequency of the audits.</p> <p>6. Corrective action to be completed by November 26, 2016.</p> <p><i>F333 POC accepted 11/22/16 Jiteswar P. / pmc</i></p>		

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F 333	Continued From page 9 Record, on 10/10/16 Resident #112's PT/INR was 45.0/3.7 (elevated). A physician verbal order stated to hold Coumadin today, decrease Coumadin dosage to 0.5 mg on Monday and Wednesday; continue Coumadin 1 mg all other days and recheck the PT/INR on 10/14/16. Per review of the MAR (Medication Administration Record), the resident continued to receive Coumadin 1 mg daily instead of the reduced dose of 0.5 mg on the following Wednesday and Monday (10/12/16 and 10/17/16). Additionally, there was no evidence that a PT/INR was done on 10/14/16 as ordered. The next documented PT/INR was done on 10/19/16 (5 days late) and the result was 46.1/3.8 (continued elevated). On 10/25/16 at approximately 1:50 PM, the facility UM (Unit Manager) confirmed that the physician verbal orders documented on the Coumadin Anticoagulation Record did not get transcribed to EMR orders or to the MAR for implementation resulting in Resident #112 continuing to receive a higher dose of Coumadin than ordered during a period when his/her PT/INR monitoring labs were elevated. This significant medication error placed the resident at increased risk for bleeding. (Refer to 281, 282, 329, 514)	F 333			
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 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.	F 353	1. Residents were not affected by this alleged deficient practice. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. Facility administration are aware of state requirements for staffing.		

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F 353	<p>Continued From page 10</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 staff and resident interviews and review of call light responses on the 4th and 5th floors, the facility failed to assure that there was sufficient nursing staff to provide care that allows residents to attain or maintain their highest practicable level of well-being. Findings include:</p> <p>Per resident interviews during Stage 1 of the survey, 8 of 31 interviewable residents stated that the facility did not have sufficient staff so that they get the care and assistance they need without having to wait a long time. In addition, 1 of 3 families interviewed stated that the facility does not have sufficient staff so that residents get the care and assistance they need without having to wait a long time. The identified problem times include nights, at mealtime, and on weekends.</p> <p>During resident interviews, one resident stated</p>	F 353	<p>4. Facility administration will continue to review staffing daily as well as conduct resident and family interviews.</p> <p>5. Weekly PPD and call bell audits will be conducted to monitor the effectiveness of the plan.</p> <p>6. The results of the audit will be reported to the QAA committee by the DNS or designee monthly X 3 months at which time the QAA committee will determine further frequency of the audits.</p> <p>7. Corrective action to be completed by November 26, 2016.</p> <p><i>F353 POC accepted 11/22/16 JHamer RN/jml</i></p>		

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F 353	<p>Continued From page 11</p> <p>that s/he has put the call light on and that by the time staff came to provide assistance, s/he had already wet his/her bed. Additionally two more residents stated, when asked if staff treat them respectfully and with dignity, that "Staff don't treat me like the [person] I am. They just come in and do whatever they are there to do and leave right away", and "No they just come in and rush through my care and then rush out because they have something else they have to do".</p> <p>In interview two direct care staff members who wished to remain anonymous stated that there is not enough staff in the facility and that it means that sometimes residents have to wait a long time and that care cannot be done in a timely manner for all the residents. They also confirm, when asked, that staff are often asked to work overtime, sometimes to do double shifts. They confirm that they are also asked to work on their days off and one staff member stated "people are getting burned out and are looking for other jobs".</p> <p>In a review of the call light response history from 10/19/16 to 10/23/16, any call light response times over 20 minutes were identified with the following results: Time range (in minutes) 21-29 minutes: 37 times on 4th floor and 49 times on the 5th floor; 30-39 minutes: 20 times on the 4th floor and 30 times on the 5th floor; 40-49 minutes: 15 times on the 4th floor and 16 times on the 5th floor; 50-59 minutes: 7 times on the 4th floor and 12 times on the 5th floor; 60-69 minutes: 3 times on the 4th floor and 6 times on the 5th floor. There are no times longer than 60-69 minutes on the 4th floor. Continuing with response times (in minutes) on the 5th floor, the</p>	F 353			

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F 353	Continued From page 12 following were identified: 70-79 minutes: 2 times; 80-89 minutes: 2 times; 90-129 minutes: 2 times; and above 120 minutes: 2 times. Additionally, a stairway door alarm on the 5th floor sounded for 155 minutes on 10/20/16. In interview on 10/26/16, the Facility Administrator confirmed that the facility recognizes that staffing levels are an issue and that the facility is not having much success, despite recruitment efforts that include holding LNA (Licensed Nursing Assistant) classes.	F 353			
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 (3) Maintains a record of incidents and corrective actions related to infections. (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	F 441	1. Resident #26 and #207 were not affected by the alleged deficient practice. 2. Residents receiving oxygen therapy and utilizing nebulizer equipment have the potential to be affected by the alleged deficient practice. 3. Education provided to staff regarding proper storage of oxygen and nebulizer tubing. 4. Weekly audits will be conducted by DNS or designee to monitor the effectiveness of the plan. 5. The results of the audit will be reported to the QAA committee by the DNS or designee monthly X 3 months at which time the QAA committee will determine further frequency of the audits. 6. Corrective action to be completed by November 26, 2016. F441 POC accepted 11/22/16 JH/MSL/PN/pma		

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F 441	<p>Continued From page 13</p> <p>from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(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 interview, the facility failed to ensure that oxygen tubing and hand-held nebulizer equipment were stored in a sanitary manner or discarded per infection control standards for 2 applicable residents (Residents #26 & 207). Findings include:</p> <p>Per observations starting on 10/24/16 at approximately 4:00 PM, Resident #26's O2 (oxygen) tubing with attached nasal cannula was observed unbagged and on the floor of his/her room. The tubing was not labeled as to when it was put into use and the resident's companion stated that the O2 had not been used recently. The same resident's handheld nebulizer face mask was observed unbagged and in contact with the surface of his/her night stand without a protective barrier.</p> <p>In Resident #207's room, O2 tubing was observed undated and unbagged and in contact with the window ledge near the resident's bed. The Unit</p>	F 441			

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F 441	Continued From page 14 Manager (UM) confirmed that the equipment was not properly stored and discarded the tubing after the observation. S/he stated that the O2 tubing should have been dated and if no longer in use, should have been discarded. The facility policy Oxygen: Nasal Cannula states in step 16, "Replace entire set-up every seven days. Date and store in treatment bag when not in use." The Nebulizer: Small Volume policy, step 20, states Place [nebulizer equipment] in treatment bag labeled with patient name and date. Replace and date the setup every seven days." Per interview on 10/25/16 at approximately 3:50 PM, the Infection Control Nurse (ICN) confirmed the above policies and stated that the night nurse was responsible for making the weekly equipment changes and labeling; she also confirmed that when equipment is no longer in use, it should be discarded.	F 441			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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. 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.	F 514	1. Resident #112 no longer resides in the facility 2. Residents receiving Anticoagulant therapy have the potential to be affected by the alleged deficiency practice. 3. Education provided to staff regarding order transcription for Anticoagulant dosing. 4. Weekly audits will be conducted by DNS or designee to monitor the effectiveness of the plan 5. The results of the audit will be reported to the QAA committee by the DNS or designee monthly X 3 months at which time the QAA committee will		

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F 514	<p>Continued From page 15</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to maintain complete and accurately documented medical records for the administration of an anticoagulant medication and monitoring labs for 1 of 26 residents (Resident #112). Findings include:</p> <p>Per record review, nursing staff failed to accurately enter new physician verbal orders for PT/INR (anticoagulant monitoring labs) and changes in Coumadin dosage in the EMR (Electronic Medical Record) resulting in labs not being done per orders and errors in Coumadin administration. (Coumadin is an anticoagulant medication which can have dangerous side effects that increase bleeding risk).</p> <p>Per review of Resident #112's nursing progress notes, on 9/20/16 Registered Nurse (RN) staff documented that the hospital lab called to report a critical PT/INR result of 65.3/5.6; an on call physician was contacted and ordered staff to hold Coumadin for the night. Orders were obtained to redraw the PT/INR on 9/21/16. Per the Coumadin Anticoagulation Record, the 9/21/16 PT/INR was 76.3/6.4 (continued critically elevated with increased risk for bleeding); nursing progress notes document orders to discontinue Coumadin; a verbal order states next PT/INR is due on Friday, 9/23/16. The next documented PT/INR was on 9/26/16 (3 days late; result: 22.1/1.8).</p> <p>On 10/10/16 the resident's PT/INR was 45.0/3.7 (elevated); a verbal order states to recheck</p>	F 514	<p>determine further frequency of the audits. 6. Corrective action to be completed by November 26, 2016.</p> <p><i>FSY POC accepted 11/22/16 JHosmer/PW</i></p>		

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F 514	<p>Continued From page 16</p> <p>PT/INR on 10/14/16, hold Coumadin today, change Coumadin dosage to 0.5 mg on Monday and Wednesday; continue Coumadin 1 mg all other days. There is no evidence that a PT/INR was drawn on 10/14/16; the next documented PT/INR was done on 10/19/16 (5 days late) and the result was 46.1/3.8 (continued elevated). Per review of the MAR (Medication Administration Record), the resident also continued to receive Coumadin 1 mg daily instead of the reduced dose of 0.5 mg on 10/12/16 and 10/17/16 as ordered on 10/10/16.</p> <p>On 10/25/16 at approximately 1:50 PM, the facility UM (Unit Manager) confirmed that the physician verbal orders documented on the Coumadin Anticoagulation Record did not get transcribed to EMR orders or to the MAR for implementation resulting in labs not being done as ordered and errors in Coumadin administration. The UM confirmed there were issues with the process of transcribing verbal orders into the EMR. The errors in transcription placed the resident at additional risk for adverse side effects including bleeding. (Refer to 281, 282, 329, 333)</p>	F 514			