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F 281 SS=B	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 document review the facility failed to ensure staff signed off influenza medications on the Residnet's Immunization Record immediately after administering them and failed to ensure it was the Nurse that administered the vaccination was the Nurse who sign it off in the Immunization Record for 3 of 3 Residents (Resident #1, Resident #2 and Resident #5). The findings included: Review of the facility policy titled Influenza Vaccine dated December 2007 revealed "For those who receive the vaccine, the date of vaccination, lot number, expiration date, person administering and the site of vaccination will be documented in the resident's/employee medical record." 1. Resident #1 was admitted on 4/19/10 with diagnoses including Alzheimer ' s disease. Review of the Quarterly Minimum Data Set (MDS) dated 9/13/12 revealed Resident #1 had memory problems and was significantly impaired in decision making. Review of the facility document titled Resident Vaccinations (2011 - 2012) revealed that it listed	F 281	1. Corrective action for affected residents was put into place at the time of the survey exit conference on 2-2-13. Effective at that time, the facility required documentation of flu shots to be completed by the nurse who administered the flu vaccine. The facility also required documentation to be completed at the time of administration. 2. The interventions put into place on 2-2-13 for previously affected residents will prevent future deficient practice as well. The facility completed a 100% audit for all current residents to ensure that any flu shot documentation since the conclusion of the survey on 2-2-13 had been completed as expected. This audit was completed on 2-14-13 and no issues were identified as the facility has not needed to administer a flu vaccination since that time.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karen B Cutts	Administrator	2-15-13

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	Continued From page 1 the facility Residents and their influenza immunization status for the 2012 - 2013 flu season. There were 55 residents who were listed as receiving influenza vaccine on 9/28/12 including Resident #1. Review of the Immunization Record for Resident #1 revealed she received the influenza vaccine on 9/28/12 and that it was signed as given by Administrative Nurse #4. On 2/1/13 at 2 PM Administrative Nurse #1 revealed that in September 2012, four nursing staff (Administrative Nurse #1, Administrative Nurse #2 [no longer working at the facility], Nurse #3 and Administrative Nurse #3) gave influenza vaccines to the facility residents, with consents and no contraindications, in a flu clinic type format over a 1 - 2 day period, on or around 9/28/12. She stated that they worked from a spreadsheet prepared by Administrative Nurse #2 and did not consult the resident ' s medical record at the time of administering the vaccinations. Administrative Nurse #1 stated that the vaccinations were signed off on the spreadsheet once they were given, along with the administration site and lot number, but were not immediately signed off in the Resident ' s clinical record. Administrative Nurse #1 added that Administrative Nurse #4, who did not give vaccinations on the day of the immunization clinic, came in the following day to help by signing off the immunizations in the medical record for the Nurses who did the vaccine administration. She further indicated that " technically " correct practice would have been for the Nurse giving the vaccination to consult the Resident ' s medical record, give the vaccination, and then for the	F 281	3. The Director of Nursing provided an in-service for the facility administrative nurses to make sure these expectations were clearly communicated as well as ensuring the facility could document completion of training. Note: the in-service was provided to administrative nurses only as they are the only nurses who can provide resident flu shots moving forward. Facility floor nurses are no longer allowed to provide resident flu shots. These changes allow the facility to streamline the vaccination administration process and ensure documentation is completely timely and accurately. The in-service for 100% of eligible administrative nurses was completed on 2-13-13. Any future administrative nurses who are added into an administrative role or position will be provided this same information/in-service as well.	

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F 281	Continued From page 2 Nurse who gave it to sign it off on the Immunization Record. On 2/2/13 at 12:13 PM telephone interview with Administrative Nurse #4 revealed that she was asked to help transcribe the influenza vaccinations that were given on or around 9/28/12. She wasn ' t certain if she came in on the evening most of the vaccinations were given or the following day but stated that at least some of the vaccinations were not signed off in the Resident ' s Immunization Record until the next day. She added that she wrote in the date the immunization was actually given, not the date of signing, and that she did not indicate that her documentation was a late entry. In addition, she said that she signed her name as the Nurse who gave the vaccinations even though at most she may have given a few of them but she did not know to whom. She acknowledged that correct practice would be for the Nurse who administered the vaccination to sign for it but stated she thought there was a 24 hour window to document vaccinations. 2. Resident #2 was admitted on 8/21/12 with diagnoses including quadriplegia, dysphasia, and depressive disorder. Review of the Admission Minimum Data Set (MDS) dated 8/28/12 revealed Resident #2 was cognitively intact. Review of the facility document titled Resident Vaccinations (2011 - 2012) revealed that it listed the facility Residents and their influenza immunization status for the 2012 - 2013 flu season. There were 55 residents who were listed	F 281	4. The facility created a QA team, The Flu Shot Action Team, on 2-13-13 to both implement a formal plan of correction as well as ensure current and future compliance. This committee consists of the Nursing Home Administrator, Director of Nursing and a current Unit Coordinator with knowledge of the processes expected by the facility. The QA team created the Flu Shot Administration Tool to allow the facility to monitor and ensure compliance with F-281, specifically that flu shots are documented at the time they are given by the nurse who provided the vaccination. This spreadsheet tool will be maintained by the Director of Nursing. The Flu Shot Action Team will meet weekly x 4 and then monthly x 3 (thru the end of the recommended flu vaccination season, 3-31-13). Information, activity and updates from this QA team will be reported to the Executive QA Committee by the Director of Nursing at the next scheduled meeting, 4-17-13. The QA team will resume activity prior to	

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F 281	Continued From page 3 as receiving influenza vaccine on 9/28/12 including Resident #2. Review of the Immunization Record for Resident #2 revealed her influenza vaccination was signed off as given on 9/26/ by Administrative Nurse #4 although on the above noted facility document the date given was listed as 9/28/12. On 2/1/13 at 2 PM Administrative Nurse #1 revealed that in September 2012, four nursing staff (Administrative Nurse #1, Administrative Nurse #2 [no longer working at the facility], Nurse #3 and Administrative Nurse #3) gave influenza vaccines to the facility residents, with consents and no contraindications, in a flu clinic type format over a 1 - 2 day period, on or around 9/28/12. She stated that they worked from a spreadsheet prepared by Administrative Nurse #2 and did not consult the resident ' s medical record at the time of administering the vaccinations. Administrative Nurse #1 stated that the vaccinations were signed off on the spreadsheet once they were given, along with the administration site and lot number, but were not immediately signed off in the Resident ' s clinical record. Administrative Nurse #1 added that Administrative Nurse #4, who did not give vaccinations on the day of the immunization clinic, came in the following day to help by signing off the immunizations in the medical record for the Nurses who did the vaccine administration. She further indicated that " technically " correct practice would have been for the Nurse giving the vaccination to consult the Resident ' s medical record, give the vaccination, and then for the Nurse who gave it to sign it off on the Immunization Record.	F 281	September 2013 when the facility is scheduled to resume flu vaccinations per facility infection control guidelines. This QA team will remain in place unless otherwise noted or reflected in the QA notes/minutes. 5. The facility states full compliance with F-281, effective 2-15-13.	

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F 281	Continued From page 4	F 281		

On 2/2/13 at 12:13 PM telephone interview with Administrative Nurse #4 revealed that she was asked to help transcribe the influenza vaccinations that were given on or around 9/28/12. She wasn ' t certain if she came in on the evening most of the vaccinations were given or the following day but stated that at least some of the vaccinations were not signed off in the Resident ' s Immunization Record until the next day. She added that she wrote in the date the immunization was actually given, not the date of signing, and that she did not indicate that her documentation was a late entry. In addition, she said that she signed her name as the Nurse who gave the vaccinations even though at most she may have given a few of them but she did not know to whom. She acknowledged that correct practice would be for the Nurse who administered the vaccination to sign for it but stated she thought there was a 24 hour window to document vaccinations.

3. Resident #5 was admitted on 1/2011 with diagnoses including chronic kidney disease, chronic heart failure and anemia.

Review of the Significant Change Minimum Data Set (MDS)dated 8/29/12 revealed the resident was cognitively intact.

Review of the facility document titled Resident Vaccinations (2011 - 2012) revealed that it listed the facility Residents and their influenza immunization status for the 2012 - 2013 flu season. There were 55 residents who were listed as receiving influenza vaccine on 9/28/12

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F 281	Continued From page 5	F 281		

including Resident #5.

Review of the Immunization Record for Resident #5 revealed she received the influenza vaccine on 9/28/12 and that it was signed as given by Administrative Nurse #4.

On 2/1/13 at 2 PM Administrative Nurse #1 revealed that in September 2012, four nursing staff (Administrative Nurse #1, Administrative Nurse #2 [no longer working at the facility], Nurse #3 and Administrative Nurse #3) gave influenza vaccines to the facility residents, with consents and no contraindications, in a flu clinic type format over a 1 - 2 day period, on or around 9/28/12. She stated that they worked from a spreadsheet prepared by Administrative Nurse #2 and did not consult the resident ' s medical record at the time of administering the vaccinations. Administrative Nurse #1 stated that the vaccinations were signed off on the spreadsheet once they were given, along with the administration site and lot number, but were not immediately signed off in the Resident ' s clinical record. Administrative Nurse #1 added that Administrative Nurse #4, who did not give vaccinations on the day of the immunization clinic, came in the following day to help by signing off the immunizations in the medical record for the Nurses who did the vaccine administration. She further indicated that " technically " correct practice would have been for the Nurse giving the vaccination to consult the Resident ' s medical record, give the vaccination, and then for the Nurse who gave it to sign it off on the Immunization Record.

On 2/2/13 at 12:13 PM telephone interview with

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F 281	Continued From page 6 Administrative Nurse #4 revealed that she was asked to help transcribe the influenza vaccinations that were given on or around 9/28/12. She wasn ' t certain if she came in on the evening most of the vaccinations were given or the following day but stated that at least some of the vaccinations were not signed off in the Resident ' s Immunization Record until the next day. She added that she wrote in the date the immunization was actually given, not the date of signing, and that she did not indicate that her documentation was a late entry. In addition, she said that she signed her name as the Nurse who gave the vaccinations even though at most she may have given a few of them but she did not know to whom. She acknowledged that correct practice would be for the Nurse who administered the vaccination to sign for it but stated she thought there was a 24 hour window to document vaccinations.	F 281		
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 duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329	1. The facility monitored resident #2 after the administration of the flu vaccine on 12-12-12. This was initiated on 12-12-12 and continued x 3 days. 2. The facility has since completed a 100% audit of all current residents to ensure that administration of the flu vaccine occurred once per resident per facility expectation. This audit was completed on 2-14-13 with no additional issues noted.	

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F 329	Continued From page 7 as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interview and document review, the facility failed to ensure 1 of 3 residents received no more than one dose of influenza vaccine for the 2012 - 2013 influenza season (Resident #2). The findings included: According to the Vaccine Information Statement (VIS) for Influenza Vaccine Inactivated dated 7/2/12 the risks from inactivated influenza vaccine include the following mild problems: soreness, redness or swelling where the shot was given, hoarseness; sore, red, or itchy eyes; cough, fever, aches, headache, itching and fatigue. Resident #2 was admitted on 8/21/12 with diagnoses including quadriplegia, dysphasia, and depressive disorder. Review of the Admission Minimum Data Set (MDS) dated 8/28/12 revealed Resident #2 was cognitively intact. Under " Did the resident received influenza vaccine in this facility for this	F 329	3. To prevent future deficient practice, the Director of Nursing provided an in-service for the facility administrative nurses on 2-13-13 to make sure the expectations of the facility were clearly communicated and understood. This in-service was given to 100% of the administrative nurses who participate in the flu vaccination process for residents. The in-service details that floor nurses are longer allowed to administer flu vaccinations; only the administrative nurses who have been trained and designated by the Director of Nursing can now provide the vaccinations. The in-service was completed on 2-13-13. Any future administrative nurses who are added into an administrative role or position will be provided this same information/in-service as well.	

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F 329	Continued From page 8 years influenza season " , " No " was checked and the reason for not receiving the vaccine was listed as other. Review of the Resident Immunization Record dated 9/26/12 revealed Resident #2 received a dose of influenza vaccine in the Left Deltoid that day. Review of the Quarterly MDS dated 11/15/12 revealed Resident #2 was cognitively intact. Under " Did the resident received influenza vaccine in this facility for this years influenza season " , " Yes " was checked. Review of the Resident Immunization Record dated 12/12/12 revealed Resident #2 received a dose of influenza vaccine in the Left Deltoid that day. Interview with Administrative Nurse #1 on 2/1/13 at 2 PM revealed that consents for influenza immunization and send out annually. She also stated that there was a standing order for influenza vaccine but that if consents came in for a small number of people she would sometimes write the order just to flag the hall nurse that the immunization needed to be given. Telephone interview with Administrative Nurse #1 on 2/7/13 at 12:01 PM revealed that the influenza vaccination consent for Resident #2 was dated 8/20/12 (obtained during the admission process). She added that in September 2012, Resident #2 got her first dose of influenza vaccine for the 2012 - 2013 influenza season and that at that time the Staff Development Coordinator, who no longer works at the facility was maintaining a	F 329	The facility removed all flu vaccine vials from their previous place of storage in the refrigerators in the medication rooms of each unit. The flu vaccine vials are now stored in a locked refrigerator; only the Administrator and Director of Nursing have access to the flu vaccinations. This was done at the suggestion of the newly created QA team, The Flu Shot Action Team. This team also appointed the Director of Nursing as the primary person responsible for monitoring, tracking and directing the efforts of the administrative nurses who provide flu shots. These interventions were implemented to better control and streamline the flu shot process as well as prevent duplication of services for the residents.	

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F 329	Continued From page 9 spreadsheet with all the residents names on it and their consent and vaccination status. Administrative Nurse #1 indicated that on 12/12/12 she observed that Resident #2 had a signed consent for influenza vaccine but the spreadsheet did not indicate that the resident had been given the vaccine. Administrative Nurse #1 also said she wrote the influenza vaccination order on 12/12/12 because of this and acknowledged that she did not check the Resident ' s Immunization Record before writing the order and asking the floor nurse (Nurse #2) to give the immunization, like she should have. She added that Nurse #2 called her immediately upon discovering that she had given Resident #2 a second influenza vaccination. Telephone interview with Nurse #2 on 2/7/13 at 3:22 PM revealed that on 12/12/12 Nurse #1 wrote the influenza vaccination order for Resident #2. She added that because Nurse #1 was an Administrative Nurse whom Nurse #2 trusted, and because it was a busy evening, she gave the influenza vaccination to Resident #2 without checking the Immunization Record first. Nurse #2 said she then went to sign the influenza vaccination as given and discovered she had just given a second dose. She acknowledged that it was correct practice to check the Medication, Treatment or Immunization record before giving a medication, treatment or immunization and that the should have done this and not relied exclusively on the written order. She said that she called Administrative Nurse #1 immediately after realizing that a second influenza vaccination had just been given and that Resident#2 ' s vital signs were closely monitored following the incident with no adverse outcomes.	F 329	4. The facility created a QA team, The Flu Shot Action Team, on 2-13-13 to both implement a formal plan of correction as well as ensure current and future compliance. This committee consists of the Nursing Home Administrator, Director of Nursing and a current Unit Coordinator with knowledge of the processes expected by the facility. The QA team created a new tool, The Flu Shot Monitoring Log, to allow the facility to remain compliant with F-329. The Flu Shot Monitoring Log will be maintained by the Director of Nursing and will be used to ensure the facility tracks the flu vaccination status of the current residents who are eligible to receive a flu vaccination. The log will prevent duplication of flu shot administration by tracking the flu shot status of all current residents who have consented to the flu shot. As residents are vaccinated, the log will be updated to reflect their updated	

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			vaccination status. The information from this log will be reported to the Flu shot Action Team at each meeting. The QA team will meet weekly x 4 and then monthly x 3 (thru the end of the recommended flu vaccination season, 3-31-13). Information, activity and updates from this QA team will be reported to the Executive QA Committee by the Director of Nursing at the next scheduled meeting, 4-17-13. The team will resume activity prior to September 2013 when the facility is scheduled to resume flu vaccinations per facility infection control guidelines. This QA team will remain in place unless otherwise noted or reflected in the QA notes/minutes. 5. The facility states full compliance with F-329, effective 2-15-13.	