



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

December 29, 2009

Wendy Beatty, Administrator
Bennington Health & Rehab
2 Blackberry Lane
Bennington, VT 05201

Provider #: 475027

Dear Ms. Beatty:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 3, 2009**. Please post this document in a prominent place in your facility.

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

Sincerely,

A handwritten signature in cursive script that reads "Suzanne E. Leavitt RN, MS".

Suzanne Leavitt, RN, MS
Licensing Chief

Enclosure



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

PRINTED: 12/15/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2009
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NAME OF PROVIDER OR SUPPLIER BENNINGTON HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 2 BLACKBERRY LANE BENNINGTON, VT 05201
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F 000	INITIAL COMMENTS	F 000		
F 241 SS=E	<p>An unannounced onsite annual re-certification survey was conducted by the Division of Licensing and Protection on 11/30/09 - 12/03/09.</p> <p>483.15(a) DIGNITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to promote care for residents in a manner that maintained and enhanced dignity for 3 of 19 residents in the targeted sample. (Resident # 22, # 23 and #24) Findings include:</p> <p>1. Per observation in the dining room, during the evening meal served on 11-30-09, Resident # 22 failed to receive a food tray when the two other table-mates received theirs at 5:30 PM. During interview at 5:40 PM, Resident # 22 stated "this happens all the time; I'm starving," as s/he observed the table-mates eating. This resident's food tray arrived at 5:51 PM, a wait of over 20 minutes and arrived after the other table-mates had finished their meals.</p> <p>2. Per observation during the noon meal served in the dining room on 12-1-09, Resident # 23 was seated at the dining room table with 4 other residents at 12:30 PM and failed to receive the meal until all other table-mates had been served their meal, eaten and/or were leaving the table. Surveyor observed Resident # 23 watching the table-mates eat. One table-mate stated "she</p>	F 241	Please see attached	1/4/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE NHA	(X6) DATE 12-24-09
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241 Continued From page 1
hasn't eaten yet." and a staff person stated, "we are waiting for her lunch." At 12:50 PM a staff person brought Resident # 23's food tray and began to feed the resident.

F 241

Please see attached

1/4/2010

3. Per observation of the evening meal served in the dining room on 11/30/09, Resident #24 failed to receive a food tray when other residents began being served theirs at 5:15 PM. H/she was observed sitting in the hallway where other residents were eating. H/she called out for food for 15 minutes before resident was brought into the dining room. H/she was seated at a table where residents were already eating and waited another 10 minutes for his tray to be served at 5:40 PM. Upon interview with staff at 5:30 PM it was confirmed that the tray for resident # 24 is always on the 3rd cart from the kitchen which is always last to arrive on the unit.

4. Per observation during the evening meal of 11-30-09 and the noon meal of 12-01-09, residents were served beverages in disposable plastic cups. Per interview with the Food Service Supervisor during the kitchen tour at 10 AM on 12-01-09, confirmed the facility had been using disposable plastic cups during the meal times.

F 281 483.20(k)(3)(i) COMPREHENSIVE CARE PLANS
SS=D

F 281

The services provided or arranged by the facility must meet professional standards of quality.

Please see attached

1/4/2010

This REQUIREMENT is not met as evidenced by:
Based on observations, staff interview and record review the facility failed to assure that care and services were provided in accordance with physician orders and professional standards of

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F 281	<p>Continued From page 2 nursing practice for 3 of 19 residents. (Residents #2, #8 & #9] Findings include:</p> <ol style="list-style-type: none"> Per record review on 12/01/09, Resident #2 had a physician's order for 2 liters of oxygen and to monitor oxygen saturation each shift. Per observation on 12/02/09, the Resident's oxygen was at 3 liters. In addition, the nursing staff was documenting 3 liters on the treatment administration record (TAR) since 11/26/09. Per interview on 12/02/09 the unit coordinator confirmed that staff did not following the physician's order. <p>Reference: Lippincott Manual of Nursing Practice, 8th Edition, pg 18.</p> <ol style="list-style-type: none"> Per record review and staff interview the route of administration for medication was not present either on the physicians's order or on the MAR for Resident # 9. Per record review on 11/30/09 in the afternoon, Resident # 9 had a physician's order for Centrum Silver 1 tab every day. No route of administration was noted on the physician's order or on the MAR. This was confirmed by interview with the unit coordinator on 11/30/09 at 3:50 PM. <p>Reference: Nursing 2010 Drug Handbook: Lippincott, Williams and Wilkins, 30th Edition, pg. 18.</p> <ol style="list-style-type: none"> Per record review, Resident #8 has a physician's order last signed on 11/10/09 that states "nothing by mouth; aspiration risk". The resident receives all nutrition and medications through a G-tube. The medication orders for this resident included: Levothyroxine 88 mcg. one tab by mouth every night at bedtime; and Lyrica 100 	F 281		
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F 281 Continued From page 3
mg. one cap by mouth twice a day. Per interview on 12/01/09 at 10:30 AM, Resident #8 confirmed that all medications are administered through the G-tube, and that the doctor said that the risk of aspiration was too high to take them by mouth. The Med Administration Record for November of 2009 showed that the PO medications were signed off as given by nursing. The orders for November were signed by the physician, and a nurse who reviewed the orders. December 2009 orders were signed as "reviewed by" the Director of Nursing on Nov. 30, 2009, and did not recognize the errors in the route of administration. Per interview on 12/2/09 at 9:30 AM, the Unit Manager confirmed that the resident takes nothing by mouth as ordered by the MD, and that the order for PO medications was not the correct route of administration for this resident, and that the nurses reviewing the orders had missed the errors.

F 281

Please see attached

1/4/2010

F 312 483.25(a)(3) ACTIVITIES OF DAILY LIVING
SS=D

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

F 312

Please see attached

1/4/2010

This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interview the facility failed to provide the necessary services to maintain good grooming for 2 applicable residents in the sample. (Resident's

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F 312	Continued From page 4 #2 & #12) Finding include: 1. Per observation during the 3 days of survey, 2 female Residents #2 and #12 had long facial hairs on their chins. Per record review of Resident #2 and #12's chart both were care planned for extensive assist with personal needs relating to their diagnosis of dementia. Per interview on 12/02/09 at 10:35 AM the Unit Nurse Manager confirmed staff are expected to provide grooming, which includes shaving.	F 312		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure the resident environment remained free of accident hazards for all residents and failed to assure adequate supervision to prevent accidents for 1 resident in the targeted sample. (Resident # 13) Findings include: 1. Per observation on 11-30-09 at approximately 5:20 PM surveyor found room 311, that was in the process of renovation, unsecured and unsupervised by staff or workmen. A cordless screwdriver and a box cutter were lying on the floor along with other building supplies. Boxes of screws and floor mouldings were on the floor in	F 323	Please see attached	1/4/2010

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F 323	Continued From page 5 the center of the room. The Nurse Surveyor notified the Interim Charge Nurse on the unit and the Director of Nurses, informing them that the room must be secured prior to the surveyors leaving the building. The Maintenance Supervisor returned to the facility and installed a lock on the door of room 311. Per interview at 6:10 PM on 11-30-09, the Maintenance Supervisor confirmed there was no process in place to monitor the contractors conducting the renovation, to assure safety for all residents. 2. Per record review, Resident # 13, with a history of 7 falls since admission to the facility on 10-22-09 failed to have the supervision needed to avoid repetitive falls. Resident # 13 fell 3 times on 11-17-09. After the first fall which occurred on the day shift, the resident was placed on 1:1 supervision with staff for the remainder of the day shift. After the second fall which occurred on the evening shift, the evening shift staff did not place the resident on 1:1 supervision until after the third fall which occurred 15 minutes later. Per record review and confirmed through interview with the MDS coordinator, six of the seven falls had occurred on the evening shift. Per interview, the MDS coordinator confirmed Resident # 13 did not receive 1:1 supervision after the second fall of the day.	F 323		
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any	F 329	Please see attached	1/4/2010

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F 329	<p>Continued From page 6 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:</p> <p>Based on record review and confirmed through interview, the facility failed to assure adequate indications for use pertaining to 2 psychoactive drugs ordered for 1 of 12 residents in the targeted sample. (Resident # 13) Findings include:</p> <p>Per record review, between the dates of October 22, 2009 and November 30, 2009 Resident # 13 received 13 doses of a PRN (as needed) Ativan and 6 doses of PRN Haldol, all given for purpose of treating "increased agitation" as the indicator for use. The medication administration record (MAR) states that both the Ativan 1 mg (milligram) orally, every 8 hours as needed and Haldol 5 mg intramuscularly every 4-6 hours are to be given for agitation. Per interview on the afternoon of 12-2-09, the MDS coordinator</p>	F 329			

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F 329	Continued From page 7 confirmed there are no specific targeted behaviors identified as indicators for use for each of these psychoactive medications. The MDS coordinator also confirmed that "agitation" does not clearly identify a targeted behavior that needs altering.	F 329		
F 363 SS=E	483.35(c) MENUS AND NUTRITIONAL ADEQUACY Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to assure that dietary staff consistently met the nutritional needs of 3 residents and followed approved, printed and complete menus. (Residents #12, #20 & #21) Findings include: 1. Per observation, interviews and record review during the evening meal on 11/30/09, dietary staff failed to assure 3 resident's nutritional needs were met by failing to follow the approved menus for the supper meal and by failing to provide menu substitutions. Per the group interview on 11/30/09 at 1:30 PM, several residents voiced concerns regarding deviations from the planned menu listed that day or items omitted from their trays but are listed on their menus. Per interview on 11/30/09 at 5:15 PM Resident's #12 family member stated that "rarely gets everything that is listed on the menu, something is always missing"	F 363	Please see attached	1/4/2010

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F 363	Continued From page 8 and the nurse surveyor observed the soup, mashed potatoes and salad were omitted. In addition staff were heard stating "(Resident#21) didn't get his/her salad again" and "(Resident#20) soup and the pudding is missing". Per record review of Residents #12, #20 & #21's chart, dietary recommendations direct the kitchen staff to provide the extra calories needed in the soup, mashed potatoes or salads, respectively. Per interview on 11/30/09 at 6:00 PM the Food Services Director confirmed kitchen staff did not provide items listed on the menus.	F 363		
F 371 SS=E	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to assure proper sanitation of a steam table used to distribute and serve food during 1 days of survey. Findings include: 1. Per observation on 11/30/09 at 4:30 PM the steam table's 4 water compartments were noted to have food particles floating in the hot water prior to the food trays being inserted. Per observation on 12/01/09 at 9:30 AM food particles were noted in the water compartments and dried stains were on the surface areas. Per	F 371	Please see attached	1/4/2010

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F 371 Continued From page 9
observation and interview on 12/01/09 at 12:15 PM, the Regional Food Director confirmed that the steam table water compartments and surface areas were dirty with old food particles and 'should be cleaned and wiped down every day'.

F 371

F 386 483.40(b) PHYSICIAN VISITS
SS=D
The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.

F 386

Please see attached

1/4/2010

This REQUIREMENT is not met as evidenced by:
Based on record review, and confirmed through staff interview, the facility failed to assure that the physician had reviewed the resident's total plan of care, including medications, for 2 residents in the sample (Resident #8 & #9). Findings include:

1. Per record review, Resident #8 has a physician's order last signed on 11/10/09 that states "nothing by mouth; aspiration risk". The resident receives all nutrition and medications through a G-tube. The medication orders for this resident included: Levothyroxine 88 mcg. one tab by mouth every night at bedtime; and Lyrica 100 mg. one cap by mouth twice a day. There is also an order "may use standing orders" which refers to standing orders in the chart that include the use of PO (by mouth) medications. Per interview on 12/01/09 at 10:30 AM, Resident #8 confirmed that all medications are administered through the

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F 386 Continued From page 10
G-tube, and that the doctor said that the risk of aspiration was too high to take them by mouth. Per interview on 12/2/09 at 9:30 AM, the Unit Manager confirmed that the resident takes nothing by mouth as ordered by the MD, and that the order for PO medications was not the correct route of administration for this resident.

F 386

2. Per record review and staff interview, Resident # 9 had a physician's order for a medication that did not contain a route of administration. Per record review on 11/30/09 medication orders have been signed by the physician monthly for Resident # 9. The route of administration for Centrum Silver is missing on all the signed orders. This was confirmed by the unit coordinator during interview on 11/30/09 at 3:50 pm.

F 411 483.55(a) DENTAL SERVICES - SNF
SS=D
The facility must assist residents in obtaining routine and 24-hour emergency dental care.

A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.

F 411

Please see attached

1/4/2010

This REQUIREMENT is not met as evidenced by:
Based on record review and confirmed through

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F 411 Continued From page 12
because 'they have been hurting for a couple of weeks' and the nurse was aware. Per record review, a nursing progress note dated 11/03/09 documented 'sore mouth, abrasion noted in lower jaw'. However, no further monitoring, care planning or outside consult was documented in the medical record for that time period. Per interview on 12/01/09 at 10:40 AM, the Staff designated as making appointments, confirmed that "no referral from nursing was received so no appointment has been made".

F 411

F 490
SS=E 483.75 ADMINISTRATION
A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:
failure to assure safety for all residents and supervise contract staff for safe environment

Based of observation and interview, the facility administrator failed to assure the safety for all residents and failed to supervise contracted personnel to assure a safe environment.
Findings include:

1. Per observation on the first day of survey, Room 311 was under room renovation. At 5:20 PM surveyor found this room unsecured and unsupervised by staff or contracted workmen. The unsupervised room contained a cordless screwdriver and a box cutter that were lying on the floor along with other building supplies. Boxes of screws and floor mouldings were on the floor in

F 490

Please see attached

1/4/2010

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

PRINTED: 12/15/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2009
NAME OF PROVIDER OR SUPPLIER BENNINGTON HEALTH & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 2 BLACKBERRY LANE BENNINGTON, VT 05201		
(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 490	Continued From page 13 the center of the room. The Nurse Surveyor notified the Interim Charge Nurse on the unit and the Director of Nurses, informing them that the room must be secured prior to the surveyors leaving the building. The Maintenance Supervisor returned to the facility and installed a lock on the door of room 311. Per interview at 6:10 PM on 11-30-09, the Maintenance Supervisor confirmed there was no process in place to monitor the contractors conducting the renovation, to assure safety for all residents.	F 490			



Bennington Health and Rehabilitation Center

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F241

How Corrected?

Seating charts were re arranged as were placement of trays on the carts for

- Resident#22
- Resident # 23
- Resident #24

Sufficient levels of glasses are now being maintained by dietary.

What residents have the potential to be affected?

Those residents who eat in the dining room

What measures will be put in to ensure the deficient practice will not occur again?

Staff will be re-educated on dining protocol related to residents seated at the same table will receive their trays in order by SDC/designee.

Dietary staff will be re-educated to use glassware and not disposable cups for liquids.

How will these corrective measures be monitored to ensure these deficient practices do not occur again? What quality assurance program will be put in place?

These corrective measures will be monitored by licensed staff supervising the distribution of trays and glassware

Weekly audits x4 and then monthly audits x 2 will be done to determine compliance

With results reported to the quality assurance committee monthly..

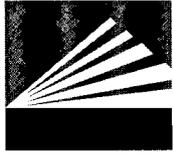
The date the corrective action will be completed?

Compliance 1/4/2010

*Re telephone connection to administrator 12/28/09 @ 10:45 am
the DMS will be responsible.*

POC complete 12-28-09

S. Evans / [Signature]



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F281

How corrected?

Residents #2,#9 and #8 had no adverse affects from the alleged deficient practice
Resident #2 The TAR was reconciled to reflect the physicians order.
Resident # 9 The MAR and the physicians order was corrected to reflect correct route of administration.
Resident#8 The MAR and physician's order were corrected to reflect medication administration via G-Tube.

What residents have the potential to be affected?

Residents receiving oxygen or medications are at risk.

What measures will be put in place to ensure the deficient practice will not occur again?

Nursing staff will be re-educated on the editing process of orders by SDC/designee

How will these measures be monitored to ensure these deficient practices do not occur again? What quality assurance program will be put in place?

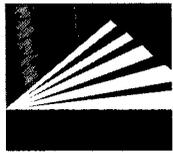
Routine audits of MARs, TARs and MD orders will be done monthly. Random audits of the charts will be done monthly by nursing management.

Results of these audits will be reported to the quality assurance committee monthly.

The date the corrective action will be complete?

Compliance 1/4/10

*Per telephone conversation 12-28-09 @ 1045pm C administered
The DWS will be the responsible person.
BC accepts 12-28-09
Sennors / [Signature]*



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F312

How corrected?

Resident #2 and Resident #12 declined to have their facial hair removed and had no adverse affects form the alleged deficient practice . Both residents care plans were updated.

What residents have the potential to be affected?

Female residents with facial hair have the potential to be affected

What measures will be put in place to ensure the deficient practice will not occur again?

Nursing staff will be re-educated on grooming by SDC/ designee

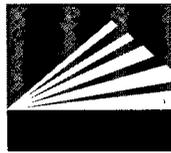
How will these measures be monitored to ensure these deficient practices do not occur again? What quality assurance program will be put in place?

Random audits on female residents will be done weekly to check for unwanted facial hair x 4weeks then monthly x2 with care plans updated as needed.
Results of these audits will be reported to the quality assurance committee monthly.

The date the corrective action will be complete?

1/4/10

*Per telephone conversation with administrator 12-28-09 1045 AM & the administrator The DNS will be the responsible person.
Poe account 12-28-09
Senna SA*



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F323

How corrected?

No resident was harmed by this alleged deficient practice
Maintenance was called and the room was secured with a lock.
Resident #13 will be assessed post falls and 1:1 supervision will be implemented if determined to be necessary.

What residents have the potential to be affected?

Residents who are assessed as being fall risks have the potential to be affected.
Residents who have access to rooms under construction have the potential to be affected.

What measures will be put in place to ensure the deficient practice will not occur again?

Maintenance will be re-educated to lock rooms under construction.
Licensed staff will be re-educated on assessing residents who sustain more than one fall in 24 hours to determine the need for 1:1 supervision

How will these measures be monitored to ensure these deficient practices do not occur again? What quality assurance program will be put in place?

Rounds will be made weekly x4 then monthly x2 on rooms under construction
Falls will be reviewed weekly x4 then monthly x2 to ensure appropriate assessment of need for 1:1 supervision .

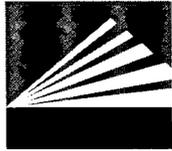
Results will be reported to quality assurance monthly.

The date the corrective action will be complete?

1/4/10

*Per telephone conversation 12-28-09 @ 10:45 am to administrator
The DRS will be the responsible person.*

*POE accepts 12-28-09
J. Emmons*



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F329

How corrected?

The resident had no ill effects from these medications.
The Haldol and the Ativan were discontinued.

What residents have the potential to be affected?

Residents on antipsychotics whose PRN medications do not have specific indicators for use are at risk.

What measures will be put in place to ensure the deficient practice will not occur again?

Licensed staff will be re educated by SDC/Designee to ensure adequate indications for use of antipsychotics will be documented..

How will these measures be monitored to ensure these deficient practices do not occur again? What quality assurance program will be put in place?

Random weekly audits of medical records for residents who receive antipsychotic medications will be done weekly x4 then monthly x 2.
Results of these audits will be reported to the quality assurance committee monthly.

The date the corrective action will be complete?

1/4/10 Per telephone consult 12-28-09 @ 1045 am c
admission the Drs will be the responsible person.
Per aupts 12-28-09
L. Orma [Signature]



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F363 – Menus and Nutritional adequacy

Corrective Action: All meal tickets were reviewed by the Dietician and errors corrected. Staff was in-serviced on accurately reading and following meal tickets and menus.

Who is at risk: All residents who received meals are at risk.

What measures have been put in place to prevent this deficient practice: Dietician will review all resident profiles for accuracy. Any menu substitutions will be recorded and signed by the dietician. All kitchen staff will be re-educated on accurately reading and following meal tickets, diets and menus.

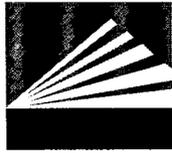
How will it be monitored: Meal service will be audited for compliance to the menu and diet weekly x 4 then monthly x 2 to determine compliance. Results will be reported to the quality assurance committee monthly.

Responsible: Dietary manager or designee

Completion date: January 4, 2010

Reamonte 12-28-09

SEMSO [Signature]



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F371- Sanitary conditions

Corrective Action: Steam table was thoroughly cleaned.

Who is at risk: Residents who eat from the steam table service are at risk.

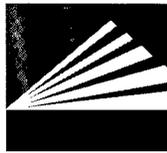
What measures have been put in place to prevent this deficient practice: The steam table will be brought to the kitchen and cleaned after each service.

How will it be monitored: The steam table has been added to the daily cleaning checklist.

Responsible: Dietary Manager or designee

Completion date: January 4, 2010.

POC amnto 12-28-09
f Emors 18



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F386

How corrected?

No resident was harmed by this alleged deficient practice.
Resident #8 physician's order was changed to reflect that medications are given only via the G-tube. A request to change her standing orders to via g-tube vs po was requested of this residents physician.
Resident #9 physician order was changed to reflect route of administration.

What residents have the potential to be affected?

Residents receiving medications are at risk.

What measures will be put in place to ensure the deficient practice will not occur again?

Nurses will be re-educated on the changeover process by SDC/Designee.

How will these measures be monitored to ensure these deficient practices do not occur again? What quality assurance program will be put in place?

Random audits of physician's orders will be done weekly x4 then monthly x 2 for correct route of administration.
Results of these audits will be reported monthly to the quality assurance committee

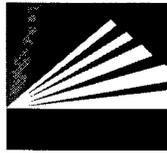
The date the corrective action will be complete?

1/4/10

*Re telephone Consult 12-28-09 @ 1045AM to administer the
DNs will be the responsible person.*

BC accepted 12-28-09

DeMars [Signature]



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F411

How corrected?

There were no ill effects noted from this alleged deficient practice.

The dentist was contacted for resident # 5 and #12.

Resident #5-the dentist submitted an estimate that was sent to New York Medicaid to see if the resident could use applied income, however the resident at this point in time declines to have anything done. Care plan was updated.

Resident #12 was seen by the dentist and was experiencing thrush at time of exam-the dentist will fit for dentures once the thrush resolves. Currently the resident remains on Nystatin.

What residents have the potential to be affected?

Residents with dental concerns are at risk.

What measures will be put in place to ensure the deficient practice will not occur again?

Nursing staff will be re- educated regarding follow through of any dental concerns expressed by residents, to include monitoring, care planning and dental consults as appropriate.

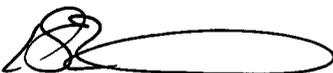
How will these measures be monitored to ensure these deficient practices do not occur again? What quality assurance program will be put in place?

Dental concerns will be reviewed 5 x a week at stand up x 4 weeks then monthly x 2.

The date the corrective action will be complete?

1/4/10

Re follow up consult 12-28-09 @ 1045am The Dnt will be the reasonable Perm.

Poe aupt 12-28-09
J. Evans 



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Annual Survey 2009
Plan of Correction
December 23, 2009

F490-E 483.75 Administration

Corrective Action: Room immediately locked secured by Maintenance supervisor.
Contractor in-serviced on safety protocols.

Who is at risk: All residents who reside at the facility are at risk.

What measures have been put in place to prevent this deficient practice: Locks have been placed on doors of rooms that are being renovated so that the area is secure when unattended. Rooms will not begin renovation unless a lock has been placed on the door. Contractors will participate in orientation and be in-serviced on safety protocols.

How will it be monitored: Renovations have been added to the rounds checklist to verify compliance with safety. Contractors will participate in orientation and sign off on the orientation checklist before they start work for the facility.

Responsible: Maintenance supervisor or Designee

Compliance date: January 4, 2010.

AOC unptr 12-28-09

[Handwritten signature] *[Handwritten signature]*