

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

January 21, 2014

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 **December 18, 2013**. 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

PC:jl

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

PRINTED: 01/02/2014
FORM APPROVED
OMB NO. 0938-0391

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Licensing and
Protection

(X3) DATE SURVEY
COMPLETED

12/18/2013

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 12/18/2013
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NAME OF PROVIDER OR SUPPLIER BURLINGTON HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 300 PEARL STREET BURLINGTON, VT 05401
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F 000	INITIAL COMMENTS			
F 279 SS=D	<p>An unannounced on-site annual recertification survey was conducted by the Division of Licensing & Protection from 12/16/13-12/18/13. The following regulatory deficiencies were cited as a result of the survey:</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to develop a comprehensive plan of care for 1 of 13 residents in the stage 2 sample (Resident # 217). Findings include:</p>	F279	<p>The following constitutes the facility's response to the findings of the Department of Licensing and Protection and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statement of deficiencies.</p> <p>The facility maintains that it develops a comprehensive care plan for residents with urinary incontinence that meets the needs identified in the comprehensive assessment.</p> <p>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice? : Resident # 217 suffered no negative outcome, care plan was updated.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice? : All residents with urinary incontinence are potentially affected by this alleged deficient practice.</p>	12/18/2013 On-going

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Cheryl Buehler* TITLE Executive Director (X6) DATE 1/10/2014

A. 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 279 Continued From page 1
Per record review on 12/17/13 at 2:00 PM, there was no plan of care to address Resident #217's needs related to bladder incontinence. Resident #217 was admitted to the facility on 6/24/13 and has diagnoses including Hypertension, Cerebrovascular accident, Aphasia, Dysphagia, Depression and Abnormal posture. There is a physicians order dated 12/3/13 for bladder management per facility protocol. Per an admission nursing assessment dated 6/24/13, the resident was admitted with a condom catheter. Per a bladder and bowel assessment dated 7/15/13, the resident is a candidate for timed voiding. Per the Minimum Data Assessment (MDS) dated 7/1/13, the resident required total assist with all activities of daily living and was frequently incontinent of bladder. The physician discontinued the condom catheter on 7/9/13. During interview with the Unit Manager (UM) on 12/17/13 at 2:32 PM, the UM confirmed there was no plan of care to address the Resident's needs related to urinary incontinence.

F 280 SS=D 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP
The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.
A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,

What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? :

All nurses will be educated re: development of comprehensive care plans will include urinary incontinence based on the comprehensive assessment. DNS, ADNS, UM &/or designee

1/18/2014

How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? :

Initial audit of all residents to determine urinary incontinence. Initial audit of all incontinent residents' care plans to ensure a care plan has been developed for urinary incontinence based on assessments. Audit all new admissions x 2 weeks to ensure urinary incontinence care plan has been developed for all incontinent residents, then 3x/wk random audits, then continued random auditing. Results reported at Action Team and QA meetings with changes made as appropriate. DNS, ADNS, UM, &/or designee
F279 POC accepted 1/16/14 Mtkgms RN/jmc

1/18/2014 & on-going

F280

The facility maintains that all residents have the right to participate in planning care and treatment or changes in care and treatment.

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F 280	<p>Continued From page 2</p> <p>and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to revise the care plan for one applicable resident in the survey sample. (Resident #81) Findings include:</p> <p>1. Per record review on 12/17/13, Resident #81, who has a diagnosis of end stage renal failure has a care plan dated 10/08/2012, which directs staff to monitor intake and output, identifies a 1500 ml (milliliter) fluid restriction and to follow dialysis recommendations. Per review of the Dialysis book that contains communication to the nursing home, it states on 10/31/13 to keep the Resident's fluid intake lower than 1000 ml. In addition, the dietary assessment on 11/16/13 also recommends a 32 oz/day [1000 ml] fluid restriction. Per interview on 12/17/13 at 3:40 P.M. the Unit Manager confirmed that the care plan has not been revised to meet the current fluid restriction needs.</p>		<p>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice? : Resident #81 suffered no negative outcome from this alleged practice.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice? : All residents on renal dialysis with a fluid restriction are potentially affected by this alleged deficient practice.</p> <p>What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? : Nurses and Dietary dept. will be educated on careplan revision and communicating changes related to dialysis fluid restrictions. DNS, ADNS, &/or designee</p>	<p>On-going</p> <p>1/18/2014</p>
F 282 SS=D	<p>Also see F-309.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in</p>		<p>How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? : Initial audit of all dialysis residents on a fluid restriction for accurate careplan revisions, then 3x/wk random audits x4 wks, then randomly. Results reported in Action Team and QA meetings with changes made as appropriate. DNA, ADNS &/or designee</p>	<p>1/18/2014 & on-going</p>

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F 282	<p>Continued From page 4 of the 16th through 30th as being monitored. There is no documentation that any formal monitoring by the nurse for the months of September through the first part of November and December 2013 were taken. Per interview on 12/17/13 at 3:20 P.M. a staff nurse stated " I saw in that [monitoring] was not on the November MAR so that is way it was started on the 14th only". S/he stated that fluid restrictions are suppose to be monitored by nursing by way of notation on the MAR. The LNAs record intakes in the system. However, per further review of the Intake sheets, LNAs were not consistently documenting the daily fluid intakes and on some days, for example, during December 2013, for 8 out of 15 days the resident was over the fluid restriction limit. Per interview at 3:40 P.M. the UM confirmed nursing staff are not consistently monitoring fluid restriction. Also see F-309</p> <p>2. Per observation on 12/18/13 at 9:05 AM, a staff member was observed feeding Resident #9 with the head of the bed (HOB) positioned at a 45 degree angle. Resident #9 is an aspiration risk and has a physician order for a Dysphagia 3 diet (The least restrictive diet for residents with impaired swallowing). Per review of the care plan, the resident's HOB is to be positioned at a 90 degree angle for all meals. On 12/18/13 at 9:12 AM, the Unit Nurse confirmed that the HOB was at 45 degrees rather than at 90 degrees per the care plan.</p>	F 309	<p>How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? : 3x/week random audit of dialysis com. books and I&O documentation, x4 wks, then randomly. Daily audit of positioning during meals for residents with aspiration precautions x1week, the 3x/wk randomly x4 weeks, then randomly. Results reported at Action Team and QA meetings with changes made as appropriate. DNS, ADNS, &/or designee</p> <p><i>F309a POC accepted 1/16/14 mtg inq in RN / PML</i></p>	1/18/2014 & on-going
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309	<p>Continued From page 5</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and interviews the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with assessment and plan of care for one applicable resident in the sample who receives hemodialysis for end stage renal failure (Resident #81) Findings include:</p> <p>1. Per record review on 12/17/13 Resident #81 is receiving end stage renal disease services with hemodialysis and has multiple co-morbidities. Per care plans, dietary recommendations and communications from the Dialysis unit, Resident #81 is to be on a 1000 ml (milliliter) fluid restriction, monitored by nursing and follow up with post treatment.</p> <p>Per the Dialysis Log Book notes multiple requests to follow treatment: on 12/11/13, 12/10/13, 11/27/13, 11/21/13, 11/14/13, 11/19/13, 10/29/13 and 10/31/13 state "too much fluid -please limit liquids ice soups etc very hard to remove this amount...please lower fluids should have no more than 32 oz. include ice soup, ice cream jello...too much fluid, please limit = very overloaded!". On</p>	F309	<p>The facility maintains that all residents receive the necessary care and services to attain/maintain their highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice? : Resident # 81 suffered no negative outcome from this alleged deficient practice.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice? : All residents on renal dialysis, with a fluid restriction, are potentially affected by this alleged deficient practice.</p> <p>What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? : Nurses will be educated re: Assessment, plan of care, and communication documentation r/t all dialysis residents with a fluid restriction. DNS, ADNS, &/or designee</p>	On- going 1/18/2014

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F 309	Continued From page 6 12/5/13 states "send nutritious breakfast [resident] is a diabetic" no donuts. Additionally, there are no post treatment notes from dialysis on 10/29/13, 11/6/13, 12/3/13 and 12/14/13. There are no nursing notes to show if the dialysis was contacted for information. Per review of the MAR, nursing notes and intake records, nursing failed to consistently monitor fluid restriction; revise the care plan to reflect dietary and Dialysis' recommendations of 1000 ml of fluid per day or follow up with interchange of information post treatment. Per observation on 12/17/13 at 3:30 P.M. in Resident #81's room there was a half-filled large bottle [2 liter] of Ginger Ale soda. Per interview on 12/17/13 at 3:50 P.M. the UM stated that the resident was "[his/her] own person" and that the resident "doesn't always follow the care plan" but acknowledged that there is no documentation that development of the care plan, goals, and interventions reflect choices and preferences, whether alternate approaches have been tried/discussed with the resident or whether there had been coordination with other inter-disciplinary members for the development of new interventions. S/he confirmed that the care plan was not revised, information was not exchanged on several occasions and staff did not consistently monitor fluid intake and/or restrictions to meet the need of the resident.		How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? : Initial audit of all dialysis residents on a fluid restriction for assessment, careplan accuracy, and dialysis communication documentation. Then 3x/wk random audits x4 wks, then randomly. Results reported in Action Team and QA meetings with changes made as appropriate. DNS, ADNS, &/or designee	1/18/2014 & on-going	
F 353 SS=F	Also see tags F-280 and F-282 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS	F 353		<i>F309 POC accepted 1/16/14 mtg/qns RN/psm</i>	

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F 353	<p>Continued From page 7</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to provide 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. This has the potential to negatively affect all residents of the facility. Findings include:</p> <p>1. Per observation on 12/16/13 on the 5th floor between 10:30 AM and 11:35 AM, 2 resident call lights went unanswered for 40 minutes (Rooms 506 and 514). The 5th floor resident census was 39. There were 2 nurses and 3 Licensed Nursing</p>	F353	<p>The facility maintains that sufficient nursing staff is provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being of all residents in the facility.</p> <p>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice? : There were no negative outcomes to any resident from this alleged deficient practice.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice? : All residents are potentially affected by this alleged deficient practice.</p> <p>What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? : Education to all nursing staff re: call light system and staffing need/patterns. DNS, ADNS, &/or designee</p>	<p>On-going</p> <p>1/18/2014</p>

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F 353	<p>Continued From page 8</p> <p>Assistants (LNAs) on duty for the day shift. There are 10 residents on the 5th floor that require assist of 2 staff for mechanical lift transfers.</p> <p>The 4th floor has 14 residents requiring 2 person assist mechanical lifts and the census and staffing are the same as the 5th floor.</p> <p>Per review of facility call light tracking logs, there were wait times of 20 minutes or greater on 27 occasions between 11:33 PM on 12/15/13 - 12/16/13 at 3:16 PM. Of these 27 wait times, some call lights were not responded to by staff at all after 40 minutes.</p> <p>During interview with 1 of the above residents who did not have their call light responded to for 40 minutes, h/she stated that h/she had been waiting 45 minutes to be lifted from bed to a wheelchair and that h/she experiences wait times up to 1 hour often. The other resident in the above observation stated that h/she waits "a long time all the time" and has waited up to 2 hours to be toileted. During interview on 12/16/13 at 3:20 PM, the Unit Manager (UM) stated that one try on the call system was equal to 5 minutes and thinks the system resets itself after 40 minutes. The UM stated that LNAs carry beepers that get calls. The nurses get a call on try 3 and a supervisor beeper gets paged on try 4. The UM stated that the supervisor beeper is not always used.</p> <p>During the 3 days of survey, the nurse's pagers were observed unattended on med carts or in the nursing stations on both 4th and 5th floors on multiple occasions. Review of daily posted staffing schedules for all floors indicates that floor nurses are expected to assist with LNA duties between 7:00 - 11:00 AM each day. 6 LNAs were</p>		<p>How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? :</p> <p>Daily review of nursing schedule/ppd by DNS &/or designee x 2 weeks, then weekly, random audit. Daily call light audits x 2 weeks, then weekly random audit. Results reported at Action Team and QA with changes made as appropriate.</p> <p>1/18/2014 & on-going</p> <p><i>F353 POC accepted 1/16/14 MHI/qmsrj/pmc</i></p>	

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F 353	<p>Continued From page 9</p> <p>interviewed and all stated that the nurses rarely are able to assist with LNA tasks. 5 nurses were interviewed on all floors and told surveyors that as little as 20 minutes of the 4 daily hours assigned to assist the LNAs were actually doing LNA tasks.</p> <p>Per interview with a Registered Nurse (RN) on 12/18/13 @ 8:30 AM confirmation is made that professional nursing staff are aware of the expectation to work four (4) hours per shift providing direct patient care. However, they are responsible for 18-20 residents each, responsible for passing medications timely to those assigned residents, carrying out physician orders for treatments on assigned residents, conducting assessments and completing necessary documentation on those assigned residents. RN confirms on 12/18/13 @ 8:30 AM that the nurses are unable to meet the 4 hour expectation and that this information has been shared with Administration, but no changes have occurred to date.</p> <p>Per interview and review of facility call light logs on 12/18/13 @ 9:45 AM with the Director of Nursing (DNS) and the Assistant Director of Nursing (ADNS), confirmation is made that the call light logs demonstrate multiple resident wait times of well over 20-40 minutes each, that the logs are reviewed for Quality Assurance purposes and confirms that audits have not been conducted frequently enough to ensure that resident call lights are answered timely. DNS confirms that wait times should be no longer than ten minutes.</p> <p>Per interview with the DNS and the ADNS at 9:45 AM on 12/18/13, confirmation is made that the</p>	F 353		
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F 353	<p>Continued From page 10</p> <p>expectation is that the nurse will work 4 hours per day and evening shifts, as assigned, in providing direct resident care on each unit. DNS and/or the ADNS do not review with the professional nurses at any time if they have in fact provided direct resident care.</p> <p>2. During resident and family interviews on Unit 2 on 12/16/13 and 12/18/13 (Resident #287), it was reported that wait times for call device response are often 30-40 minutes. The resident is assessed as needing 2 staff assist for transfer and toileting, and requires pain management for cancer and chronic back pain. Posted staffing on Unit 2 for 12/16-18/13 for day and evening shifts included 2 nurses and 2 LNAs for 21 residents, and on night shift 1 nurse and 1 LNA. During an interview on 12/18/13, the Unit 2 nurse manager reported that staffing is assigned for the facility census and not targeted to resident needs and census on the unit. The unit manager additionally acknowledged that the demands of medication administration and resident assessment from 7-11 AM make it quite difficult for nurses to meet the requirement of sharing LNA duties.</p> <p>3. Per Stage I Resident Interview, Resident # 96 (R#96), who is interviewable, stated that there is not enough staff. S/he stated that there isn't a specific time that is worse-it varies. R#96 stated that there are many times when it takes a long time for anyone to answer the call light and that one time the light was on for over an hour and s/he couldn't wait any longer and "I couldn't hold it anymore and I had a B.M. [bowel movement] in the bed."</p>	F 353		

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NAME OF PROVIDER OR SUPPLIER BURLINGTON HEALTH & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 300 PEARL STREET BURLINGTON, VT 05401		
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F 353	Continued From page 11 4. Per Stage I Resident Interview Resident #48 (R#48) who is interviewable, stated that there is not enough staff. S/he stated that you have long waits when you put your call light on but it is worst at meal times and at change of shifts. R#48 stated that waits are often a half hour or more and that once s/he waited in the bathroom for over a hour for someone to come and help him/her out. S/he stated that he has complained to staff nurses and also at the care plan meetings where the Unit Manager is present.	F 353			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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 observations and interviews the facility failed to store, prepare, distribute and serve food under sanitary conditions. This has the potential to effect all residents in the facility. Findings include: Based on observation during the initial tour on 12/16/13 at 10:15 A.M., with the Food Service Supervisor (FSS), the facility failed to prepare, distribute and serve food under sanitary conditions as follows:	F371	The facility maintains that it stores, prepares, distributes and serves food under sanitary conditions. How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice? : No resident was affected by this alleged deficient practice. All noted areas were immediately cleaned. A thermometer was placed in the milk refrigerator, reading 38 degrees. How will the facility identify other residents having the potential to be affected by the same deficient practice? : All residents are potentially affected by this alleged deficient practice.	12/18/2013 On-going	

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F 371	Continued From page 12 a) The small milk refrigerator's outside temperature gauge had a reading of 42 degrees F and had no inside thermometer to verify the correct temperature range. The FSS stated that there "should be one in there so staff can check but it must have gotten thrown out"; b) The brown plastic warming cart had 3 trays, inside the cart, that were greasy and contained wet food crumbs. This is used to transport residents trays and "should be cleaned after use"; c) The meat slicer was noted to have crumbs/dust present and it was not covered. This was situated near the three pot sink. The FSS stated "it should be covered and clean"; d) The blender had food particles [used this morning but not cleaned, just rinsed] and the base had a build up of crumbs/dust/grease. The cook immediately proceeded to wash the blender. e) The steam serving tables on Unit 3 and 4 as well as a steam table stored outside the kitchen door were noted to have floating food particles and food debris around the trays and a build up of dried food matter. Per interview with the FSS at this time, confirmed the above findings.		What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? : -Educate all food service staff re: storing, preparing, distributing and serving food under sanitary conditions → -thermometer will remain in the milk refrigerator and temperature checked 2 times a day, 7 days a week -Warming cart will be cleaned after every use -Meat slicer will be cleaned and covered after every use -Blender will be cleaned after every use -All steam tables will be drained and cleaned every evening and as needed with de-liming once a week FSS &/or designee	1/12/2014	
F9999	FINAL OBSERVATIONS Vermont State Licensing and Operating Rules for Nursing Homes 7.13 Nursing Services: The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial		How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? : All areas will be audited daily at random times x 2 wks then randomly. Results reported at Action Team and QA meetings with changes made as appropriate FSD &/or designee	12/18/2013 & on-going 1/18/2014 & on-going	
			<i>F371 poc accepted 1/16/14 mth/qms/rw/pmc</i>		

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F9999	<p>Continued From page 13</p> <p>well-being of each resident, as determined by resident assessments and individual plans of care or as specified by the licensing agency.</p> <p>(d) Staffing Levels. The facility shall maintain staffing levels adequate to meet resident needs. (1) At a minimum, nursing facilities must provide:</p> <p>(i) no fewer than 3 hours of direct care per resident per day, on a weekly average, including nursing care, personal care and restorative nursing care, but not including administration or supervision of staff, and of the three hours of direct care, no fewer than 2 hours per resident per day must be assigned to provide standard LNA care (such as personal care, assistance with ambulation, feeding, etc.) performed by LNAs or equivalent staff and not including meal preparation, physical therapy or the activities program.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on review of the facility staffing patterns, observations and staff interviews, the facility failed to meet the 2 hours per resident per day to provide standard Licensed Nurse Aide (LNA) care for the months of September, October, November and December 2013. The findings include:</p> <p>Per review of the daily staffing sheets for all four (4) Units, documentation identifies that Professional Nurses (Registered Nurses and/or Licensed Practical Nurses) are assigned to provide LNA duties on the day and evening shifts</p>	F9999	<p>The facility maintains that sufficient nursing staff is provided to attain or maintain the highest practicable physical, mental and psychosocial well-being of all residents in the facility.</p> <p>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice? : There were no negative outcomes to any resident from this alleged deficient practice.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice? : All residents are potentially affected by this alleged deficient practice.</p> <p>What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? : Education to all nursing staff re: staffing need/patterns. DNS, ADNS, &/or designee</p>	<p>On-going</p> <p>1/18/2014</p>	

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F9999	<p>Continued From page 14 from 7-11. This equates to thirty-two hours of LNA work per day delivered by the professional nurse. These hours are included in the LNA hours on the facility staffing pattern for the calculations of LNA hours per resident per day.</p> <p>Per interviews with Licensed Nurse Aide (LNA) staff, confirmation is made on 12/16/13 @ 11 AM and 12/18/13 @ 9:24 AM that direct care staff can not provide quality care to residents they are assigned to. They are having difficulty completing assignments timely and often leave the shift with feeling they did not deliver the care they have been trained to. LNA's confirm on 12/18/13 @ 8:45 AM that they have assignments of 10-14 residents each depending on the census and the unit assigned to. Morning care is often not completed until 2-2:30 PM.</p> <p>Per observations and interviews with LNA staff on 12/18/13 at 8:30, 9:00 and 9:24 AM, confirmation is made that the nurses do not assist with direct resident care for four (4) hours per shift per unit as identified on the daily staffing sheets. Nurses have assisted with position change or call light answering, but do not assist LNA staff with direct resident care.</p> <p>Per interview with a Registered Nurse (RN) on 12/18/13 @ 8:30 AM confirmation is made that professional nursing staff are aware of the expectation to work four (4) hours per shift providing direct patient care. However, they are responsible for 18-20 residents each, responsible for passing medications timely to those assigned residents, carrying out physician orders for treatments on assigned residents, conducting assessments and completing necessary documentation on those assigned residents. RN</p>		<p>How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? : Daily review of nursing</p> <p>schedule by DNS &/or designee x 2 weeks, then weekly random audit. Results reported at Action Team and QA with changes made as appropriate. DNS, ADNS &/or designee</p> <p><i>F9999 POC accepted 1/16/14 Mthiggins RN/AMC</i></p>	<p>12/18/2013 & on-going</p>	

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F9999	<p>Continued From page 15</p> <p>confirms on 12/18/13 @ 8:30 AM that nurses is unable to meet the four (4) hour expectation and that this information has been shared with Administration, but no changes have occurred to date.</p> <p>Per interview with Payroll Staff, Director of Nurses (DNS) and Assistant Director of Nurses (ADNS) on 12/18/13 @ 9:45 AM, facility staffing pattern is calculated by utilizing payroll documents and daily staffing sheets. There is no actual nurse assigned to the 4 hours per day and evening shifts, but 32 hours is automatically added into the LNA category daily as directed by the DNS. This was confirmed at the time of this interview by the payroll staff member and the DNS.</p> <p>Per interview with the DNS and the ADNS at 9:45 AM on 12/18/13, confirmation is made that the expectation is that the nurse will work those 4 hours as assigned in providing direct resident care per day and evening shifts on each unit. DNS and/or the ADNS do not review with the professional nurses at any time, if they have in fact provided direct resident care.</p> <p>Therefore, it can not be confirmed that the 32 hours per day of direct care by professional staff was actually provided. Therefore, we can not confirm the facility meets the 2 hours per resident per day in providing standard LNA care as required.</p>	F9999			