

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

PRINTED: 04/19/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/14/2010
NAME OF PROVIDER OR SUPPLIER CEDAR HILL HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 49 CEDAR HILL DRIVE WINDSOR, VT 05089	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 281 SS=D	<p>An unannounced, on-site complaint investigation was conducted by the Division of Licensing and Protection on 04/14/2010.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Per record review and staff interview on 04/14/2010, the facility failed to meet standards of practice for medication administration for 1 resident of 5 in the sample population (Resident #1). Findings include:</p> <p>Per record review on 04/14/2010 at 1:00 pm, Resident # 1 received 1"as needed medication" (PRN) dose of oxycodone SR (sustained release) on 02/16/2010 at 4:45 am. The documentation on the narcotic sheet indicates that the extended form of medication was given to the resident rather than the short acting form that was ordered for breakthrough pain. The nurses' notes for 02/16/2010 indicate that resident was relieved of pain after the 4:45 am administration of the medication. There is no indication that the nurse who administered the medication was aware that the wrong medication was given. Per interview with the DNS at 3:00 pm on 04/14/2010, s/he confirmed that there were no incident reports initiated on 02/16/2010 or any time after regarding this resident and this medication. The DNS also confirmed at this time that the incorrect medication was administered. Per record review and staff interview, Resident #</p>	F 281	<p>An in service on medication disbursement and the 5 rights, (right person, right drug, right dose, right time and right route) will be mandated for all licensed nurses. An in-service on both oxycodone and oxycontin. and an updated method of counting narcotics and discovering discrepancies in the in service will also be offered to all licensed staff.</p> <p>We will review each resident receiving oxycontin and oxycodone and their records audited for the 5 rights.</p> <p>To ensure this doesn't happen again the narcotic count will be reviewed to check the previous 24 hour period for proper dosage given for the MD order at the beginning and end of each shift.</p>	

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

James B. Sutton

TITLE

Administrator

(X6) DATE

5-4-2010

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 1 did not receive the scheduled 9:30 am dose of oxycodone SR on 04/03/2010 as ordered by the physician. The DNS confirmed this on 04/14/2010 at 3:00 pm. Reference: Nursing 2010 Drug Handbook, Lippincott, Williams & Wilkins, pgs 12-19.	F 281	 The Director of Nurses or designee will monitor with bi-weekly audits of the narcotic books and will follow up with discrepancies and/or errors made. Audits, discrepancies and errors will be reviewed at the quarterly Quality Assurance Meeting. Corrective action to be completed by May 12, 2010 <i>acc count 5/14/10</i> 	