

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

February 10, 2011

Bruce Bodemer, Administrator
Centers For Living And Rehab
160 Hospital Drive
Bennington, VT 05201

Provider ID #:475029

Dear Mr. Bodemer:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 12, 2011**.

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,



Pamela M. Cota, RN
Licensing Chief

PC:jl

Enclosure



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

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PRINTED: 01/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	Licensing and Protection	(X3) DATE SURVEY COMPLETED 01/12/2011
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NAME OF PROVIDER OR SUPPLIER CENTERS FOR LIVING AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 160 HOSPITAL DRIVE BENNINGTON, VT 05201
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F 000	INITIAL COMMENTS	F 000		
F 221 SS=D	<p>An unannounced re-certification survey was conducted by the Division of Licensing and Protection from 01/10/11 - 01/12/11. The following are regulatory findings.</p> <p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure that residents are free from physical restraints for 1 of 3 applicable residents in the sample. (Resident #267) Findings include:</p> <p>1. Per observation during the initial tour on 1/10/11 and on the following 2 days of survey (1/11/11 and 1/12/11), Resident #267's bed had 1 half rail in the middle of the bed and 2 deep wedge devices on each side of the mattress. Per review of the medical record on 01/11/11, no assessments were documented for the use of the half rail and wedges. There was no care plan for the wedges, or devices used for positioning or bed mobility. Per a nurse note dated 12/31/10 at 6:56 PM, the nurse sent a fax to the physician stating "may we have wedges because resident tries to crawl out of bed, also floor mats in both sides of bed". Per interview on 01/12/11 at 11:59 the DNS (Director of Nursing) and Administrator-in-training confirmed that the half rail and wedges were not assessed and were a</p>	F 221	<p>F221- Resident #267 admitted on 12/13/10; resident was admitted with staged pressure ulcers which resolved on 1/10/11. Resident was assessed for appropriate/continued use of In-Bed Positioning device (wedge) on 1/12/11. On 1/12/11 physician was notified of resolution of impaired skin integrity and removal of in-bed positioning devices, which were care planned. Restraint assessment was performed by the MDS care coordinator on 1/12/11 to assess low bed. MDS care coordinator confirmed that the low bed is not considered a restraint as resident is able to get out of the bed in the lowest position.</p> <p>Siderail assessment was redone on 1/31/11, as resident uses the ¼ rails for positioning and utilization when getting out of bed, thus not a restraint.</p> <p>Care plan will reflect side-rails to remain in the ¼ rail position at all times while in bed, as this particular type of bed (Low Bed) has the capability of moving rail to a ½ rail position. All residents with low bed type have been identified and siderail assessments reviewed. Verified use of ¼ rails for positioning purposes and care planned for such.</p> <p>Staff education will be performed by Education Coordinator on the safety of maintaining siderails in the ¼ position on these identified beds.</p> <p>Weekly random audit will be performed by nursing staff to ensure rails are in ¼ rail position on these identified low beds. (See Exhibit A.) Nurse Manager will provide DNS a copy of audit weekly; DNS will report results monthly to Quality-Safety Committee; after 6 months of 100% compliance, will report to Committee quarterly for 2 quarters.</p> <p>All residents with current orders for in-bed positioning devices (wedges) will be assessed by Physical Therapist for appropriate use and documented. A restraint assessment will be</p>	<p>1/12/11</p> <p>1/31/11</p> <p>2/12/11</p> <p>2/12/11</p> <p>2/12/11</p> <p>2/12/11</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Grace Sodeme* TITLE: *Interim Administrator* (X6) DATE: *2/4/11*

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 221	Continued From page 1 potential restraint.	F 221	documented by MDS care coordinator for those residents currently using the in bed positioning device.		
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by:	F 272	All residents deemed appropriate for use by PT will be audited weekly by nursing to verify use of in-bed positioning device, and to verify care plan implemented appropriately. Nurse manager will provide DNS a copy of audit weekly; DNS will report results monthly to Quality-Safety Committee; after 6 months of 100% compliance, will report to Committee quarterly for 2 quarters. <i>F221 POC Accepted 2/10/11 SEMUNSON/PMCOTURN</i> F272 - Restraint assessment performed and documented on Resident #267 regarding low bed, which, due to resident's ability to get out of bed independently, is not considered a restraint; assessment performed by MDS care coordinator on 1/12/11. In-bed positioning devices (wedges) were discontinued on 1/12/11. During restraint assessment resident #267 utilized siderail in ¼ rail position to assist with getting out of the bed to a standing position. Siderail assessment also re-documented on 1/31/11 for use in repositioning and to sit up in the bed. All residents with this low bed type have been identified and siderail assessments reviewed. Verified use of ¼ rails for positioning purposes and care planned for such. Staff education will be performed by Education Coordinator on the safety of maintaining siderails in the ¼ position on these identified beds. Weekly random audit will be performed by nursing staff to ensure in-bed positioning devices are in place as assessed, planned and ordered. (See Exhibit B.) Nurse Manager will provide DNS a copy of audit weekly; DNS will report results monthly to Quality-Safety Committee; after 6	2/12/11 1/31/11 2/12/11 2/12/11 2/12/11	

Grace Bodner 2/4/11

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F 272	Continued From page 2 Based on staff interview and record review, facility staff failed to assess 1 of 3 applicable residents in the stage 2 sample who had a potential restraint. (Resident # 267) Findings include: 1. Per observation during the initial tour on 1/10/11 and on the following 2 days of survey (1/11/11 and 1/12/11), Resident #267's bed had 1 half rail in the middle of the bed and 2 deep wedge devices on each side of the mattress. Per interview on 01/10/11 at 2:30 PM, the Unit Manager identified Resident #267 as having quarter rails and no potential restraining devices. Per review of the medical record on 01/11/11, no assessments were documented for the use of the half rail and wedges. There was no care plan for the wedges or other devices used for positioning or bed mobility. Per a nurse note dated 12/31/10 at 6:56 PM, the nurse sent a fax to the physician stating "may we have wedges because resident tries to crawl out of bed, also floor mats in both sides of bed". Per interview on 01/12/11 at 11:59 the DNS (Director of Nursing) and Administrator-in-training confirmed that the half rail and wedges were not assessed and were a potential restraint.	F 272	months of 100% compliance, will report to Committee quarterly for 2 quarters. All residents with current orders for in-bed positioning devices (wedges) will be assessed by Physical Therapist for appropriate use and documented. A restraint assessment will be documented by MDS care coordinator for those residents currently using the in bed positioning device. All in-bed positioning devices (wedges) removed from nursing utility room and stored in secured location off nursing units. Positioning devices will require nursing request to Physical Therapy for use. Therapy will determine appropriate positioning devices based upon screen. MDS care coordinator will perform restraint assessment if therapist issues an in-bed positioning device and ensure that order is obtained and device is appropriately care planned. <i>F272 POC Accepted 2/10/11. S. Emmons RN PMA/turn</i>	2/12/11 2/12/11
F 278 SS=D	Refer F221 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the	F 278	F278 – Resident #263, Section F was miscoded; prior software issue did not allow for transmission of MDS if interview was not completed prior to the ARD. Software update had been corrected prior to survey. Correction of Section F will be completed and MDS re-submitted by 2/12/11. MDS care coordinators will review all in-house residents'/patients' MDS Section F in conjunction with nursing cognitive assessment to ensure they	2/12/11 2/12/11

Grace Gudeman 2/4/11

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F 278	<p>Continued From page 3 assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the assessment failed to accurately reflect the status for 1 of 28 sampled residents (Resident # 263). Findings include:</p> <p>Per record review for Resident #263 on 1/11/10 at 4:32 PM, the Minimum Data Set (MDS) section F0300 is checked "no", indicating the resident rarely/never is understood and family/significant other is not available, which indicates that an activities interview will not be conducted. The initial nursing assessment indicates that the Resident is alert and oriented and able to make his/her needs known. MDS coding for cognitive status indicates that the Resident has no cognitive deficits. In a 1/11/11, 5:02 PM interview</p>	F 278	<p>are accurate. Any corrections necessary will be made and MDS will be re-submitted if necessary.</p> <p>Interview process for MDS Section F is assigned to one department (Activities), previously was split between nursing and activities departments. Electronic Charting System (ECS) task folder is set up to allow Activities staff awareness of when Section F interview is due to be done.</p> <p>A weekly audit will be performed by Activities Program Director to verify Section interviews have been completed as required and submit audit to MDS care coordinator who will verify Section F accuracy.</p> <p>Audit will be submitted weekly to DNS who will report results to Quality Safety Committee meeting monthly. After 6 months of 100% compliance will report to Committee quarterly for 2 quarters. (See <u>Exhibit C.</u>)</p> <p><i>F278 POC Accepted 2/10/11. S. Emmons RN / Pm cotar RN</i></p>	<p><i>2/12/11</i></p> <p><i>2/12/11</i></p> <p><i>2/12/11</i></p>

Juice Bodine

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F 278	Continued From page 4 with two MDS Coordinators, one Coordinator confirmed that section "F" on the MDS is a coding error and should have coded as a "yes" which indicates that an activities interview should be conducted.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to develop a comprehensive care plan for 1 of 28 sampled residents (Resident 44). Findings include: 1. Per record review on 01/12/2011, the Care Plan for Resident #44, who receives hemodialysis	F 279	F279 – Resident #44 receives dialysis three times per week. Care plan updated to include monitor of fatigue post dialysis with nursing intervention and goal. Care plan updated for risk of alteration in vital signs and level of consciousness relative to dialysis procedure with nursing intervention to monitor blood pressure pre/post dialysis days. Care plan also updated to monitor for other physical conditions post dialysis procedure. Care plan updated to send dialysis communication binder with resident to outpatient dialysis on dialysis days. Care plan updated to indicate the specific type of dialysis catheter in use and to monitor the site. Nutrition care plan already in place includes monitoring of weights, supplements and refusals of supplements, fluid restrictions, intake and output, and other specific dietary measures related to dialysis. Care plan updated to include foods to avoid. All other identified dialysis residents will have care plans reviewed to ensure care plan is updated to reflect monitoring pre/post dialysis, communication binder, monitoring effects of medications, shunt site protocols and dietary measures. Electronic Charting System (ECS) has been updated to include one specific hemodialysis care plan folder. The contents of the folder include: potential problems/strengths; related to factors; manifested by factors; nursing, LNA and dietary interventions, all specifically related to hemodialysis. Care plan folder also includes area in folder to document the specific type of catheter or fistula site and type. Folder also includes area to chart alternates and to encourage alternates. Dialysis residents/patients will have specific	1/12/11 2/12/11 2/12/11



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F 279	Continued From page 5 treatments three times a week, did not address all aspects of care and services for this dialysis patient. The care plan does not address: A) monitoring of vital signs, weights, and physical condition pre and post dialysis; B) medication dialysis interactions and possible adverse effects; C) dialysis related risk factors D) dialysis center protocols E) communication between the facility and the dialysis center F) evidence of attempts to find acceptable alternatives for aspects of dialysis care when the resident refuses (such as diet). Per staff interviews, the Unit Manager on 01/12/2011 at 8:45 AM and the Facility Administrator and Director of Nursing on 01/12/2011 at 10:25 AM confirmed the lack of developing a comprehensive care plan for this resident.	F 279	dialysis care plan. Also changed in ECS is a documented button "hemodialysis" in the Admit/Discharge/Pass folder to identify newly admitted patients receiving hemodialysis. ECS changes have already occurred. For the identified residents receiving dialysis, the care plan will be merged into a specific dialysis care plan problem identification Weekly audit will be performed by nurse manager and submitted to DNS. DNS will report to Quality Safety Committee monthly; after 6 months at 100% compliance, the audit results will be reported quarterly for 2 quarters. (See Exhibit D.) F279 POC Accepted 2/10/11. S. Emmons RN / D. McCoturn	2/12/11
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to meet professional standards for quality by not carrying out physician orders for 2 of 11 applicable residents in the targeted sample (Residents #168 and #267). Findings include: 1. Per observation and interview, nursing staff failed to administer medication in a timely manner and according to accepted standard of practice.	F 281	F281 - Coaching was provided to individual nurse regarding standards of professional practice in relation to medication administration, such as medications that require special instructions and use of nursing drug handbook for medications requiring additional information. All residents/patients with current orders for Synthroid will be identified. Education coordinator and nurse managers will provide education to nursing staff on importance of Synthroid to be given on an empty stomach Pharmacy IT will make systemic change to Medication Administration Record (MAR) that will identify with a comment - Synthroid to be given on an empty stomach.	1/12/11 2/12/11 2/12/11

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F 281	Continued From page 6 Per observation during a medication administration on 01/12/11 at 9:22 AM, nursing staff administered Synthroid 0.075 mg (milligrams) with Resident #267's other morning medications after breakfast. Additionally, per observation at 9:30 AM, Resident #168 also received Synthroid 0.15 mg with their morning medications after breakfast. Per record review during the medication reconciliation at 10:00 AM for both Resident #168 and Resident #267, the physician's orders directed staff to give Synthroid at 7:00 AM. Per the Lippincott's Nursing Drug Book 2011, page 1167 states 'Synthroid is to be given on an empty stomach and/or 1 to 1/2 hour before breakfast.' Per interview at 10:15 AM nursing staff confirmed "I gave all the meds together" and was not aware of why the med was to be given at a different time. Per interview on 01/12/11 at 2:00 PM, the DNS confirmed that the medications were not given as ordered and according to accepted standards of practice.	F 281	Nurse managers will randomly monitor administration of Synthroid through an audit prior to breakfast. Audit will be provided to DNS weekly; DNS will report to Quality-Safety Committee monthly; after 6 months of 100% compliance will monitor quarterly for 2 quarters. (See Exhibit E.) F281 POC Accepted 2/10/11. S. EMMONS RN / P.M. COLEMAN	2/12/11
F 309 SS=D	Reference: Lippincott's Nursing Drug Book 2011, page 1167 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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.	F 309	<u>F309 -</u> 1. Resident #44 receives dialysis three times per week. Care plan updated to include monitor of fatigue post dialysis with nursing intervention and goal. Care plan updated for risk of alteration in vital signs and level of consciousness relative to dialysis procedure with nursing intervention to monitor blood pressure pre/post dialysis days. Care plan also updated to monitor for other physical conditions post dialysis procedure. Care plan updated to send dialysis communication binder with resident to outpatient dialysis on dialysis days. Care plan updated to indicate the specific type of dialysis catheter in use and to monitor the site.	1/12/11

Grace Bodman 2/4/11

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F 309	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being for 3 applicable residents regarding a medical treatment and medication administration (Resident #44, #168, #267). Findings include: 1. Per record review on the afternoon of 01/11/11, there is no evidence in the medical record for monitoring of Resident #44 pre and post dialysis treatment, including vital signs and physical condition. During review of the facility's policies, there was no information pertaining to specific dialysis related care needs, communication with the dialysis center, dialysis center protocols and resident refusal of services. In an interview with the Unit Manager on 01/12/11 at 8:45 AM, s/he stated that the facility does not monitor vital signs for the dialysis resident pre and/or post dialysis on dialysis days, and that vital signs are monitored weekly for all residents. S/he further stated that there was no additional monitoring or assessment performed related to dialysis. She also confirmed that there was no routine communication between the Dialysis center and the facility regarding the dialysis treatments including labs, weights, resident tolerance of treatment and vital signs while at the center. The Facility Administrator and the Director of Nursing on 01/12/2011 at 10:25 AM confirmed the facility was not evaluating the resident's outcomes pre or post dialysis. 2. Per observation and interview, nursing staff failed to administer medication in a timely manner and according to accepted standard of practice.	F 309	Nutrition care plan already in place includes monitoring of weights, supplements and refusals of supplements, fluid restrictions, intake and output, and other specific dietary measures related to dialysis. Care plan updated to include foods to avoid. All other identified dialysis residents will have care plans reviewed to ensure care plan is updated to reflect monitoring pre/post dialysis, communication binder, monitoring effects of medications, shunt site protocols and dietary measures. Electronic Charting System (ECS) has been updated to include one specific hemodialysis care plan folder. The contents of the folder include: potential problems/strengths; related to factors; manifested by factors; nursing, LNA and dietary interventions, all specifically related to hemodialysis. Care plan folder also includes area in folder to document the specific type of catheter or fistula site and type. Folder also includes area to chart alternates and to encourage alternates. Dialysis residents/patients will have specific dialysis care plan. Also changed in ECS is a documented button "hemodialysis" in the Admit/Discharge/Pass folder to identify newly admitted patients receiving hemodialysis. ECS changes have already occurred. For the identified residents receiving dialysis, the care plan will be merged into a specific dialysis care plan problem identification Weekly audit will be performed by nurse manager and submitted to DNS. DNS will report to Quality Safety Committee monthly; after 6 months at 100% compliance, the audit results will be reported quarterly for 2 quarters. (See Exhibit D.) 2. Coaching was provided to individual nurse regarding standards of professional practice in relation to medication administration, such as medications that require special instructions and	2/12/11 2/12/11 2/12/11 1/12/11	

Grace Godwin

2/4/11

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NAME OF PROVIDER OR SUPPLIER CENTERS FOR LIVING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 160 HOSPITAL DRIVE 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 309	Continued From page 8 Per observation during a medication administration on 01/12/11 at 9:22 AM, nursing staff administered Synthroid 0.075 mg (milligrams) with Resident #267's other morning medications after breakfast. Additionally, per observation at 9:30 AM, Resident #168 also received Synthroid 0.15 mg with their morning medications after breakfast. Per record review during the medication reconciliation at 10:00 AM for both Resident #168 and Resident #267, the physician's orders directed staff to give Synthroid at 7:00 AM. Per the Lippincott's Nursing Drug Book 2011, page 1167 states 'Synthroid is to be given on an empty stomach and/or 1 to 1/2 hour before breakfast.' Per interview at 10:15 AM nursing staff confirmed "I gave all the meds together" and was not aware of why the med was to be given at a different time. Per interview on 01/12/11 at 2:00 PM, the DNS confirmed that the medications were not given as ordered and according to accepted standards of practice.	F 309	use of nursing drug handbook for medications requiring additional information. All residents/patients with current orders for Synthroid will be identified. Education coordinator and nurse managers will provide education to nursing staff on importance of Synthroid to be given on an empty stomach Pharmacy IT will make systemic change to Medication Administration Record (MAR) that will identify with a comment – Synthroid to be given on an empty stomach. Nurse managers will randomly monitor administration of Synthroid through an audit prior to breakfast. Audit will be provided to DNS weekly; DNS will report to Quality-Safety Committee monthly; after 6 months of 100% compliance will monitor quarterly for 2 quarters. (See Exhibit E.) F309 POC Accepted 2/10/11. S. Emmons RN <i>AMCOTURN</i>	2/12/11 2/12/11 2/12/11
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	F 329	F329 – Resident #267 admitted to facility with Alzheimer dementia depressive disorder syncope malaise and fatigue. Resident had recent history of agitated aggressive behavior in the ED that required medication with short acting benzodiazepine. Fax sent to M.D. on 1/3/11 reporting agitated behaviors at night and requesting PRN order. Physician ordered Xanax at bedtime as needed for agitation. On 2/3/11 follow up fax sent to M.D. reporting continued need of Xanax at bedtime also for anxiety. All residents with current orders for psychotropic medications have been identified to ensure supporting documentation for indication of use. Any resident/patient without supporting diagnosis	1/31/11 2/12/11

Juice Bodeme 2/4/11

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

PRINTED: 01/25/2011
FORM APPROVED
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NAME OF PROVIDER OR SUPPLIER CENTERS FOR LIVING AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 160 HOSPITAL DRIVE BENNINGTON, VT 05201
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F 329	<p>Continued From page 9</p> <p>given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure the drug regimen was free from the use of unnecessary psychoactive drugs for 1 of 11 applicable residents. (Resident #267). Findings include:</p> <p>1. Per record review and interview, there was no evidence that staff had identified Resident #267's specific symptoms or causes of anxiety/restlessness, had considered non-pharmacological interventions prior to administration of a psychotropic medication, or had an indication for use of the medication. Per record review on 01/12/11, Resident #267 has diagnoses of Alzheimer's, depressive disorder, syncope, malaise and fatigue. There is no diagnosis of anxiety or sleeplessness. The resident is care planned for alteration in thought process related to dementia. The LNA behavior sheets noted one entry on 12/13/10 for 'uncooperative in P.M. with staff, restless in bed, adapting'. Per nursing notes, there are no assessments for behavior nor do the daily summary nursing notes for the month of</p>	F 329	<p>will be followed up with physician to request indication for use or discontinuation of medication if not needed.</p> <p>Follow up education will be provided to licensed nursing staff regarding importance of documentation of behaviors and non-pharmalogical interventions prior to medication administration.</p> <p>Weekly audit of PRN Psychotropic medications will be performed by nurse managers; nurse managers will provide audit results to DNS. DNS will report results monthly to Quality-Safety Committee; after 6 months of 100% compliance, DNS will report to Committee quarterly for 2 quarters. (See Exhibit F.)</p> <p><i>F329 POC Accepted 2/10/11. S. Emmons RN / PNCoturn</i></p>	<p>2/12/11</p> <p>2/12/11</p>
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Suzanne Bodeme 2/4/11

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

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F 329	Continued From page 10 December 2010 and January 2011 have documentation regarding behavior monitoring. Per the MAR (medication administration record) and daily nursing notes of 01/05/11 at 8:00 PM, 01/07/11 at 7:00 PM and 01/10/11 at 7:00 PM, Xanax (a psychotropic medication), was given for anxiety/sleeplessness. Per interview on 01/12/11 at 2:00 PM, the DNS and Administrator-in-training confirmed the resident was given a psychotropic medication without adequate monitoring, without attempts of non-pharmacological interventions, and without adequate indications for its use.	F 329			

Juice Bodemer 2/4/11

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475029	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 1/12/2011
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NAME OF PROVIDER OR SUPPLIER CENTERS FOR LIVING AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 160 HOSPITAL DRIVE BENNINGTON, VT
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 156

483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible

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

The above isolated deficiencies pose no actual harm to the residents

Grace Bodmer 2/4/11

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475029	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 1/12/2011
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 156 Continued From Page 1
for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to provide for 1 applicable resident, or their representative, information regarding charges for items or services (Resident #52). Findings include:

1. Per interview on 01/10/11 at 2:48 PM, Resident #52's representative stated that s/he was not aware of the Medicaid charges for services or items. Per review of the record, there was no documentation or signed forms that information was provided, at the time when the resident became eligible for Medicaid, of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services. Per interview on 01/11/11 at 4:06 PM, the Business office Manager verified that there is no process for when a resident, who had other insurance coverage, becomes eligible for Medicaid, to notify them of the fees and charges. In addition, the Business Office Manager confirmed that Resident #52 or the representative did not receive information regarding Medicaid charges or fees.

F 247 483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE

A resident has the right to receive notice before the resident's room or roommate in the facility is changed.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to give notice prior to a room change for 1 applicable resident in the sample. (Resident #83) Findings include:

1. Per interview on 01/11/10 at 2:00 PM, a family member which is also the DPOA (Durable Power of Attorney) of Resident #83 stated that " I was just told that they we're moving for safety reason but they didn't notify me prior to the move...my understanding is that it was a done deal". Per review of the Facility's Policy and Procedures -' the resident or family will be notified 72 hours prior to a move'. Per a 07/22/10 at 12:39 PM nursing note, "the resident eloped although the tab alarm was working". A nursing note dated 07/23/10 at 8:08 AM stated "discussed move (with family member) for resident safety". Per interview on 01/11/10 at 4:54 PM the DNS and Unit Manager confirmed the family was notified after the decision to move the resident.

Grace Bodine 2/4/11

CENTERS FOR LIVING AND REHABILITATION

BENNINGTON, VT

QUALITY MONITORING TOOL

TOPIC: SIDERAIL (QUARTER RAIL) AUDIT

OBJECTIVE: For Low Beds in use, all side rails will be in the quarter rail position at all times, while resident is in bed.

UNIT: _____

DATE: ____/____/____

AUDITOR: _____

CRITERIA	YES	NO	# of OPPORTUNITIES OBSERVED
1. Were side rails in the quarter rail position?			
For any NO observations – the IMMEDIATE corrective action taken:			
**Report immediately any side rail NOT in the quarter rail position to the DNS or Administrator.			

CENTERS FOR LIVING AND REHABILITATION

BENNINGTON, VT

QUALITY MONITORING TOOL

TOPIC: IN-BED POSITIONING DEVICE AUDIT

OBJECTIVE:

UNIT: _____

DATE: ____/____/____

AUDITOR: _____

CRITERIA	YES	NO	# OF OPPORTUNITIES
1. Was device assessed by P.T.?			
2. Is there an M.D. order for device?			
3. Was device careplanned?			
4. Was restraint assessment documented?			
5. Visual observation of appropriate use?			
If NO for any of the above – the IMMEDIATE corrective action taken:			

CENTERS FOR LIVING AND REHABILITATION

BENNINGTON, VT

QUALITY MONITORING TOOL

TOPIC: MDS SECTION F COMPLETION AND ACCURACY

OBJECTIVE: To verify Section F interview is completed and accurate.

DATE: ____/____/____

ACTIVITIES PROGRAM DIRECTOR: _____

MDS CARE COORDINATOR: _____

CRITERIA	# OF OPPORTUNITIES	# REQUIRED	# COMPLETED
1. MDS Section F interview completed			
2. MDS Section F verified accurate			
If NO to any of above, the IMMEDIATE corrective action taken:			

CENTERS FOR LIVING AND REHABILITATION

BENNINGTON, VT

QUALITY MONITORING TOOL

TOPIC: ADMINISTRATION OF SYNTHROID

**OBJECTIVE: To ensure Synthroid is administered on an empty stomach.
(Random audit prior to breakfast.)**

UNIT: _____

DATE: ____/____/____

AUDITOR: _____

CRITERIA	YES	NO	# of OPPORTUNITIES OBSERVED
1. Was medication given on an empty stomach prior to breakfast			
For any NO observations – the IMMEDIATE corrective action taken:			

CENTERS FOR LIVING AND REHABILITATION

BENNINGTON, VT

QUALITY MONITORING TOOL

TOPIC: PSYCHOTROPIC MEDICATION AUDIT

OBJECTIVE: To monitor as needed psychotropic medications for appropriate diagnosis, charting and non-pharmalogical interventions prior to administration.

UNIT: _____

DATE: ____/____/____

OF RESIDENTS NEEDING PRN PSYCHOTROPIC MEDICATION THIS WEEK: _____

AUDITOR: _____

CRITERIA	YES	NO	# OF OPPORTUNITIES
1. Does resident(s) requiring use of PRN psychotropic medications have a documented indication for use of the medication?			
2. Was non-pharmalogical intervention(s) documented as attempted prior to administration of medication?			
3. Was behavior documented appropriately in ECS?			

For any NO observation – the IMMEDIATE corrective action taken: