

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

PRINTED: 03/05/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/23/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MENIG EXTENDED CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>44 SOUTH MAIN STREET RANDOLPH, VT 05060</b>
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F 000	INITIAL COMMENTS	F 000		
F 279 SS=D	<p>An unannounced on-site annual recertification survey was conducted by the Division of Licensing and Protection on 2/22/10 - 2/23/10. 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 observation, interview and record review, the facility failed to develop a comprehensive care plan based on the results of the resident assessment for 1 applicable resident in the sample (Resident #35). Findings include:</p> <p>Per record review, the comprehensive care plan for Resident #35 does not address the use of an</p>	F 279	<p><b>F-279 Develop Comprehensive Care Plans</b></p> <p><b>Corrective Action Resident #35: Care Plan reviewed and revised and now includes measurable objectives, timetables or nursing interventions related to the use of a catheter.</b></p> <p><b>How will you identify other residents having the potential to be affected: Three (3) care plans/month will be audited for accuracy and completion by MDS coordinator and designee of administrative staff.</b></p> <p><b>Measures to ensure that it does not recur: Three (3) care plans a month ongoing will be audited for completion/accuracy.</b></p> <p><b>Monitoring of correction action plan: Three (3) care plans a month ongoing will be audited and documented on flow-sheet as completed.</b></p> <p><b>Dates corrective action will be completed: 3/12/10: Resident #35 care plan has been reviewed and updated. Three care plans a month will be audited ongoing.</b></p> <p><i>P.O.C. Accepted 3/23/10 Randa... RN</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Linda Mersinger</i>	TITLE  <i>Administrator</i>	(X6) DATE
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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 279	Continued From page 1 indwelling urinary catheter. Per observations during the 2 days of survey, Resident #35 is currently using an indwelling catheter. Per review of the Admission MDS (Minimum Data Set), completed 1/21/10, Resident #35 was coded appropriately for the indwelling catheter, and it triggered on the RAP (Resident Assessment Protocol) that a care plan should be developed to address the use of the catheter. Per review of the RAP summary, the nurse indicated that they would proceed with care planning for the use of the catheter. Per review of the care plan, it identifies that the resident uses a catheter, but does not contain measurable objectives, timetables or nursing interventions related to the use of a catheter. The above was confirmed by the DON (Director of Nurses) on 2/23/10 at 2:15 PM.	F 279	<b>Refer to Page 3</b>	
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, 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.	F 280		

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F 280	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to revise the plan of care to reflect the current needs of the resident for 2 applicable residents in the sample (Resident #35 &amp; #2). Findings include:</p> <p>1. Per record review, the care plan regarding alteration in skin integrity was not revised to reflect the current stage and treatment of a pressure ulcer for Resident #35. On 2/18/10, a surgical physician progress note states that Resident #35's pressure ulcer is a stage 4, with an area of exposed bone. Per review of the care plan, it identified multiple pressure areas ranging from stage 1-3. Per observation of a dressing change on 2/22/10, there is now only one wound, due to surgical debridement of the area, which was identified as stated above as a stage 4 on 2/18/10. Additionally, the care plan stated that a wound vac is in place, when it was discontinued in January 2010. Per observation and interview, staff are currently performing the correct dressing change as ordered by the physician. During an interview on 2/23/10 at 2:15 PM, the DON confirmed that the care plan did not reflect the current status of the wound or the current treatment the resident is receiving.</p> <p>2. Per record review, the care plan for Resident #2 was not updated to reflect the use of an assistive device [gait belt] when ambulating. Per interview staff stated that Resident #2, who has a history of falls, now needs to have a gait belt</p>	F 280	<p><b>F-280 Right to Participate in Planning Care – Revise</b></p> <p><b>Corrective Action Resident #35:</b> Care Plan reviewed and revised and now includes the current stage and current treatment of the wound.</p> <p><b>Corrective Action Resident #2:</b> Care Plan reviewed and revised and now reflects the use of an assistive device (gait belt) when ambulating.</p> <p><b>How will you identify other residents having the potential to be affected:</b> Three (3) care plans/month will be audited for accuracy and completion by MDS coordinator and designee of administrative staff.</p> <p><b>Measures to ensure that it does not recur:</b> Three (3) care plans a month ongoing will be audited for completion/accuracy.</p> <p><b>Monitoring of correction action plan:</b> Three (3) care plans a month ongoing will be audited and documented on flow-sheet as completed.</p> <p><b>Dates corrective action will be completed:</b> <u>3/12/10:</u> Resident #35 and Resident #2 care plans have been reviewed and updated. Three care plans a month will be audited ongoing.</p> <p><i>P.C.C. Accepted 3/23/10 Pamela Mettaran</i></p>	
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F 280	Continued From page 3 when ambulating. Per interview on 2/23/10 at 2:24 PM, the DON confirmed that the care plan was not revised to reflect the use of an assistive device when ambulating.	F 280	<b>F-281 Services Provided Meet Professional Standards</b>	
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 staff interview and record review, the facility failed to assure that care and services were provided in accordance with physician orders for 1 applicable resident (Resident #2). Findings include:  1. Per record review and confirmed by staff interview, Resident #2 failed to receive services per physician's order. Per record review on 2/23/10, a physician's order, dated 12/02/09, directed Physical Therapy to evaluate Resident's #2's unsteadiness and possible use of an assistive device. The Resident's medical record, as well as the electronic record in the physical therapy department, lacked evidence that the evaluation was completed. Per interview on 02/23/10 at 12:45 PM, the Physical Therapist confirmed that the evaluation was not completed as ordered.	F 281	<b>Corrective Action:</b> A system has been implemented for notification of rehab for new admissions and new orders via fax with order, resident name and diagnosis and assessment will be completed within one week.  <b>How will you identify other residents having the potential to be affected:</b> Any resident with a significant change in status will be assessed by rehabilitation and prioritized for severity.  <b>Measures to ensure that it does not recur:</b> Charts will be monitored to ensure visit completed.  <b>Monitoring of correction action plan:</b> DNS or designee will monitor compliance  <b>Dates corrective action will be completed:</b> 3/12/10  <i>P.O.C accepted 3/23/10 Pamela M. ...</i>	
F 362 SS=B	483.35(b) SUFFICIENT DIETARY SUPPORT PERSONNEL  The facility must employ sufficient support personnel competent to carry out the functions of the dietary service.	F 362		

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F 362	Continued From page 4  This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to have sufficient support personnel to carry out dietary assistance for 3 residents (Residents #11, #20 & #14). Findings include: Per observation on 02/22/10 at the noon meal, the following was observed: 1. There were 2 staff members in the dining room for a period of 20 minutes to serve/assist/feed approximately 22 residents via a steam table serving style. The Activity Director was designated as the person who dishes the food on the plates, but was also serving residents at their table, as well as 1 other LNA. 2. Resident #11 was served a covered beverage; however, the lid was not removed nor was the Resident assisted to drink, and waited 15 minutes (11:50 AM -12:05 PM) while the tablemate was drinking. 3. Resident #20 was using a fork to try to pry open a chocolate milk carton placed at the table. He/she was unsuccessful and waited 20 minutes [11:50 AM - 12:10 PM] for assistance while tablemates were already drinking. 4. Resident #14 waited 20 minutes [12:15 PM to 12:35 PM] to be fed while tablemates ate. Resident #14 was eventually fed by the activity director, who was serving and plating food during the time frame when the Resident was waiting. Per interview on 02/23/10 at 3:05 PM, the Activity Director confirmed that not enough staff were present to help with the noon meal on 2/22/10.  F 406 SS=D 483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES  If specialized rehabilitative services such as, but	F 362	<p><b>F-362 – Sufficient Dietary Support Personnel</b>  <b>Corrective Action:</b> Reviewed and revising morning routine; implementing a “buddy system” to improve efficiency.</p> <p>Staggered shifts of LNA’s scheduled to increase staffing participation with mealtime.</p> <p><b>How will you identify other residents having the potential to be affected:</b> Server will notify charge nurse/DON if inadequate staff in dining room.</p> <p><b>Measures to ensure that it does not recur:</b> Rounding at mealtime by administrative staff</p> <p><b>Monitoring of correction action plan:</b> Charge Nurse/Director of Nursing or designee will monitor mealtime to ensure sufficient staff for dietary assistance.</p> <p><b>Dates corrective action completed: 3/12/10</b></p> <p><i>P.L.C. Accepted 3/23/10 Dorinda Motta RN</i></p>	

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F 406	<p>Continued From page 5</p> <p>not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to provide rehabilitative services to 1 applicable resident (Resident #2), whose assessments documented declines in functional mobility and activities of daily living (ADLs). Findings include:</p> <p>Per record review Resident #2's quarterly MDS assessment dated 12/08/09 had noted changes in the ADL section 'G' which was coded as needing extensive assist with transferring, walking in room/corridor or on the unit. The resident was also coded as unsteady, needing partial physical support for balance while standing. The previous quarterly MDS dated 9/15/09 was coded as needing supervision for walking in the room/corridor and on/off the unit. The balance test showed the resident was unsteady but able to re-balance without support. The resident also has a documented history of falls including a fall within the past 30 days of the quarterly assessment dated 9/15/09, and a fall within the past 31-180 days of the assessment dated 12/08/09.</p> <p>A review of the medical record for this resident</p>	F 406	<p><b>F-406 – Provide/Obtain Specialized Rehab Services</b></p> <p><b>Corrective Action Resident #2: A system has been implemented for notification of rehab for new admissions and new orders via fax with order, resident name and diagnosis and assessment will be completed within one week.</b></p> <p><b>How will you identify other residents having the potential to be affected:</b> Any resident identified with a significant change in status will be assessed by rehabilitation</p> <p><b>Measures to ensure that it does not recur:</b> Charts will be monitored to ensure visit completed. Director of Nursing or designee will notify rehab when no consult obtained.</p> <p><b>Monitoring of correction action plan:</b> <b>DNS or designee will monitor compliance</b></p> <p><b>Dates corrective action completed:</b> <b>3/12/10</b> <i>P.C.C. Accepted 3/23/10</i> <i>Pamela M. RIN</i></p>	

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F 406	Continued From page 6 did not reveal any documentation of therapy evaluations, treatments, or screenings, which were ordered by the physician on 12/02/09, due to the recent increase in unsteadiness. During an interview on 02/23/10 at 12:45 PM, the Physical Therapist confirmed that the resident had not been screened, evaluated, or treated by any of the rehabilitation services after the physicians's order was received.	F 406		
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