

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

July 18, 2013

Mr. Marc Hunter, Administrator  
Rowan Court Health & Rehab  
378 Prospect Street  
Barre, VT 05641-5421

Dear Mr. Hunter:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 5, 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

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Division of  
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PRINTED: 06/20/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475037</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	Licensing and Protection	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/05/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ROWAN COURT HEALTH &amp; REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>378 PROSPECT STREET BARRE, VT 05641</b>
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F 000	INITIAL COMMENTS	F 000	Rowan Court provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. This plan of correction is prepared and executed solely because it is required by federal and state law.	
F 159 SS=B	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p>	F 159	<p>F159</p> <p>Currently, residents have ready access to their personal funds on weekends and Holidays.</p> <p>Residents who request that the center manage their funds have the potential to be affected. Notification of availability of funds has been posted. The resident council president has been notified. The new process will be communicated to residents and family member during council meetings.</p> <p>The facility has revised its system for providing resident access to their personal funds on weekends and Holidays. \$60.00 will be kept in a locked box in the Unit one medication cart for distribution by the licensed nurse holding the keys for that cart. For each transaction a receipt will be filled out and signed</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Maria A. Hunter</i>	TITLE <i>EXECUTIVE DIRECTOR</i>	(X6) DATE <i>7-2-2013</i>
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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.

*MHC*

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F 159	Continued From page 1  The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.  The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.  This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, the facility does not have a current system to ensure that residents have ready access to their personal funds held by the facility on weekends and some Holidays. This has the potential to affect all residents who request that the facility manage their personal funds accounts.  Per resident interviews during Stage 1 of the survey on 6/3/13 and 6/4/13, 2 residents reported a lack of access to personal funds on weekends. Per interview on 6/5/13 at 11:05 AM, staff from the Business Office confirmed that there is no current system to assure residents have ready access to their funds on weekends and some Holidays.	F 159	by both the licensed nurse and the resident. Personal funds accounts will be balanced by the business office at least weekly. Facility staff will be provided with education on the process, roles, and responsibilities for the new system.  Personal funds accounts will be balanced by the business office at least weekly. Residents, families, and staff members will be interviewed minimally weekly for 4 weeks and then monthly for 3 months with remedial measures initiated as indicated. Trending results of audits will be reported to the facility QA meeting with revisions made to the plan as needed. The Administrator/designee will be responsible to monitor compliance with this individual plan of correction.  July 8, 2013 <i>F159 POC accepted 7/15/13 M Higgins RN/PMC</i>		
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS  The resident has the right to be free from any	F 221	Resident #84 was evaluated by P.T. The use of the seatbelt was re-assessed.  Any resident with a seat belt,		

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F 221	<p>Continued From page 2</p> <p>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, interview and record review, the facility failed to assure 1 of 2 residents in the Stage 2 sample were free from physical restraints imposed for the purpose of discipline or convenience (Resident #84). Findings include:</p> <p>Per observation, interview and record review, Resident #84 uses a alarmed seat belt device for safety reasons due to a history of falls and lack of safety awareness while in his/her wheelchair. Per observations on 6/3/13, 6/4/13, and 6/5/13, the resident was able to release the device independently at times. However, when the resident was asked by the surveyor to release his/her seatbelt on 6/4/13 at 2 PM and 6/5/13 at 8:44 AM, the resident did not appear to comprehend the request despite many attempts at re-phrasing by the surveyor, and was not able to release the device on command. Despite the resident being able to remove his/her seatbelt at times, staff are not allowing him to rise from the chair when s/he does successfully release it.</p> <p>Per observations on 6/3/13 at 12:22 PM and 12:40 PM, 6/4/13 at 2:40 PM and 3:57 PM, and 6/5/13 at 9:48 AM, 1:30 PM, 3:06 PM, 3:16 PM and 3:52 PM, when the resident successfully removes the seatbelt and the alarm sounds, staff immediately respond to the alarm and fasten the seatbelt back up, without assisting him to rise or allowing him to rise from the chair at that time.</p>	F 221	<p>unable to be released on command, has the potential to be affected by this alleged deficient practice.</p> <p>An audit of all seat belts utilized was completed. Any resident rising from a chair, needing assistance has the potential to be affected by this alleged practice.</p> <p>Nursing staff have been inserviced on actions/interventions to take when a resident rises from their chair.</p> <p>Daily rounds will be conducted, at random times, on the units. Results of the rounds will be reported to the facility QA meeting.</p> <p>DNS/designee is responsible to monitor compliance.</p> <p>July 8, 2013</p> <p><i>F221 POC accepted 7/15/13 MHiggins RN/PMC</i></p>		

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F 221	<p>Continued From page 3</p> <p>During the intermittent observations on those 3 days, only the primary LNA in the Memory Lane room was observed offering diversional activities and also offering to bring the resident to the bathroom (after re-fastening the seatbelt). During the observation on 6/5/13 at 9:48 AM, staff stated to the resident "we got to leave that buckled pal...you don't want to fall on your nose do you?" During the observation on 6/5/13 at 1:30 PM, staff told the resident "no" each time he unbuckled the seatbelt, stated "Hey, you got to leave this buckled up", and staff pulled his shirt over the seatbelt so he would stop releasing it. During the observation on 6/5/13 at 3:06 PM, staff stated to the resident "You got to put that back on". Finally, during the observation on 6/5/13 at 3:52 PM, staff stated "You are upsetting people, leave it on."</p> <p>During many of the above observations, the resident appeared agitated, gripping and pulling at the seatbelt with shaking hands, repeatedly trying unsuccessfully to rise with the seatbelt on, then trying to pull on the metal parts of the wheelchair.</p> <p>Per review of the plan of care regarding Risk for Falls for Resident #84, it states "[Resident] has an alarmed seatbelt he is able to remove independently. Nursing to continue to monitor safe removal." There are no further care plans or interventions around the use of the seatbelt device.</p> <p>Per review of staff progress notes, a nursing note on 1/31/13 states "constant removal of seatbelt. PRN [anti-psychotic medication] given for [increased] agitation." A nurses note on 4/4/13</p>	F 221		

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F 221	<p>Continued From page 4</p> <p>states "Resident experiencing increased agitation &amp; anxiety... unbuckling belt, becoming upset with staff for having to buckle him back up." A nurses note dated 5/6/13 states, "Resident continued to undo seatbelt every minute or two for the remainder of this shift, safety maintained, however, did not stand or fall so far this shift."</p> <p>Per record review, the resident has had a functional decline effecting his ability to ambulate, however, per interview with a Physical Therapy Aide on 6/5/13 at 2:45 PM, the resident ambulated about 80 ft that day with staff assistance.</p> <p>Per interview on 6/5/13 at 10:20 AM, a staff nurse stated that most of Resident #84's agitation (for which he is sometimes administered PRN psychoactive medication) stems from his seatbelt and trying to stand up.</p>	F 221		
F 241 SS=E	<p>See also F241.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure care is provided to residents in a manner and in an environment that enhances each resident's dignity and respect for 1 of 25 residents in the</p>	F 241	<p>F241 Resident #84 has been reevaluated by P.T.</p> <p>Any resident with a seat belt, unable to be released on command, has the potential to be affected by this alleged deficient practice. An audit of all seat belts utilized was completed. Any resident rising from a chair, needing assistance, has the potential to be affected by this alleged practice.</p> <p>Nursing staff has been inserviced on actions/interventions to take when a resident rises from their</p>	

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F 241	<p>Continued From page 5 Stage 2 sample (Resident #84). Findings include:</p> <p>Per observation, interview and record review, Resident #84 uses a alarmed seat belt device for safety reasons due to a history of falls and lack of safety awareness while in his/her wheelchair. Per observations on 6/3/13 at 12:22 PM and 12:40 PM, 6/4/13 at 2:40 PM and 3:57 PM, and 6/5/13 at 9:48 AM, 1:30 PM, 3:06 PM, 3:16 PM and 3:52 PM, when the resident successfully removes the seatbelt and the alarm sounds, staff immediately respond to the alarm and fasten the seatbelt back up, without assisting him to rise or allowing him to rise from the chair at that time.</p> <p>During the observation on 6/5/13 at 9:48 AM, staff stated to the resident "we got to leave that buckled pal...you don't want to fall on your nose do you?" During the observation on 6/5/13 at 1:30 PM, staff told the resident "no" each time he unbuckled the seatbelt and "Hey, you got to leave this buckled up", and staff pulled his shirt over the seatbelt so he would stop releasing it. During the observation on 6/5/13 at 3:06 PM, staff stated to the resident "You got to put that back on". Finally, during the observation on 6/5/13 at 3:52 PM, staff stated "You are upsetting people, leave it on."</p> <p>During many of the above observations, the resident appeared agitated, gripping and pulling at the seatbelt with shaking hands, trying unsuccessfully to rise with the seatbelt on, then trying to pull on the metal parts of the wheelchair.</p>	F 241	<p>chair.</p> <p>Daily rounds will be conducted, at random times, on the units. Results of the rounds will be reported to the facility QA meeting.</p> <p>DNS/designee is responsible to monitor compliance.</p> <p>July 8, 2013</p> <p><i>F241 POC accepted 7/15/13 MHiggins RN / BMC</i></p>	
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES	F 242		

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F 242	<p>Continued From page 6</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure each resident is given the right to make choices about aspects of his or her life in the facility that are significant for 1 of 25 residents in the sample (Resident #63), and failed to ensure each resident is given the right to make choices about activities and given the right to interact with others inside the facility for those residents who are brought to the Memory Lane room on the basement level of the facility, which includes Resident #103, among others. Findings include:</p> <p>1. Per direct observation during the noon meal on 06/03/12 during the Noon meal in the small dining area on Unit 2, Resident #63 did not receive food items as listed on the meal slip. The resident had sliced carrots, ground chicken and mashed potatoes/gravy, and was offered a beverage at the beginning of the meal. The meal slip states ground chicken, potato pureed, green peas, assorted dessert, 1 cup milk nectar thick, 1 cup beverage of choice nectar thick. The resident at that time stated "I had carrots three days in a row and we never get what it says, I get milk only once in a great while and I love it".</p>	F 242	<p>F242 Resident #63 is receiving food items as listed on the meal tickets</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>Random audits of the food items, on the meal ticket, compared to what is served are conducted weekly by the Food Service Manager/designee.</p> <p>The Food Service Manager is conducting meetings with the residents to identify food likes/dislikes.</p> <p>Nursing staff has been reeducated on the need to check the meal ticket and compare what is served. Any discrepancies are to be corrected prior to serving the resident.</p> <p>Results of audits will be reported to the facility QA committee.</p> <p>DNS/designee will be responsible for compliance</p> <p>No residents were adversely affected by this alleged deficient</p>	
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F 242	<p>Continued From page 7</p> <p>Per the nutrition assessment on 4/24/13 list the goals as Consume 75% of meals, show no further significant weight changes, maintain hydration and skin integrity, show no signs and symptoms of aspiration and/or hypo/hyperglycemia. A Dehydration risk screen on 5/20/13 notes history of dehydration and refusing liquids.</p> <p>The Care Plan dated 05/09/13 directs staff to provide Diet per physician order and individual food preferences. Per interview at 12:35 P.M. the LNA stated the resident "is a level two and can't have peas, has to do with choking". However the LNA wanted to check with nursing and came back to the room with peas and butter and also some milk [nectar thick] and stated that staff have to watch to make sure the resident doesn't cough or choke. The resident was observed eating all the peas and drinking all the milk without any choking or coughing episodes.</p> <p>Per interview on 06/04/13 at 1:15P.M. the Dietician stated that level 2 food has to be soft and well-cooked. And usually the skin on the peas could present a problem but staff would have to make sure the peas were soft. S/he did state "it does appear [resident] gets carrots and/or green beans as a substitute often". The Dietician confirmed that the resident did not receive his/her meal choices.</p> <p>2. Per observations from 6/3/13 to 6/5/13, the</p>	F 242	<p>practice.</p> <p>Resident #103 and any other cognitively impaired resident is now able to leave Memory Lane after a call to the unit for a staff member to accompany them. The devise has been removed from the door.</p> <p>Any cognitively impaired resident has the potential to be affected by this alleged deficient practice.</p> <p>Nursing and Memory Lane staff have been educated on the actions to take should a Memory Lane participant wish to leave the Memory Lane program.</p> <p>A review of the actions in place will be conducted at concurrent review. Results of the review will be reported to the facility QA committee.</p> <p>DNS/designee will be responsible to monitor compliance.</p> <p>July 8, 2013</p> <p><i>F242 POC accepted 7/15/13 mthigginsRN/PMC</i></p>	

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F 242	<p>Continued From page 8</p> <p>Memory Lane activity room is on the basement floor of the facility, separate from other residents of the facility, facility common areas, and all of the residents' rooms, which are on the upper floor of the facility. The programming is geared towards activities and supervision for cognitively impaired residents, and per staff interview on 6/3/13, there are always 2 staff members in the Memory Lane room when residents are present, at least one of which is an LNA. Per observations, some of the residents are able to ambulate independently. Per observations on 6/3/13, 6/4/13 and 6/5/13, the door to the basement hallway was always kept closed and there was a plastic device, similar to child lock, on the inside door handle to prevent residents from readily exiting the room. The device makes the user squeeze the plastic device while turning the door handle to exit the room. The door handle was difficult for the surveyor to open, and took 3 attempts before getting the door handle to turn successfully.</p> <p>Per staff interview on 6/4/13, a staff member in the Memory Lane room stated that the device was placed on the inside of the door when they found out that the residents could and would open the door to exit the area. Staff requested something from the facility to "prevent them from opening the door." Per observation on 6/4/13, Resident #103 was trying to leave the area, ambulating independently with his/her walker, and staff would not allow the resident to leave the room at that time.</p> <p>At 2:30 PM on 6/5/13, the facility Administrator observed the device with the surveyor, and agreed that the type of device that was being used on the inside door handle may violate the</p>	F 242		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475037</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/05/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>ROWAN COURT HEALTH &amp; REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>378 PROSPECT STREET</b> <b>BARRE, VT 05641</b>		
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F 242	Continued From page 9 residents' right to make choices about leaving the Memdry Lane room to return to the upstairs area and the residents' right to interact with others in the facility.	F 242			
F 272 SS=D	483.20(b)(1) 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 resident assessment instrument (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 on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	F272 Resident #68 had a dental consult on June 13, 2013. Careplan was updated to include any dental recommendations.  All residents have the potential to be affected by this alleged deficient practice.  Audits of dental need for residents have been completed. Any resident not seen by dentist in the last year will have a dentist visit scheduled with the resident/responsible parties consent.  Nurses have been inserviced to complete full evaluations quarterly, which includes the oral assessment.  Random audits of full evaluations will be completed weekly times 3 months.  Results of the audits will be reported to the facility QA meeting.  DNS/designee will be responsible for compliance.  July 8, 2013		

F272 POC accepted 7/15/13  
M Higgins RN | AMC

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F 272	Continued From page 10  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to conduct periodically a comprehensive, accurate, assessment of each resident's needs for 1 of 25 residents in the Stage 2 sample. Findings include:  Per record review, an annual MDS for Resident #68 (R#68) states that the resident has no obvious or likely cavity and no inflamed or bleeding gums. According to the record R#68 has had dental consults on 8/18/2011 and 11/15/2011. The consult on 11/15/2011 states "Her nurse will monitor the cheek irritation." There are no mentions of dental condition or oral health in the record in the last six months other than one note on 3/11/2013 stating "Res [complained of] discomfort during breakfast, pointed at mouth, unable to locate source of discomfort. Res resistive to oral care. Apap 650 mg po adm for discomfort with positive effect.". This note was written by an LPN. The second note, written 1/27/2013 states "No changes in vision, hearing, or dental" and was written by the Social Work Director. There are no further Dental consults in the record.  In interview, a family member stated that the family has brought an electric toothbrush because they noted that R#68's gums were getting red. In	F 272			

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F 272	Continued From page 11 an interview on 6/4/13 the Unit Manager (UM) confirmed that s/he was not aware that the resident had reddened gums and that the family had brought an electric toothbrush. S/he stated that nurses do not do oral/dental assessments on a routine basis. They are not done Quarterly or annually and are done only as necessary. S/he stated that oral care is done twice daily as part of AM and HS care and that the nurse is generally notified if issues arise. S/he also stated that s/he is unaware of where the MDS nurse gets the information for section L of the MDS.  In an interview on 6/5/13 at 10 AM, the MDS Clinical Reimbursement Coordinator confirmed that the MDS stated that the resident had no obvious or likely cavity and no inflamed or bleeding gums. S/he stated that information regarding dental status is obtained by reviewing the resident's record, looking at Dental consults, care plans and notes and looking at the resident's teeth. S/he also states that the MDS RN signature on Section Z Assessment Administration- attests only to the completion of the MDS and not the accuracy. Further s/he states that the LPN completing section L of the MDS (Oral/Dental Status) is only gathering information and not assessing the oral/dental status, which does not require an RN signature to attest to accuracy.  See also F278.	F 272			
F 278 SS=F	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.	F 278	F278 Resident #51 and #68 were not adversely affected by this alleged deficient practice and their most recent MDS reflects each resident's current status. All MDS' with the diagnosis of psychosis have been modified to remove the diagnosis for resident #51.		

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F 278	<p>Continued From page 12</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the 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 facility failed to assure the assessment accurately reflects each resident's status and failed to assure a registered nurse conducted or coordinated each assessment with the appropriate participation of qualified health professionals for 2 of 25 residents (Resident #51, #68), however the general practice has the potential to affect all residents of the facility. Findings include:</p>	F 278	<p>Resident #68 had a dental consult.</p> <p>All residents have the potential to be affected by this alleged deficient practice.</p> <p>IDT members will be provided with education on completing assessments.</p> <p>Information obtained from the medical record will be gathered by the LPN and he/she will enter the data into the MDS. An RN will conduct and/ or coordinate the assessment and will sign attesting to the completion of the MDS.</p> <p>Random audits of MDS' will be done weekly x 4 wks and then monthly x 3 months.</p> <p>Results of the audits will be reported to the facility QA Meeting. DNS/Designee will be responsible for compliance</p> <p>July 8, 2013</p> <p><i>F278 POC accepted 7/15/13 MHiggins RN / pme</i></p>		

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F 278	<p>Continued From page 13</p> <p>1. Per interview on 6/4/13 at 3:14 PM with the RN (Registered Nurse) who signs MDS's (Minimum Data Sets) currently at this facility, s/he stated that s/he does not check any MDS's for accuracy. S/he stated that the staff who complete each section are responsible for the accuracy of the assessments in their section and provided a document from the RAI manual that indicated the RN only signs that the MDS is "complete".</p> <p>However, the 2 MDS Coordinators in the facility are both LPN's (Licensed Practical Nurses). In the State of Vermont, it is not within the scope of practice of an LPN to complete an assessment, therefore, the RN failed to assure each section is completed by qualified professionals, and again, stated that s/he does not review the LPN's documentation/MDS coding for accuracy. *See references. While LPN's can collect data, the MDS is intended to be a real-time assessment, involving actual assessments of the resident and not just record review and staff interview (gathering of data). MDS information serves as the clinical basis for care planning and delivery. The results of the MDS assessment are used to formulate and make revisions to resident plans of care.</p> <p>2. Per record review on 06/04/13 of Resident #51's MDS, the resident is coded of having a diagnosis of "psychosis". Per review of the History and Physical, physician notes, the facility behavior sheet and other assessments, they show no evidence to support the diagnosis of psychosis. Resident #51's diagnosis list</p>	F 278		

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F 278	<p>Continued From page 14</p> <p>'unspecified psychosis' as one of the medical problems including dementia, on the face sheet. Physician orders dated 11/12/12 notes the use of an anti-psychotic medication for the diagnosis of agitation. Per review of the initial MDS, dated 11/20/12, lists no episodes of delusions or hallucinations and no behaviors except wandering. The Initial Care Plan, dated 11/28/13 notes Ineffective Individual Coping Mechanisms: related to dementia as seen by possible agitation which [resident] has shown previously prior to this admit. There is no initial care plan for psychosis.</p> <p>Per record review and interview on 06/04/13 at 3:59 P.M., the MDS coordinator was unable to locate evidence regarding the diagnosis of psychosis. When the nurse surveyor asked if the assessments are obtained by staff that have the requisite knowledge to complete an accurate assessment relevant to care, the MDS coordinator stated that "the RN only signs to say it is complete but not accurate, the RAI manual says the RN doesn't have to make sure it is accurate but that only the MDS assessment is completed". The MDS coordinator [a LPN-licensed practical nurse] acknowledged that s/he is not qualified to make an assessment of psychosis and confirmed the diagnosis was inaccurate. S/he also confirmed that the RN did not assess or coordinate the assessment but only signed that it was completed.</p> <p>3. Per record review, an annual MDS for Resident #68 (R#68) states that the resident has no obvious or likely cavity and no inflamed or bleeding gums. According to the record R#68 has had dental consults on 8/18/2011 and 11/15/2011. The consult on 11/15/2011 states</p>	F 278		

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F 278	<p>Continued From page 15</p> <p>"Her nurse will monitor the cheek irritation." There are no mentions of dental condition or oral health in the record in the last six months other than one note on 3/11/2013 stating "Res [complained of] discomfort during breakfast, pointed at mouth, unable to locate source of discomfort. Res resistive to oral care. [Acetaminophen 650 milligrams by mouth administered] for discomfort with positive effect." This note was written by an LPN. The second note, written 1/27/2013 states "No changes in vision, hearing or dental" and was written by the Social Work Director. There are no further Dental consults in the record.</p> <p>In interview, a family member stated that the family has brought an electric toothbrush because they noted that R#68's gums were getting red. In an interview on 6/4/13 the Unit Manager (UM) confirmed that s/he was not aware that the resident had reddened gums and that the family had brought an electric toothbrush. S/he stated that nurses do not do oral/dental assessments on a routine basis. They are not done Quarterly or annually and are done only as necessary. S/he stated that oral care is done twice daily as part of AM and HS (bedtime) care and that the nurse is generally notified if issues arise. S/he also stated that s/he is unaware of where the MDS nurse gets the information for section L of the MDS.</p> <p>In an interview on 6/5/13 at 10 AM, the MDS Clinical Reimbursement Coordinator confirmed that the MDS stated that the resident had no obvious or likely cavity and no inflamed or bleeding gums. S/he stated that information regarding dental status is obtained by reviewing the resident's record, looking at Dental consults, care plans and notes and looking at the resident's</p>	F 278		

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F 278	Continued From page 16 teeth. S/he also states that the MDS RN signature on Section Z Assessment Administration- attests only to the completion of the MDS and not the accuracy. Further s/he states that the LPN completing section L of the MDS (Oral/Dental Status) is only gathering information and not assessing the oral/dental status.  *References: 1. Vermont Statutes - Title 26, Chapter 28, Section 1572. 2. Vermont State Board of Nursing - The Role of the Licensed Practical Nurse in Patient Assessment and Triage - Position Statement 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).	F 278	F279 Resident #68 had a dental consult on June 13, 2013. Care plan has been updated to include dental.  All residents have the potential to be affected by this alleged deficient practice.  Audits of dental need for residents have been completed. Any resident not seen by dentist in the last year will have a dentist visit scheduled with the resident/responsible parties consent. Care plans will be updated as indicated.  Nurses have been inserviced to complete full evaluations quarterly, which includes the oral assessment. Care plans will be updated as determined necessary.	
F 279 SS=D		F 279		

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F 279	Continued From page 17  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure development of a comprehensive plan of care for one resident in a sample of 25 Stage 2 residents. Findings include:  Per record review, an annual MDS for Resident #68 (R#68) states that the resident has no obvious or likely cavity and no inflamed or bleeding gums. According to the record R#68 has had dental consults on 8/18/2011 and 11/15/2011. The consult on 11/15/2011 states "Her nurse will monitor the cheek irritation." The 11/15/2011 consult also calls for brushing teeth twice a day as the resident allows and rinsing the mouth with salt water for irritation of the inside of the mouth if the resident is able. There is a note on 3/11/2013 stating "Res [complained of] discomfort during breakfast, pointed at mouth, unable to locate source of discomfort. Res resistive to oral care. [Acetaminophen 650 milligrams by mouth administered] for discomfort with positive effect."  In interview, a family member stated that the family has brought an electric toothbrush because R#68's gums were getting red. In an interview on 6/4/13 the UM confirmed that s/he was not aware that the resident had reddened gums and that the family had brought an electric toothbrush. S/he stated that nurses do not do oral/dental assessments on a routine basis. S/he stated that oral care is done twice daily as part of AM and HS (bedtime) care and that the nurse is generally notified if issues arise.	F 279	Random audits of full evaluations will be completed weekly times 3 months.  Results of the audits will be reported to the facility QA meeting.  DNS/designee will be responsible for compliance.  July 8, 2013  <i>F279 POC accepted 7/15/13</i> <i>M Higgins RN / Pmc</i>	

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F 279	Continued From page 18  In a review of the record, the plan of care states that the resident needs assistance with oral hygiene but there is no care plan in the record for dental care to reflect any of the above information. The Unit Manager confirmed at 4:20 PM on 6/4/2013 that there is no dental care plan for this resident.	F 279		
F 280 SS=E	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.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to revise the care plan for 4 of 25 residents in the stage 2 sample	F 280	F28D Resident #54 was not affected by this alleged deficient practice. Precautions were discontinued related to no longer necessary.  Any resident on Infection Control precautions has the potential to be affected by this alleged deficient practice.  Staff has been reeducated on precautions for Infection Control purposes and required protective equipment as per policy and procedures. Residents on precautions have been audited for proper protective equipment as per policy and procedure.  Random audits of adherence to Infection Control policy and procedures will be conducted weekly times 1 month then monthly times 3 months.	

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F 280	<p>Continued From page 19 (Residents #54, 101, 50, &amp; 100) Findings include:</p> <p>1. Per observation, record review and interview, Resident #54's care plan did not reflect his/her current needs regarding precautions for infection control. Per observation during the initial tour on 06/04/13 at 9:45 AM Resident #54's room door had a precaution sign [to see the nurse before entering] and a box [containing gloves and gowns]. At that time, housekeeping staff were observed entering the room without a gown and when asked about the sign/box on the room and asked if anyone is on precautions, the housekeeping staff "oh yes" and went to get a gown. The Director of Housekeeping confirmed at 10:00 A.M. that a gown should be worn during the cleaning because the "[resident] was on precautions".</p> <p>Per review of the care plan dated 05/21/13, it states - Actual gastric intestinal infection related to positive C-diff toxin. C-diff treatment completed, no active symptoms. The care plan directs staff to "Assess abdomen for distention, and bowel sounds as needed; encourage PO fluids; Maintain contact precautions in place for duration of treatment; Monitor for signs and symptoms of isolation while on precautions; Medications as ordered; Monitor for any adverse side effects related to prescribed medications for C-diff toxin; Report abnormal findings to RN/LPN and MD; Started Vanco last day to be given 3-17-13; Monitor for loose stools and complaints of abdominal pain and report to MD as needed; 3-14-13, continues with loose stool at once every other day. Staff will continue to monitor".</p> <p>Per interview on 06/04 13 at 1:20 P.M. the Unit</p>	F 280	<p>Results of audits will be reported to the facility QA committee.</p> <p>DNS/designee will be responsible to monitor for compliance.</p> <p>Resident #101 no longer resides in the facility</p> <p>Any resident with a foley catheter has the potential to be affected by the alleged deficient practice.</p> <p>Nurses have been reeducated to update careplans for foley catheters inserted and discontinued.</p> <p>Audits of residents with foley catheters have been completed to ensure careplan is in place. Careplans are updated as required and reviewed at morning concurrent review.</p> <p>Random audits will be completed for careplan updates weekly times 4 weeks, then monthly for 3 months.</p> <p>Results of audits will be presented to QA committee.</p>		

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F 280	<p>Continued From page 20</p> <p>Manager stated that the resident is no longer actively infected and the precaution sign and precaution box should have been removed after the last lab test was negative {May 2013}. S/he confirmed that the care plan was not revised to reflect current status.</p> <p>2. Per review of the nurses' notes in the electronic medical record revealed that on 5/3/13 Resident #101 was fitted with a Foley Catheter due to increased urinary incontinence. The notes further reveal that the catheter was removed on 5/12/13 due to the resident pulling on the tubing in an apparent attempt to self-remove the catheter. Review of Resident #101's care plan showed the document contained no mention of either the administration of the catheter on 5/3/12 or the removal of the catheter on 5/12/13. These omissions were confirmed by the Unit Nurse Manager in an interview at 3:20 PM on 6/4/13. The Nurse Manager also acknowledged that both events, the administration and the removal of the Foley Catheter should have been documented in the resident's care plan.</p> <p>3. Per record review for Resident #100, the care plan for Falls Risk for Resident #100 was not revised after falls on 5/31/13, 5/30/13, 5/23/13,</p>	F 280	<p>DNS/designee will monitor for compliance.</p> <p>Resident #100 was not affected by the alleged deficient practice.</p> <p>Any resident with a fall has the potential to be affected by the deficient practice.</p> <p>Nurses have been reeducated to update careplans for any resident sustaining a fall.</p> <p>Audits of residents with falls have been completed to ensure careplan is in place.</p> <p>Careplans are updated as required and reviewed at morning concurrent review.</p> <p>Random audits will be completed for careplan updates weekly times 4 weeks, then monthly for 3 months.</p> <p>Results of audits will be presented to QA committee</p> <p>DNS/designee to monitor for compliance.</p>	

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F 280	<p>Continued From page 21 and 5/8/2013 to include new or revised strategies to prevent further falls. The last revision of the care plan related to a fall was done on 4/12/2013. On 6/5/2013 at 2:40 PM the Unit Manager confirmed that the Falls Risk care plan had not been revised for Resident #100 following four new falls in May.</p> <p>4. Per record review on 6/4/13, Resident #50's care plan was not revised to show current status of a pressure ulcer. Medical Record review on 6/4/13 identifies that the resident had previous pressure ulcers on February 1, 2013 that resolved by February 18, 2013. The Care plan initiated on 2/8/2011 and revised on 1/15/13 identifies problem as: Alteration in skin integrity related to pruritis, chronic rash, decreased mobility and occasional incontinence. The initiatives for care are to relieve pressure while in bed and chair, to monitor skin daily and report to nurse any abnormalities and reposition keep off bony prominences. Medical Record review identifies a nurses note dated 6/2/13, "patient was found to have a stage two on his left buttocks". There was no revised care plan with new interventions at the time the resident was noted to have a new stage two on 6/2/13. A Care plan updated on 6/4/13 Alteration in Skin Integrity Stage II pressure sore related to impaired mobility, incontinence. On 6/5/13 at 3:00 PM Unit Manager confirmed that the care plan was revised on 6/4/13, not on the day the wound was identified which was 6/2/13.</p>	F 280	<p>Resident #50 was not affected by this alleged deficient practice.</p> <p>Any resident with a pressure ulcer has the potential to be affected by this deficient practice.</p> <p>Nurses have been reeducated to update careplans for any resident with a pressure ulcer.</p> <p>Audits of residents with pressure ulcers have been completed to ensure careplan is in place.</p> <p>Careplans are updated as required and reviewed at morning concurrent review.</p> <p>Random audits will be completed for careplan updates weekly times 4 weeks, then monthly for 3 months.</p> <p>Results of audits will be presented to QA committee</p> <p>DNS/designee to monitor for compliance.</p> <p>July 8, 2013</p> <p><i>F280 POC accepted 7/15/13 MHiggins RN/PMC</i></p>	

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F 280	Continued From page 22	F 280		
F 281	Failed to revise care plan resident #50. 483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281		

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F 281 SS=F	<p>Continued From page 23 <b>PROFESSIONAL STANDARDS</b></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: Based on staff interview and record review, the facility failed to assure that the nurses met professional standards of nursing practice regarding the use of expired standing orders that also were not individualized for each resident. This has the potential to affect all residents of the facility. Findings include:</p> <p>Per interview on 6/5/13 at 8:12 AM the LPN, Unit Manager of Unit One stated that the Facility Standing Orders are kept in a separate notebook at the nursing stations and they are kept for reference per physician and not individualized for the resident. It was also verified that the standing orders are not kept in each resident's chart. When asked to review a copy of the physician standing orders for a resident, the LPN produced Standing Orders that were dated and signed by the physician on 1/13/2011. The Unit Manager confirmed that the effective date for the standing orders present for Resident #58 was January 1, 2012 to December 31, 2012. S/he stated that these orders were the orders currently in use for Resident #58. On 6/5/2013 at 8:30 AM, per statement from Vice President of Clinical Operations of Corporate for the facility, the practice has been to use standing orders for all residents and they are not individualized per resident.</p>	F 281	<p>F281 Resident #55 was not affected by the alleged deficient practice.</p> <p>Any residents that standing orders were utilized have the potential to be affected by the alleged deficient practice.</p> <p>The practice of standing orders for residents has been discontinued.</p> <p>Orders will be individualized according to the resident.</p> <p>Nurses have been reeducated on the policy and procedure for securing an MD order as needed.</p> <p>Random audits of MD orders will be conducted at morning concurrent review.</p> <p>Results of audits will be presented to the QA committee.</p> <p>DNS/designee will monitor for compliance.</p> <p>July 8, 2013</p> <p><i>F281 POC accepted 7/15/13 MHiggins RN   amc</i></p>	
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F 281	Continued From page 24 The standing orders included treatments and medication usage for Chest Pain; SOB; Cough; Pain or Fever; Indigestion; Loose stools; Chronic constipation; No Bowel movement for 3 days; Dry eyes; Cerumen impaction; Hyper/Hypoglycemia; Vaccines/screening; Treatments/wound care; Labs and Miscellaneous treatment and therapies. Resident #58 had received treatment for pressure ulcers per standing orders which had expired 12/31/2012.	F 281		
F 282 SS=E	Reference: Lippincott Nursing Manual, Williams and Wilkins, 8th Edition 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to provide services in accordance with the care plan for 5 of 25 residents identified in the sample. (Residents #24, 40, 58, 84 & 83) Findings include:  1. Per record review, staff failed to provide services according to the care plan for Resident #24 for dining assistance and monitoring weight loss. Per observation of the Noon meal on 06/03/13, Resident #24 was noted to be sitting and sleeping at the table with minimal staff assistance. When staff were able to assist after	F 282	F282 Resident #24 was not affected by the alleged deficient practice.  All resident identified with significant weight loss are have potential to be affected by the alleged deficient practice.  Resident's weights have been reviewed and any necessary notifications to MD and Registered Dietician have been completed. Nutritional interventions have been initiated as per Registered Dietician.  Residents with identified weight loss will be discussed at the weekly At-Risk meeting. Minutes will be maintained and dietary progress note written.	

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F 282	<p>Continued From page 25</p> <p>a period of greater than 20 minutes, staff did not offer to reheat the meal or offer an alternative. Two staff were noted serving, cueing and assisting a total of 18-20 residents in the large dining area and confirmed "we're late getting to help" the residents.</p> <p>Per review of the 04/25/13 care plan for Resident #24, it notes an alteration in nutrition related to chewing/swallowing problems of Dysphagia, Edentia and weight loss. Staff are directed to provide total assistance with meals and fluids to assure no instances of aspiration. Further interventions include: Diet as ordered-mechanical soft diet and monitor weights per facility policy/MD orders. The current physician orders state 'daily weight upon rising'.</p> <p>Per review of recorded weights, weekly weights are noted on 05/28/13 at 176.5 lbs; 05/30/13 at 178.5 [Hoyer]; 06/01/13 at 174 lbs and on 06/02/13 -173.5 lbs. Per interview on 06/05/13 at 12:32 P.M. the dietician stated "I was aware of weight loss about a month ago and we implemented new measures with staff monitor closely the intake and fluids. The dietician stated that "per policy staff should should re-weigh weights greater or less than 3 lbs and alert the physician and myself." S/he confirmed a 5 lb weight loss from 05/30/13 to 06/02/13 and that neither the physician nor the dietician was alerted to the weight loss of greater than 3 lbs.</p> <p>Per interview on 06/05/13 at 1:30 P.M. the DNS also stated that "staff are to call the dietician if weight loss [3 lbs up or down] prior to the weekly nutrition meeting, via e-mail or phone". In addition, to "call the doctor and also nursing</p>	F 282	<p>Nurses have been reeducated on the process for MD and Registered Dietician notification of weight changes...</p> <p>Audits of notification to MD and Registered Dietician will be completed at the concurrent review.</p> <p>Results of audits will be presented to the facility QA committee.</p> <p>DNS/designee will monitor for continued compliance.</p> <p>Resident #84 has been reevaluated by P.T. The use of seatbelt has been reassessed.</p> <p>Any resident with a seat belt, unable to be released on command, has the potential to be affected by this alleged deficient practice.</p> <p>An audit of all seat belts utilized was completed.</p> <p>Any resident rising from a chair, needing assistance, has the potential to be affected by this alleged practice.</p>	

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F 282	<p>Continued From page 26</p> <p>should be aware if the resident is sick or not taking in food they would be alerted". The DNS confirmed the facility failed to ensure services were provided according to the care plan.</p> <p>Also see F325.</p> <p>2. Per observation and record review, staff are failing to consistently implement the care plan for Resident #84 regarding fall prevention and use of an alarmed seat belt device. Per record review, Resident #84 has a recent history of falls and the care plan for Resident #84 titled "High Risk for Falls [related to] decreased mobility, poor safety awareness, impaired balance" includes multiple interventions. Interventions include: an alarmed seat belt when in his wheelchair, ambulating the resident with assist of staff, using re-direction tools including using his "Royal crown", offering diversional activities such as watching TV, books, something to eat, and offering the "busy board".</p> <p>Per observations on 6/4/13 at 2:40 PM and 3:57 PM, and 6/5/13 at 9:48 AM, 1:30 PM, 3:06 PM,</p>	F 282	<p>Nursing staff has been inserviced on actions/interventions to take when a resident rises from their chair.</p> <p>Daily rounds will be conducted, at random times, on the units.</p> <p>Results of the rounds will be reported to the facility QA meeting.</p> <p>DNS/designee is responsible to monitor compliance.</p> <p>July 8, 2013</p> <p>Resident #83 was not affected by the alleged deficient practice.</p> <p>Any resident with orders for PRN medications for treatment of anxiety/agitation have the potential to be affected by the alleged deficient practice.</p> <p>Nursing staff have been reeducated on the need to implement nonpharmacological interventions, found on the careplan and behavior flow sheets, prior to administering any PRN medications to treat residents behaviors.</p>	

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F 282	<p>Continued From page 27</p> <p>3:16 PM and 3:52 PM, when the resident successfully removes the seatbelt and the alarm sounds, staff immediately respond to the alarm and fasten the seatbelt back up, without assisting him or allowing him to rise from the chair at that time and without offering him/her any of the care planned diversional activities or re-direction strategies. During the observation on 6/5/13 at 9:48 AM, staff stated to the resident "we got to leave that buckled pal...you don't want to fall on your nose do you?", and didn't offer assistance with ambulation or any care planned intervention strategies. During the observation on 6/5/13 at 1:30 PM, staff told the resident "no" each time he unbuckled the seatbelt, stated "Hey, you got to leave this buckled up", and staff pulled his shirt over the seatbelt so he would stop releasing it, again without offering intervention strategies. During the observation on 6/5/13 at 3:06 PM, staff stated to the resident "You got to put that back on", without offering to assist the resident ambulate or offering the care planned strategies for diversional activities. Finally, during the observation on 6/5/13 at 3:52 PM, staff stated "You are upsetting people, leave it on" and did not offer ambulation or the care planned interventions.</p> <p>During many of the above observations, the resident appeared agitated, gripping and pulling at the seatbelt with shaking hands, trying unsuccessfully to rise with the seatbelt on, then trying to pull on the metal parts of the wheelchair.</p> <p>See also F221.</p> <p>3. Per record review and staff interview, staff failed to consistently implement the care plan</p>	F 282	<p>Nursing staff have been reeducated on the use of the behavior flow sheet.</p> <p>Audits of resident's behavior will be completed at morning concurrent review.</p> <p>Results of audits will be sent to facility QA committee.</p> <p>DNS/designee to monitor for compliance.</p> <p>July 8, 2013</p> <p>Resident #40 was not affected by the alleged deficient practice.</p> <p>All residents requiring some or complete assist with a meal have the potential to be affected by the alleged deficient practice.</p> <p>Nursing staff has been reeducated on the need to serve meals timely and allow resident rest periods if resident fatigues. If resident has a rest period the meal will be reheated and/or refreshed.</p> <p>Random observations of the dining service will be conducted weekly times 4, then monthly times 3 months.</p>	

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F 282	<p>Continued From page 28</p> <p>regarding attempting non-pharmacological interventions prior to administering PRN (as needed) anti-anxiety medication for Resident #83. Per record review, Resident #84 has a physician order for Lorazepam (an anti-anxiety medication) 0.5 milligrams by mouth every 6 hours as needed for "agitation". The care plan for Resident #83 addressing "altered thought process" and "ineffective individual coping mechanisms" both related to dementia, directs staff to use the following interventions: "When [Resident] appears to be agitated, consider [his/her] background as a police officer and give [him/her] the clipboard with a map of the building and ask him to check on the security of the building", "ask [Resident] to tell you about [where s/he is from]...offer drinks..snacks, Lavender drops...enjoys baseball games", "encourage resident to talk about feelings", among other listed interventions.</p> <p>Per review of the Medication Administration Record (MAR) for May 2013, Resident #83 received as needed Lorazepam on 5/5/13, 5/6/13, 5/9/13, 5/10/13, 5/11/13, 5/12/13, 5/21/13, 5/24/13, 5/28/13 and 5/31/13 without any indication on Behavior Monitoring flowsheets, the back of the MAR, or the nursing notes that any non-pharmacological interventions were attempted or offered prior to giving the resident medication.</p> <p>Per interview on 6/5/13 at 9:30 AM, a staff nurse reviewed behavior monitoring documentation on the dates noted above with the surveyor, and verified there is no documentation or evidence that non-pharmacological interventions were attempted on the above listed dates in May 2013 prior to giving as needed psychoactive medication</p>	F 282	<p>Observation results will be taken to the facility QA meeting.</p> <p>DNS/designee will monitor for continued compliance.</p> <p>July 8, 2013</p> <p>Resident #58 pressure ulcer did not increase in size and has resolved. The resident was not adversely affected by the alleged deficient practice.</p> <p>Any resident with a pressure ulcer has the potential to be affected by this alleged deficient practice. Treatment order was clarified with the physician to ensure accurate treatment was being utilized.</p> <p>Nurses have been reeducated on the process for checking the accuracy of the MD order and comparing the accuracy of the order on the treatment administration record. Necessary changes will be made. All treatments will have an MD order.</p> <p>Random audits of treatment records and MD orders will be completed weekly times 4 weeks and monthly for 3 months.</p>		

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F 282	<p>Continued From page 29 to Resident #83.</p> <p>See also F329.</p> <p>4. Per record review on 6/4/13, Resident #40 has diagnoses including dementia with depressed mood, chronic fatigue, and dysphagia oral phase (trouble swallowing). The comprehensive resident assessment of 4/25/13 notes the need for one staff assist during eating. Resident #40 has been followed by the Registered Dietician (RD) and the weekly nutrition high risk committee for a weight loss trend, per interview with the RD at 11:16 AM on 6/5/13. The RD confirmed a 5.5 pound weight loss from 2/27/13 to 6/5/13. The written plan of care for Resident #40 directs staff to provide setup, encouragement and reminders for eating. Feed him/her if cannot focus on the task. Additionally, in the portion addressing moderate nutritional risk, the staff are directed that if fatigue is interfering with intake, allow for rest periods and reheat and refresh meals as needed.</p> <p>During an observation of the midday meal in the main dining room on 6/3/13, Resident #40 was noted to eat a few bites of the hot meal and then doze off. S/he was not awakened to eat, nor did staff refresh the meal, including when another resident sampled his/her thickened juice and it was discarded. There were 18-20 residents in the dining room at any given time, with two Licensed Nurse Assistants (LNAs) assisting residents who required supervision, cueing, and feeding assistance. There was no offer to reheat the meal or provide feeding assistance to Resident #40. At 12:55 PM one of the LNAs confirmed that there</p>	F 282	<p>Results of audits will be reviewed at facility QA meeting.</p> <p>DNS/designee will be monitor of compliance.</p> <p>July 8, 2013</p> <p><i>F282 POC accepted 7/15/13 M Higgins RN / POC</i></p>	

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F 282	<p>Continued From page 30</p> <p>are usually three staff to assist and that today they had only two, and that even with three they are unable to offer timely assistance.</p> <p>On the 6/5/13 at 7:45 AM, the surveyor visited Resident #40 in his/her room where the surveyor found him to be up to the wheelchair, groomed and dressed, and calling out repetitively. The Registered Nurse administered the 8:00 AM medications, and the LNA wheeled Resident #40 to the main dining room (8:00 AM). Resident #40 was observed to remain at the table, calling out repetitively, with no food or drink or attention from staff until 8:55 AM. At this time an LNA offered a glass of milk, and Resident #40 requested something to eat. An appropriate hot breakfast was provided, though an hour after arrival to the dining room. Later in the day at 1:10 PM, the surveyor observed Resident #40 asleep in the dining room, with a partially eaten lunch meal (approximately 25% consumed) on his/her plate. An LNA then confirmed that s/he had fed Resident #40 until he fell asleep. There were no attempts to awaken the resident or refresh the meal during my observation [until 1:30 PM] when staff returned him/her to the room to lie down.</p> <p>5. Per record review on 6/5/2013 of Resident #58, he/she presented with a posterior medial left knee Stage 2 pressure ulceration on 4/8/2013 that measured 7.5 cm x 1.0 cm and with a posterior lateral left knee Stage 2 pressure ulceration measuring 8.0 x 1.5 cm. His/her treatment noted in the Treatment Administration Record (TAR) was for these areas to be cleansed with normal</p>	F 282			

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F 282	<p>Continued From page 31</p> <p>saline, have No Sting applied and then covered with a Tegaderm Foam dressing per standing orders, and the monthly physician orders with the treatment order crossed out were signed by the physician on this date.</p> <p>The April Treatment Administration Record (TAR) showed the treatment to be crossed off. A telephone order received and noted on 4/11/2013 ordered Foam Island dressing to left leg, posterior knee, change twice weekly and as needed. The physician order was transcribed to the TAR, but there was no notation of the order on the Monthly Physician orders. On April 18, 2013 the TAR presented with a treatment of Foam adhesive dressing to left leg posterior knee change once a week. No physician order was found to change the treatment times in the medical record and this was confirmed by the Unit Manager (UM). Review of the TAR for May 2013 indicates the treatment to remain as: change weekly and there is no physician order for this change.</p> <p>The TAR for June 2013 indicates the treatment to revert back to: cleanse areas topically to left knee, inner knee and with normal saline apply No Sting apply Tegaderm Foam change every 3 days until resolved per standing order. Per interview with the UM at 10:30 AM the physician orders are checked by the night nurse, record revealed that the chart was checked and indicated med orders. UM verified the check was done and that the order was not carried over from 4/11/2013 and that when the monthly orders are reviewed they are checked twice and that this did occur, but the nurses did not pick up on the change. She also verified that the treatment and the physician</p>	F 282		

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F 282  F 314 SS=G	Continued From page 32 orders did not match. The resident's care plan indicated to follow treatment orders by the MD. 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview the facility failed to provide treatment and services to promote healing of a pressure ulcer for 2 of 25 residents in Stage 2 survey sample. Findings include:  1. Resident #58 presented with a posterior medial Left knee Stage 2 pressure ulceration on 4/8/2013 that measured 7.5 x 1.0 cm and with a posterior lateral Left knee Stage 2 measuring 8.0 x 1.5 cm. These areas were to be cleansed and apply No Sting and Tegaderm Foam to be changed every 3 days until resolved per monthly orders signed 4/6/13 by the physician. A telephone order dated 4/11/2013 from the physician indicated a change in the treatment, to apply Foam Island dressing to left leg and change twice weekly and as needed. The treatment administration record (TAR) dated for April indicates the change of order for 4/11/2013 was	F 282  F 314	F314 Resident #58 pressure ulcer did not increase in size. Treatment order was clarified with the physician to ensure accurate treatment was being utilized. The resident was not adversely affected by the alleged deficient practice.  Any resident with a pressure ulcer has the potential to be affected by this alleged deficient practice.  Nurses have been reeducated on the process for checking the accuracy of the MD order and comparing the accuracy of the order on the treatment administration record. Necessary changes will be made. All treatments will have an MD order.  Random audits of treatment records and MD orders will be completed weekly times 4 weeks and monthly for 3 months.  Results of audits will be reviewed at facility QA meeting.  DNS/designee will be monitor of compliance.  July 8, 2013		

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F 314	<p>Continued From page 33</p> <p>done per physician order for one week and then the treatment was changed with no physician orders to indicate a change in treatment. The treatment change was to apply the Foam Island dressing and change weekly, instead of twice a week. This treatment, to change the Foam Island dressing weekly instead of twice a week, remained in effect for May although the orders dated and signed by the physician on 5/12/2013 indicated treatment dressing to be changed every 3 days. In June the monthly orders continue to read change every 3 days and the Unit Manager verified that the orders were changed in April and not carried through onto the monthly physician orders. He/she also indicated that the orders were not being followed correctly.</p> <p>2. Per record review, Resident #50 was admitted to the facility on 9/1/12 with diagnoses including renal failure, anemia and failure to thrive. The resident has a history of pressure ulcers on right and left buttocks in February 2013. Medical record review reveals the resident is incontinent of urine and is unaware when s/he is wet. Per a Braden Scale form, completed 6/4/13, Resident #50 currently has a Stage 2 pressure ulcer on right buttock (discovered on 6/2/13), requires moderate to maximum assistance in moving, and s/he frequently slides down in chair, requiring frequent repositioning with maximum assistance. The Braden Scale also states that the resident's nutrition is "probably inadequate: Rarely eats a complete meal and generally eats only about 1/2 of any food offered..." Per review of the care plan addressing the Alteration in Skin Integrity, staff are directed to reposition with toileting/incontinence care before and after meals, with AM and HS (bed time) care and as needed. A dietary assessment on 4/25/13</p>	F 314	<p>Resident #50 developed a pressure ulcer on the coccyx. The pressure ulcer is now healed.</p> <p>The resident was assessed for a turning schedule and is now turned repositioned per schedule.</p> <p>A Dietician notification form is in place and is being used to notify the Registered Dietician of any changes in a resident's condition that requires dietary intervention or recommendations.</p> <p>Random audits of timely turning and incontinence care are being conducted 5 times per week for one month and then 3 times per week for 2 months.</p> <p>Nursing staff have been reeducated in the need to follow the residents turning/repositioning and incontinence care schedule</p> <p>Audits will be reviewed by facility QA committee.</p> <p>DNS/designee will monitor for compliance.</p> <p>July 8, 2013 F314 POC accepted 7/15/13 Mihiggins RN   Ame</p>	

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F 314	<p>Continued From page 34</p> <p>documented that the resident's skin was intact at that time.</p> <p>Per continuous observation on 6/5/13 from 8:15 AM to 10:45 AM, the resident was not repositioned during this time, and was sitting in a wheelchair with both legs elevated. At 10:45 PM, staff provided care to the resident after transferring him/her back to bed using a mechanical lift. The surveyor observed the provision of care at this time. The resident's incontinence brief was saturated with urine when it was removed. At the time of the observation, the resident had the stage 2 pressure ulcer on the buttock, which was identified on 6/2/13. Further, a new pressure ulcer was observed during this provision of care, on the coccyx area, with an open area measuring 0.8 centimeters (cm) by 0.2 cm.</p> <p>Per facility policy, residents with pressure ulcers are to be assessed to determine a turning/repositioning schedule to meet the resident's needs. There is no evidence this assessment was completed or a new repositioning schedule was implemented since the discovery of the first pressure ulcer on 6/2/13. Also, per interview with the Registered Dietician on 6/5/13 at 11:30 AM, s/he stated that s/he was not aware of any skin breakdown for Resident #50. During an interview on 6/5/13 at 3:00 PM, the Unit Manager confirmed that the resident should be moved every 2 hours and that the protocol for skin care management has not been followed.</p> <p>2. Based on record review, observation and staff</p>	F 314		
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F 314	<p>Continued From page 35</p> <p>interview the facility failed to provide treatment and services to promote healing of a pressure ulcer. Per observation on 6/4/13 resident #50 was witnessed in the sun room eating lunch at 12:00 noon, he was taken to his room at 2:45 PM at which time incontinent care was provided and he returned to the sun room at 3:15 PM. On 6/5/13 8:15 AM resident witnessed in the sun room eating breakfast. At 10:20 AM Resident removed from Day Room brought back to his room so that Surveyor could observe wound treatment. The resident is non-weight-bearing and sits in a wheel chair with legs elevated. The Resident was brought to the room but not until 10:45 AM that the Licensed Practical Nurse (LPN) and Unit Manger (UM) with 2 Licensed Nurses Aides's transferred resident via a mechanical lift to bed. After adult brief saturated with urine was removed and a transparent dressing removed, the wound cleansed and measured to be 1.2 cm by .4 cm on the left buttocks. At this time a second pressure ulcer noted on the resident's coccyx (crack) that was not present on 6/4/13. Measures taken on 6/5/13 to be 0.8 cm's by 0.2 cm. A four inch diameter circumference to include both buttocks, are noted to be red and non-blanchable. Per facility policy for repositioning the patient should be assessed to determine how often the resident needs repositioning. The facility has developed a Flip-Flop initiative that alerts care staff that the resident in a particular room or device needs to be turned frequently as they are at risk for skin breakdown as well as for comfort. During interview with two LNA staff on 6/5/13 at 3:00 PM they confirm that the flip flop symbol identifies that the patient needs to be reposition every two hours. During an interview with the UM on 6/5/13</p>	F 314		
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F 314	Continued From page 36 at 3:00 PM he/she confirms that the resident should be moved every two hours and that the protocol per skin care management has not been followed. also see F-282	F 314	F323 Resident #100 was not adversely affected by this alleged deficient practice. The metal bracket was immediately removed from the bed.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to keep the environment as free of accident hazards as possible in 1 resident's room (Resident #100), and one of two common shower/tub rooms (unit two). Findings include:  During the environmental tour of the facility on 6/4/13 at 1:30 PM, the Maintenance Director confirmed that a metal bracket protruded from the bed frame in Resident #100's room, causing a potential hazard to Resident #100. Additionally, at 1:20 PM, the Maintenance Director confirmed that on unit 2 there were 2 wall mounted baseboard heating units near the floor (1 in the entry to the shower room and 1 in the tub room) which had bent metal edges protruding.	F 323	No resident was adversely affected by the metal brackets on the bed.  Audit of beds was conducted and any metal brackets protruding from the bed were removed.  No resident was adversely affected by the bent metal edges protruding from the wall mounted baseboard heating unit.  The bent metal edges now have end caps replaced and metal edges have been sanded smooth.  Wall mounted baseboard heating units have been inspected and no other areas were identified.  Weekly audits will be completed as part of ongoing preventative maintenance program for 4 weeks, then monthly for 3 months.  Results of audits will be reviewed by facility QA committee. Maintenance Director/designee will monitor for compliance. July 8, 2013	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325		

F323 POC accepted 7/15/13  
MHiggins RN / PML

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F 325	<p>Continued From page 37</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and staff interviews, the facility failed to provide nutritional care and services consistent with each resident's assessed needs for 2 of 3 residents in the stage 2 sample (Residents #24 and #40 ). Findings include:</p> <p>1. Per record review on 6/4/13, Resident #40 has diagnoses including dementia with depressed mood, chronic fatigue, and dysphagia oral phase (trouble swallowing). The comprehensive resident assessment of 4/25/13 notes the need for one staff assist during eating. Resident #40 has been followed by the Registered Dietician (RD) and the weekly nutrition high risk committee for a weight loss trend, per interview with the RD at 11:16 AM on 6/5/13. Recorded weights were 159.5 on 1/29/13, 148 on 2/27/13, and 139 on 5/7/13. During this interview, the RD further confirmed having questioned the accuracy of the weight taken on 5/7/13, as it was significantly out of range from the previous weight. The RD stated the expectation of reweigh when there is a 3</p>	F 325	<p>F325</p> <p>Resident #24 and #40 were not adversely affected by the alleged deficient practice.</p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>The weight policy and procedure has been reviewed.</p> <p>Nursing staff have been reeducated as to weights/reweights. All weights plus or minus 3 pounds will be reweighed.</p> <p>Adherence to the policy for weights within 24 hours. is checked daily by the charge nurse/Unit Manager.</p> <p>Weights to be reviewed weekly at the "At Risk" meeting.</p> <p>Results of weights will be reviewed by facility QA committee.</p> <p>DNS/designee to monitor for compliance.</p> <p>Staff has been reeducated to serve meals timely allowing resident to rest when needed and to</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475037</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/05/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ROWAN COURT HEALTH &amp; REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>378 PROSPECT STREET BARRE, VT 05641</b>
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F 325	<p>Continued From page 38</p> <p>pound change from the previous weight. At the weekly nutrition high risk meeting of 5/29/13, the RD requested a reweigh. The reweigh of 6/5/13 was 144, and the RD confirmed a 5.5 pound weight loss from 2/27/13 to 6/5/13. Per interview with the unit manager/Registered Nurse (RN) on 6/5/13 at 1:45 PM, it was confirmed that the expectation is that staff will reweigh a resident if the weight shows a 3 pound change from the previous weight. The RN confirmed that staff should have conducted a reweigh on 5/7/13 and that the unit manager should have assured this, so that physician notification or corrective action might be taken in a timely manner.</p> <p>Further, the written plan of care for Resident #40 directs staff to provide setup, encouragement and reminders for eating; "Feed him/her if cannot focus on the task". Additionally, in the care plan addressing moderate nutritional risk, the staff are directed that "if fatigue is interfering with intake, allow for rest periods and reheat and refresh meals as needed".</p> <p>During an observation of the midday meal in the main dining room on 6/3/13, Resident #40 was noted to eat a few bites of the hot meal and then doze off. S/he was not awakened to eat, nor did staff refresh the meal, including when another resident sampled his/her thickened juice and it was discarded. There were 18-20 residents in the dining room at any given time, with two Licensed Nurse Assistants (LNAs) assisting residents who required supervision, cueing, and feeding assistance. There was no offer to reheat the meal or provide feeding assistance to Resident #40. At 12:55 PM one of the LNAs confirmed that there are usually three staff to assist and that today</p>	F 325	<p>reheat/refresh meals by dietary department as indicated.</p> <p>Residents have been assessed to determine the number of residents requiring assistance or dependent on staff for meals. Redistribution of staff during meals has been completed to ensure adequate staff is available to meet the needs of the residents in a timely fashion.</p> <p>The facility QA committee will review dining program.</p> <p>DNS/designee will monitor for compliance.</p> <p>July 8, 2013</p> <p><i>F325 POC accepted 7/15/13 MHigginsRN   PML</i></p>	
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F 325	<p>Continued From page 39</p> <p>they had only two, and that even with three they are unable to offer timely assistance.</p> <p>On the 6/5/13 at 7:45 AM, I visited Resident #40 in his/her room where I found him to be up to the wheelchair, groomed and dressed, and calling out repetitively. The Registered Nurse administered the 8:00 AM medications, and the LNA wheeled Resident #40 to the main dining room (8:00 AM). Resident #40 was observed to remain at the table, calling out repetitively, with no food or drink or attention from staff until 8:55 AM. At this time an LNA offered a glass of milk, and Resident #40 requested something to eat. An appropriate hot breakfast was provided, though an hour after arrival to the dining room. Later in the day at 1:10 PM, I observed Resident #40 asleep in the dining room, with a partially eaten lunch meal (approximately 25% consumed) on his/her plate. An LNA then confirmed that s/he had fed Resident #40 until he fell asleep. There were no attempts to awaken the resident or refresh the meal during my observation [until 1:30 PM] when staff returned him/her to the room to lie down.</p> <p>2. Per record review on 06/03/13 the facility failed to maintain acceptable parameters of nutritional status for Resident #24, by failing to assure proper dining assistance and monitoring of weight loss. Per review of the care plan dated 04/25/13, it notes an alteration in nutrition related to chewing/swallowing problems regarding Dysphagia, Edentia and weight loss. Staff are directed to provide total assistance with meals and fluids to assure no instances of aspiration. Other interventions include: Diet as ordered-mechanical soft diet, monitor weights per facility policy/MD orders. The current physician</p>	F 325			

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F 325	<p>Continued From page 40 orders state 'daily weight upon rising'.</p> <p>Per observation of the Noon meal on 06/03/13, Resident #24 was sitting and sleeping at the table with minimal staff assistance. When staff were able to assist after a period of greater than 20 minutes, staff did not offer to reheat the meal or offer an alternative. Per review, the weights are noted on 05/30/13 at 178.5 lbs [Hoyer]; 06/01/13 at 174 lbs and on 06/02/13 at 173.5 lbs, a loss of 5 lbs in 6 days. Per interview on 06/05/13 at 12:32 P.M. the dietician stated "I was aware of weight loss about a month ago and we implemented new measures with staff to monitor closely the intake and fluids." The dietician stated that "per policy staff should re-weigh weights greater or less than 3 lbs and alert the physician and myself." S/he confirmed a 5 lb weight loss from 05/30/13 to 06/02/13 and that neither the physician nor the dietician was alerted to the weight loss of greater than 3 lbs.</p> <p>Per interview on 06/05/13 at 1:30 P.M. the DNS also stated that "staff are to call the dietician if weight loss [3 lbs up or down] prior to the weekly nutrition meeting, via e-mail or phone". In addition, to "call the doctor and also nursing should be aware if the resident is sick or not taking in food they would be alerted". The DNS confirmed the facility failed to ensure the resident received nutritional care and services consistent with the resident's comprehensive assessment.</p> <p>2. Per record review on 6/4/13, Resident #40 has diagnoses including dementia with depressed</p>	F 325		

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F 325	<p>Continued From page 41</p> <p>mood, chronic fatigue, and dysphagia oral phase (trouble swallowing). The comprehensive resident assessment of 4/25/13 notes the need for one staff assist during eating. Resident #40 has been followed by the Registered Dietician (RD) and the weekly nutrition high risk committee for a weight loss trend, per interview with the RD at 11:16 AM on 6/5/13. Recorded weights were 159.5 on 1/29/13, 148 on 2/27/13, and 139 on 5/7/13. During this interview, the RD further confirmed having questioned the accuracy of the weight taken on 5/7/13, as it was significantly out of range from the previous weight. The RD stated the expectation of reweigh when there is a 3 pound change from the previous weight. At the weekly nutrition high risk meeting of 5/29/13, the RD requested a reweigh. The reweigh of 6/5/13 was 144, and the RD confirmed a 5.5 pound weight loss from 2/27/13 to 6/5/13. Per interview with the unit manager/Registered Nurse (RN) on 6/5/13 at 1:45 PM, it was confirmed that the expectation is that staff will reweigh a resident if the weight shows a 3 pound change from the previous weight. The RN confirmed that staff should have conducted a reweigh on 5/7/13 and that the unit manager should have assured this, so that physician notification or corrective action might be taken in a timely manner.</p> <p>Further, the written plan of care for Resident #40 directs staff to provide setup, encouragement and reminders for eating; "Feed him/her if cannot focus on the task". Additionally, in the care plan addressing moderate nutritional risk, the staff are directed that "if fatigue is interfering with intake, allow for rest periods and reheat and refresh meals as needed".</p>	F 325			

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F 325	<p>Continued From page 42</p> <p>During an observation of the midday meal in the main dining room on 6/3/13, Resident #40 was noted to eat a few bites of the hot meal and then doze off. S/he was not awakened to eat, nor did staff refresh the meal, including when another resident sampled his/her thickened juice and it was discarded. There were 18-20 residents in the dining room at any given time, with two Licensed Nurse Assistants (LNAs) assisting residents who required supervision, cueing, and feeding assistance. There was no offer to reheat the meal or provide feeding assistance to Resident #40. At 12:55 PM one of the LNAs confirmed that there are usually three staff to assist and that today they had only two, and that even with three they are unable to offer timely assistance.</p> <p>On the 6/5/13 at 7:45 AM, I visited Resident #40 in his/her room where I found him to be up to the wheelchair, groomed and dressed, and calling out repetitively. The Registered Nurse administered the 8:00 AM medications, and the LNA wheeled Resident #40 to the main dining room (8:00 AM). Resident #40 was observed to remain at the table, calling out repetitively, with no food or drink or attention from staff until 8:55 AM. At this time an LNA offered a glass of milk, and Resident #40 requested something to eat. An appropriate hot breakfast was provided, though an hour after arrival to the dining room. Later in the day at 1:10 PM, I observed Resident #40 asleep in the dining room, with a partially eaten lunch meal (approximately 25% consumed) on his/her plate. An LNA then confirmed that s/he had fed Resident #40 until he fell asleep. There were no attempts to awaken the resident or refresh the meal during my observation [until 1:30 PM] when staff returned him/her to the room to lie down.</p>	F 325		
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F 329 SS=E	<p><b>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b></p> <p>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.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assure that the resident's medication regimen had adequate indications for use, consistent monitoring and/or care planning for 5 of 10 residents in the stage 2 sample (Resident #40, #51, #83 and #84). Findings include:</p> <p>1. Per record review and interview Resident #51</p>	F 329	<p>F329 Resident #1 now has adequate indication for psychotropic drug. Behavioral interventions and care plan have been updated. An AIMS test has been completed.</p> <p>Any resident using a psychotropic drug has the potential to be affected by this alleged deficient practice.</p> <p>Reeducation of nurses has been completed for documentation on the behavior monitoring form, behavioral interventions and care plan updates.</p> <p>An audit of residents receiving psychotropic drugs has been completed. Residents have adequate indication for psychotropic drug use.</p> <p>Random audits of adequate indication for psychotropic drug use, appropriate interventions and care plans will be done 5 times weekly for 3 months.</p> <p>New admissions will be reviewed for psychotropic drugs at the time of admission. The MD will be</p>	

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	<p>Continued From page 44</p> <p>was admitted with a psychotropic drug without adequate indication, behavioral interventions or care planning. Per record review on 06/04/13, Resident #51 was admitted on 11/12/12 with an anti-psychotic drug per the physician orders on 11/12/12 - "Risperidone 0.5 mg b.i.d. (twice a day) DX (diagnosis) agitation."</p> <p>The pharmacy review on 12/20/12 states "agitation is not approved diagnosis for use of risperdal please consider getting corrected diagnosis or ask MD [physician] to document risk/benefit for use of medication so we are compliant." The response is noted as "agitation is correct diagnosis". There is no further documentation to support the use of the anti-psychotic as evident by the History and Physical, physician notes, or the facility behavior sheet. There was no initial monitoring of extrapyramidal symptoms (EPS) or other side effects via the facilities' "AIMS" testing until four months later in February 2013.</p> <p>The Initial Care Plan, dated 11/28/12 states "Ineffective Individual Coping Mechanisms: related to: dementia as seen by possible agitation which [resident] has shown previously prior to this admit. Assess for changes in food or fluid intake, sleep pattern changes, changes in mood and behavior and report to MD. Assess for non verbal signs of altered coping such as restlessness, crying, reduced social interaction and report to MD. Assess prior use of coping mechanisms and support systems, Assist to make positive affirmations, Assist to process feelings and find positive outcomes, Encourage socialization with others who have a common background, Encourage appropriate expression of mood</p>		<p>notified if there is no indication for psychotropic drug use.</p> <p>A baseline AIMS test will be conducted on new psychotropic drug orders and every 6 months.</p> <p>Resident #84 was not adversely affected by this alleged deficient practice.</p> <p>Non-pharmacological interventions are in place and noted in care plans. An adequate indication for drug use is in place.</p> <p>Residents currently on psychotropic medication have the potential to be affected by this alleged practice.</p> <p>Nurses have been reeducated on documentation on the behavior monitoring form. Behavioral interventions and care plans have been updated.</p> <p>Random audits of adequate indications for psychotropic drug use, appropriate interventions and care plans will be done 5 times weekly for 3 months.</p> <p>New Admissions on psychotropic drugs will be reviewed at the time of admission. MD will be notified if</p>		

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F 329	<p>Continued From page 45</p> <p>alterations. Encourage communication with support system, Express limits when behaviors occur. Bring to area of low stimuli environment. Reaffirm appropriate behavior. Maintain safety when behavior escalates and attempt to reapproach. monitor mood and behavior daily, Provide 1:1 encouragement and support for involvement in care and daily routines." A care plan for psychotropic drug use was initiated in February 2013 four months later</p> <p>Per review of the Behavior/Intervention Monthly Flow Record shows for November 2012 through December 2012 a behavior of 'agitation' was being monitored. Per January - March 2013, the listed behaviors are agitation and refusal of care. In April 2013 anxious/combatative and refusals are being monitored and in May 2013 only combative during care is being monitored.</p> <p>Per review of the initial MDS (Minimum Data Set) dated 11/20/12 lists no episodes of delusions nor hallucinations and no behaviors, except wandering. Per interview on 06/04/13 at 3:13 P.M. the Regional Clinical Manger stated "agitation is a symptom not a diagnosis" and confirmed inadequate indications for use, consistent monitoring and/or care planning for the anti-psychotic drug use.</p> <p>2. Per review of Medication Administration Records (MAR), Behavior Monitoring flowsheets, and staff progress notes, Resident #84 received PRN (as needed) anti-psychotic medication when</p>	F 329	<p>there is no adequate indication for psychotropic drug use.</p> <p>Residents currently on psychotropic drugs will be reviewed at the time of the resident's quarterly review. AIMS testing will be completed prior to psychotropic drug use and every 6 months thereafter.</p> <p>The completion of AIMS testing will be reviewed quarterly.</p> <p>Results of reviews will be brought to the facility QA meeting.</p> <p>DNS/designee to monitor for compliance.</p> <p>Resident #40's pain was not affected by the alleged deficient practice.</p> <p>Any resident receiving PRN pain medication has the potential to be affected by this alleged deficient practice.</p> <p>Nurses have been reeducated on the policy and procedure for PRN pain documentation including:</p> <ul style="list-style-type: none"> <li>• Reason for use</li> <li>• Necessary assessments</li> </ul>	

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F 329	<p>Continued From page 46</p> <p>there was no documented evidence of specific behaviors and no evidence staff attempted non-pharmacological interventions prior to giving the anti-psychotic medication. Per review of the MAR for May 2013, Resident #84 received a PRN anti-psychotic medication with no evidence of other non-pharmacological interventions attempted by staff on May 4, 5, 14, 16, 18 and 20, 2013. The behavior sheets for these dates in May indicated there were no behaviors on any of the shifts. In addition, there was a lack of consistent documentation as to the effect of the PRN medication when it was given. Per review of the care plan, it does not specifically direct staff to attempt non-pharmacological interventions prior to giving the PRN anti-psychotic medication. Per interview with a staff nurse at 9:30 AM and 10:20 AM, s/he verified the lack of evidence of the existence of behaviors and the lack of evidence that non-pharmacological interventions were attempted, prior to giving the as needed anti-psychotic medication, on the behavior sheet for the dates indicated above.</p> <p>3. Per record review and staff interview, staff failed to consistently implement the care plan regarding attempting non-pharmacological interventions prior to administering PRN (as needed) anti-anxiety medication for Resident #83. Per record review, Resident #84 has a physician order for Lorazepam (an anti-anxiety medication) 0.5 milligrams by mouth every 6 hours as needed for "agitation". The care plan for Resident #83 addressing "altered thought process" and "ineffective individual coping mechanisms" both related to dementia, directs staff to use several non-pharmacological interventions.</p>	F 329	<ul style="list-style-type: none"> <li>Behaviors exhibited</li> <li>Effect of the medication</li> </ul> <p>Audits of PRN pain medication administration will be done 3 times per week for 3 months.</p> <p>Results of audits will be brought to the facility QA Committee</p> <p>DNS/designee will monitor for compliance.</p> <p>July 8, 2013</p> <p><i>F329 POC accepted 7/15/13 MHiggins RN / PMC</i></p>		

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F 329	<p>Continued From page 47</p> <p>Per review of the Medication Administration Record (MAR) for May 2013, Resident #83 received PRN Lorazepam on 5/5/13, 5/6/13, 5/9/13, 5/10/13, 5/11/13, 5/12/13, 5/21/13, 5/24/13, 5/28/13 and 5/31/13 without any indication on Behavior Monitoring flowsheets, the back of the MAR, or the nursing notes regarding what the specific behaviors that require medication were, and no evidence of any non-pharmacological interventions attempted or offered prior to giving the resident medication.</p> <p>Per interview on 6/5/13 at 9:30 AM, a staff nurse reviewed behavior monitoring documentation on the dates noted above with the surveyor, and verified there is no documentation of behaviors or evidence that non-pharmacological interventions were attempted on the above listed dates in May 2013 prior to giving as needed psychoactive medication to Resident #83.</p> <p>4. Per record review, Resident #83 was started on a daily dose of anti-psychotic medication on 3/7/13. Per review of diagnosis lists and other medical records, Resident does not have a diagnosis that indicates the need for treatment with anti-psychotic medication. As of the date of survey, the resident remains on the anti-psychotic medication daily with evidence in the clinical record of ongoing behavioral issues that were present before the start of the medication on 3/7/13. The resident also continues to require administration of PRN anti-anxiety medication for "agitation".</p> <p>Per record review, there is no evidence of psychological consults regarding the initiation or continued use of anti-psychotic medication. A</p>	F 329		
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NAME OF PROVIDER OR SUPPLIER  <b>ROWAN COURT HEALTH &amp; REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>378 PROSPECT STREET</b> <b>BARRE, VT 05641</b>		
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F 329	<p>Continued From page 48</p> <p>physician progress note dated 2/21/13 states "[Resident] has interestingly been easier to manage. [S/he] has not been as forceful in his activities...The patient's family thinks that some of his difficulties may be increasing depression..." A physician progress note dated 3/7/13 (2 weeks later) states the resident has been having a lot of difficulties recently. [His/her] agitation level has increased...he is more irritable...his outbursts have become more violent...striking out more...The patient has been getting PRN Lorazepam for this...the patient has been having increasingly frequent hallucinations...the patient had escalated to the point where he was uncontrollable the other day...The most likely explanation for the symptomatology is progression of his underlying dementia...Although there are no perfect treatments for this, neuroleptic medications are probably the best option...The patient's [family] has been reluctant to allow us to use neuroleptics because the patient has been on Risperidone in the past and it did not seem to help [his/her] behavior all that much and the patient became very drowsy... [family] agreed to a trial of a neuroleptic." As of 6/5/13 the resident remains on the daily dose of the anti-psychotic medication. Per observation throughout the day on 6/4/13, and confirmed by staff interview with the evening nurse on 6/4/13 at 4:30 PM, the resident has remained in bed all day and had been very tired, refusing care offered by staff.</p> <p>In addition, behavior monitoring sheets and nurses notes are not being completed consistently in order to accurately track actual incidents of behavior, and the care plan for non-pharmacological interventions to be used</p>	F 329			

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F 329	Continued From page 49 when the resident displays behavior is not consistently being implemented (See F282 for Resident #83 and example #3 in this citation), so it is unclear how the facility and the physician are accurately reviewing the behavioral symptoms of this resident to evaluate the ongoing need for the daily use of anti-psychotic medication to treat symptoms of dementia.  See also F282.  5. Per record review on 6/5/13, Resident #40 was prescribed by the physician as needed (prn) pain medication (Percocet 5-325 mg tab orally) to be given at bedtime when pain was expressed by anger or agitation. Per review of the Medication Administration Record (MAR), Resident #40 received the as needed medication on four occasions (5/2, 5/4, 5/9, 5/30/13) at bedtime. The nurse did not document on these dates the reason for use, a pain assessment, or any behaviors exhibited on either the MAR or the nurse progress notes. The nurse also did not document the effect of the medication following as needed administration. On 6/5/13 at 11:00 AM, the Registered Nurse confirmed that on 5/2, 5/4, 5/9, and 5/30/13, the nurse did not document anywhere in the medical record the reason for use, behaviors, pain assessment, or effect of the medication administered under the physician's order for as needed use regarding pain expressed by anger or agitation.	F 329			
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS	F 353			

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F 353	<p>Continued From page 50</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, record review and staff interviews, the facility failed to provide sufficient staff to provide timely dining assistance to 3 of 20 residents (Residents #24, 40, 43), failed to provide staff who are knowledgeable of resident's specific care needs, and failed to provide overall levels of staffing to meet all nursing care and supervision needs. Findings include:</p> <p>1. Per record review on 6/4/13, Resident #40 has nutritional needs related to diagnoses including dementia with depressed mood, chronic fatigue, and dysphagia oral phase (trouble swallowing).</p>	F 353	<p>F353</p> <p>Resident(s) #24, 40, and 43 are receiving timely dining assistance in accordance with their care plans.</p> <p>Residents who reside at the center are identified as having the potential to be affected. The process for providing dining assistance has been reviewed by the center QA team and adjustments (including staff assignments) made so that each resident receives timely assistance.</p> <p>Staff has been provided with education on the revised dining process. Resident care plans and care kardexes have been revised to include dining related care needs.</p> <p>The Executive Director/designee will conduct direct observations of dining service 4 times per week for one month, then, weekly for 3 months, at various meals to monitor ongoing compliance. Trends of the audits will be reviewed at the center QA committee with remedial measure initiated as identified.</p> <p>Administrator/designee will monitor for compliance.</p> <p>July 8, 2013</p>	

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F 353	<p>Continued From page 51</p> <p>The comprehensive resident assessment of 4/25/13 notes the need for one staff assist during eating. Resident #40 has been followed by the Registered Dietician (RD) and the weekly nutrition high risk committee for a weight loss trend, per interview with the RD at 11:16 AM on 6/5/13. The written plan of care for Resident #40 directs staff to provide setup, encouragement and reminders for eating; "Feed him/her if cannot focus on the task". Additionally, in the care plan addressing moderate nutritional risk, the staff are directed that "if fatigue is interfering with intake, allow for rest periods and reheat and refresh meals as needed".</p> <p>During an observation of the midday meal in the main dining room on 6/3/13, Resident #40 was noted to eat a few bites of the hot meal and then doze off. S/he was not awakened to eat, nor did staff refresh the meal after a 30 minute period, including when another resident sampled his/her thickened juice and it was discarded.</p> <p>Additionally, Resident #24 was observed asleep at the table with a meal and beverages in front of him/her for a period of at least 30 minutes. The meal was not refreshed for Resident #24. Per review the care plan dated 04/25/13 notes an alteration in nutrition related to chewing/swallowing problems regarding Dysphagia, Edentia and weight loss. Staff are directed to provide total assistance for Resident #24 with meals and fluids to assure no instances of aspiration.</p> <p>Resident #43 fell asleep and did not eat until a nurse came into the dining room 30 minutes after the meal was served. The meal was not</p>	F 353	<p>The center has secured eight (8) licensed nurses who will have a long term contract to work at the center on all 3 shifts. The contract will remain in effect until permanent nursing staff have been hired.</p> <p>Licensed Nursing Assistants (6) six have been hired. They are permanent employees of the center. Currently there are (4) four more individuals in the LNA training program. They will be ready to assume their duties mid August.</p> <p>All of the above have or will have orientation to the center and units they will be assigned to.</p> <p>Recruitment and retention committee meets weekly and will audit hiring needs. Results will be reported to the QA committee</p> <p>Director of Nursing/designee will monitor of compliance.</p> <p>July 8, 2013</p> <p>F353 POC accepted 7/15/13 MHiggins RN   Pmc</p>		

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F 353	<p>Continued From page 52</p> <p>refreshed for Resident #43 prior to feeding assistance. There were 18-20 residents in the dining room at any given time during this observation on 6/4/13, with two Licensed Nurse Assistants (LNAs) assisting residents who required supervision, cueing, and feeding assistance. A nurse came in to assist briefly, 30 minutes into the dining experience. At 12:55 PM one of the LNAs confirmed that there are usually three LNA staff to assist at the midday meal in the main dining room, and that today they had only two, and that even with three they are unable to offer timely assistance. This LNA confirmed that Residents #24, 40, and 43 were not assisted for 30 minutes after the hot meal was served.</p> <p>2. On the 6/5/13 at 7:45 AM, I visited Resident #40 in his/her room where I found him/her to be up in the wheelchair, groomed and dressed, and calling out repetitively. The Registered Nurse administered the 8:00 AM medications, and the LNA wheeled Resident #40 to the main dining room (8:00 AM). Resident #40 was observed to remain at the table, calling out repetitively, with no food or drink or attention from staff until 8:55 AM. At this time an LNA offered a glass of milk, and Resident #40 requested something to eat. An appropriate hot breakfast was provided, though an hour after arrival to the dining room. Later in the day at 1:10 PM, I observed Resident #40 asleep in the dining room, with a partially eaten lunch meal (approximately 25% consumed) on his/her plate. An LNA then confirmed that s/he had fed Resident #40 until he fell asleep. There were no attempts to awaken the resident or refresh the meal during my observation [until 1:30 PM] when staff returned him/her to the room to lie down.</p>	F 353		

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F 353	<p>Continued From page 53</p> <p>2. Per family interviews during the survey, concerns were raised regarding staff turnover and the need for "traveling" (agency sub-contracted) nurses and Licensed Nurse Aides (LNAs). In the first instance a resident with difficulty swallowing required medications crushed and liquids thickened. A family member was present when a traveling nurse entered the room to administer medications. The family member noted that the medications were not crushed and the liquids were not thickened, and stopped the nurse from administering them.</p> <p>Secondly, for a resident with contact dermatitis, the dermatologist has recommended certain personal hygiene products and stated that the products provided by the facility should not be used. The family member was in the residents room when a "traveling" LNA prepared to provide personal hygiene care to the resident. The LNA took facility products (not the resident's specialized products) from the resident's bedside stand and when questioned stated "this is what we always use." The family member stated that they then showed the LNA where the special products, provided by the family, were kept.</p> <p>In a review of schedules, dated May 12, 2013 to June 2, 2013, the facility does use both agency sub-contracted nurses (Registered Nurses [RNs] and Licensed Practical Nurses [LPNs]) and LNAs. There are three to five nurses used per day and three to six LNAs used per day on most days. On five days the numbers of agency nurses were lower and on two days the numbers were higher.</p>	F 353		

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F 353	Continued From page 54 There were no days with no agency staff. In an interview on the afternoon of 6/4/2013 the DNS confirmed that the facility does use agency staff to fill the gaps in the schedule and that the need varies.  While it is not a violation of regulatory requirements to use agency staff, all agency staff must be educated to each resident's specific care needs and provide care as directed by the comprehensive plan of care and each resident's choices.  3. Per record review of resident needs on both units, provided by unit managers, and the numbers of staff on each shift on each day, there are insufficient numbers of direct care staff to meet the identified needs of all residents. This was calculated using the specific needs of residents on the unit in regards to transfer needs, assistance levels, toileting/incontinence care needs as compared to the number of staff assigned per unit.	F 353		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	F428 Resident #83 was not affected by the alleged deficient practice. A pharmacist medication regime review has been conducted with physician and nursing responses being carried out with regards to the pharmacist's recommendations.  Residents who reside at the center are identified as having the potential to be affected. Pharmacist medication regime	

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F 428	<p>Continued From page 55</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to assure the pharmacist reports any irregularities to the attending physician and Director of Nursing for 1 of 10 residents reviewed. Findings include:</p> <p>1. Per record review for Resident #83, there is no evidence an irregularity was reported by the pharmacist to the physician and no evidence of a physician response to an irregularity, regarding a lack of appropriate diagnosis to start an anti-psychotic medication in March 2013. Per the monthly pharmacy review summary, in March 2013, the consulting pharmacist made multiple notes, including "Why Zyprexa [anti-psychotic medication]?". Per staff interview on 6/5/13, notes under this section would indicate the pharmacist also completed a typed pharmacy consultation report and would be sent to the facility (and to the physician). Facility staff, including the DNS, were asked to provide evidence of the pharmacist communicating this irregularity to the facility and/or the physician, and also were asked to provide evidence of the physician's response to the pharmacist if a report was sent. Neither was provided to the surveyor despite ongoing requests for this evidence and statements that the facility was in communication with the pharmacist, and the facility was given 2 days after the completion of the survey to send this information to the surveyor. As of 6/14/13, nothing has been received regarding evidence that the irregularity regarding the start of a daily anti-psychotic medication without an appropriate diagnosis was reported to the attending physician</p>	F 428	<p>reviews have been conducted with resultant recommendations being acted upon by the physician and nursing staff.</p> <p>Ongoing, interim and monthly medication regime reviews, recommendations, and evidence of physician and/or nursing response will be maintained in the resident's medical record.</p> <p>At each consultant visit, the pharmacist will provide the Director of Nurses with a list of residents of medication regime reviews conducted.</p> <p>The Director of Nurses/Nurse Supervisors/designee will conduct audits monitor ongoing compliance. Remedial measures will be initiated as identified. A summary of findings and trends will be reported to the QA committee with additional actions towards performance improvement taken as necessary.</p> <p>DNS/designee will monitor for ongoing compliance.</p> <p>July 8, 2013</p> <p><i>F428 POC accepted 7/15/13</i> <i>M Higgins RN   PMC</i></p>	
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<p>F 428</p> <p>F 463 SS=D</p>	<p>Continued From page 56 and director of nursing.</p> <p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH</p> <p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to assure that the nurses' station was equipped to receive calls from resident rooms for 2 residents (Resident #51 and #100). Findings include:</p> <p>1. During the environmental tour of the facility on 6/4/13 at 1:00 PM, the Maintenance Director confirmed that the call system was non-functional for Resident #51. At 1:20 PM s/he additionally confirmed that the call system was non-functional for Resident #100. During the tour, it was confirmed by work request record review at the nurses' station and interview of the Maintenance Director that there had not been communication to maintenance regarding the non-functional call devices for Residents #51 and #100.</p>	<p>F 428</p> <p>F 463</p>	<p>F463 Resident #51 and resident #100 was not adversely affected by the alleged deficient practice.</p> <p>Both call lights were replaced immediately and are functional.</p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>An audit of all rooms was conducted and no other malfunctioning call light was found.</p> <p>Hand call bells will be provided to any resident with malfunctioning call light until call light system is fixed.</p> <p>Weekly audits of call light functionality will be conducted weekly times 4 weeks, then monthly for 3 months, to ensure all are functional.</p> <p>Staff has been inserviced on notification to maintenance for call lights that are non-functioning.</p> <p>Audit of call light functionality will be brought to the facility QA meeting.</p> <p>Maintenance Director/designee will monitor for compliance.</p>	
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F463 POC accepted 7/15/13  
MHigginsRN | AMC