



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

July 14, 2010

James Beeler, Administrator
Rowan Court Health & Rehab
378 Prospect Street
Barre, VT 05641

Provider #: 475037

Dear Mr. Beeler:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 16, 2010**. Please post this document in a prominent place in your facility.

We will 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,

Suzanne Leavitt, RN, MS
Assistant Director

Enclosure



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

RECEIVED
Division of

PRINTED: 06/29/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	JUL 12 10 Licensing and Protection (X3) DATE SURVEY COMPLETED 06/16/2010
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NAME OF PROVIDER OR SUPPLIER ROWAN COURT HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000		
F 155 SS=D	<p>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES</p> <p>The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to allow 2 residents in the stage 2 sample to exercise their right to refuse treatment or services (Residents #130, #101). Findings include:</p> <p>1. Per interview and record review, Resident #130, who was found by the surveyor to be alert and oriented during interviews, was not allowed to refuse placement of a tabs alarm (observed as a string clipped to the back of the resident's shirt that is connected to an alarm device). During interviews on 6/14/10 and on 6/15/10 at 1:00 PM, Resident #130 informed the surveyor that s/he did not want the tabs alarm in place because it made the resident feel "like a prisoner." Per record review, a nurses' note dated 6/5/10 states "TABS alarm in place. Multiple requests by resident to remove;" a nurses' note dated 6/6/10 states "Tab alarm in place and functioning. Asking staff to remove the alarm. Explained its purpose, however resident remains unhappy with its</p>	F 155	<p>F 155</p> <p>1. Resident # 130 was not affected by this alleged deficient practice.</p> <p>Resident # 130 had his/her alarm removed on 06/16/10.</p> <p>Any resident utilizing an alarm has the potential to be affected by this alleged deficient practice.</p> <p>All residents with alarms will be audited for alarm discontinuance.</p> <p>Nursing staff will be re-educated regarding alarm usage and the resident's right to refuse.</p> <p>All alarm placements will be reviewed at concurrent review.</p> <p>The results of all audits will be reported to the facility QA Committee for review for 90-days.</p> <p>The DNS/designee will be responsible for compliance.</p> <p>Corrective Action date: July 23, 2010</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE **Administrator** (X6) DATE **7/9/2010**

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 155	<p>Continued From page 1</p> <p>presence;" and another nurses note dated 6/7/10 states "resident [no] self transfers but not altogether happy [with] tabs alarm reacting to [his/her] getting up." There was no evidence that the tabs alarm was discontinued at any time. Per observations on 6/14/10 and on 6/15/10 at 1:00 PM, the tabs alarm was in place and connected to the back of the resident's shirt, out of reach of the resident. Per record review, Resident #130 has had no falls since admission to the facility.</p> <p>Per record review, a form labeled "Level of Understanding-Patient's Rights", signed by a Physician's assistant, indicates that the resident will be able to understand an explanation of Resident's Rights. A Mini-Mental State Examination, completed shortly after admission indicates only Mild Impairment. Per review of the current care plan, the use of the tabs alarm was not identified as an intervention used for this resident. During an interview on 6/15/10 at 3:14 PM, the Unit Manager confirmed that s/he was aware that Resident #130 did not want the tabs alarm in place, and confirmed that the alarm continues to be used.</p> <p>2. Per record review and family interview, the Durable Power of Attorney (DPOA) for Resident #101 was not allowed to participate in the care planning process without the resident being present. Per interview with the family on 06/14/2010 it was reported that Resident #101 had expressed a wish to his/her family that they not attend care plan meetings as it caused the resident undue stress and the preference was for the DPOA to 'handle everything'. Per MDS dated 04/02/2010, Resident #101 is coded as a '2' "moderately impaired" for cognition. Per family interview on 06/14/2010 and confirmed during interview with the Administrator on 06/16/2010 at</p>	F 155	<p>2. Resident # 101 was not affected by this alleged deficient practice.</p> <p>Any resident due for a care planning conference has the potential to be affected by this alleged deficient practice.</p> <p>The care plan coordinator will continue to invite the resident to care planning and honor preference for attendance.</p> <p>His/her attendance at care plan meetings is now being verified in writing to avoid discrepancies between the resident and care plan team.</p> <p>Care plan attendance will be reported to the QA Committee for review for 90-days.</p> <p>The DNS/designee will be responsible for compliance.</p> <p>Corrective Action date: July 23, 2010</p> <p>3. Resident # 101 was not affected by this alleged deficient practice.</p>		

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F 155	Continued From page 2 2:00 pm, two care plan meetings were cancelled by the facility administration when the DPOA arrived and requested that Resident #101, per the resident's previous wishes, be returned to his/her room. 3. Per record review, staff and family interview, the facility failed to honor the DPOA's request for Resident #101 for refusal of treatment. Per record review Resident # 101 fell on Friday, 06/11/2010 sustaining a 'bump on the head.' Documentation in the nurses notes of 06/11/2010 substantiate that the resident fell and made comments that s/he'd "be better off dead." The facility determined that Resident #101 was suicidal and attempted to have him/her transported by ambulance to the behavior unit. The DPOA requested that resident not be transferred and that the DPOA would make arrangements for psychological evaluation. The local hospital beds were not available at the time and a decision made by the facility, was to transport the resident 60 miles away to another behavior unit. On 6/11/10 a local mental health agency screener determined during an on site evaluation on that the resident was not a suicide risk. This was confirmed by a psychiatric visit to resident on the morning of 06/14/2010. Despite these two evaluations the resident was maintained on 15-minute suicide checks from 06/11/2010 through 06/15/2010. Per record review and confirmed with the Administrator during interview, the ambulance transfer did not occur because the ambulance crew would not transfer [because the resident and DPOA refused]. The facility honored the policy of the ambulance crew and not the wishes of the resident or DPOA to refuse treatment.	F 155	The resident was not sent to the emergency room as per his/her request but, the centers suicide precaution policy was initiated. He/she was maintained on 15-minute checks as per policy. Any/all residents experiencing suicidal ideations have the potential to be affected by this alleged deficient practice. Any/all residents experiencing suicidal ideations will be treated and monitored as per policy. Any refusal of treatment will not supersede the center's obligation to provide precautionary non-invasive monitoring. Any refusals of treatment and measures taken will be reviewed at concurrent review for follow-up. Nursing will be re-educated on the facility's suicide precaution policy and resident's rights. Refusal of treatment will be reported to the QA Committee for 90 days.	
F 221	483.13(a) RIGHT TO BE FREE FROM	F 221		

Corrective Action date: July 23, 2010

P.O.C. Accepted 7/13/10 [Signature]

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F 221 SS=D	<p>Continued From page 3 PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that 1 applicable resident from the total sample is free from any physical restraints not required to treat the resident's medical symptoms (Resident #130). Findings include:</p> <p>1. Per observation, interview and record review, Resident #130, who was found by the surveyor to be alert and oriented during interviews, is not free from physical restraints. A tabs alarm, observed on 6/14/10 and 6/15/10 as a string clipped to the back of the resident's shirt, out of reach of the resident, that is connected to an alarm device, is used daily on Resident #130 to prevent falls since the day of admission to the facility. Per record review, Resident #130 has had no falls since admission to the facility. During resident interviews on 6/14/10 and on 6/15/10 at 1:00 PM, Resident #130 informed the surveyor that s/he did not want the tabs alarm in place because it made the resident feel "like a prisoner." The resident further stated that it restricts his freedom of movement and normal access to his/her body in the wheelchair and in bed, giving the examples of not being able to lean forward to scratch his/her leg and not being able to roll over in bed without the alarm sounding.</p>	F 221	<p>F 221</p> <p>Resident # 130 was not affected by this alleged deficient practice.</p> <p>Resident # 130 had his/her alarm removed on 06/16/10.</p> <p>Any resident utilizing an alarm has the potential to be affected by this alleged deficient practice.</p> <p>All residents with alarms will be audited for alarm discontinuance.</p> <p>Nursing staff will be re-educated regarding alarm usage and the resident's right to refuse.</p> <p>All alarm placements will be reviewed at concurrent review.</p> <p>Alarm usage will be reported to the QA Committee for review for 90-days.</p> <p>The DNS/designee will be responsible for compliance.</p> <p>Corrective Action date: July 23, 2010</p> <p><i>P.O.C. Accepted 7/13/10 [Signature]</i></p>		

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F 221	<p>Continued From page 4</p> <p>The resident has made several requests for staff to remove the alarm. Per record review, a nurses' note dated 6/5/10 states "TABS alarm in place. Multiple requests by resident to remove;" a nurses' note dated 6/6/10 states "Tab alarm in place and functioning. Asking staff to remove the alarm. Explained its purpose, however resident remains unhappy with its presence;" and another nurses note dated 6/7/10 states "resident [no] self transfers but not altogether happy [with] tabs alarm reacting to his getting up." There was no evidence that the tabs alarm was discontinued at any time. Per observations on 6/14/10 and on 6/15/10 at 1:00 PM, the tabs alarm was in place and connected to the back of the resident's shirt, out of reach of the resident.</p> <p>Per record review, a form labeled "Level of Understanding-Patient's Rights", signed by a Physician's assistant, indicates that the resident will be able to understand an explanation of Resident's Rights. A Mini-Mental State Examination, completed shortly after admission indicates only Mild Impairment. A nurses' note, dated 6/6/10 identifies Resident #130 as "alert and oriented, pleasant and cooperative" and nurses notes dated 6/9/10 and 6/15/10 indicate that the resident is able to make his needs known to staff. Per review of the current care plan, the use of the tabs alarm was not identified as an intervention used for this resident, and per review of the physician's orders, this was not a physician ordered treatment. Per review of the Physical and Occupational Therapy notes, there were no notes regarding or recommending the use of the alarm. There was no evidence of an assessment for a potential restraint device or any attempt to use a less restrictive measure. During an interview on 6/15/10 at 3:14 PM, the Unit</p>	F 221	/		

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F 221	Continued From page 5 Manager confirmed that s/he was aware that Resident #130 did not want the tabs alarm in place, stated that the alarm is used as a safety nursing measure to prevent falls, confirmed that there has not been less restrictive measures attempted for this resident, and confirmed that staff has not assessed the alarm as a potential restraint device.	F 221	<p>F241</p> <p>Resident # 130 was not affected by this alleged deficient practice.</p> <p>Resident # 130 had his/her alarm removed on 06/16/10.</p> <p>Any resident utilizing an alarm has the potential to be affected by this alleged deficient practice.</p> <p>All residents with alarms will be audited for alarm discontinuance.</p> <p>Nursing staff will be re-educated regarding alarm usage and the resident's right to refuse.</p> <p>All alarm placements will be reviewed at concurrent review.</p> <p>Alarm usage will be reported to the QA Committee for review for 90-days.</p> <p>The DNS/designee will be responsible for compliance.</p> <p>Corrective Action date: July 23, 2010</p> <p><i>P.O.C. Accepted 7/13/10 [Signature]</i></p>		
F 241 SS=D	<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 provide care for 1 applicable resident in the stage 2 sample in a manner that maintains or enhances the resident's dignity and respect (Resident #130). Findings include:</p> <p>1. Per interview and record review, Resident #130, who was found by the surveyor to be alert and oriented during interviews, was not allowed to refuse placement of a tabs alarm (observed as a string clipped to the back of the resident's shirt that is connected to an alarm device) and indicated that it negatively affects his/her dignity. During interviews on 6/14/10 and on 6/15/10 at 1:00 PM, Resident #130 informed the surveyor that s/he did not want the tabs alarm in place because it made the resident feel "like a prisoner." Per record review, a nurses' note dated 6/5/10 states "TABS alarm in place.</p>	F 241			

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F 241	Continued From page 6 Multiple requests by resident to remove;" a nurses' note dated 6/6/10 states "Tab alarm in place and functioning. Asking staff to remove the alarm. Explained its purpose, however resident remains unhappy with its presence;" and another nurses note dated 6/7/10 states "resident [no] self transfers but not altogether happy [with] tabs alarm reacting to [his/her] getting up." There was no evidence that the tabs alarm was discontinued at any time. Per observations on 6/14/10 and on 6/15/10 at 1:00 PM, the tabs alarm was in place and connected to the back of the resident's shirt, out of reach of the resident. Per record review, a form labeled "Level of Understanding-Patient's Rights", signed by a Physician's assistant, indicates that the resident will be able to understand an explanation of Resident's Rights. A Mini-Mental State Examination, completed shortly after admission indicates only Mild Impairment. During a resident interview on 6/15/10 at 1:00 PM, Resident #130 stated that the placement and sounding of the alarm negatively affects his dignity, and indicated that s/he feels embarrassed by the alarm.	F 241	F 248 Resident #67 and #101 were not affected by the alleged deficient practice. All residents have the potential to be affected by this alleged deficient practice. All resident's activities care plans will be audited. Residents due for care planning will be reviewed weekly for 90-days. Care plan will be implemented and/or changed as necessary. The results of all audits will be reported to the facility QA committee for review for 90 days. The Activities Director/designee will be responsible for compliance. Corrective Action date: July 23, 2010		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to provide activities designed to meet the	F 248			

P.O.C. Accepted 7/13/10 Pmcsturn

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F 248	Continued From page 7 interests for 2 applicable residents in the target sample. (Resident #67 and #101) Findings include: 1. Per record review on 6/15/10, there was no indication that Resident #67 had been encouraged to participate in facility and / or 1:1 activities from 5/15/10 to 5/30/10 according to the Resident's daily activity log. Per interview with the Activities Director on 6/15/10 at 3:50 PM, it was confirmed that no evidence was available to indicate that Resident #67 had been encouraged to participate or had participated in any activities during this time period. Per record review on 06/15/2010, there is no evidence that the activity care plan for Resident #101 reflects the current status of this resident since s/he returned from the hospital on 03/23/2010. Per staff interview on 06/16/2010 it was confirmed that Resident #101 does not participate in the offered organized activities at the facility. It was further confirmed during interview with the Activity Director on 06/16/2010 that there are no individualized approaches for the staff to use to encourage resident's involvement nor measurable goals for which to aim.	F 248	/	
F 279 SS=E	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	F 279		

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F 279	<p>Continued From page 8 assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to develop a comprehensive care plan for 3 applicable residents in the stage 2 sample. (Resident #82, #67, & #130) Findings include:</p> <p>1. Per record review on 06/15/10 for Resident # 82, a resident who was on fluid restriction, a care plan addressed fluid volume excess but not a comprehensive care plan specific to fluid restriction. The general care plan used for all residents, states 'obtain vital signs, baseline weight, monitor I&O (intake & output), meds and treatments as ordered'. However, there were no quantifiable objectives with measurable outcomes for fluid restriction.</p> <p>Per interview on 06/16/10 at 11:30 A.M. the ADNS (Assistant Director of Nursing) confirmed a failure to develop a comprehensive care plan to address interventions, measurable objectives or goals.</p> <p>2. Per record review on 6/15/10, there was no dental care plan established for Resident #67,</p>	F 279	<p>F279</p> <p>1. Resident #82 was not affected by this alleged deficient practice.</p> <p>He/she was discharged to home.</p> <p>All residents with a fluid restriction have the potential to be affected by this alleged deficient practice.</p> <p>All residents on fluid restriction will be audited for compliance, MD notification, and care planning with quantifiable objectives.</p> <p>Nursing staff will be re-educated on fluid restrictions and required documentation.</p> <p>Residents with fluid restrictions will be reviewed at concurrent review.</p> <p>The results of all audits will be reported to the facility QA committee for review for 90-days.</p> <p>The DNS/designee will be responsible for compliance.</p> <p>Corrective Action date: July 23, 2010</p>	

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F 279	<p>Continued From page 9</p> <p>although the admission assessment indicated the need for a dental evaluation. Per nurse manager interview 6/16/10 at 9:15 AM, no dental care plan had been developed for this resident as was indicated by original nursing assessment.</p> <p>3. Per record review on 6/15/10, there was no resident specific care plan developed for Resident #67 related to activity preferences. Per interview on 6/15/10 @ 3:15 PM, the Activity Director confirmed that resident preferences, identified during admission assessments, had not been transferred from the admission assessment to the plan of care for this resident.</p> <p>4. Per record review on 6/15/10, there was no care plan development related to pain for Resident #67, who was assessed upon admission to experience pain. Further record review identified that the resident received daily scheduled pain medication and had intermittently received PRN (as needed) pain medication to supplement routine medication. During interview on 6/16/10 at 9:15 AM, the Unit Nurse Manager confirmed that no plan of care related to pain had been completed prior to that morning.</p> <p>5. Per interview and record review, a care plan was not developed to reflect the use of a tabs alarm (alarm that sounds when the resident rises from his/her chair or bed) for Resident #130. Per observations on 6/14/10 and on 6/15/10 at 1:00 PM, the tabs alarm was in place and connected to the back of the resident's shirt. Per review of the Nurses' Notes, the tabs alarm was placed on the resident on the day of admission to the facility and used on a daily basis. Per review of the current care plan, the use of the tabs alarm was not identified as an intervention used for this resident. During an interview on 6/15/10 at 3:14 PM, the</p>	F 279	<p>2. Resident #67 was not affected by this alleged deficient practice.</p> <p>He/she was discharged to a residential care center.</p> <p>All residents in need of a dental evaluation have the potential to be affected by this alleged deficient practice.</p> <p>All residents with the need for a dental assessment will be audited and care plans devised as appropriate.</p> <p>Nurses will be re-educated on the need to care plan for dental needs.</p> <p>The results of all audits will be reported to the facility QA committee for review for 90-days.</p> <p>The DNS/designee will be responsible for compliance.</p> <p>Corrective Action date: July 23, 2010</p>	

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F 279	<p>Continued From page 9</p> <p>although the admission assessment indicated the need for a dental evaluation. Per nurse manager interview 6/16/10 at 9:15 AM, no dental care plan had been developed for this resident as was indicated by original nursing assessment.</p> <p>3. Per record review on 6/15/10, there was no resident specific care plan developed for Resident #67 related to activity preferences. Per interview on 6/15/10 @ 3:15 PM, the Activity Director confirmed that resident preferences, identified during admission assessments, had not been transferred from the admission assessment to the plan of care for this resident.</p> <p>4. Per record review on 6/15/10, there was no care plan development related to pain for Resident #67, who was assessed upon admission to experience pain. Further record review identified that the resident received daily scheduled pain medication and had intermittently received PRN (as needed) pain medication to supplement routine medication. During interview on 6/16/10 at 9:15 AM, the Unit Nurse Manager confirmed that no plan of care related to pain had been completed prior to that morning.</p> <p>5. Per interview and record review, a care plan was not developed to reflect the use of a tabs alarm (alarm that sounds when the resident rises from his/her chair or bed) for Resident #130. Per observations on 6/14/10 and on 6/15/10 at 1:00 PM, the tabs alarm was in place and connected to the back of the resident's shirt. Per review of the Nurses' Notes, the tabs alarm was placed on the resident on the day of admission to the facility and used on a daily basis. Per review of the current care plan, the use of the tabs alarm was not identified as an intervention used for this resident. During an interview on 6/15/10 at 3:14 PM, the</p>	F 279	<p>3. Resident #67 was not affected by the alleged deficient practice.</p> <p>All residents have the potential to be affected by this alleged deficient practice.</p> <p>All resident's activities care plans will be audited.</p> <p>Residents due for care planning will be reviewed weekly for 90-days. Care plan will be implemented and/or changed as necessary.</p> <p>The results of all audits will be reported to the facility QA committee for review for 90 days.</p> <p>The Activities Director/designee will be responsible for compliance.</p> <p>Corrective Action date: July 23, 2010</p> <p>4. Resident # 67 was not affected by the alleged deficient practice.</p> <p>He/she was discharged to a residential care facility.</p> <p>All residents who experience pain have the potential to be affected by this alleged deficient practice.</p>		

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F 279	<p>Continued From page 9</p> <p>although the admission assessment indicated the need for a dental evaluation. Per nurse manager interview 6/16/10 at 9:15 AM, no dental care plan had been developed for this resident as was indicated by original nursing assessment.</p> <p>3. Per record review on 6/15/10, there was no resident specific care plan developed for Resident #67 related to activity preferences. Per interview on 6/15/10 @ 3:15 PM, the Activity Director confirmed that resident preferences, identified during admission assessments, had not been transferred from the admission assessment to the plan of care for this resident.</p> <p>4. Per record review on 6/15/10, there was no care plan development related to pain for Resident #67, who was assessed upon admission to experience pain. Further record review identified that the resident received daily scheduled pain medication and had intermittently received PRN (as needed) pain medication to supplement routine medication. During interview on 6/16/10 at 9:15 AM, the Unit Nurse Manager confirmed that no plan of care related to pain had been completed prior to that morning.</p> <p>5. Per interview and record review, a care plan was not developed to reflect the use of a tabs alarm (alarm that sounds when the resident rises from his/her chair or bed) for Resident #130. Per observations on 6/14/10 and on 6/15/10 at 1:00 PM, the tabs alarm was in place and connected to the back of the resident's shirt. Per review of the Nurses' Notes, the tabs alarm was placed on the resident on the day of admission to the facility and used on a daily basis. Per review of the current care plan, the use of the tabs alarm was not identified as an intervention used for this resident. During an interview on 6/15/10 at 3:14 PM, the</p>	F 279	<p>All residents experiencing pain/potential for pain will be audited weekly and care plans will be devised as appropriate.</p> <p>Nurses will be re-educated on care planning for pain.</p> <p>The results of all audits will be reported to the facility QA Committee for review for 90-days.</p> <p>The DNS/designee will be responsible for compliance.</p> <p>Corrective Action date: July 23, 2010</p> <p>5. Resident # 130 was not affected by this alleged deficient practice.</p> <p>Resident # 130 had his/her alarm removed on 06/16/10.</p> <p>Any resident utilizing an alarm has the potential to be affected by this alleged deficient practice.</p> <p>The care plans of all residents with an alarm will be audited.</p> <p>Nurses will be re-educated on care planning for alarm use.</p>		

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F 279 F 280 SS=E	Continued From page 10 Unit Manager confirmed that the care plan did not identify the use of the tabs alarm. 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 staff interviews and record review, the facility failed to revise the care plan to reflect each resident's identified needs for 4 applicable residents. (Residents #82, #67, #35 & #101) Findings include: 1. Per record review on 06/15/10, nursing staff failed to evaluate and revise the care plan interventions for Resident #82 for dehydration and fluid restriction. The Admission care plan	F 279 F 280	The results of all audits will be reported to the facility QA Committee for review for 90-days. The DNS/designee will be responsible for compliance. Corrective Action date: July 23, 2010 <i>P.O.C. Accepted 7/13/10 FMCOTARW</i> F280 1. Resident # 82 was not affected by this alleged deficient practice. He/she has been discharged home. Any resident with a diagnosis of dehydration has the potential to be affected by this alleged deficient practice. Any resident with a diagnosis of dehydration will have his/her care plan revised as appropriate. Residents with a diagnosis of dehydration will be reviewed at concurrent review. The care plans of residents with a diagnosis of dehydration will be audited.		

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F 280	<p>Continued From page 11 dated 01/01/10 was a general fluid volume excess care plan used for all residents which stated 'obtain vital signs, baseline weight, monitor I&O (intake & output), meds and treatments as ordered'. The resident went to the emergency room 03/19/10 -03/22/10 [for 3 days] and returned with an admit diagnosis of dehydration. The care plan had not been updated to reflect the resident's specific status change and interventions. Per interview on 06/16/10 at 11:30 A.M. the ADNS (Assistant Director of Nursing) confirmed a failure to develop a revised care plan to address interventions and status change.</p> <p>2. Per record review on 6/15/10, there was no revision of the initial care plan identifying resident specific activities for Resident #67, who does not participate in group activities. During interview on 6/15/10 at 3:50 PM, the Activities Director confirmed this resident 'is a loner' who enjoys 1:1 visits and that the care plan does not describe specific interventions for this resident.</p> <p>3. Per interview and record review, staff failed to revise the care plan for Resident #35 regarding a skin condition. Per record review, Resident #35 has had an ongoing skin irritation with complaints of continued itching made by the resident from 12/09 to present. Per review of the Care Plan Conference Summary dated 5/4/10, it states "continues to itch and scratch self...will request special linen." Social Service notes made during care plan meetings on 3/16/10 and 5/4/10 state, respectively, "...complaining of constant itching...discussed trial of using special linen to see if this will help..." and "still c/o itching and scratches herself...will do special linen to decrease itching." Per review of the current care plan for Resident #35, there is no mention of special linen. During an interview on 6/16/10 at</p>	F 280	<p>Nurses will be educated on the need for dehydration care planning.</p> <p>The results of all audits will be reported to the facility QA Committee for review for 90-days.</p> <p>The DNS/designee will be responsible for compliance.</p> <p>Corrective Action date: July 23, 2010</p> <p>2. Resident #67 was not affected by the alleged deficient practice.</p> <p>All residents have the potential to be affected by this alleged deficient practice.</p> <p>All resident's activities care plans will be audited.</p> <p>Residents due for care planning will be reviewed weekly for 90-days. Care plan will be implemented and/or changed as necessary.</p> <p>The results of all audits will be reported to the facility QA Committee for review for 90 days.</p> <p>The Activities Director/designee will be responsible for compliance.</p>	

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F 280	Continued From page 11 dated 01/01/10 was a general fluid volume excess care plan used for all residents which stated 'obtain vital signs, baseline weight, monitor I&O (intake & output), meds and treatments as ordered'. The resident went to the emergency room 03/19/10 -03/22/10 [for 3 days] and returned with an admit diagnosis of dehydration. The care plan had not been updated to reflect the resident's specific status change and interventions. Per interview on 06/16/10 at 11:30 A.M. the ADNS (Assistant Director of Nursing) confirmed a failure to develop a revised care plan to address interventions and status change. 2. Per record review on 6/15/10, there was no revision of the initial care plan identifying resident specific activities for Resident #67, who does not participate in group activities. During interview on 6/15/10 at 3:50 PM, the Activities Director confirmed this resident 'is a loner' who enjoys 1:1 visits and that the care plan does not describe specific interventions for this resident. 3. Per interview and record review, staff failed to revise the care plan for Resident #35 regarding a skin condition. Per record review, Resident #35 has had an ongoing skin irritation with complaints of continued itching made by the resident from 12/09 to present. Per review of the Care Plan Conference Summary dated 5/4/10, it states "continues to itch and scratch self...will request special linen." Social Service notes made during care plan meetings on 3/16/10 and 5/4/10 state, respectively, "...complaining of constant itching...discussed trial of using special linen to see if this will help..." and "still c/o itching and scratches herself...will do special linen to decrease itching." Per review of the current care plan for Resident #35, there is no mention of special linen. During an interview on 6/16/10 at	F 280	3. "Special linen" was never ordered by resident # 35's attending physician. Resident # 35 is currently using anti-itch creams and anti-anxiety medications. Resident # 35 has infrequent complaints of itching. He/she has as needed anti-itch cream ordered. Resident # 35 went to a dermatology consult on 07/08/10. All residents with skin irritations with complaints of itching have the potential to be affected by this alleged deficient practice. The care plans of residents with skin irritations with complaints of itching will be audited. All residents with symptoms of itching will be reviewed at concurrent review. Nurses will be re-educated on care planning all interventions used. The results of all audits will be reported to the facility QA Committee for review for 90-days.		

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F 280	Continued From page 11 dated 01/01/10 was a general fluid volume excess care plan used for all residents which stated 'obtain vital signs, baseline weight, monitor I&O (intake & output), meds and treatments as ordered'. The resident went to the emergency room 03/19/10 -03/22/10 [for 3 days] and returned with an admit diagnosis of dehydration. The care plan had not been updated to reflect the resident's specific status change and interventions. Per interview on 06/16/10 at 11:30 A.M. the ADNS (Assistant Director of Nursing) confirmed a failure to develop a revised care plan to address interventions and status change. 2. Per record review on 6/15/10, there was no revision of the initial care plan identifying resident specific activities for Resident #67, who does not participate in group activities. During interview on 6/15/10 at 3:50 PM, the Activities Director confirmed this resident 'is a loner' who enjoys 1:1 visits and that the care plan does not describe specific interventions for this resident. 3. Per interview and record review, staff failed to revise the care plan for Resident #35 regarding a skin condition. Per record review, Resident #35 has had an ongoing skin irritation with complaints of continued itching made by the resident from 12/09 to present. Per review of the Care Plan Conference Summary dated 5/4/10, it states "continues to itch and scratch self...will request special linen." Social Service notes made during care plan meetings on 3/16/10 and 5/4/10 state, respectively, "...complaining of constant itching...discussed trial of using special linen to see if this will help..." and "still c/o itching and scratches herself...will do special linen to decrease itching." Per review of the current care plan for Resident #35, there is no mention of special linen. During an interview on 6/16/10 at	F 280	The DNS/designee will be responsible for compliance. Corrective Action date: July 23, 2010 4. Resident # 35 was not affected by this alleged deficient practice. All residents with loose stools have the potential to be affected by this alleged deficient practice. The care plans of residents with loose stools will be audited. All residents with loose stools will be reviewed at concurrent review. Nurses will be re-educated on care planning loose stools. The results of all audits will be reported to the facility QA Committee for review for 90-days. The DNS/designee will be responsible for compliance. Corrective Action date: July 23, 2010 5. Resident # 101 was not affected by the alleged deficient practice.	

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F 280	Continued From page 12 11:57 AM, the Housekeeping Manager confirmed that Resident #35 is not receiving special linens and stated that s/he was never informed about the resident's need for special linens. 4. Per interview and record review, staff failed to revise the care plan for Resident #35 to address episodic loose stools. Per review of Nurses' notes and physician progress notes, Resident #35 has had ongoing episodic loose stools since 2/10 and requests imodium to treat the symptoms. Per review of the current care plan, there is no mention of the episodic loose stools that the resident is experiencing. During an interview on 6/16/10 at 11:40 AM the Director of Nursing confirmed that there is no care plan that addresses the resident's ongoing problem with loose stools. 5. Per record review on 06/15/2010 there was no revision of the care plan for Resident #101 since s/he was readmitted to facility on 03/23/2010. There are no measurable goals on the activity care plan related to a resident who does not participate in the planned activity program. During interview on 06/16/2010 the Activities Director confirmed that the care plan for Resident #101 was incomplete and that a new activity assessment had not been done for this resident after an 8-day hospitalization.	F 280	All residents have the potential to be affected by this alleged deficient practice. All resident's activities care plans and activity assessments will be audited. Residents due for care planning will be reviewed weekly for 90-days. Care plans will be implemented and/or changed as necessary. All activity department staff members will be re-educated on care plan and assessment documentation. The results of all audits will be reported to the facility QA Committee for review for 90 days. The Activities Director/designee will be responsible for compliance. Corrective Action date: July 23, 2010		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 281	<i>P.O.C. Accepted 7/13/10 [Signature]</i> F281 1. Resident # 82 was not affected by this alleged deficient practice. He/she was discharged to home.		

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F 281	<p>Continued From page 13</p> <p>review, the facility failed to provide services in accordance with professional standards of practice or follow physician's orders for 2 applicable residents in the targeted sample (Residents # 82 & 92) Findings include:</p> <p>1. Per record review on 06/15/10 Resident #82 had intake and output (I&O) recordings greater than the fluid restriction requirements. Per current physician's orders dated March 2010, staff are to monitor I&O's in accordance to the daily fluid requirement and limit the fluid to 1500 cc daily. Per review of the I&O flowsheet on March 13, 14, 25, 28 and April 1, 8, 15, 27, & 29 2010 all had greater than 1500 cc of fluids per day. Per interview on 06/16/10 at 11:00 A.M. nursing staff stated "probably the patient requested [more fluids] and the LNA's gave extra". Nursing staff were not aware of who was providing oversight to the I&O flowsheets and did not notify the physician. Per interview on 06/16/10 at 1:40 P.M.. the ADNS confirmed that staff did not follow physician's orders for fluid restriction or follow professional standard of practice.</p> <p>2. Per observation, record review and interview Resident #92 received less than the ordered amount of a feeding supplement. Per observation on 6/14/10 at 2:15 PM, an LPN (Licensed Practical Nurse) administered 120 ml (milliliters) of a feeding supplement (Jevity 1.2 calories per ml) to Resident #92 via peg-tube. Per record review immediately following this observation and by interview the LPN confirmed, the physician order for this feeding indicated 240 ml of Jevity was to be administered was not followed.</p>	F 281	<p>All residents with a fluid restriction have the potential to be affected by this alleged deficient practice.</p> <p>All residents on fluid restriction will be audited for compliance, MD notification, and care planning with quantifiable objectives.</p> <p>Nursing staff will be re-educated on fluid restrictions and required documentation.</p> <p>Residents with fluid restrictions will be reviewed at concurrent review.</p> <p>The results of all audits will be reported to the facility QA Committee for review for 90-days.</p> <p>The DNS/designee will be responsible for compliance.</p> <p>Corrective Action date: July 23, 2010</p> <p>2. Resident # 92 was not affected by this alleged deficient practice.</p> <p>All residents receiving tube feedings have the potential to be affected by this alleged deficient practice.</p> <p>Random audits will be conducted on</p>		

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F 281	Continued From page 14	F 281	The results of all audits will be reported to the facility QA Committee for review for 90-days.	
F 309 SS=D	<p>*The Lippincott Manual of Nursing Practice, 5th edition</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide care and services to ensure 1 applicable resident in the stage 2 sample attains the highest practicable physical, mental, and psychosocial well being (Resident #35). Findings include:</p> <p>1. Per interview and record review, staff failed to provide care to ensure adequate pain control for Resident #35. Per review of Nurses' notes dated 5/13/10, a family member of Resident #35 informed the nurse that the resident was in pain at 5:00 PM. Per the nurses' note, there was an emergency situation happening with another resident, and the nurse was not able to speak with the family member or Resident #35 at that time. Per review of the MAR (Medication Administration Record) for 5/13/10, Resident #35 was not given medication for the complaint of pain until 9:15 PM on 5/13/10, over 4 hours later. There were no scheduled pain medications given</p>	F 309	<p>The DNS/designee will be responsible for compliance.</p> <p>Corrective Action date: July 23, 2010 <i>P.O.C. Accepted 7/13/10 [Signature]</i> F309</p> <p>1. Resident # 35 is receiving pain medication as ordered.</p> <p>All resident with complaints of pain have the potential to be affected by this alleged deficient practice.</p> <p>All residents with complaints of pain will be reviewed at concurrent review.</p> <p>All residents with new or chronic complaints of pain will be reviewed weekly.</p> <p>Nursing staff will be re-educated on administration of as needed pain medication.</p> <p>The results of all audits will be reported to the facility QA Committee for review for 90-days.</p>	

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NAME OF PROVIDER OR SUPPLIER ROWAN COURT HEALTH & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641		
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F 309	<p>Continued From page 15</p> <p>during the time frame specified above. During an interview on 6/16/10 at 11:33 AM, the nurse who wrote the above nurses' note confirmed that s/he did not administer pain medication at the time of the complaint of pain.</p> <p>2. Per interview and record review, staff failed to provide services to assist Resident #35 attain or maintain the highest practicable well-being regarding a skin condition. Per record review, Resident #35 has had an ongoing skin irritation with complaints of continued itching made by the resident from 12/09 to present. Per review of the Care Plan Conference Summary dated 5/4/10, it states "continues to itch and scratch self...will request special linen." Social Service notes made during care plan meetings on 3/16/10 and 5/4/10 state, respectively, "...complaining of constant itching...discussed trial of using special linen to see if this will help..." and "still c/o itching and scratches herself...will do special linen to decrease itching." Per review of the current care plan for Resident #35, there is no mention of special linen. During an interview on 6/16/10 at 11:57 AM, the Housekeeping Manager confirmed that Resident #35 is not receiving special linens and stated that s/he was never informed about the resident's need for special linens.</p> <p>3. Per interview and record review, the facility failed to administer medications to treat Resident #35's symptoms. Per review of Nurses' Notes, a note dated 2/14/10 states that Resident #35 requested imodium to treat loose stools, and according to the MAR, was not documented as being administered on 2/14/10. Another Nurses' note dated 3/9/10 states that Resident #35 was reporting soft stools and requested imodium. At this time, the Nurses' note indicates that the</p>	F 309	<p>The DNS/designee will be responsible for compliance.</p> <p>Corrective Action date: July 23, 2010</p> <p>2. "Special linen" was never ordered by resident # 35's attending physician.</p> <p>Resident # 35 is currently using anti-itch creams and anti-anxiety medications.</p> <p>Resident # 35 has infrequent complaints of itching. He/she has as needed anti-itch cream ordered.</p> <p>Resident # 35 went to a dermatology consult on 07/08/10.</p> <p>All residents with skin irritations with complaints of itching have the potential to be affected by this alleged deficient practice.</p> <p>All residents with symptoms of itching will be reviewed at concurrent review.</p> <p>The results of all audits will be reported to the facility QA Committee for review for 90-days.</p>		

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F 309	<p>Continued From page 15 during the time frame specified above. During an interview on 6/16/10 at 11:33 AM, the nurse who wrote the above nurses' note confirmed that s/he did not administer pain medication at the time of the complaint of pain.</p> <p>2. Per interview and record review, staff failed to provide services to assist Resident #35 attain or maintain the highest practicable well-being regarding a skin condition. Per record review, Resident #35 has had an ongoing skin irritation with complaints of continued itching made by the resident from 12/09 to present. Per review of the Care Plan Conference Summary dated 5/4/10, it states "continues to itch and scratch self...will request special linen." Social Service notes made during care plan meetings on 3/16/10 and 5/4/10 state, respectively, "...complaining of constant itching...discussed trial of using special linen to see if this will help..." and "still c/o itching and scratches herself...will do special linen to decrease itching." Per review of the current care plan for Resident #35, there is no mention of special linen. During an interview on 6/16/10 at 11:57 AM, the Housekeeping Manager confirmed that Resident #35 is not receiving special linens and stated that s/he was never informed about the resident's need for special linens.</p> <p>3. Per interview and record review, the facility failed to administer medications to treat Resident #35's symptoms. Per review of Nurses' Notes, a note dated 2/14/10 states that Resident #35 requested imodium to treat loose stools, and according to the MAR, was not documented as being administered on 2/14/10. Another Nurses' note dated 3/9/10 states that Resident #35 was reporting soft stools and requested imodium. At this time, the Nurses' note indicates that the</p>	F 309	<p>The DNS/designee will be responsible for compliance.</p> <p>Corrective Action date: July 23, 2010</p> <p>3. Resident # 35 continues to receive medication as ordered by his/her physician for "loose stools".</p> <p>All residents with complaints of loose stools have the potential to be affected by this alleged deficient practice.</p> <p>All residents with complaints of loose stools will be reviewed at concurrent review.</p> <p>Nurses will be re-educated on administration of as needed medications used for loose stools.</p> <p>The results of all audits will be reported to the facility QA Committee for review for 90-days.</p> <p>The DNS/designee will be responsible for compliance.</p> <p>Corrective Action date: July 23, 2010</p> <p><i>P.O.C. Accepted 7/13/10 P.M. Motar</i></p>	
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F 309	Continued From page 16 medication was not given, and indicates that the resident was upset by this. Per review of the MAR, the medication was not documented as being given on 3/9/10. Per review of a physician progress note dated 4/8/10, the physician states, "...concerned that not getting enough prn imodium when needs it..." During an interview on 6/16/10 at 11:22 AM, the Director of Nursing confirmed that the MAR indicates that the medication was not given on the above dates, and stated that imodium should be given per resident request when reporting loose stools.	F 309	<p>F329</p> <p>Resident # 35 was not affected by this alleged deficient practice.</p> <p>All residents receiving medication requiring scheduled labs have the potential to be affected by this alleged deficient practice.</p> <p>All residents will be audited for the use of medications requiring scheduled labs.</p> <p>Nurses will be re-educated on medications requiring scheduled labs.</p> <p>The results of all audits will be reported to the facility QA committee for review for 90-days.</p> <p>The DNS/designee will be responsible for compliance.</p> <p>Corrective Action date: July 23, 2010</p>		
F 329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</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>	F 329			

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F 329	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure each resident's drug regimen is free from unnecessary drugs for 1 of 11 residents in the targeted sample (Resident #35). Findings include: 1. Per record review, staff failed to ensure adequate monitoring for the drug regimen of Resident #35. Per review of the most recent signed physician orders, signed on 6/4/10, there is an order to complete a CBC (Complete Blood Count) every 6 months for residents receiving daily aspirin for MI or stroke prophylaxis. Per review of the MAR, Resident #35 is receiving daily aspirin with an indication listed as "MI prophylaxis." Per review of the labs, the last CBC for Resident #35 was completed on 10/16/09. During an interview on 6/16/10 at 11:48 AM, the Director of Nursing confirmed that the CBC due in April of 2010 was not completed.	F 329	F441 1. Resident # 74 was not affected by this alleged deficient practice. All residents have the potential to be affected by this alleged deficient practice. Random infection control audits will be conducted for 90-days. Nursing staff will be re-educated regarding infection control practices. The results of all audits will be reported to the facility QA committee for review for 90-days. The DNS/designee will be responsible for compliance. Corrective Action date: July 23, 2010	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441		

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F 441	<p>Continued From page 18</p> <p>should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to provide a safe and sanitary environment in which to help prevent the development and transmission of disease and infection for two applicable residents in the sample.(Resident # 74, #36) Findings include:</p> <p>1. Per observation on 6/14/10 at 4:05 PM during medication administration to Resident # 74 the Licensed Practical Nurse (LPN) bumped into the air mattress flow regulator attached to the foot of the resident's bed and it fell on to the floor. The</p>	F 441	<p>2. Resident # 36 was not affected by this alleged deficient practice.</p> <p>All residents have the potential to be affected by this alleged deficient practice.</p> <p>Random infection control and medication administration audits will be conducted for 90-days.</p> <p>Nursing staff will be re-educated regarding infection control practices.</p> <p>The results of all audits will be reported to the facility QA committee for review for 90-days.</p> <p>The DNS/designee will be responsible for compliance.</p> <p>Corrective Action date: July 23, 2010</p> <p><i>P O.C. Accepted 7/13/10 JMcHARN</i></p>		

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F 441	Continued From page 19 LPN picked up the regulator with gloved hands and placed the regulator back on to the foot of the bed without sanitizing the flow regulator. The LPN then handled the outside of the medication cup and the cup of fluids without changing gloves or washing hands, and placed these on the resident's overbed table. The LPN confirmed at 4:08 PM that the other resident in the room was on infectious disease precautions for MRSA, and s/he should have sanitized the regulator after replacing it on the foot of the bed, washed hands, and changed gloves before handling the medication cups. 2. Per observation during medication administration on 6/14/10 @ 12:31 PM, an LPN (Licensed Practical Nurse) failed to follow infection control protocols during 1 of 4 applicable observations. The LPN entered the room of Resident #36, removed an inhaler from the labeled plastic bag, placed that bag on the bed of Resident #36 (who is on infectious disease precautions). Following medication maladministration the LPN picked up the bag, replaced the inhaler in it, held the contaminated bag against his / her uniform, placed the bag on top of medication cart, documented the administration and placed the bag inside the medication cart. Per interview at 10:30 AM on 6/16/2010, the LPN confirmed that the resident was on infectious disease precautions at the time of the observation and that s/he should not have placed the bag on the bed.	F 441	/	
F 514 SS=B	483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete;	F 514		

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F 514	Continued From page 20 accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to maintain clinical records that are complete, accurately documented and systematically organized for 2 applicable discharged residents. (Residents #82 & #25) Findings include: 1. Per record review on 06/15/10 of discharge records, the clinical records for Residents #82, discharged 03/19/10 & #25, discharged 2/22/10, did not contain information regarding the residents' status upon discharge. In addition, progress notes containing treatment plans, discharge plans and physician orders were not found in the records. Per interview on 06/15/10 at 2:10 PM the DNS (Director of Nursing Service) confirmed the clinical records lacked accurate information and were not systematically organized.	F 514	F514 Resident # 82 and # 25 were not affected by this alleged deficient practice. All residents have the potential to be affected by this alleged deficient practice. Audits of discharged records will be conducted by the DNS/designee. Nursing staff will be re-educated regarding discharge documentation. Medical records staff will be re-educated on chart organization. The results of all audits will be reported to the facility QA Committee for review for 90-days. The DNS/designee will be responsible for compliance. Corrective Action date: July 23, 2010 <i>P.D.C. Accepted 7/13/10 [Signature]</i>		
F9999	FINAL OBSERVATIONS Licensing And Operating Rules for Nursing Homes, December 15, 2001 7.13 Nursing Services The facility must have sufficient nursing staff to provide nursing and related services to attain or	F9999			

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F9999	Continued From page 21 maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care or as specified by the licensing agency. (a) Sufficient staff. 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: (1) licensed nurses and (2) other nursing personnel. (b) The facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (c) Registered Nurse. (1) The facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. (2) The facility must designate a registered nurse to serve as the director of nursing on a full time basis. (3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. (d) Staffing Levels. The facility shall maintain staffing levels adequate to met resident needs. (1) At a minimum, nursing facilities must provide: (i) no fewer than 3 hours of direct care per resident per day, on a weekly average, including nursing care, personal care and restorative nursing care, but not including administration or supervision of staff; and (ii) of the three hours of direct care, no fewer than 2 hours per resident per day must be assigned to provide standard LNA care (such as personal care, assistance with ambulation, feeding, etc.) performed by LNAs or equivalent staff and not including meal preparation, physical therapy or the activities program.	F9999	F9999 No residents were affected by this alleged deficient practice. All residents have the potential to be affected by this alleged deficient practice. The PPD for the building will be calculated daily to ensure that the state standards of 2.0 for LNAs and 3.0 for total staff are met. The scheduling manager and nursing managers will be educated on state staffing standards. Staffing will be reviewed by the QA Committee for 90 days. The DNS/designee will be responsible for compliance. Corrective Action date: July 23, 2010 <i>P.O.C. Accepted 7/13/10 Pmcatarn</i>	

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F9999	Continued From page 22 (2) The facility shall provide staffing information to the licensing agency in a manner and on a schedule prescribed by the licensing agency. Based on interview and records review, the facility failed to provide 2 hours of direct care per resident per day on a weekly average. Findings include: 1. Per interview with a family member on 06/14/10 at 10:00 AM, complained that there "was not enough staff, especially on the weekends" Per review of staffing hours for the month of May and June 2010, for the week beginning 05/23/10, the facility provided a weekly average of 1.95 hours of direct care per day. In addition, during the month of May, 13 out of 31 days while June had 5 out of 14 days had below average of 2 hours of direct care per day. During an interview on the morning of 06/16/10, the DNS confirmed the above staffing levels and stated that they had occurred due to 'call-outs'.	F9999		