

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

May 19, 2016

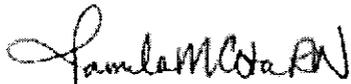
Mr. Shawn Hallisey, Administrator  
St Johnsbury Health & Rehab  
1248 Hospital Drive  
Saint Johnsbury, VT 05819-9248

Dear Mr. Hallisey:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 25, 2016**. 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

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

PRINTED: 05/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/25/2016
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NAME OF PROVIDER OR SUPPLIER  ST JOHNSBURY HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1248 HOSPITAL DRIVE SAINT JOHNSBURY, VT 05819
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F 000	INITIAL COMMENTS	F 000	The filing of this plan of correction does not constitute an admission of the allegations set forth in the statement of deficiencies. The plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law.	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE  A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.  The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post the results of the State survey, posted in a place readily accessible to residents and post a notice of their availability. Findings include:  Per observation on 04/24/16 at 4:30 PM, the survey results were located in a plastic wall-mounted display folder approximately 58-59 inches off the floor, near the offices. Residents in wheelchairs would not have ready access. In addition, there were other informational documents in the plastic wall-mounted folder. There was no notice of availability posted. The facility Administrator confirmed the above	F 167	How will the corrective action be accomplished for those residents found to have been affected by the alleged deficient practice?  The Survey Result Book will be moved to the Family Communication board. The pocket that houses the Survey Book will be lowered for w/c accessibility. The Pocket will be clearly labeled and identifiable.  How will the facility identify other residents having the potential to be affected by the alleged deficient practice?	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Shawn I. Hallsey Administrator* 5/17/16 (X6) DATE

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 167  F 250 SS=D	Continued From page 1 findings, later that evening. <b>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</b>  The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interviews, the facility failed to ensure that medically- related social services were provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 for 5 residents sampled (Resident #1). Findings include:  1. Per record review, Resident #1 was admitted (approximately two years ago) for rehab and/or possible long term care placement. Based on record review, there was no social service notes available to indicate that there had been any care plan decision made to determine if the resident would be attempting to return to [his/her] home, nor what assistance, interventions, and services have been offered or obtained. Per interview on 04/24/16 at 7:25 PM the family member stated that [Resident #1] was still in pain and not strong enough yet to go home but "lots of things have to happen, like getting stronger, a handicapped van, caregivers...I guess I got to look into it". Per interview on 04/25/16 at 8:25 AM the staff member responsible for medically-related social services acknowledged	F 167	All residents have the potential to be at risk.  What measures will be put in place to ensure the alleged deficient practice will not reoccur?  Families and Residents will be notified of the location of the Survey Results book.  How will the Facility monitor its corrective action to ensure that this alleged deficient practice will not reoccur?  The Administrator or designee will audit family, residents, and staff to inquire if they know where the Survey Results book is located. There will be audits x 4 weekly for a month. The x 3 monthly.  Results will be reported and reviewed at the QAPI Committee meeting for further recommendation. <input checked="" type="checkbox"/>  Compliance Date is 05/20/2016.  F167 POC accepted 5/19/16 Semmon RN/PMU	

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F 250	Continued From page 2 that a meeting took place in March (2016) but "there hasn't been much movement on getting [Resident #1] home on a temporary basis...some delays in therapy...I am not sure why". The DNS on 04/25/16 at 3:19 PM confirmed there was no care plan written for possible discharge and/or provision of services to meet the needs of the resident, as would be expected from that meeting in March.	F 250	How will the corrective action be accomplished for those residents found to have been affected by the alleged deficient practice?  The Care Plan for Resident #1 has been reviewed and revised.  How will the Facility identify other residents having potential to be affected by the same deficient practice?  All residents have the potential to be at risk.  What measures will be put in place to ensure that the deficient practice will not reoccur?  The S.W. staff will be re-educated that D/C Planning process.  How will the Facility monitor its corrective action to ensure that the deficient practice will not reoccur?  The Administrator or designee will conduct audits to ensure compliance weekly x4 monthly x 3. Results will be reviewed at QAPI for further recommendations.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to update the Care Plan			
			FASO POC accepted 5/19/16 Semmons RJJ pme 5/20/16	

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F 280	Continued From page 3 for one of the applicable residents reviewed. (Resident #4) The findings include the following:  Per observations on 4/24 and 4/25/16 and during interview, Resident #4 stated that [s/he] gets fluids provided with the meals and "I am sure I can get more if I ask". A family member during interview stated "I have to give [resident] water because I think they don't give [her/him] fluids." Resident record review demonstrated that on 04/07/16, Resident #4 went to the hospital for a diagnosis of dehydration and received IV [intravenous] fluids. There is no care plan for dehydration or recommended amounts by the dietician. A Dietary Assessment dated 02/17/16 demonstrates at risk for dehydration related to [his/her] medical condition and diuretic use. The dietician recommended approximately 1975 cc (cubic centimeters) of fluids daily.  Per review of the Intake record for the month of April demonstrates that the resident has been receiving less than a 1000 cc a day, with two days greater than 1000 cc (April 10 and 19 with 1380 cc and 1060 cc, respectively). Per interview on 04/25/16 at 6:30 PM, the Unit Manager (UM) stated that there should have been a revision to the care plan, related to dehydration, in which there would be alert charting [documenting each shift] at least for a week, monitoring and then re-assess for any additional interventions, or continue. The UM confirmed the above. Also see F-353	F 280	F-280  Resident #4 careplan has been updated to reflect his current condition.  All Residents have the potential to be affected.  Residents have had their careplans reviewed and updated as needed.  The Interdisciplinary teams have been re-educated and are involved in the careplanning process.  The DNS or designee will conduct to ensure compliance weekly x's4, monthly x'3. Results will be reported and reviewed at the QAPI meeting for further recommendation.  Date of compliance is May 20, 2016  <i>F280 POC accepted 5/19/16 SEMMONS/Palme</i>		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility	F 281			

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F 281	Continued From page 4 must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to ensure that services provided or arranged by the facility meet professional standards of quality regarding medication management and medication administration for 1 of 5 applicable residents in the sample. (Resident #1) Findings include:  1. Per an anonymous complaint and facility self report, controlled medications were not disposed or destroyed according to acceptable standards of practice. It was reported that staff nurse #1 did not follow facility guidelines for destroying (wasting) controlled medication that was either refused or dropped, nor were pharmacy guidelines followed for wasting unused medications by mixing with noxious materials. Furthermore, two other staff nurses did not follow the protocol for witnessing the wasting of the controlled medications. Per interview the Staff Development Coordinator (SDC) stated that several nurses would co-sign for the wasting of the controlled drug as required but did not actually witness or have full view of the medication being dropped into the container of noxious material. Nurse #1, who is no longer employed, acknowledged that medications were not wasted as per the protocol. In addition, the SDC stated that review of residents records and interviews did not show that residents were harmed. The SDC further stated they changed their policy on who shall perform the destruction of the medications.	F 281	F-281  Resident #1 has not been negatively affected.  All Residents have the potential to be affected by the alleged deficient practice.  Nurses have been re-educated on the policy and procedure of narcotic destruction. And the policy for medication administration.  The DNS or designee will conduct audits weekly X's 4 and monthly X's 3 monitoring narcotic destruction and adherence to medication administration.  Results will be reported and reviewed at the QAPI Committee meeting for further recommendations.  Compliance Date is 05/20/2016.  <i>F281 PDC accepted 5/19/16 Semmona RN/ML</i>		

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F 281	Continued From page 5  2. Per observation on 04/24/16 at 7:25 PM, a family member was noted to be administering medications, evening pills and applying analgesic cream to Resident #1. The family member stated that the nurse came into the room and stated that the family member could give the pills and apply the cream. The nurse did not stay to monitor effects or assure medications were given as ordered. Per interview shortly thereafter, the nurse stated that the family can give the medication because "[family] asked and I'll document it". When asked by the nurse surveyor if there was a protocol regarding medication administration by someone other than the nurse, the staff nurse was unable to answer saying "I only work weekends". Per interview at 8:56 PM the SDC stated that family members are not supposed to give medications unless evaluated and with a physician order. The SDC confirmed there was no order or evaluation for the family member to give medications and is not a standard procedure.  Reference: Facility Policy -Destruction of Controlled Drugs: 6.2.1.1 Drug must be destroyed by the person who poured or removed [patch] notes that Licensed nursing staff ... must actually witness the destruction.  Reference: Lippincott Manual of Nursing Practice (9th edition) Wolters Kluwer Health/Lippincott Williams and Wilkins	F 281			
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282			

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F 282	<p>Continued From page 6</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to implement the plan of care for 2 of 4 residents in the sample (Resident #1 &amp; #2). Findings include:</p> <p>1. Per record review, Resident # 1 has a diagnosis of hemiparesis on the right side and relies on staff for extensive assist for activities of daily living (ADLs). The resident did not receive care and services according to the care plan during two days of survey. The care plan for ADLs and nutrition, directs staff to assist with meals for cueing; provide adaptive self feeding equipment (rimmed plate and built up utensils) as needed; when in bed to keep the heels elevated upon pillows; right arm and elbow on a pillow when in bed; call bell in reach and to re-approach and try a new staff when the resident refuses care. Per observations at 5:00 PM on 04/24/16, the Resident was in bed with no pillows under the feet nor under the right arm/elbow. Two pillows were noted on opposite side of the room. The LNA acknowledged at 8:00 PM it is good to try to keep the heels elevated and that [resident] will try to remove or refuse the pillows. Pillows were provided at that time. On 04/25/16 at 8:05 AM the nurse surveyor inquired what the resident had for breakfast as</p>	F 282	<p>F-282</p> <p>Resident #1 has had his care plan reviewed and updated. The staff have reviewed the updated care plan and will provide assistance as needed and permitted by the Resident.</p> <p>Resident #2's care plan has been updated and reviewed by staff.</p> <p>All Residents have the potential to be affected by the alleged deficient practice. No other residents were negatively impacted by the deficient practice</p> <p>Nursing staff have re-educated on following the plan of care and providing assistance as needed. Re-education has also been provided to the LNA's on when to report issues with skin integrity. LNA have also been re-educated on safe mechanical lift transfers.</p> <p>The DNS or designee will conduct audits to ensure compliance weekly X'4 then monthly times X'3 .</p> <p>Results will be reported and reviewed at the QAPI Committee meeting for further recommendations</p> <p>Compliance Date is 05/20/2016.</p> <p><i>Excp POC accepted 5/19/16 semmons rd / amc</i></p>	

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F 282	<p>Continued From page 7</p> <p>no tray was located. The LNA stated that the Resident had refused breakfast, as it is his/her choice. When asked if the resident might eat later in the morning the LNA stated that he'll get his lunch but acknowledged that the resident was not re-approached nor did another staff attempt to offer breakfast. The resident was observed prior and during the provision of morning care not to have the call bell, and the LNA confirmed the call bell was out of reach on the wall. The Resident's tray for the Noon time meal did not have a adaptive equipment as care planned. The Food Service Supervisor (FSS) at 12:36 PM stated "I am not aware of the [adaptive equipment] and it should be on the slip, but it is not". Per interview at 12:57 PM the Occupational Therapist confirmed that there should be a rimmed plate and the built-up spoon and fork along with a regular set of utensils, as the resident will often use one or the other.</p> <p>2. During observation, record review and confirmed by staff, Resident #2 was not provided care and services according to the care plan. Resident's diagnoses include diabetes, a stroke with resulting effects for right hemiparesis [partial paralysis] and dysphasia. The care plan for diabetic care, immobility and pressure ulcer risk, states skin is assessed daily with care and PRN [as needed]; extensive 2 assist with turning and repositioning; use of mechanical lift; to check all of the body for breaks in the skin and report/treat promptly; and wears glasses that are to be kept clean, in good repair and kept by the bedside. Per observation on 04/24/16 at 5:10 PM the Resident was not wearing glasses and they were not found by the bedside. In addition, a large bruise was noted on the upper left arm.</p>	F 282			

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F 282	Continued From page 8 Review of the progress notes does not show an assessment or report for the bruises. Per observation at 9:30 AM on 04/25/16, abrasions/scratches were also noted on the right hip/upper leg area. Staff found the glasses on the dresser. Per an interview at 2:15 PM the staff nurse was not aware of any abrasions/scratches or bruising to the left upper arm. There was no report nor any treatment ordered for the abrasions/scratches. The DNS during interview at 2:45 PM confirmed that the bruises were several days old. The DNS acknowledged that although there was a reporting system, staff failed to report timely and the glasses are to be worn.	F 282		
F 323 SS=D	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 observations, record review and interviews the facility did not assure adequate supervision for one of two applicable residents using an assistive device for transfer. (Resident #2) Findings include:  1. During observation and interview on the evening of 04/24/16, Resident #2 had bruises,	F 323		

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F 323	<p>Continued From page 9</p> <p>one large black/blue (greater than 5 cm in diameter) &amp; one smaller (less than 4 cm - directly above the large bruise) on the upper left arm. When asked how the bruises happened, Resident #2, who has a diagnoses of diabetes, a stroke with resulting right hemiparesis [partial paralysis] and dysphasia, was unable to explain and just sighed and shook his/her head. A progress note/incident report on 04/17/16 states 'right arm squeezed between hoier [mechanical lift] and body'; however, there are no reports of any injury, bruising or any other related skin issues. The bruises were visible on both days due to the resident wearing a short sleeve shirt. The care plan noted for diabetic care, immobility and pressure ulcer risk states skin is assessed daily with care and PRN [as needed], extensive 2 assist with turning and repositioning, two staff for stand/pivot transfer on days and two staff for mechanical transfer on the other shifts, and to check all of the body for breaks in the skin and report/treat promptly.</p> <p>During observation of provision of morning care on 04/25/16, additional skin abrasions/scratches were noted on the resident's right hip/upper leg area. Staff at that time stated "sometimes [residents] get pinched by the hoier...and those marks can be from the fingernails when (his/her) hands get caught in the wheelchair." During interview, prior to the change of the day shift, the nurse was not aware of any injuries especially to the left arm. The nurse said that there was an analgesic patch on the left shoulder, which is what the nurse surveyor "probably saw". The nurse further stated that LNAs would also report if there where any skin issues. At that time the nurse surveyor then requested the staff nurse</p>	F 323	<p>F-323</p> <p>Resident #2 was assessed and the medical record was updated.</p> <p>All Residents have the potential to be affected by the alleged deficient practice.</p> <p>Nursing staff have been re-educated on timely skin assessments and the timely reporting of skin issues.</p> <p>Nursing staff have been re-educated and monitored on staff transfers.</p> <p>The DNS or designee will conduct weekly audits on accurate skin assessment and safe transfers x's 4 and monthly x's 3</p> <p>Results will be reported and reviewed at the QAPI Committee meeting for further recommendation. W</p> <p>Compliance Date is 05/20/2016.</p> <p><i>F323 POC accepted 5/19/16 SEMMONS/PML</i></p>	

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NAME OF PROVIDER OR SUPPLIER  ST JOHNSBURY HEALTH & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1248 HOSPITAL DRIVE SAINT JOHNSBURY, VT 05819	
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F 323	Continued From page 10 look at the bruising, during which the staff nurse acknowledged the large bruises but stated "maybe it might have been with the hoier lift last night when they were putting the resident to bed.	F 323		
F 353 SS=E	Per interview at 2:45 PM the DNS confirmed that the bruises where several days old. The DNS acknowledged that although there was a reporting system staff failed to report timely, monitor and/or supervise the practice of transferring a resident with mobility issues and who has experienced being injured by the hoier. <b>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</b>  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.  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:  Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.  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.	F 353	How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?  Administrative staff have reviewed staffing requirements. The Facility will continue all of its recruitment efforts to hire more staff.  How will the Facility identify other residents having the potential to be affected by the alleged deficient practice?  All residents have the potential to be affected.  What measures will be put in place to ensure that the deficient practice will not reoccur?  Staffing will be reviewed daily. All recruitment efforts are ongoing. Sign on bonus is offered. For hire ads are in print and ongoing.  How will the Facility monitor its corrective actions to ensure that the deficient practice will not reoccur?	

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F 353	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to provide sufficient staffing to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. (including residents #1, #2, #5) Findings include:  1. Refer to examples at citation F282 and F323 (for Resident #1 & #2);  2. Per review of staffing records, the facility failed to meet the state-required minimum staffing levels. See F9999;  3. Per interviews throughout the two day survey, numerous anonymous residents, family members and staff report facility staffing challenges, high turnover of staff and lack of care related to poor staffing levels. A visiting relative for Resident #5 complained to the survey agency that call lights go unanswered; sometimes it takes as long as 45 minutes to get care. S/he reported that his/her relative was incontinent of urine on the evening of 04/08/16 and put on the call light, staff answered in 5 minutes but turned the light off and stated "will be right back". The staff person returned 45 minutes later. This day was identified as having below the required 2 hours of personal care as listed at F9999.  Per interview on 04/25/16, the Administrator acknowledged there are several initiatives to correct the staffing problems such as sign-on bonuses and pay increases. S/he confirmed that the facility was aware of staffing problems.	F 353	The Administrator or designee will perform audits to ensure compliance weekly x's 4, monthly x's 3.. Results will be reported and reviewed at the QAPI meeting for further recommendation.  Date of compliance is May 20, 2016  <i>F353 POC accepted 5/19/16 semm/marn/pme</i>		
F 356	483.30(e) POSTED NURSE STAFFING	F 356			

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F 356 SS=C	<p>Continued From page 12 INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to post the nurse staffing data as specified on a daily basis, at the beginning of each shift. The</p>	F 356	<p>How will the corrective action be accomplished for those residents found to have been affected by the alleged deficient practice?</p> <p>The posting will be moved to the Family Communication board. The posting will be posted for the day at hand. The posting will be updated as needed.</p> <p>How will the Facility identify other residents having the potential to be affected by the alleged deficient practice?</p> <p>All residents have the potential to be at risk.</p> <p>What measures will be put in place to ensure that the alleged deficient practice will not reoccur?</p> <p>Nursing Staff will be educated on staffing posting requirements.</p> <p>How will the Facility monitor its corrective action to ensure that the alleged deficient practice will not reoccur?</p> <p>The Administrator or designee will audit the posting for timeliness and accuracy weekly x 4 for 1 month and the monthly x 3. Results will be reviewed at QAPI for further recommendations.</p> <p><i>F356 POC accepted 5/19/16 SEMMORP/PA 5/20/16</i></p>	

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F 356	Continued From page 13 findings include the following:  Per observation by the Registered Nurse (RN) Surveyor, on Sunday 04/24/16 at 4:30 PM on entrance to the facility, the facility nurse staffing was posted on the bulletin board on the hallway towards the Kitchen, employee lounge and therapy office. The date on the posting was Friday 04/22/16 that had the required information visible, while Saturday 04/23/16 and Sunday 04/24/16's Information was filed behind Friday's posting and not visible. In addition, when the postings were taken down and reviewed, showed Sunday's nursing hours were incorrect. Per interview on 04/25/16 the Administrator and DNS confirmed that the postings were made in advance (not on a daily basis), not in a prominent place and contained incorrect information.	F 356			
F9999	FINAL OBSERVATIONS  Per Vermont Licensing and Operating Rules for Nursing Homes regulation 7.13(d)(1)(i):  (d) Staffing Levels. The facility shall maintain staffing levels adequate to meet 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 of the three hours of direct care, no fewer than 2 hours per resident per day (PPD) 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	F9999			

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F9999	<p>Continued From page 14 the activities program.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and review of facility staffing schedules the facility failed to provide direct care staff (LNAs) to meet 2 hours per resident per day (PPD) as well as the 3 hours. Direct care staff provide personal care, assistance with ambulation and feeding etc., but do not assist with meal preparation, physical therapy or the activities program. The findings include the following:</p> <p>Per review of facility staffing schedules for the months of January, February, March and April 2016 (to date), the following PPD's identified that the facility did not meet the LNA requirement.</p> <p>January 2016: Identified that 5 of the 31 days were below the 2.0 PPD for LNA staffing. And on 01/16/16 below the 3.0 hours of direct care. February 2016: Identified that 2 of the 29 days were below the 2.0 PPD for LNA staffing. March 2016: Identified that 2 of the 31 days for the month were below the 2.0 PPD for LNA staffing. April 2016: Identified 9 of 24 (to date) were below the 2.0 PPD for LNA as well as 5 days below the 3.0 hrs/direct care</p> <p>Per interview through out the two day review numerous anonymous family members and staff report lack of care related to poor staffing levels, turnover of staff, facility staffing challenges, IE; staff doing double shifts, cobbling together coverage and lack of per diem pool.</p>	F9999	<p>How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Administrative staff have reviewed staffing requirements. The Facility will continue all of its recruitment efforts to hire more staff.</p> <p>How will the Facility identify other residents having the potential to be affected by the alleged deficient practice?</p> <p>All residents have the potential to be affected.</p> <p>What measures will be put in place to ensure that the deficient practice will not reoccur?</p> <p>Staffing will be reviewed daily. All recruitment efforts are ongoing. Sign on bonus is offered. For hire ads are in print and ongoing.</p> <p>How will the Facility monitor its corrective actions to ensure that the deficient practice will not reoccur?</p> <p>The Administrator or designee will audit the schedules and PPD daily to ensure sufficient nursing staff to meet all the resident's needs. Audits will be reviewed at QAPI for further recommendations</p> <p>F9999 PDL accepted 5/14/16 SEMMONARD/PMC</p> <p>5/20/16</p>

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F9999	Continued From page 15  Per interview on 04/24 and 04/25 /16, the Administrator and the Director of Nursing Service (DNS) confirmed that the above information is correct. Confirmation was also made that the facility developed numerous initiatives to correct the staffing problems to include, limiting admissions, placing Ads and offering sign on bonuses  See also F353.	F9999			