



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

May 25, 2010

Shawn Hallisey, Administrator
St Johnsbury Health & Rehab
1248 Hospital Drive
Saint Johnsbury, VT 05819

Provider #: 475019

Dear Mr. Hallisey:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 28, 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

PRINTED: 05/06/2010
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 04/28/2010
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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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(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

An unannounced onsite recertification survey was completed 4/26/10 to 4/28/10 by the Division of Licensing and Protection.

F 156 SS=D 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES

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

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

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

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F 156

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UNIVERSITY OF VERMONT

1. Resident #171 and Resident #74 have been discharged.
2. All residents have the potential to be affected. All residents who have been admitted or discharged from skilled nursing services since 4/28/10 have received and signed all necessary Medicare notification letters.
3. The Social Service Director and Admissions Coordinator will be inserviced as to the presentation of the (NEMB-SNF) and the Medicare Denial/Exhaust letters.
4. The Administrator or designee will conduct random audits for the timeliness and completion of the letters of (NEMB-SNF) and all Medicare Denial/Exhaust letters. These audits will be completed weekly x 8 and monthly x 4 with results submitted to the QA Committee monthly.
5. The Administrator or designee will be responsible for compliance.

5/28/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Shawn T. Hallisey

TITLE

administrator

(X6) DATE

5.19.10

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 156 Continued From page 1
under Medicare or by the facility's per diem rate.

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

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

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

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents

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F 156 Continued From page 2
concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

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

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to provide written Liability Notices and Beneficiary Appeal Rights Review for 2 of 5 applicable residents (#171, #74). Findings include:

1. During record review of the facility's demand billing procedures, the facility failed to provide either the Skilled Nursing Advanced Beneficiary Notice (SNFABN) (Centers for Medicare/Medicaid form 10055) or one of 5 uniform Denial Letters found in section 358 of the Skilled Nursing Facility Manual, to Resident #171. Per staff interview on 4/28/10 at 12:13 PM, the Business Services Manager confirmed that the facility had no evidence of a notice of denial of coverage for Medicare services for a demand bill for Resident

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F 156 Continued From page 3
#171.

2. Based on staff interview and record review the facility failed to provide the Medicare Non-Coverage Notice for 1 of 3 residents prior to their discharge from skilled nursing services. This notice informs beneficiaries of their right to an expedited review of the termination of services, by the Quality Improvement Organization (QIO). Per interview on 4/28/10 at 1:00 PM, the Business Services Manager confirmed that the facility had no evidence of a signed notice of non-coverage for Resident #74, who was discharged from Medicare services.

F 156

F 272 SS=D 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following:
Identification and demographic information;
Customary routine;
Cognitive patterns;
Communication;
Vision;
Mood and behavior patterns;
Psychosocial well-being;
Physical functioning and structural problems;
Continence;
Disease diagnosis and health conditions;
Dental and nutritional status;
Skin conditions;
Activity pursuit;

F 272 1. Resident reassessed for bowel incontinence. Assessment was completed. At that time, resident refused to participate in bowel/bladder training. As of this date, resident has been re-evaluated and reapproached and is willing to participate in further assessment of bowels and retraining. The resident's careplan has been updated to reflect changes.

2. All residents who have had an MDS since 4/28/10 have been assessed for bowel incontinence and careplans have been updated.

3. Bowel assessments will be conducted upon admission,

5/28/10

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F 272 Continued From page 4
Medications;
Special treatments and procedures;
Discharge potential;
Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and
Documentation of participation in assessment.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to conduct an assessment of a decline in functional bowel continence for 1 of 24 residents in the stage 2 sample (Resident #106). Findings include:

Per record review and confirmed by staff interview on 4/28/10, Resident #106 developed bowel incontinence during February, 2010, and this new problem was not addressed on the resident's care plan. Per review of 4 Minimum Data Assessments (MDS) from June 2009 - February 2010, the resident was fully continent of bowel function until the February 2010 Quarterly MDS coded the resident as frequently incontinent of bowel. Per review of the Licensed Nursing Assistant (LNA) flow sheets for the months of February through April, and confirmed during interview with the RN who completed the MDS (during the morning of 4/28/10) the resident had bowel incontinence multiple times on all shifts during the time period. Per interview with the Unit Manager on the morning of 4/28/10, she had not been aware of the recent development of bowel incontinence and confirmed that she had not conducted an in depth assessment to determine possible causes and treatments for this condition. Refer also to F279

F 272:

quarterly, annually and with a significant change. LNAs and Nurses will be inserviced on the bowel assessment management system.

4. The DNS or designee will conduct Random audits to ensure completion of bowel assessments for admissions, quarterly, annually and with a significant change. Weekly x 8, then monthly x 4 with results reviewed monthly by the QA Committee.

5. The DNS or designee will be responsible for compliance.

*POC Accepted 5/24/10
LanulaMcotARN*

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F 279
SS=D

483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to use the results of the assessment to develop a comprehensive care plan that includes measurable objectives and appropriate goals to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being for 2 of 24 residents in the stage 2 sample (Resident #72, #106). Findings include:

1. Per record review, Resident #72 was coded on a significant change MDS (Minimum Data Set), dated 2/2/10, as having a significant decline in urinary continence. Per review of the current

F 279

1. Resident #72 has had her careplan reviewed and updated to maintain or improve continence status. Resident #106's careplan has been reviewed and updated to reflect current bowel continence status.
2. All resident's careplan updates have been reviewed to accurately reflect current bowel and bladder status.
3. Nurses and LNAs have been re-educated regarding reporting any changes in ADL function to the nurse. The nurse is responsible to update the careplan.
4. The DNS or designee will conduct random audits of the ADL sheets with the careplans to ensure the careplan reflects the current status of the resident. Audits will be conducted weekly x 8, monthly x 4 with results reviewed monthly by the QA Committee.
5. The DNS or designee will be responsible for compliance.

5/28/10

*POC Accepted 5/24/10
Janella Mestarn*

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F 280 Continued From page 7
physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

F 280 conducted weekly x 8, monthly x 4 with results reviewed monthly by QA Committee.
5. The DNS or designee will be responsible for compliance.

*POC Accepted 5/24/10
Pamela Mcota RN*

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 regarding weight loss for 1 of 4 applicable residents in the stage 2 sample. (Resident #121) Findings include:

Per record review on 4/27/10, Resident #121 sustained a significant weight loss of greater than 5% during the first 30 days after admission. The weight logs documented a weight loss from 153 lbs. on admission 2/1/10 to 140 lbs. on 2/22/10. Per review of the current care plan, there was no plan to address the resident's significant weight loss. When the Unit Manager was interviewed about the issue, she confirmed she had not been previously aware of the weight loss until the surveyor brought it to her attention on 4/27/10. Refer also to F325

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS
SS=D
The services provided or arranged by the facility must meet professional standards of quality.

F 281 1. Resident #84 has been discharged home with hospice. The careplan was updated to reflect the approaches specific hemodialysis treatment. The ADL

5/28/10

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F 281	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide services in accordance with professional standards for 2 of 24 residents in the stage 2 sample (Resident #84, #72). Findings include:</p> <ol style="list-style-type: none"> 1. Per record review, the admission care plan developed for Resident #84, who receives hemodialysis three times a week, did not include goals or interventions related to dialysis treatment or the diagnoses of acute renal failure. Per review of the Nursing Manual available in the facility for reference*, residents receiving hemodialysis are required to be monitored for specific conditions and/or reactions to hemodialysis treatment. On 4/28/10 at 10:52 AM, the Unit Manager confirmed that the care plan for Resident #84 did not include any goals or approaches specific to hemodialysis treatment or acute renal failure. See also F309. 2. Per interview and record review, the facility failed to effectively communicate specific needs regarding communication deficits to care staff for Resident #84. Per interview on 4/27/10 at 4:00 PM, Resident #84 reported that earlier that day, a staff member assisted him/her into bed who was not knowledgeable about a communication deficit, which resulted in the resident being left in an uncomfortable position for a period of time. During the interview, the resident expressed to the surveyor that s/he was upset and frustrated about the incident. Per interview on 4/28/10 at 10:15 AM, Resident #84's primary LNA confirmed that, while s/he was not the staff member identified by the resident regarding the incident, s/he had not been informed of the communication 	F 281	<p>careplan was updated to reflect the resident's communication deficit. Resident #72 has had a bladder assessment completed.</p> <ol style="list-style-type: none"> 2. There are no current residents on dialysis. 3. Nurses have been inserviced on the hemodialysis policy and procedure which includes a communication form. LNAs have been re-inserviced on the ADL assignment sheet. 4. The DNS or designee will review records of any dialysis resident who resides in the facility weekly x 8, then every 2 weeks x 8, then monthly. Results will be reported monthly to the QA Committee. 5. The DNS or designee will be responsible for compliance. <p>POC Accepted 5/24/10 LanhamCotarn</p>	

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F 281 Continued From page 9
deficit, and confirmed that the deficit was not listed on the LNA care sheet. Per interview on 4/28/10 at 10:55 AM, the Unit Manager stated that the LNA's are expected to use the LNA care sheet to direct care for residents in their assignment.

3. Per record review and interview, staff failed to assess for causes of urinary incontinence, and failed to re-assess bladder function after a decline in continence status for Resident #72. Per review of the 2 most recent MDS assessments, dated 11/6/09 and 2/3/10 respectively, Resident #72 went from "usually continent" to "frequently incontinent" of urine. Per review of the plan of care addressing urinary incontinence, dated 2/10/10, staff were directed to complete a bladder assessment. Per medical record review, and confirmed with the Unit Manager on 4/27/10 at 1:55 PM, there was no record of a bladder assessment completed for this resident and no evidence of assessment for causes of urinary incontinence. Per medical record review, there is no present diagnosis of incontinence or bladder dysfunction. Per review of the Nursing Manual available in the facility for reference*, residents experiencing urinary incontinence should be assessed for type of incontinence and possible causes for the incontinence. See also F279, F315.

*The Lippincott Manual of Nursing Practice, 5th edition

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN
SS=D

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of

F 281

F282

1. Resident #72 has had a careplan developed for urinary incontinence. A bladder assessment has been completed. Resident #27 has been wearing his splints at meals. He has experienced no skin breakdown.
2. All residents with urinary incontinence and those who wear splints are at risk for this alleged deficient practice.

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F 282	<p>Continued From page 10 care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, staff failed to provide services in accordance with each resident's written plan of care for 2 of 24 residents in the stage 2 sample (Resident #72, #27). Findings include:</p> <ol style="list-style-type: none"> 1. Per record review and interview, staff failed to implement Resident #72's plan of care regarding urinary incontinence. The care plan, developed on 2/10/10 directed staff to complete a bladder assessment. Per medical record review, and confirmed by the Unit Manager on 4/27/10 at 1:55 PM, there was no record of a bladder assessment completed for this resident. 2. Per record review on 4/27/10, the care plan for Resident #27 stated: "Elbow/wrist splint for meals for at least 1 and 1/2 hours. Check skin [for bruising/breakdown] when in use." Over 2 days of survey, it was observed that Resident #27 was not wearing his/her splints at mealtimes. Staff interview on 4/27/10 at 12:30 PM with the LNA providing care to Resident #27 confirmed that there was no skin bruising or breakdown, therefore no contraindication for applying splints. The LNA also confirmed splints were to be used during meals and had not been applied, stating "I did not put them on today." Interview with the Unit Manager on 4/27/10 at 1:30 PM confirmed that the Care Plan for the resident states splints should be worn around mealtimes for at least 1 and 1/2 hours. 	F 282	<ol style="list-style-type: none"> 3. All residents who have a careplan for urinary incontinence have been reviewed and bladder assessments completed as indicated. All residents who have splints have been reviewed and careplans have been updated. 4. The LNAs and Nurses involved have had individual inservices on the application of splints. Nurses and LNAs have been re-educated on the application of splints and following the plan of care. Nurses have been re-educated on the completion of the urinary incontinence careplan. 5. The DNS or designee will perform random audits on the completion of urinary incontinence careplans, in the following of MD orders for the application of splints weekly x 8, monthly x 4 with results reviewed at monthly QA Committee meeting. 6. The DNS or designee will be responsible for compliance. <p><i>PDC Accepted 5/24/10 Pamela Mcotarn</i></p>
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309	

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F 309 SS=D	<p>Continued From page 11 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 the necessary care and services to attain or maintain the highest practicable physical well-being for 1 applicable resident (Resident #84). Findings include:</p> <p>Per record review and interview, the facility failed to develop a plan of care regarding dialysis treatment, the medical condition requiring treatment, and failed to coordinate effective communication with the dialysis center providing treatment to Resident #84. Per medical record review and confirmed by the Unit Manager on 4/28/10 at 10:52 AM, the admission care plan developed for Resident #84, who receives hemodialysis three times a week, did not include goals or interventions related to dialysis treatment or acute renal failure. Per review of the dialysis communication book on 4/28/10 at 9:10 AM, there were no entries by either the dialysis center or the facility. Per interview on 4/28/10 at 9:15 AM, the primary nurse for Resident #84 stated that s/he does not receive any medications during dialysis. Per interview on 4/28/10 at 11:17 AM, the Clinical Manager of the dialysis center confirmed that Resident #84 does receive</p>	F 309	<ol style="list-style-type: none"> 1. Resident #84 has a careplan for renal hemodialysis. The facility established communication regarding the resident with dialysis. 2. All dialysis residents have the potential to be affected. There are no residents currently on dialysis. A policy regarding dialysis treatment is in place. 3. Nurses have been educated on the policy and procedure regarding hemodialysis. 4. The DNS or designee will audit all dialysis records for adherence to the policy and procedure weekly x 8 and monthly x 4. Results will be submitted to the QA Committee monthly. 5. The DNS or designee will be responsible for compliance. <p><i>PDC Accepted 5/24/10 Lamela Mcota RN</i></p>	5/28/10

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F 309	Continued From page 12 medications at dialysis that include electrolyte supplementation and administration of Epoetin alfa (a drug that requires close monitoring of the resident and certain lab values*). Per interview on 4/28/10, the Nurse Supervisor verified that Resident #84's primary physician was not aware of the medications being given at dialysis. Per interview on 4/28/10, the DNS (Director of Nursing Services) stated that the facility did not have a policy regarding dialysis treatment or an agreement in regards to communication with the outside facility providing treatment to this resident. See also F281, F329.	F 309		
F 315 SS=D	*2010 Lippincott's Nursing Drug Guide 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Resident 72: Based on interview and record review, the facility failed to provide services to improve and/or prevent decline in normal bladder function for 1 of 3 applicable residents (Resident #72). Findings include: Per record review and interview, staff failed to	F 315	1. Resident #72 has had a bladder incontinence assessment for type and possible causes of incontinence. 2. All residents have the potential to be affected. Residents who have been identified as having a change in urinary incontinence have had a bladder assessment to determine the most appropriate toileting interventions. 3. Nurses and LNAs will be re-educated on the facility's protocol for bladder continence.	5/28/10

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F 315 Continued From page 13
assess for causes of urinary incontinence, and failed to re-assess bladder function after a decline in continence status for Resident #72. Per review of the 2 most recent MDS assessments, dated 11/6/09 and 2/3/10 respectively, Resident #72 went from "usually continent" to "frequently incontinent" of urine. Per review of the plan of care addressing urinary incontinence, dated 2/10/10, the goal identified pertaining to urinary incontinence did not address maintaining or improving the urinary incontinence Resident #72 is experiencing, and only addressed skin integrity. The same care plan directed staff to complete a bladder assessment. Per medical record review, and confirmed with the Unit Manager on 4/27/10 at 1:55 PM, there was no record of a bladder assessment completed for this resident and no evidence of assessment for causes of urinary incontinence. Per medical record review, there is no present diagnosis of incontinence or bladder dysfunction. Per review of the Nursing Manual available in the facility for reference*, residents experiencing urinary incontinence should be assessed for type of incontinence and possible causes for the incontinence. See also F279, F281.

- F 315
- The DNS or designee will audit the identified residents with changes in urinary status weekly x 8, monthly x 4 with results to be reviewed at the monthly QA Committee meeting.
 - The DNS or designee will be responsible for compliance.

*PDC Accepted 5/24/10
Pamela Mestarn*

F 325 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE
SS=D

Based on a resident's comprehensive assessment, the facility must ensure that a resident -
(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and
(2) Receives a therapeutic diet when there is a nutritional problem.

- F 325
- Resident #121 has been discharged home.
 - All residents have the potential for weight loss.
 - All residents weights have been reviewed for weight loss and addressed at Nutrition at Risk.
 - Nurses, LNAs and the Dietitian have been re-educated on the nutritional management system.

5/28/10

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F 325	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that 1 of 4 residents in the applicable sample with a history of weight loss/at risk for weight loss maintained acceptable parameters of nutritional status (Resident #121). Findings include: Per record review and confirmed during interview with the Unit Manager on 4/27/10 at 3:10 PM, Resident #121, who had multiple comorbidities, had sustained a significant weight loss in the first 30 days after admission to the facility and no assessment had been conducted nor had care plan interventions been revised to address this issue. Per review of the weight log, the resident weighed 153.8 lb. on admission to the facility on 2/1/10. On 2/18/10 the weight was recorded as 153 lb. On 2/22/10, the weight was recorded as 140 lb., with subsequent weights recorded ranging from 134 lb. - 144 lb, and including the most recent weight as 143 lb on 4/22/10. When the Unit Manager was asked if she was monitoring the weights for the resident, she stated no. Per review of the intake logs for February - April, the resident had multiple intakes recorded as 0 to 35% of meal consumed. The only dietary assessment in the record was completed by the Registered Dietician (RD) on 2/6/10 and concluded, "weight stable at 150 lb. last 6 months...intake fair at 25-50%...swallowing difficulties....do not recommend use of nutritional liquid supplement at this time...consult RD PRN (as needed), we can re-evaluate". During interview on the morning of 4/28/10 the RD	F 325	5. All residents at risk for weight loss will be reviewed weekly at the At Risk meeting. 6. The DNS or designee will conduct random audits to monitor for weight loss and to ensure appropriate interventions are in place, weekly x 8 and monthly x 4 with results reviewed monthly at QA committee. 7. The DNS or designee will be responsible for compliance. <i>POC Accepted 5/24/10 Pamela Mcota RN</i>

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F 325 Continued From page 15
confirmed that she had not been previously aware of the weight loss and there had been no subsequent nutritional assessment since the admission assessment of 2/11/10.
On 4/27/10 the Unit Manager confirmed that although they had reviewed the resident at the 3/4/10 weekly 'skin/nutrition at risk' meeting, they had not reviewed the significant weight loss because she was not aware of it. In addition, the weight log contained numerous weights crossed out as "errors" with no written policy/procedure to direct staff on the process of reweighs for changes in resident weights of plus or minus 3 lbs. since the last weight. This was confirmed during interviews with the Unit Manager and the Director of Nursing Services.
Refer also to F280

F 325

F 329 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS
SS=D

F 329

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not 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

1. Resident #84 has been discharged home with hospice, and dialysis has discontinued. Prior to discharge the MD was aware of the meds being given at dialysis.
2. There are no other residents on dialysis at this time.
3. Licensed nurses will be re-educated on monitoring of medications that are administered at ancillary treatment centers.
4. The DNS or designee will audit residents who receive ancillary treatments weekly x 8 and

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F 329	<p>Continued From page 16</p> <p>contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assure that 1 of 11 applicable resident's drug regimen is free from unnecessary drugs (Resident #84). Findings include:</p> <p>Per interview and record review, the facility failed to identify all medications being administered to Resident #84. Based on the fact that facility staff and the resident's primary care physician were unaware that the resident was receiving medications during hemodialysis, the facility is unable to adequately monitor Resident #84 in regards to his/her drug regimen. Per review of the dialysis communication book on 4/28/10 at 9:10 AM, there were no entries by either the dialysis center or the facility. Per interview on 4/28/10 at 9:15 AM, the primary nurse for Resident #84 stated that s/he does not receive any medications during dialysis. Per interview on 4/28/10 at 11:17 AM, the Clinical Manager of the dialysis center confirmed that Resident #84 does receive medications at dialysis that include electrolyte supplementation and administration of Epoetin alfa (a drug that requires close monitoring of the resident and certain lab values*). Per interview on 4/28/10, the Nurse Supervisor verified that Resident #84's primary physician was not aware of the medications being given at dialysis. See also F309.</p> <p>F 371 483.35(i) FOOD PROCURE,</p>	F 329	<p>monthly x 4 and results will be reviewed monthly at the QA Committee.</p> <p>5. The DNS or designee will be responsible for compliance.</p> <p><i>POC Accepted 5/24/10 Famela McOTRN</i></p>	

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F 371 SS=F	Continued From page 17 STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to assure that dietary staff adhered to accepted standards of safe and sanitary food handling practices. Findings include: Per observations, staff interview and record review, the Food Service Director (FSD) failed to assure that foods were properly stored and that dishwashing equipment was properly functioning. During observations and log reviews during the initial tour of the kitchen on 4/26/10 at 10:45 AM, the temperature logs for recording wash and rinse temperatures for the dish machine revealed 3 days during April when the final rinse temperature failed to reach the minimum 180 degrees Fahrenheit required for hot water sanitization. The dates included 4/5/10, 4/24/10 and 4/25/10. Per interview on 4/26/10 at 10:55 AM, the FSD stated that he was not called on these dates and made aware of the low DW rinse cycle temperatures per facility policy. He was not previously aware of these low rinse temperatures until they were brought to his attention by the surveyors. In addition, at 2:45 PM on 4/27/10, the following	F 371	1. No identified individual residents were affected. 2. All residents have the potential to be affected. 3. All dietary staff have been inserviced on these procedures for checking and maintaining temperatures during dishwashing processes. 4. The Administrator or designee will conduct random audits of all dish machine temperatures for appropriateness. Audits will be conducted daily x 7, weekly x 8, monthly x 4 and results will be reviewed monthly at the QA Meeting. 5. The Administrator or designee will be responsible for compliance. <i>POC Accepted 5/24/10 Samuel M. CotarN</i>	5/28/10

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F 431	<p>Continued From page 19</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to store all drugs in locked compartments. Findings include:</p> <p>Per continuous observation on 4/26/10 from 3:10 PM to 3:24 PM, an open bag containing multiple full or partially full medication blister packs was sitting on a desk, unattended by licensed staff, in a facility hallway easily accessible to residents, staff, and/or visitors. An inspection of the contents with the DNS at 3:25 PM, after s/he had picked the bag up off the table, revealed multiple prescription medications belonging to a discharged resident. Per interview on 4/26/10 at 3:30 PM, the Director of Social Services stated that the bag of medications had been stored in his/her office since the prior week, awaiting shipment to another facility, and had been moved out of her office into the hallway due to renovations on 4/26/10. The Director of Social Services confirmed that his/her office is not locked or attended by licensed personnel during business hours on weekdays, and at this time the DNS confirmed that the Social Service office was not an appropriate place to store medications.</p>	F 431		

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