



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

April 26, 2011

Linda Phypers, Administrator
Wake Robin-Linden Nursing Home
200 Wake Robin Drive
Shelburne, VT 05482

Provider ID #:475056

Dear Ms. Phypers:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 23, 2011.**

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,

A handwritten signature in black ink that reads "Pamela M. Cota RN". The signature is written in a cursive style.

Pamela M. Cota, RN
Licensing Chief

PC:jl

Enclosure



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Division of

APR 19 11

PRINTED: 04/05/2011
FORM APPROVED
OMB NO. 0938-0391

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

Licensing and
Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/23/2011
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NAME OF PROVIDER OR SUPPLIER WAKE ROBIN-LINDEN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 200 WAKE ROBIN DRIVE SHELBURNE, VT 05482
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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
F 000 F 279 SS=D	<p>INITIAL COMMENTS</p> <p>An unannounced on-site Federal and State re-certification survey was conducted by the Division of Licensing and Protection from 03/21/11- 03/23/11. The following are regulatory findings.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to develop a comprehensive care plan for 1 of 6 residents in the stage 2 sample (Resident #37). Findings include:</p> <p>1. Per record review on 3/23/11, there was no</p>	F 000 F 279	<p>Resident #37's CP revised to reflect weight loss problem on 03/24/11. Resident #37 reviewed during weight wellness on 03/23/11. Resident placed on weekly weights. All other dietary interventions were already in place. However, resident refuses additional supplements.</p> <p>Residents will be weighed according to policy. Weights entered into EMR when obtained. Those residents who flag for a 3lb weight variance gain or minus are reweighed. Residents with 5% in 30 day variance or 10% in 180 day variance automatically are flagged when documenting. LNAs who are entering weights alert nursing of those who flag for any variance. Nursing places residents on weekly weights, notifies physician and family, diet manager, and updates CCP. Weekly weight review will be completed on all residents by charge nurse. Monthly summary for all residents will be completed via EMR for compliance per policy, and reported at the CQI meetings in April and July. All completed 04/06/11.</p> <p><i>POC for F.279 accepted with addendum that the DNS will ensure compliance per telephone call e 4:21 pm Sharon J. Connor RN 4/2/11</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Ronda Phipps</i>	TITLE DHS	(X8) DATE 4/15/11
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279 Continued From page 1
care plan developed that addressed weight loss for Resident #37, who experienced a significant weight loss of 12 pounds during the period from 2/8/11 to 3/14/11. The weight logs for this resident show a re-weigh on 3/16/11 to confirm the weight loss, from 106 pounds on 2/8/11 to 94 pounds on 3/14/11 and 3/16/11 respectively. The lack of care plan to address the weight loss was confirmed during interviews with the Registered Dietician (RD) and the MDS (Minimum Data Set) Nurse during the morning of 3/23/11.

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, interview and record

F 279

F 280

Resident #3's CCP has been updated 03/24/11 to reflect motion sensor activation.

Resident #37's CCP has been updated to include date of revision.

All residents' CCP have been reviewed for accuracy or revisions. Effective date 04/06/11.

CCP are updated by nursing – DCC or primary nurse in the event a new problem arises. CCP are reviewed during care conferences with dates. All revisions are entered during the care conference to ensure compliance.

Any resident who has a fall will be reviewed and discussed by the Falls Team during regular meetings. Any revisions or recommendations are added to the CCP by the primary nurse. The Falls Team will audit weekly. The CQI Falls Report will include summary audits of falls at the July 2011 and October 2011 meetings.

Pol for F280 accepted with addendum that the DNS will assure compliance.

Susan L. Emmerson, RN 4/21/11

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F 280	<p>Continued From page 2</p> <p>review, the facility failed to assure that care plans were revised to reflect the current identified needs for 2 of 7 applicable residents in the Stage 2 sample. (Residents #3 & #37) Findings include:</p> <ol style="list-style-type: none"> Per review of nursing notes, Resident # 3 sustained a fall in October 2010 and an unwitnessed fall on 02/27/11. The care plan for falls dated 4/27/09 states provide therapies, inform family/physician of changes, transfer according to ADL, keep area free of clutter, toilet schedule. The last updated care plan dated 1/4/11 states 'approaches ongoing'. Per observation on 03/22/11 the resident's room had a motion sensor detector. Per interview on 3/22/11 at 5:19 PM the primary nurse stated the motion detector is not on the working care plan. Per interview at 2:00 PM on 3/23/11, the MDS nurse confirmed the care plan was not updated to reflect the use of the sensor monitor, which was installed after the October fall. Per record review on 3/23/11, Resident #37's care plan for falls risk/history was not revised to reflect the resident's most recent falls. Review of fall investigation documentation revealed the resident sustained falls on 1/31/11, 3/11/11 and 3/20/11 and noted environmental hazards included - "furniture poorly arranged". A nursing progress note of 3/12/11 stated that the 'resident's room has a lot of furniture and other items and he/she is resistant to moving things around, but his/her son states he is visiting tomorrow and will try and work with him/her on some of the clutter'. As of 3/23/11, the care plan was not revised to reflect the most recent falls, nor was there evidence of follow up on the attempt to decrease clutter and environmental 	F 280		
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F 280	Continued From page 3 hazards in the room. The lack of care plan revision after the falls was confirmed during interview with the MDS nurse on the morning of 3/23/11.	F 280		
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</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 interview and record review, the facility failed to assure services are provided in accordance with the plan of care for 1 of 3 sampled residents (Resident #3). Findings include:</p> <p>1. Per record review on 3/23/11 at 3:00 PM, Resident # 3's plan of care directed staff to provide AM/PM snacks as well as ROM [range of motion] daily . Per the care plan dated 01/04/11 and current LNA flow sheets, they direct staff to 'use walker or wheelchair and gentle ROM to bilateral lower extremities 2x every day'. ROM exercises remain ongoing. goals and approaches remain current. Per review of the LNA flow sheets for the months of January - March 2011, there was no documentation that staff offered the AM/PM snacks, nor the amount or type consumed. In addition, the LNA flow sheet for ROM was not consistently documented as being completed in February 2011, 7 missed opportunities out of 28 days, and in March 2011, 10 missed opportunities out of 22 days. Per interview on 3/23/11 at 9:30 AM, the DNS</p>	F 282	<p>Resident #3's LNA flow sheet revised on 03/24/11 to include documentation of ROM as well as 2m and HS snack.</p> <p>All residents' LNA flow sheets in EMR have been updated to ensure that documentation is captured. Effective date 03/28/11.</p> <p>Shift exception reports are printed by nursing prior to dismissal of LNA/nursing staff to ensure documentation compliance. All shift exception reports are forwarded to DNS for review. Summarization of exception reports will be reported at the CQI meetings in April and July. Exception reports are reviewed each shift by the primary nurse and daily review by the DNS or designee. Frequency of reviews will be in the above format for 3 months and then reevaluated by the DNS and the DHS for frequency.</p>	

*POC F282 accepted with addendum that DNS will assure compliance per telephone call 4/21/11 @ 4:21 p
Susan J. Emmons, RN*

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F 282	Continued From page 4 (Director of Nursing Services) stated that 'there is a glitch in the system in which the LNA flow sheet doesn't capture that snacks that were given, and also stated the nurses were 'assuming' that it was documented. The DNS also confirmed that there is no documentation that ROM was performed on the missed days noted above.	F 282		
F 325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that 1 of 4 applicable residents in the sample at risk for weight loss maintained acceptable parameters of nutritional status. (Resident #37) Findings include:</p> <p>Per record review on 3/23/11, Resident #37 experienced a significant weight loss of 8.8% (12 pounds) during the period from 2/8/11 to 3/14/11 and staff failed to follow it's Weight Monitoring Policy regarding notification to the RD, assessment and care planning. Per review of the weight logs, the resident weighed 106 pounds on 2/8/11 and weighed 94 pounds on 3/14/11. The</p>	F 325	<p>Resident #37's weight was reviewed on schedule by the dietician 03/23/11. There were no changes with current approaches as resident refuses any interventions suggested. Resident placed on weekly weights and maintains stable weight of 95lbs. Dietician suspects weight loss is inevitable. Weight monitoring policy has been revised to include weekly weights for those with 3+ or steady changes in weight. Dietary notification via ECS message to of 5% change within 30 days or 10% within 180 days to dietician and diet manager 04/07/11. Three day calorie count to obtain current intake status. DCC reviews weekly weights for any residents who flag. Notify dietician during the next visit for review, training, and education. Weekly weights have been added to the LNA flow sheet to alert LNAs that the weight is required. Completed 04/07/11. Summary of weekly audits reported at CQI meetings in July 2011 and October 2011.</p> <p><i>Per telephone call e 4:21 pm POC F 325 will be accepted with addendum that the DNS will assure compliance. Susan J. Emmers RN</i></p>	

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F 325	<p>Continued From page 5 resident was reweighed on 3/16/11 and found to weigh 94 pounds again.</p> <p>During interview on 3/23/11 at 9:25 AM, the RD stated that she attends monthly Weight Wellness Meetings (last meeting was 2/16/11) and is at the facility to review residents weekly on Wednesdays. Although the resident was reweighed on Wednesday 3/16/11 to confirm the weight loss, the RD stated that she had not been notified of the weight loss. During interview with the Dietary Manager (who is also member of the Weight Wellness Team) at 10:15 AM the same day, he stated that he was not aware of the 12 pound weight loss.</p> <p>Per review of the facility's Weight Monitoring Policy/Procedure on 3/23/11, #4 states "Weight losses of 5% in 30 days or 10% in 180 days will be reported to the attending physician and the dietician. Contributing factors will be identified and the care plan updated with amended problem, goals and approaches." There was no care plan to address the nutritional needs and the weight loss and no evidence of an assessment to determine the possible cause(s). The failure to follow the facility's policy regarding weight monitoring and take timely action regarding assessment and care planning in response to the resident's weight loss was confirmed with the RD and the Nurse Manager on 3/23/11 at 9:25 AM and 11 AM, respectively.</p>	F 325		
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</p>	F 329	<p>Resident #37's medications reviewed by physician 03/23/11. New orders obtained to include maximum daily dose and clarification for parameters for use.</p>	

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F 329	<p>Continued From page 6</p> <p>without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that each resident's drug regimen was free from unnecessary drugs for 1 of 10 residents in the targeted sample. (Resident #37) Findings include:</p> <p>Per record review on 3/23/11, Resident # 37, had routine MD (physician) orders for APAP (acetaminophen, an analgesic) 650 mg. (milligrams) PO (by mouth) TID (3 times daily) at 0600, 1200 and 1800 and PRN at HS (hour of sleep). Additional routine orders for APAP included: 650 mg. twice a day for HA (headache). Another order included APAP 650 mg. every 3 hours times 3 days PRN pain/fever. There were</p>	F 329	<p>Consulting pharmacist will review all residents' medication regimens monthly for maximum dosing and parameters for use.</p> <p>Nursing will be provided with education regarding complete orders for new meds. Effective 03/28/11 and 03/30/11.</p> <p>The pharmacist will report to the DNS monthly. The DNS will report to the CQI committee quarterly. Completed 05/13/11.</p> <p><i>F329 POC accepted with addendum per telephone call e 4/2/11 that DNS will assume compliance</i></p> <p><i>Josann D. Emmons RN</i></p>	
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F 329	Continued From page 7 no parameters for administering PRN doses and there was no maximum daily dose stated for APAP from all orders. The Nursing 2011 Drug Handbook states that the maximum dose of acetaminophen should not exceed 4 grams daily. During interview with the DNS and the MDS nurse on 3/23/11 at 1:45 PM, it was confirmed that there was no daily maximum dose specified and there were 2 separate orders for routine APAP, although the resident was receiving the APAP per the TID order at present. The discrepancy had not been noted and clarified with the ordering provider. Resident #37 also had 2 separate orders for PRN (as needed) Risperdone. The orders included: Risperdone 0.25 mg PO BID (2 times daily) PRN dementia with agitation; and Risperdone 0.5 mg PO HS PRN agitation with dementia. The resident also received Risperdone 0.5 mg PO routinely at HS. Per review of the nursing behavior notes from 11/1/10 - 3/21/11, there were no behaviors documented. During interview with the Nurse Manager on 3/23/11 at 2 PM, she confirmed there should not be 2 orders for PRN Risperdone and that there were no specific parameters for administering the PRN doses.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, 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	F 371	All walk-in and reach-in refrigerators have been inspected by the facility's outside contractor, and required temperature setting of 41° have been verified. Completed 03/24/11. Temperature readings of each unit will be checked and documented daily on a log for each unit. Procedure for checking temperatures has been revised effective 03/24/11. Monthly reviews of temperature logs will be done by the Director of Dining or designee to ensure compliance.	

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F 371	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to assure that dietary staff stored and prepared foods under sanitary conditions and in accordance with accepted safe food handling practices. Findings include: Per observation in the kitchen during the initial tour on 3/21/11 at 9:45 AM, the following areas/practices were noted: a. The temperature of the first walk-in cooler was observed to be 42 degrees F (Fahrenheit). Per review of refrigerator temperature logs and refrigeration temperatures recorded on the daily Closing log for January - March 2011, there were multiple days when the temperatures exceeded the recommended maximum of 41 degrees F for storage of perishable foods. Per review of the facility's policy on Storage of Frozen and Refrigerated Foods, it stated "Keep refrigerator temperatures between 32 degrees and 45 degrees F." The ranges specified on the policy are not in accordance with accepted safe standard that refrigerator temperatures should be maintained at 41 degrees or below. This was confirmed with the Food Service Director (FSD) the same morning. b. Three raw beef steak packages were observed in a reach-in refrigerator on 3/21/11 at 10 AM, with a date of 3/1/11. There was also a wrapped piece of cooked steak in one of the walk-in refrigerators labeled from February, 2011. The cook said all of these meats were in the freezer and had not been relabeled when	F 371	Procedure for labeling and dating food has been reviewed to include dating foods removed from the freezer. Completed 03/24/11. The Dining Coordinator will conduct a kitchen review monthly to include the above observation. A sanitizing dispenser was installed. Completed 03/22/11. Procedure for manual dishwashing was reviewed effective 03/24/11. Monthly monitoring of the sanitizer will be conducted by the contracted company and the results directed to the Director of Dining. Trash containers were replaced effective 04/07/11. Trash containers are cleaned weekly. Compost container will be rinsed weekly and switched out for new containers monthly by the contracted vendor effective 03/28/11. Procedure for the care of containers was reviewed effective 03/28/11. Monthly review of the condition of trash and compost containers will be done by the Director of Dining or designee.	

F 371 POC
accepted [Signature]
4/21/11

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NAME OF PROVIDER OR SUPPLIER WAKE ROBIN-LINDEN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 200 WAKE ROBIN DRIVE SHELBURNE, VT 05482
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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 371	Continued From page 9 removed. Per interview with the FSD on 3/21/11 and 3/23/11, the facility's policies for dating of foods do not provide specific guidelines for staff in dating/labeling of perishable food items. c. Per observation of the 3 bay manual dishwashing sink on 3/21/11 at 9:45 AM, washed items were sitting in the drained middle sink. When staff were asked to describe the process for manual dishwashing, they confirmed they were not using a wash, rinse and final sanitizer or hot water final rinse in accordance with safe food handling practices. This was confirmed by the FSD who was also present. d. One trash container and the compost container were observed in the kitchen and were heavily soiled on the outside of the containers. This was confirmed with the cook and the FSD at the time.	371	All licensed nurses have been educated regarding the procedure for checking the med room refrigerator temperature and documenting. Completed 03/28/11, 03/30/11. Completed temperature logs will be reviewed by the day nurse and forwarded to the DNS at the end of the month. The DNS will monitor and report to the CQI committee quarterly for the next 2 quarters and then randomly. All LTC LNA competency skills will have been completed with each LTC LNA as of April 29 th , 2011. Orientation of new LNAs has been reviewed to include verification of skills checklist by the end of orientation monitored by the Clinical Coordinator who will report to the CQI committee quarterly. The Clinical Coordinator will verify completion for staff every 6 months.	
F9999	FINAL OBSERVATIONS 1. Per Vermont Statutes of the Vermont Licensing and Operating Rules for Nursing Homes December 15, 2001 "All drugs must be administered in conformance with the requirements of 18 V.S.A. Chapter 84." The facility failed to meet the requirement of 7.18 (f) (1) which states: "In accordance with the State and Federal laws, the facility must store all drugs and biological's in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys." This REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interview on 03/23/2011 at 2:20 PM the facility failed to ensure	F9999	F9999 POC accepted w/ the addendum per telephone call @ 4:21 pm that DNS will assure compliance Susan J. Emmons, RN	

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F9999	<p>Continued From page 10</p> <p>that proper temperatures were maintained in the medication refrigerator on the Long Term Care Unit (LTC). Temperature logs for the medication refrigerator indicate that only 9 days of the 23 days in March 2011 had recorded temperatures. During interview with the staff nurse and DNS (Director of Nursing Services) on 03/23/2011 at 3:00 PM, they confirm that daily temperatures have not been recorded. They further indicate that it is the facility expectation that temperatures will be checked daily by the night shift and documented on the temperature logs in the medication room.</p> <p>2. Per Vermont Statutes of the Vermont Licensing and Operating Rules for Nursing Homes December 15, 200110.6 (a) (2) Regular In-Service Education: (a) "Performance reviews. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. (2) address areas of weakness as determined in the nurse aide's performance reviews and may address special needs of residents as determined by the facility staff."</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on review of personnel files and staff interview, the facility failed to ensure that the LNAs (Licensed Nursing Assistants) working on the LTC unit had inservice training based on their identified weaknesses because the facility did not perform annual performance, competency evaluations. Findings include:</p> <p>Per review of LNA personnel records there are no</p>	F9999	<p>Preparation and submission of this plan of correction is required by state and federal law. This plan of correction does not constitute as admission for the purposes of general liability, professional malpractice or any other court proceeding.</p>	
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F9999	Continued From page 11 annual evaluations or competencies present in the files. The required In-Services for hours are met but are not tailored to the individual needs of the LNAs. This is confirmed during interview with the Clinical Care Coordinator on 03/23/2011 at 4:20 PM.	F9999		