

"A" FORM

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

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNF AND NF:	PROVIDER # 475046	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETES: 11/4/2009
NAME OF PROVIDER OR SUPPLIER CEDAR HILL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 49 CEDAR HILL DRIVE WINDSOR, VT		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 247	<p>483.15(e)(2) NOTICE BEFORE ROOM CHANGE</p> <p>A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to demonstrate that notice was given to 1 applicable resident prior to a roommate change. (Resident #65) Findings include:</p> <p>1. Per an initial interview, on 11/2/09, Resident #65 stated that s/he did not receive notice prior to a recent room mate change and further commented that the beds were there for people to use as they come and go from the facility and s/he did not think the facility had to provide any notice. During a subsequent interview on 11/4/09 at 12:15 PM, with a different surveyor, the resident confirmed that notice was not given prior to the room mate change and reiterated the belief that the facility did not have to provide notification. Per interview at 12:58 PM the Social Worker stated that residents, if able to understand, are verbally told of a roommate change, while families are notified via letter for residents who are confused or unable to understand and this is documented in the chart. Per record review there was no evidence of a note verifying that notice was given to the resident, or other responsible party, prior to a new roommate. Per interview at 1:38 PM on 11/4/09 the Social worker confirmed that there was no evidence, to demonstrate that the resident was given notice.</p>
F 514	<p>483.75(l)(1) CLINICAL RECORDS</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to document sufficient information for 1 applicable discharged resident. (Resident 14) Findings include:</p> <p>1. Per record review on 11/3/09 of a discharge record, the nursing note did not contain enough information regarding the status of Resident #14's disposition upon death. The nursing notes documented medication administration prior to death and the time of death. There was no documentation regarding physician's notification, family notification or release of the body. Per interview on 11/3/09 at 3:30 PM the ADNS (Assistant Director of Nursing Service) confirmed the lack of information pertaining to the Resident's death.</p>

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

The above isolated deficiencies pose no actual harm to the residents

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

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM OR SNFs AND NFs	PROVIDER # 475046	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 11/4/2009
NAME OF PROVIDER OR SUPPLIER CEDAR HILL HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 49 CEDAR HILL DRIVE WINDSOR, VT	

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F 514

Continued From Page 1

F 247 Notice Before Room Change

The Social Service Director will notify resident/resident family of a potential admission and that the resident will be having a room mate. The Director will document this notification in social service notes.

F 514 Clinical Records

Nursing staff will be in-serviced on appropriate nursing documentation to be put in the nurse notes following the death of a resident.

The Director of Nurses will review the documentation in the medical record with the Clinical Coordinator to assure that all documentation requirements are completed.

RESULTS OF REVIEW WILL BE FOLLOWED UP AT QA MEETING. (JOS)

FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

475046

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____
B. WING _____

(X3) DATE SURVEY
COMPLETED

11/04/2009

NAME OF PROVIDER OR SUPPLIER

CEDAR HILL HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
49 CEDAR HILL DRIVE
WINDSOR, VT 05089

(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	INITIAL COMMENTS	F 000		
F 221 SS=D	<p>A recertification survey was conducted at the Facility November 2 through 4, 2009.</p> <p>483.13(a) PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to assure an ongoing process to assess the continued need for a physical restraint for one applicable resident in the total sample. (Resident #24). Findings include:</p> <p>Per record review there was no evidence of any ongoing process to assess the continued need for, or reduce the use of, a physical restraint for Resident #24. Although an initial assessment, completed on 4/24/08, had identified the resident at high risk for injury related to a history of falls with significant injury as a result of his/her lack of safety awareness, and despite the fact that the last fall, sustained when the resident fell out of bed, was on 5/12/08, there was no evidence of any assessment or attempt to reduce the use of the restraint since 2/25/09. Throughout the 3 days of survey the resident was observed, on multiple occasions, including during the noon meals on 11/2 and 11/3/09 and the evening meal on 11/2/09, seated in a wheel chair with a restraint applied around their trunk with the straps crossed behind the chair and the looped ends attached at the back of the wheelchair. During interview, on</p>	F 221	<p>F 221 Physical Restraint</p> <p>Resident #24.</p> <p>Corrective action to be accomplished for this deficiency: a restraint assessment will be completed and will be updated every 3 months.</p> <p>Nursing administration in collaboration with the Medical Director will review and revise as appropriate the facility's policy and procedures related to the use of physical restraints and the types of physical restraints allowed to be used.</p> <p>A nursing assessment will be completed on any resident considered at risk for bodily injury with consideration to other alternatives to the use of physical restraints. Should a physical restraint be considered necessary, the nursing physical restraint assessment with alternatives to be attempted will be reviewed and reconsidered quarterly at the Plan of Care meeting with the resident, resident family, guardian or durable power of attorney.</p> <p>The clinical coordinator will monitor this corrective action on a weekly basis.</p> <p>Corrective action to be completed by December 28, 2009</p> <p>CORRECTIVE ACTION RESULTS WILL BE REVIEWED AT QA MEETING (S/S)</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
James B. Autton

TITLE
ADMINISTRATOR
DATE
12-1-2009

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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COMPLETED

11/04/2009

NAME OF PROVIDER OR SUPPLIER

CEDAR HILL HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
49 CEDAR HILL DRIVE
WINDSOR, VT 05099

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F 221	Continued From page 1	F 221		
F 280 SS-D	<p>the afternoon of 11/4/09, the RN Clinical Coordinator confirmed the lack of ongoing assessment to determine continued need for, or reduce use of, the restraint.</p> <p>483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to revise the care plan to reflect current status for 2 of 18 applicable residents in the sample. (Residents #7 and #8) Findings include:</p> <p>1. Per record review on 11/3/09 for Resident #8, the Resident returned to the facility on 8/21/09</p>	F 280	<p>F 280 Comprehensive Care Plans</p> <p>1) Resident #8 Care Plan revision completed on November 4, 2009</p> <p>2) Resident #7 Care Plan revision completed on November 4, 2009</p> <p>To identify if other resident are being affected by this deficient practice, the MOS coordinator will complete a medical record audit of all residents admitted to the facility since November 11, 2009. Measures to be put in place to ensure this deficient practice will not occur again. Nursing Administration and Staff Education Coordinator will develop an admission packet with a check off list of work to be completed within 3 days of admission. The Clinical Coordinator will be responsible for the completion of the work and will submit the check off list to the Director of Nurses every Friday.</p> <p>Corrective action to be completed by December 28, 2009</p> <p>RESULTS OF CORRECTIVE ACTIONS WILL BE REVIEWED AT QA MEETING. (TAS)</p>	

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NAME OF PROVIDER OR SUPPLIER CEDAR HILL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 49 CEDAR HILL DRIVE WINDSOR, VT 05089
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F 280 Continued From page 2
from an appointment with the urologist with an indwelling foley catheter in place. The care plan was not revised to reflect the use and care of the indwelling foley catheter. Per interview on 11/4/09 at 2:30 PM, the Unit Manager confirmed that the care plan had not been revised to reflect the current status and care of the resident's indwelling catheter.

F 281 SS=D
2. Per record review Resident #7's care plan did not address the use of rubber mats attached to side rails on the bed to prevent injury to the resident. Per observation throughout the 3 days of survey the resident was positioned in bed with two half side rails, one on each side of the bed, in the raised position with rubber mats attached to the inside of each of the rails. During interview, on the afternoon of 11/4/09, the RN Clinical Coordinator stated that the resident had very fragile skin and the mats were placed on the side rails to prevent injury to the resident's skin when moving about in the bed. The Clinical Coordinator confirmed at that time that the care plan did not address the use of the mats.
483.20(k)(3)(i) COMPREHENSIVE CARE PLANS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review the facility failed to assure that care and services were provided in accordance with professional standards of nursing practice for 2 of 16 applicable residents. (Residents #24 and #37).
Findings include:

F 281 F 281 Comprehensive Care Plans
1) Consulted Registered Resident #37

Dietician was aware of the weight loss and developed a plan to address it, the care plan has been updated. Registered Dietician will complete an audit on all resident weights for November and December to assure appropriate following through for any resident experiencing weight loss or gain.

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F 281

Continued From page 3

1. Based on record review and interview, the facility failed to assure that professional standards of care and quality were met for a resident with weight loss, regarding coordination with the dietician. Per record review for Resident #37, who was admitted on 6/19/09, the weight listed on the initial MDS dated 6/26/09 was 128 lbs. Per the weight book the resident's weights for July were; 7/2/09 - 117 lbs; 7/3/09 -113 lbs; 7/4/09 -125 lbs; 7/17/09 -108 lbs; 7/23/09 - 109 lbs. For the month of October the weights were as follows: 10/07/09 - 120 lbs; 10/14/09 -118 lbs; 10/21/09 - 108 lbs; 10/22/09 - 113 lbs; 10/23/09 - 120 lbs; 10/26/09 - 117 lbs.

The care plan directed staff to report "any weight change of +/- 5 lbs will be retaken if verified dietician notified within 24 hours if weight is desirable no change. If wt. loss significant (5% in 30 days) MD will be notified for specific orders and interventions". Per interview on 11/3/09 at 2:53 PM, the dietician stated, "I've should've done a care plan review in September and staff know that if there is a 3 lbs weight loss I should be notified." Per interview, on 11/3/09 at 3:30 PM, the ADNS confirmed that staff failed to report/coordinate with the dietician and failed to monitor and/or assess the weight loss.

2. Per record review nursing staff failed to assure timely physician follow up regarding a pharmacy recommendation for dose reduction of a psychoactive medication for Resident #24. A recommendation by the consultant Pharmacist to the physician stated, " (resident) has taken paroxetine (antidepressant) 20 mg since 8/08.....please consider a gradual dose reduction, perhaps decreasing to 10 mg daily.....If therapy is to continue at the current dose, please provide rationale describing a dose

F 281

Measures put in place to make sure this deficient practice does not happen, the Clinical Coordinator will monitor the weights on Monday, Wednesday and Friday, giving an update to the Director of Nurses or designee of any weights not within the guidelines of the policy and procedure. The Clinical Coordinator will notify the Registered Dietician of any discrepancy and the Registered Dietician will receive a weight loss report with a check off to acknowledge this notification.

The MDS coordinator will monitor this practice weekly.

2) Resident #24
The pharmacy consult was signed by the physician prior to the survey and had remained in her folder and had not been placed in the resident's chart. It has been placed in the chart.
Director of Nursing will audit the pharmacy consults since November 1, 2009 for completion and follow up with the physician in a timely manner.

Measures put in place to make sure this does not occur again: list of the pharmacy consults will be kept by the Director of Nurses will follow up with the Clinical Coordinator within one week of receiving the consults to assure that it has been addressed with the attending physician and filed appropriately in the residents chart. This corrective action will be monitored by the Director of Nurses or designee, for completions 1 week after the pharmacy consults are given to the clinical coordinator.

Corrective action to be completed by December 28, 2009
CORRECTIVE ACTIONS WILL BE REVIEWED AT QA MEETING (1/5)

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11/04/2009

NAME OF PROVIDER OR SUPPLIER

CEDAR HILL HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
49 CEDAR HILL DRIVE
WINDSOR, VT 05089

(X5)
COMPLETION
DATE

(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)

F 281

Continued From page 4
reduction as clinically contraindicated." Despite
the fact that the recommendation was dated
7/15/09 there was no evidence of physician
notification or a response until 9/9/09, almost 2
months later, at which time the practitioner
concurred with the recommendation and wrote an
order to decrease the dose from 20 mg to 10 mg
daily. During interview, on the afternoon of
11/4/09, the ADNS (Assistant Director of Nursing
Services) stated that it is the responsibility of
nursing staff to assure practitioners are aware of
pharmacy recommendations and s/he confirmed
the lack of follow up by nursing to assure a timely
response by the physician.

F 281

F 309
SS=D

483.25 QUALITY OF CARE
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.

F 309

F 309 Quality of Care

Resident #21 orders for physical therapy
have been carried out and the Registered
Physical Therapist who was to work with this
resident no longer comes to this facility due
to her inability to work with residents who
have a medical diagnosis of Dementia.

This REQUIREMENT is not met as evidenced
by:
Based on interview and record review, the facility
failed to provide necessary therapy services to
attain the highest practicable physical well-being
for 1 of 9 residents in the sample (Resident #21)
Findings include:

To identify other residents who may be
affected by orders for therapy: The 11pm to
7 am Charge Nurse for each resident's chart
will complete an audit of each resident's
medical orders nightly, checking to assure
follow through on medical orders, making
sure the medical order have been schedule
for therapy.

1. Per record review on 11/10/09, Resident #21
had a physicians order for physical therapy
services, 12 visits over a 1 month period that was
not carried out. During an 8:20 AM interview on
11/10/09 with a staff Registered Nurse (RN) and
the current Physical Therapist (PT), the RN stated

Measures put into place to alleviate this
deficient practice are the 11pm to 7am
Charge Nurse will notify the MDS
coordinator of therapy orders that require
follow through.

Corrective action to be completed by
December 28, 2009
CORRECTIVE ACTIONS WILL BE
REVIEWED AT QA MEETING

502

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

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NAME OF PROVIDER OR SUPPLIER CEDAR HILL HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 49 CEDAR HILL DRIVE WINDSOR, VT 05089	
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F 310	Continued From page 6 discharged resident #21 from skilled therapy services. The PT stated that normal standards of care would have been to transition the Resident into a restorative nursing program after cessation of skilled services. The PT confirmed that this did not occur in this case and that that the Resident had experienced an avoidable decline in ADL abilities.	F 310		
F 311 SS=D	483.25(a)(2) ACTIVITIES OF DAILY LIVING A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to give appropriate treatment and services to maintain oral health abilities for 1 resident in the sample. (Resident #65). Findings include: 1. Per interview with Resident #65, at 8:37 AM on 11/10/09, the facility did not provide the Resident with supplies necessary to maintain oral health. During an 8:37 AM interview on 11/10/09, a staff Registered Nurse (RN) stated that standard procedure for all new admissions is for Licensed Nursing Assistants (LNAs) to provide a "pink bucket" containing a denture cup, toothbrush and toothpaste to residents. On 11/10/09 at 9:15 AM, accompanied by an LNA, the surveyor observed that there was no toothbrush, toothpaste or denture cup any where in the resident's room. This observation was confirmed by the LNA at the time of the observation.	F 311	F 311 Activities of Daily Living Resident #65 This resident has all necessary supplies to maintain oral hygiene. To identify other residents having this potential deficient practice a specific LNA will be assigned to complete an audit of personal care items in each resident's bedside stand by the 15 th of each month.. Measures to be put into place: a monthly audit of residents personal care needs will be completed by the 15 th of each month by an assigned LNA. This will be submitted to Clinical Coordinator who will submit a completed report to the Director of Nurses and the Quality Assurance Committee. The Director of Nurses will monitor this corrective action. Corrective action to be completed by December 28, 2009	
F 329 SS=D	483.25(I) UNNECESSARY DRUGS	F 329	F 329 Unnecessary Drugs	

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F 329	<p>Continued From page 7</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assure all residents drug regimens were free from unnecessary drugs for 2 of 10 applicable residents. (Residents #24 and #37). Findings include:</p> <p>1. Per record review, staff failed to clarify the indication for use of , failed to adequately monitor and failed to consistently document non-pharmacological interventions attempted prior to administering a PRN (as needed)</p>	F 329	<p>1) Resident # 37 will have attempts made to reassure/reposition the resident prior to giving antipsychotic with documentation noted in the nurses notes. AIMS test was completed on November 4, 2009.</p> <p>Using a specific audit form, the medical records documentation will be audited by the Clinical Coordinator to determine whether appropriate interventions were attempted to alleviate inappropriate behaviors prior to anti psychotic medication being administered. Resident's behavioral issues and appropriate interventions will be addressed in the Plan of Care and reviewed quarterly. The Staff Education Coordinator and the Consultant Pharmacist will develop an education program for nurses to improve their knowledge in managing behavioral issues.</p> <p>New orders for antipsychotic will be brought to the attention of the DNS or designee for follow through.</p>	
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NAME OF PROVIDER OR SUPPLIER CEDAR HILL HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 49 CEDAR HILL DRIVE WINDSOR, VT 05089	
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F 329	Continued From page 8 antipsychotic medication for Resident #37. Per the physician order dated 6/24/09 stated "she is probably delirious because of the UTI. please try reassurance first, if needed Haldol 1 mg subcu Q hour as needed max 8 doses per day". Per review of nurses' notes and the behavior monitoring flowsheet, there was no evidence of non-pharmacological interventions attempted prior to administering the anti-psychotic medication on 7/31/09, 8/3/09, 8/8/09, 9/9/09, 9/13/09 and 9/29/09. In addition the pharmacy review dated 9/18/09 stated 'Haldol PRN without indication, clarify order to include target behavior and quantitatively monitored, also AIMS should be done for base line. Per interview on 11/3/09 at 5:15 PM the ADNS confirmed staff failed to consistently monitored the target behaviors, attempts at non-pharmacological interventions on the behavior or nursing note, clear indication for use and failed to obtain a baseline AIMS test in June 2009. 2) Per record review nursing staff failed to assure timely physician follow up regarding a pharmacy recommendation for dose reduction of a psychoactive medication for Resident #24. A recommendation by the consultant Pharmacist to the physician stated; "(resident) has taken paroxetine (antidepressant) 20 mg since 8/08 when it was decreased from 30 mg daily. The depression scale on 3/09 measured 9 with 12	F 329	2) Resident #24 The pharmacy consult was signed by the physician prior to the survey and had remained in her folder and had not been placed in the resident's chart. It has been placed in the chart. An audit will be completed for the past 30 days of all pharmacy consults to make sure they have been referred to the physician and follow up has been completed in a timely manner.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/04/2009
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NAME OF PROVIDER OR SUPPLIER CEDAR HILL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 48 CEDAR HILL DRIVE WINDSOR, VT 05089
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F 329 Continued From page 9
being probable depression.....please consider a gradual dose reduction, perhaps decreasing to 10 mg daily.....if therapy is to continue at the current dose, please provide rationale describing a dose reduction as clinically contraindicated." Despite the fact that the recommendation was dated 7/15/09 there was no evidence that the practitioner was notified and there was no response until 9/9/09, almost 2 months later, at which time the practitioner concurred with the recommendation and wrote an order to decrease the dose from 20 mg to 10 mg daily. During interview, on the afternoon of 11/4/09, the ADNS (Assistant Director of Nursing Services) confirmed the lack of follow up by nursing to assure a timely response by the physician.
483.60(b); (d), (e) PHARMACY SERVICES

F 431
SS=D

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

F 329 An audit will be completed for the past 30 days of all pharmacy consults to make sure they have been referred to the physician and follow up has been completed in a timely manner.

Measures put in place to make sure this does not occur again will be a list of the pharmacy consults will be kept by the Director of Nurses or designee with follow up with the nurse after one week if consult has been addressed by the physician and filed appropriately in the residents chart.

The Director of Nurses or designee will monitor this corrective action, for completions 1 week after the pharmacy consults are given to the clinical coordinator

F 431 Corrective action to be completed by December 28, 2009
RESULTS OF CORRECTIVE ACTIONS WILL BE REVIEWED AT QA MEETING. (1/05)

F 431 Pharmacy Services

Corrective action was accomplished with the vials of pneumococcal vaccine with the expiration of 7/11/09 being destroyed appropriately.
Completed audit of the medication room and medication carts for expired medications with expired medications destroyed appropriately.

Measures put in place to ensure that this deficient practice does not recur: The DNS or designee will work with the pharmacist to monitor for expired medications and nurses will perform a bi-weekly check for expired medications.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/04/2009
NAME OF PROVIDER OR SUPPLIER CEDAR HILL HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 49 CEDAR HILL DRIVE WINDSOR, VT 05089	
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F 431	Continued From page 10 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to assure that outdated medications were not available for resident use. Findings include: Per inspection of the medication storage area, at 2:54 PM on 11/2/09, 2 single dose vials of pneumococcal vaccine, each with an expiration date of 7/11/09, were stored in the bottom of the medication refrigerator and available for potential use with residents. The observation was confirmed, at the time of inspection by one of the LPNs responsible for administering medications.	F 431	A signed form stating that all medication in the refrigerator, cabinets and medication cart has not expired will monitor this practice. Corrective action to be completed by December 28, 2009 CORRECTIVE ACTION RESULTS TO BE REVIEWED AT Q A MEETING (JMS)	

Admission: Nursing Admission Checklist

Admission Item	Responsible Staff/Shift	Dated and Initial When Done
Set up chart according to Admissions list. Check for allergies and label chart	Ward Clerk	
Record admission number on all paperwork	Ward Clerk	
Report necessary information to care providers	SS/DNS/ADNS/Nursing	
LNA to get weight, height, clothing list and label personal care items	LNA on the shift person is admitted	
Set up 3 day food diary and I/O	Charge Nurse	
Notify Dietary and Activities of admission	Charge Nurse	
Call M.D. to confirm orders *MD must come in 48 hours before or after admission to see resident and sign orders	Charge Nurse	
Write all orders on telephone slips and physicians orders sheets. Include "Admit to CHHCCC SNF or ICF. Diet, activity level, generic equivalents may be used unless otherwise noted. Renew physicians routine orders plus all other orders q 60 days." Set up monthly visit X3 then every other month	Charge Nurse/Med Nurse	
Schedule all PT, OT, and speech therapies that are ordered	Charge Nurse	
Complete nursing assessment, skin assessment	Nursing-to be started when admitted. Skin check to be done by 3-11 shift when preparing for bed	
Nurses notes x 3 days. Record VS in nurses notes and graphic section. If Medicare and skilled, continue nurses notes until no longer receiving skilled care	Nursing	
Complete problem list	Ward Clerk, nursing	
TB test	Nursing	
If on psychoactive medication, complete restraint assessment and consent forms	MDS Coordinator, Nursing	
Initiate assessments ***	MDS Coordinator, Nursing	
Fall Risk		
Braden scale - skin assessment		
Bowel and bladder		
Pain		
Restraint		
Mini mental status exam		
Discus:		
Admitting Nurse initiate care plan. Must include pertinent problems.	Charge Nurse on admission	
Care Plan completed at 14 days.	Charge Nurse on admission	
Care Plan Revision.	Charge Nurse on admission	
Notify pharmacy of admission and medications	Charge Nurse /Med Nurse on admission	
Place MAR in med book and treatment sheet in treatment book	Charge Nurse/Med Nurse	
***Based on assessments, provide any preventative or safety devices that are indicated.		

