

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

June 25, 2012

Ms. Patricia Horn, Administrator
Cedar Hill Health Care Center
49 Cedar Hill Drive
Windsor, VT 05089

Provider #: 475046

Dear Ms. Horn:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 24, 2011**. Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN, MS
Licensing Chief

PC:ne

Enclosure - This version replaces the existing Accepted POC (survey date 2/24/2011) as a result of a settlement the facility reached with the Centers for Medicare and Medicaid Services (CMS).



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

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PRINTED: 06/06/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ Licensing and Protection B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2011
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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 000	INITIAL COMMENTS An unannounced, on-site recertification survey was conducted by the Division of Licensing and Protection from 02/22/2011 through 02/24/2011. Immediate Jeopardy was determined to exist on 2/22/11, which also resulted in Substandard Quality of Care. An extended survey was conducted. The immediate jeopardy was removed on 2/24/11, but deficient practice remains. The following are regulatory violations as a result of the survey.	F 000	See attached Plans of Correction.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Patricia Horn</i>	TITLE <i>LNHA</i>	(X6) DATE <i>6/8/2012</i>
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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 225	Continued From page 1 prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to thoroughly investigate and report an incident in which a resident had bruising of unknown origin for 1 applicable resident. (Resident #34) *This is a repeat deficiency. Findings include: 1. Per record review on 2/22/11 at 2:30 PM of Resident #34's chart, a nurses note dated 01/12/11 on 3-11 PM shift states, "on evening rounds 2 large bruised areas. one on right elbow 5-6 cm one on right upper arm about 3 cm. cause and time of event unknown, areas clean and intact at this time." Per staff interview at 4:30 PM, the staff member confirmed the noted bruise at that time for this resident, but was unable to verify if an incident report was completed or given to the DNS (Director of Nursing Services), or if the family or physician were notified. Per interview on 02/23/11 at 1:33 PM, the DNS confirmed no incident report was written and that staff did not follow procedures for reporting unknown bruising.	F 225			
F 226	483.13(c) DEVELOP/IMPLMENT	F 226			

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F 226 SS=D	Continued From page 2 ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement it's abuse policy regarding background checks for 2 of 6 recently hired employees. Findings include: 1. Per record review on the afternoon of 02/23/11, the personnel file for 2 recently hired employees had no evidence of completion of the required Vermont Criminal and Adult Protective Service registry background checks. During interview on 02/23/11 at 4:00 PM, the DNS confirmed that the facility failed to adequately provide background checks for pre-screening of new hires, and stated that "the human resource person recently left and there was no follow up."	F 226			
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.	F 279			

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F 279	Continued From page 3 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 observation, record review and staff interviews, the facility failed to develop a care plan for 1 of 16 residents in the stage 2 sample. (Resident #5) Findings include: 1. Per observation on 2/22/11 at 11 AM & 2 PM and for several observations during the morning of 2/23/11, Resident #5 had no clothes/nightgown on when lying in bed. S/he, who spends most of their time in bed, was observed to be partially covered with a sheet, with the bed curtains pulled around the bed. Per review of the licensed nursing aide (LNA) flowsheets, which record personal care, there were several notations by the LNA since December 2010 that the resident 'refuses to wear a nightgown.' Per record review, this preference was not present on the care plan for Resident #5. Per interview on 2/23/11 at 2:30 PM with the LNA who was caring for the resident and the Assistant Director of Nursing Services (ADNS), they confirmed that the resident frequently prefers not to wear clothes because s/he gets 'too hot.' In addition, the ADNS confirmed that his/her preference not to wear	F 279			

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F 279	Continued From page 4 clothes happens 'almost everyday' and that this is not on the care plan.	F 279		
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 upon interviews, observations and record reviews, the facility failed to revise the plan of care to reflect the needs of 4 of 16 Residents in the Stage 2 sample. (Resident #34, #26, #33, & #2). Findings include: 1. Per record review on 2/22/11, Resident #34's care plan for bruising of unknown etiology had an original date of 4/24/08 with a target date of	F 280		

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F 280	<p>Continued From page 5</p> <p>7/23/08. The plan was 'to educate staff on using gait belt and proper repo/transfer techniques; educate staff on protecting body to decrease risk of bruising by utilizing proper techniques; alert charge nurse of any further bruising & monitor daily; alert family and MD'. Per the nurses note dated 01/12/11 on 3-11 PM shift, 2 bruises were noted; however, there was no evaluation or revision of the care plan relating to a recent bruise of unknown cause. Per interview on 02/11/11 at 4:45 PM, the charge nurse confirmed that the care plan was neither updated nor revised to show the resident's current status change.</p> <p>2. Per record review on 02/22/11 at 8:45 AM, Resident #26's care plan, as well as Physical Therapy notes of 11/10/10, 11/27/10 and 12/01/10, state the resident "may ambulate 30-35 ft w/ 2 person assist and gait belt as tolerated". Per observation on 02/22/11 & 02/23/11, Resident #26 was seen self propelling in a wheelchair at all times observed during the day. Per interview on 02/23/11 at 9:30 AM, the Director of Therapy Services was unable to explain why the resident was not being ambulating by staff as there is no clear documentation regarding transition from ambulation to full wheelchair use. Per interview on 02/23/11 at 11:30 AM the LNA stated "oh she never gets up and walks, maybe stands to pivot but she motors about in the wheelchair for awhile now". Per interview on 02/22/11 at 12 noon, the DNS confirmed that the care plan was not revised to reflect full wheelchair use and that the resident was not ambulating at this time.</p> <p>3. Per record review on 2/22/11 at 2:40 PM,</p>	F 280			

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F 280	Continued From page 6 Resident #2's care plan was not revised to include an 18 cm (centimeter) by 6 cm burn with two blistered areas, which was reported to the nursing staff by the resident on 2/14/11 as a result from accidentally touching a facility fireplace. In addition, the care plan did not include preventative measures to prevent further accidents. Per interview on 2/22/11 at 2:41 PM, the Director of Nursing (DNS) confirmed that the care plan for Resident #2 was not revised to include the 18 cm by 6 cm burn with 2 blistered areas and did not include measures to prevent further incidents. Per interview on 2/22/11 at 12:23 PM, Resident #2 stated the burn on his/her forearm is cleaned with saline, Bacitracin ointment (antibiotic) is applied, and the dressing is changed every day. In addition, Resident #2 stated the right forearm was burned when s/he went to turn off the fireplace in the Victorian House living room. Also see F323. 4. Per record review on 2/24/11 at 1:53 PM, Resident #33's care plan was not revised to include the use of Amitriptyline (a psychoactive medication) for restorative sleep. Per record review on 2/24/11 for Resident #33, the Physician Orders state Amitriptyline 10 mg (milligrams), give one tablet by mouth at bedtime at 2200 (10:00 PM). In addition, the medical record documents use of Amitriptyline for restorative sleep. The Assistant Director of Nursing (ADNS) confirmed on 2/24/11 at 1:59 PM that the care plan was not revised include the use of Amitriptyline for restorative sleep.	F 280			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282			

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F 282	Continued From page 7 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement the care plan for 1 of 16 residents in the stage 2 sample. (Resident #36) Findings Include: 1. Per record review on 2/23/11, Resident #36, who has a care plan for nutrition risk with an intervention of weekly weights, failed to have weekly weights taken although s/he experienced weight fluctuations, including an 11 pound (lb) weight loss between the dates of 12/20/10 and 1/3/11. On 2/24/11 at 9:25 AM the ADNS confirmed that the resident has a care plan for weekly weights and although s/he had experienced recent weight loss, there was no evidence (after reviewing the weight book) that weights were obtained weekly. In addition, although Resident #36 had experienced an 11 lb weight loss between the dates 12/20/10 and 1/3/11, and facility policy stated a referral would be sent to the dietician if there was a 5 lb weight loss within a 30 day period, no referral had been sent to the dietician. During an interview with the Registered Dietician (R.D.) on 2/24/11 at 10 AM, s/he confirmed that they were unaware of the recent 11 lb. weight loss and that they had not received a referral from the facility for this resident.	F 282			

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F 282	Continued From page 8	F 282			
F 323 SS=J	<p>Refer also to F325.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon observation, interview and record review, the facility failed to provide an environment that is free from accident hazards over which the facility has control, and failed to provide resident supervision to prevent avoidable accidents, including identifying hazards and risks, evaluating and analyzing hazards and risks, or implementing interventions to reduce hazards and risks, which resulted in Immediate Jeopardy. 1 applicable resident sustained harm as a result of the unidentified accident hazard (Resident #2). Findings include:</p> <p>1. Per observation on 2/22/11 at 12:23 PM, Resident #2 was observed with a dressing on the underside of the right forearm. Per resident interview on 2/22/11 at 12:23 PM, Resident #2, who is cognitively intact, stated s/he has a burn on his/her right forearm arm which occurred a couple of weeks ago. The Resident stated when s/he went to press the switch to turn off the fireplace, s/he burned the right forearm on the</p>	F 323			

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F 323	<p>Continued From page 9</p> <p>glass door which was "scorching hot".</p> <p>Per observation on 2/22/11 at 12:33 PM of the Victorian House living room, the propane fueled fireplace with a glass door was turned on and there was no fireplace guard, cover, or protector in front of the glass door of the fireplace. Per observation on 2/22/11 at 10:30 AM of the Victorian House living room, Resident #21 was observed sitting in front of the propane fueled fireplace, which was on, with no staff supervision. In addition, there was no fireplace guard, cover or protector in front of the glass fireplace door. Per observation on 2/22/11 at 2:00 PM, Resident #49 was observed walking in the Victorian House living room without staff supervision and the propane fueled fireplace was turned on. Per interview on 2/22/11 at 2:17 PM, the DNS (Director of Nursing Services) stated all residents potentially have access to the Victorian House Living room and the fireplace with the glass door, which is turned on by staff in the morning, and off in the afternoon.</p> <p>Per observation, by two surveyors concurrently, of the fireplace in the Victorian House living room on 2/22/10 at 1:40 PM, the temperature of the exterior metal, surrounding the fireplace glass and exposed to resident contact, was 300 degrees Fahrenheit at the top of the fireplace and 298 degrees Fahrenheit on the right side of the fireplace, per Raytek MiniTemp Laser Temperature Gun.</p> <p>Per interview on 2/22/11 at 2:17 PM, the DNS stated s/he was aware that Resident #2 was burned and that an incident report was written on 2/14/11. The DNS stated Resident #2 was in the</p>	F 323			

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F 323	<p>Continued From page 10</p> <p>Victorian House living room and sustained a burn, approximately 18 cm (centimeters) by 6 cm (approximately 7 inches by 2.5 inches) with 2 open areas, on the right forearm after reaching over to turn off the fireplace. The DNS stated the burn occurred on 2/13/11 and Resident #2 notified staff on 2/14/11. The DNS stated the Advanced Practice Registered Nurse (APRN) was notified on 2/14/11.</p> <p>Per record review on 2/22/11, the nursing notes on 2/14/11 state Resident #2 approached nurse after shower at 2200 hours (10 PM) with a burn on his/her right forearm approximately 18 cm x 6 cm with two small open areas. The Resident stated s/he was trying to shut off the fireplace last evening and "got too close". Per record review on 2/23/11, there was no documentation concerning burn staging in the medical record for Resident #2. Per interview with DNS on 2/23/11 at 4:04 PM, the DNS confirmed the burn was not staged by the APRN when Resident #2 was assessed on 2/15/11. Per interview with the APRN on 2/24/11 at 12:39 PM, the APRN confirmed that the burn was not staged when Resident #2 was assessed on 2/15/11, and that there was an 18 cm by 6 cm burn with 2 small blistered areas.</p> <p>Per care plan review on 2/22/11 at 2:40 PM, the care plan was not revised to include the 18 cm by 6 cm burn with two blistered areas, nor any measures to prevent further accidents. Per interview with the DNS on 2/22/11 at 2:41 PM, the DNS confirmed the care plan was not revised to include the 18 cm by 6 cm burn with 2 blistered areas for Resident #2 and did not include measures to prevent further incidents.</p>	F 323			

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F 323	Continued From page 11 Per interview with the DNS on 2/22/11 at 3:11 PM, the DNS stated the incident report for Resident #2 was written on 2/14/11 and was found by the DNS on 2/22/11 on a clipboard at the nurse's station, after the surveyor requested the report. The DNS stated s/he had not seen the 2/14/11 incident report for Resident #2's injury until 2/22/11. The DNS also stated that no corrective action concerning the Victorian House Living Room fireplace had been implemented following the 2/14/11 incident, and the incident had not been reviewed by QA (Quality Assurance). Per interview with the Administrator (ADM) on 2/23/11 at 8:49 AM, the ADM was on site at Cedar Hill on 2/15/11 and was aware that Resident #2's right forearm was burned after touching the glass on the fireplace in the Victorian House living room. The ADM stated s/he was present at morning meeting when Resident #2's burn was discussed on either 2/15/11 or 2/16/11. The ADM stated the medical care for Resident #2 was initiated, but this incident was not dealt with in any depth at morning meeting, as there is an incident reporting process that staff follow. Per record review on 2/22/11 of the Accidents and Incidents facility policy, a completed Incident/Accident form must be submitted to the DNS no later than 12 hours after the occurrence of the incident or accident. Per interview with the staff nurse on 2/22/11 at 3:30 PM, s/he stated the incident report for Resident #2 was filled out the evening of 2/14/10, the night shift was notified, the incident was discussed the next day during morning meeting; however, the staff nurse stated	F 323			

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F 323	Continued From page 12 she did not give the incident report to the DNS per the Accident and Incident facility policy. Per interview on 2/22/11 at 2:56 PM, the DNS and Ward Clerk confirmed the Ward Clerk did not receive a copy of the incident report and that it was not entered into the facility's risk management contractor's database, MIMIC Magnolia Critical Incident Technology. Per interview with the Maintenance Director on 2/22/11 at 4:02 PM, electricity powers the blower for the fireplace and the fireplace is fueled by propane (a gas) in the Victorian House living room. The Maintenance Director stated the propane fueled fireplace is approximately 25 years old, has a switch at the bottom which turns the fireplace off, and residents have access to turn off the fireplace. On 2/23/11 at 8:44 AM, the Maintenance Director confirmed there is no Preventative Maintenance Log for the Victorian House living room fireplace. The Maintenance Director also stated there has been no preventative maintenance since s/he started working at the Facility (from 3/22/10 to 2/22/11). In addition, the Maintenance Director confirmed on 2/24/11, that the facility does not have a manufacturer's manual for the fireplace in the Victorian House living room.	F 323			
F 325 SS=D	Refer also to F465 & F520. 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE 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,	F 325			

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F 325	<p>Continued From page 13</p> <p>unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure that 1 of 16 residents in the stage 2 sample (Resident #36) had interventions put in place to ensure that s/he maintained acceptable parameters of nutritional status. Findings Include:</p> <p>Per record review on 2/23/11, Resident #36, who has a care plan for being a nutrition risk with an intervention of weekly weights, failed to have weekly weights taken although s/he experienced weight fluctuations, including an 11 pound (lb) weight loss between the dates of 12/20/10 and 1/3/11. On 2/24/11 at 9:25 AM, the ADNS confirmed that the resident has a care plan for weekly weights and although s/he had experienced recent weight loss, there was no evidence (after reviewing the weight book) that weights were obtained weekly.</p> <p>In addition, although Resident #36 had experienced an 11 lb weight loss between the dates 12/20/10 and 1/3/11, and the facility policy stated a referral would be sent to the dietician if there is a 5 lb weight loss within a 30 day period, no referral had been sent to the dietician. During an interview with the Registered Dietician (R.D.) on 2/24/11 at 10 AM, s/he confirmed that they</p>	F 325			

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F 325	Continued From page 14 were unaware of the recent 11 lb. weight loss and that they had not received a referral from the facility for this resident.	F 325			
F 329 SS=D	Refer also to F282. 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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 contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure the drug regimen was free	F 329			

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F 329	Continued From page 15 of unnecessary medications for 1 of 10 applicable residents [Resident #1]. Findings include: 1. Per record review, there was a request for clarification from the pharmacy for the use of Lorazepam for Resident #1, dated 1/21/11, that was not followed up on by nursing staff. Per review of the pharmacy's Medication Regimen Review for Resident #1, dated 1/21/11, the review states "need PRN Lorazepam specific behavior for 'anxiety'". The Medication Regimen Review dated 2/7/11 states, "above concern [note dated 1/21/11] repeated". Per interview with the Assistant Director of Nursing Services [ADNS] on 2/24/11 at 10:42 AM, the ADNS confirmed there was no order clarifying the use for the drug Lorazepam [an anti-anxiety medication] on a PRN [as needed] basis for Resident #1. Per interview with the ADNS, requests from the pharmacy for order clarifications are put in a folder for the Nurse Practitioner [NP] to review and sign. The ADNS confirmed that the request for clarification from the pharmacy for the use of Lorazepam for Resident #1, dated 1/21/11, was at the present time on Resident #1's chart and was not placed in the folder for the NP to sign per the facility's policy.	F 329			
F 428 SS=D	Refer also to F428. 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of	F 428			

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F 428	Continued From page 16 nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to act upon the pharmacist's report regarding medication for 1 of 10 applicable residents (Resident #1). Findings include: 1. Per review of the pharmacy's Medication Regimen Review for Resident #1, dated 1/21/11, the review states "need PRN Lorazepam specific behavior for 'anxiety'". The Medication Regimen Review dated 2/7/11 states, "above concern [note dated 1/21/11] repeated". Per interview with the Assistant Director of Nursing Services (ADNS) on 2/24/11 at 10:42 AM, the facility's policy is that requests from the pharmacy for order clarifications are put in a folder for the Nurse Practitioner [NP] to review and sign. The ADNS confirmed that the request for clarification from the pharmacy for the use of Lorazepam [an anti-anxiety medication] on a PRN [as needed] basis for Resident #1, dated 1/21/11, was at the present time on Resident #1's chart and was not placed in the folder for the NP to sign. Per interview on 2/24/11 at 10:42 A.M. the ADNS confirmed there was no order on Resident #1's chart clarifying the use for the drug Lorazepam. Refer also to F329.	F 428			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431			

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F 431	<p>Continued From page 17</p> <p>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.</p> <p>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.</p> <p>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.</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 staff interview, the facility failed to ensure that facility staff labeled a</p>	F 431			

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F 431	Continued From page 18 bottle of insulin after it was opened for 1 applicable resident in the sample. (Resident # 9) Findings include: 1. Per observation of a bottle of Novolin insulin during a medication pass on 2/23/11 at 12:10 PM, there was no date written on an opened bottle of Novolin Insulin regarding when it was opened. After this surveyor questioned the medication nurse, s/he confirmed immediately after the observation, that there was no date on the bottle when it was opened and then immediately discarded it. Per review of medication information, Novolin insulin should only be used within 30 days of opening the bottle.	F 431			
F 441 SS=B	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441			

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F 441	Continued From page 19 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based upon observation and staff interview, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of disease and infection. Findings include: 1. Per observation on 02/22/2011, Resident #49 was observed dragging his/her fingers through an uncovered dish of pudding that was on the medication cart to be used for medication administration. It was later confirmed during staff interview that the pudding used for medication administration should be covered between uses.	F 441			
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	F 456			

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F 456	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation and review of documents, the facility failed to maintain all essential patient care equipment per the manufacturer's instructions for 7 applicable residents (Residents #2, #6, #7, #9, #17, #30, and #37). Findings include: 1. Per observation of a medication pass on 2/23/11, the medication nurse was observed cleaning a glucometer with an alcohol swab following a blood sugar check for Resident #6. Per review on 2/23/11, the glucometer manufacturer guidelines states: Do not use alcohol, Cleaning meter with alcohol will cause damage, Clean with mild detergent or mild soap and water. Per interview at 11:15 AM on 2/24/11, the Assistant Director of Nursing (ADNS) and the Director of Nursing (DNS) confirmed the Glucometer Tru Balance Owner's Booklet 2009 states: Do not use alcohol, Cleaning meter with alcohol will cause damage, Clean with mild detergent or mild soap and water. Per interview on 2/24/11 at 11:24 AM, the ADNS confirmed that 7 residents in the facility are receiving injectable insulin and require the use of a glucometer. (Residents #2, #6, #7, #9, #17, #30, and #37). Per interview on 2/24/11 at 11:27 AM, the DNS stated, per telephone interview with the Tru Balance company on 2/24/11, that alcohol could ruin the electronics. During an interview on 2/24/11 at 1:00 PM, the ADNS and surveyor reviewed the faxed policy received from Tru Track Manufacturer for the glucometers. The	F 456			

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F 456	Continued From page 21 policy states "At a minimum, your facility must follow the Manufacturer's Care and Cleaning instructions". On 2/24/11 at 1:00 PM, the ADNS confirmed that the faxed information received from Tru Track states at a minimum the facility must follow the manufacturer's care and cleaning instructions and that the facility was not following the manufacturer's minimum care and cleaning instructions.	F 456		
F 498 SS=B	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that 3 applicable Licensed Nurse Aides (LNAs) demonstrated competency skills and techniques necessary to care for residents needs. Findings include: 1. Per review of personnel files on the afternoon of 02/23/11, the facility's staff development person was unable to provide evidence of competency reviews for 3 LNAs who had been employed for greater than 1 year. Per interview on 02/23/11 at 4:00 PM, the DNS stated the facility "is working on a system to do that" and confirmed the competencies were not demonstrated.	F 498		
F 514 SS=C	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB	F 514		

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F 514	<p>Continued From page 22 LE</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 staff interview, the facility failed to have systematically organized records for residents. The findings include:</p> <p>Per medical record review for 39 residents in the Stage 1 sample on 02/22/2011 and 02/23/2011 by 5 surveyors, the medical records are found to be incomplete and information is not consistently readily available or systematically organized. Weights are recorded in several different places, both in the medical record, on flow sheets, under the dietary tab, and in a weight book. The dietician confirmed during interview on 02/24/2011 that it is often difficult to track weight loss because weights are difficult to find. Staff confirmed, during interviews, that charts are disorganized and that they are in the process of trying to streamline charting and make it more consistent.</p>	F 514			

The following columns are sized for the VT state Plan of Correction

- Column A - put ID Prefix Tag
- Column B - List action item
- Column C - leave blank
- Column D - put date in 1/1/10 format
- Column E - leave blank

EXAMPLE

- For ease of print and cut/paste to form:
- Do not change size of columns
- Do not outline or put borders on cells
- Skip a line between action items
- Insert page break for each new ID Tag

ID Tag

Comp Responsible Person
Date

F225 There was an incident report completed for this event, kept in the DNS office in the incident report book. On 1/12/11, a fax of the incident report was sent to the Resident's physician. No further action was requested by the physician. See attached. The Facility notes that surveyor guidance for this citation shows that injuries of unknown source that are to be investigated must be both: (1) unexplained (as was this bruising) and (2) suspicious because of extent or location or number of injuries at one time or over time. The minor arm bruising on Patient #34, does not rise to the level of an "incident" or "injury of unknown source." Notwithstanding, the Facility offers the following plan of correction for this citation.

All residents are potentially at risk.

The resident's bruising is resolving, with no adverse effects.

The Facility has a Policy and Procedure in place for reporting and recording accidents and incidents and will continue to follow this policy. See attached Exhibit #1

The Facility will re-orient appropriate personnel to the Policy and Procedure for Reporting Accidents and Incidents.

pre-dating Director of Nursing Services
survey

3/23/11 Administrator's Delegee/Outside Consultant

*accepted
Coleman
3/24/11*

F226 The Facility notes that the surveyors did not identify the two employees for whom they did not locate evidence of completion of the required Vermont background checks. All residents have the potential to be impacted.

The Facility has obtained favorable background check for all current employees.

The Facility has hired a new personnel director and transitioned that person in the role of conducting Vermont specific background checks.

No person will be permitted to work at the Facility without first having passed a general and a Vermont specific background check. See attached new policy - Exhibit #2

3/17/11 Human Resources Coordinator

3/17/11 Personnel Director

3/17/11 Personnel Director

*accepted
Coleman
3/24/11*

F279	<p>The plan of care for Resident #5 has been updated to reflect her clothing preferences. All residents with particular clothing preferences have the potential to be impacted.</p> <p>Licensed staff will be re-educated about the documentation of specific/unusual clothing preferences on the resident care plan.</p> <p>Licensed staff will update care plans to reflect unusual clothing preferences.</p> <p>Care plans will be randomly audited to review for clothing preferences.</p> <p>Quality Assurance Committee will receive results of chart audit at the next two quarterly meetings, and if appropriate, on a continuing basis.</p>	<p>3/17/11</p> <p>3/24/11</p> <p>3/17/11 and ongoing</p> <p>3/24/11</p> <p>next meeting and ongoing</p>	<p>Assistant Director of Nursing</p> <p>Staff Development Coordinator/Designee</p> <p>Director of Nursing</p> <p>Assistant Director of Nursing with Quality Assurance and Committee</p> <p>Quality Assurance Committee</p>
F280	<p>1. All residents have the potential to be impacted by plan of care deficiencies. Regarding Patient #34, please see responses to F225, F279.</p> <p>The Facility does not believe that Resident #34's bruising of unknown etiology in 2008 is related to the 2011 bruising that his/her physician was advised of via the incident report.</p> <p>Care plans will be updated to reflect significant bruising of unknown etiology.</p> <p>2. The plan of care for Resident #26 has been revised to reflect the current wheelchair status of the resident.</p> <p>The plan of care for Resident #2 has been updated to reflect the burn, care of the burn and interventions to prevent recurrence.</p> <p>3. The plan of care for Resident #33 has been revised to reflect the use of Amitriptyline for restorative sleep.</p> <p>Licensed staff will be re-educated about updating patients' plans of care, and appropriate documentation in those plans. This will include education on revising plans of care for bruising, burns, clothing preferences, use of antipsychotic medications and wheelchair use.</p>	<p>3/17/2011</p> <p>3/17/2011</p> <p>3/17/2011</p> <p>3/17/2011</p> <p>3/24/11</p>	<p>Licensed Nursing Staff</p> <p>Director of Nursing</p> <p>Director of Nursing</p> <p>Director of Nursing</p> <p>Staff Development Coordinator/Designee</p>

*accepted
Boren
3/24/11*

*accepted
Boren
3/24/11*

Care plans will be randomly audited to ensure they are updated and contain appropriate information.	3/24/11 ongoing for at least 6 mos	Assistant Director of Nursing and Quality Assurance and Committee	
Quality Assurance Committee will review care plan audits.	next meeting after 3/24/11 and ongoing for at least 6 months	Quality Assurance Committee	
F282	Residents with orders for weekly weight checks may be at risk.	3/17/11 and ongoing	Licensed Staff
	Residents' weights will be recorded in a weight book on an individual weight sheet when weights are ordered to be taken.		
	Weight sheets will be audited weekly and results referred to Dietician as appropriate per policy. Care plans will be revised where indicated.	3/17/11 and ongoing	Director of Nursing/Designee
	Weekly weight audit results will be reported to the Quality Assurance Committee.		
	Licensed staff will be re-educated on on weight policy.	3/24/2011	Staff Development Coordinator or Designee
F323	The Facility disagrees with the assessment of this citation at the level of Immediate jeopardy. Immediate Jeopardy means that there is a crisis situation in which the health and safety of resident are at risk. SOM §3010. Examples of immediate jeopardy situations are given in Appendix Q, and those that relate to the safety of the environment do not include the use of gas fireplaces. As recited more fully after, the fact that this fireplace has been in use since 1995 without incident demonstrates the lack of a crisis in and of itself. Surveyor guidance for F323, guides that Immediate Jeopardy should only be cited where the defect has caused serious harm to a resident AND requires immediate corrective action as the facility allowed the situation to continue by failing to implement corrective measures. The examples of level 4 severity in guidance for F323 include a third degree burn or a second degree burn over a large area. The examples of Level 3 severity include a 2nd degree burn and the examples of Level 2 severity include a 1st degree burn. Here, the Resident suffered a 18 cm by 6 cm red burn on the forearm with two small blistered areas which would most likely meet the criteria for a first degree burn.		

*accepted
CA 3/24/11*

*accepted
CA 3/24/11*

Resident #2 does not fit the usual profile of residents, s/he is a 47 year old diabetic who was admitted for rehabilitation after an amputation. On 2/13/11, s/he was wheelchair bound waiting for her prosthesis to arrive after which she would resume therapy to learn to ambulate with her prosthesis. This resident is fiercely independent and does not want to be told where she can and cannot go, s/he enjoys the Victorian House living room in the evening because it is quiet and comfortable. Resident # 2 did not ask staff about the fireplace, but determined on her own to turn on the fireplace from her wheelchair. It was not expected that s/he could operate the switch, but s/he managed to turn on the fireplace. When s/he planned to leave, s/he attempted to turn off the fireplace and accidentally touched the glass sustaining a first/second degree burn. S/he did not report the burn to a nurse until the next evening and the nurse completed an incident report. The administrator and key department heads reviewed the incident the next morning and determined, because of the incident free use of the fireplace for 16 years, the residents' enjoyment and the a typical nature of Resident #2 and did not warrant discontinuing the gas line at that time. The gas to the fireplace was disconnected on 2-22-2011. There were no incidents related to the fireplace after this decision.

The gas line to the fireplace was disconnected on 2-22-2011.

2/22/2011 Maintenance Director as Exhibit 3A.

A wall mounded on/off switch for the fireplace with a lock box covering it was installed on 2-17-2011.

3/17/2011 Maintenance Director

A protective screen, covering will be installed over the fireplace before it is turned back on. We are researching an appropriate screen

4/1/2011 Maintenance Director

*accepted
GA 2/24/11*

The propane fireplace in the living room of Victorian House was installed in February 1995 during the rehabilitation of the Facility. The fireplace was permitted and approved "as is" by Life Safety inspector and has never been cited as a cause for concern on any survey or HUD inspection. Enclosed is the most recent HUD inspection, showing the fireplace was not raised as an issue. See Exhibit 3B. In fact, until this one incident, that involved an atypical resident, no resident living in either Victorian House (Level III) or the nursing home has ever attempted to turn the fireplace on or off or otherwise touch it. No other resident has been injured by the fireplace. Quite to the contrary, the fireplace has been a source of comfort and homelike atmosphere for our residents. The fireplace is greatly enjoyed by residents and families -- activities such as coffee hour are held before the fireplace in winter and many residents enjoy simply sitting by the fireplace. The fireplace was turned on an off by staff, generally early before breakfast on cold days for a while after breakfast. Staff would turn off the fireplace, unless there was coffee hour when it would remain on, and upon requests from family.

The Facility notes that, generally, residents sitting in the Victorian House living room are supervised by the activities staff who are able to keep an eye on them from the activities room. The activities director has a direct view of the fireplace from her desk. The day of the survey, the surveyors refused to conduct the survey from any location other than the activities room, thereby displacing the personell who monitored residents in the living room. See attached statement of Barbara Flinn, Director of Activities - See Exhibit 3C.

Residents in close proximity to the fireplace will be supervised when the fireplace is on.

APRN will be educated about staging burns.

Staff education on plans of care will include revisions to reflect burns and measures to prevent future incidents.

Staff will be educated about Accidents and Incident report policy and directed to provide reports to Director of Nursing.

The Maintenance Director does not believe his statements were accurately reported.

The fireplace was serviced in October 2009 see attached - See Exhibit 3D.

The fireplace was serviced again on 3-16-2011 - Attendant to installing the on/off switch - See Exhibit 3B

3/17/2011 Administrator and staff

3/24/11 Director of Nursing

3/24/11

3/24/11

3/16/2011 Maintenance Director

*Accepted 62
3/24/11*

The fireplace will be put on a preventive maintenance schedule for biannual service by Contractor Service.

3/16/11 Maintenance Director

The Facility encloses a copy of a survey from an Idaho facility, which had an F323 citation for a gas fireplace without a screen, very similar to the issues cited in this survey. The scope and severity rating for that, when combined with medication issues, was only "E." See also responses to F465 and F520. Exhibit 3D

The incident was discussed at morning meeting by all members of the Quality Assurance Committee other than the Medical Director. See statement - Exhibit 3E

2/15/11 Department Heads

*Accepted
GC 3/24/11*

F326

See also response to F282

Resident #36 is having weekly weights taken and documented per policy.

3/11/11 Director of Nursing

A referral to the dietician has been made for Resident #36.

3/11/2011 Director of Nursing

Weights will be recorded in a weight book on an individual sheet of paper for each resident. Significant fluctuations will be referred to the dietician, reflected in the plan of care.

3/11/2011 Licensed Staff

Licensed staff will be re-educated on referral and care plan revision policies.

3/22/2011 Staff Development Coordinator/Designee

Weight fluctuation referrals and care plan revisions will be audited weekly with results reported to Quality Assurance Committee for at least 6 months.

3/24/11 Director of Nursing/Designee/Quality Assurance and Committee ongoing

*Accepted
GC 3/24/11*

F329

See also response to F428

The medication order for Lorazepam for Resident #1 has been revised to reflect specific behaviors of agitation, confusion or irritability as requested by the pharmacy recommendaton.

3/11/11 Director of Nursing

PRN antianxiety medications will have specific indications for use included in the Order and Orders will be revised as necessary.

3/24/11 Director of Nursing

Licensed staff will be re-educated on the policy for including specific indications for use of PRN medication orders and for securing review of pharmacy recommendations by NP.

3/24/11 Staff Development Coordinator/Designee

Director of Nursing/Designee will audit orders for antipsychotic/antianxiety medications to assure specific documentation of symptoms. Results will be reported to Quality Assurance.

3/24/11 Director of Nursing and ongoing at least 6 mos

*Accepted
GC 3/24/2011*

	Pharmacy recommendations will be reviewed for signature and/or comments by Director of Nursing or designee, results reported to Quality Assurance.	3/24/11 and ongoing at least 6 mos	Director of Nursing	
F428	The medication order for anxiety for Resident #1 has been revised to reflect specific behaviors. Residents receiving prn antipsychotic medication are at risk for the deficient practice. Pharmacy recommendations are put in a folder for the Nurse Practitioner to review and sign. The policy will be re-inserviced for the licensed nurses by the SDC/Designee.	3/24/11	Pharmacy recommendations will be reviewed for signature and/or comments by the ADON/Designee. Results of the reviews will be reported to QA quarterly X2.	<i>accepted GC 3/24/11</i>
F431	Resident #9 received Novolin Insulin properly labeled after opening. Residents who receive Novolin Insulin are at risk for the deficient practice. Bottles of insulin will be labeled when opened and discarded 30 days after opening. Licensed staff will be re-inserviced on the policy of dating Novolin Insulin bottles upon opening and discarding 30 days after opening. Audits of the medication carts will be done daily X1 month, weekly X4 weeks and monthly X3 months by 11-7 shift charge nurse to ensure appropriate labeling.	3/24/11	Results of the audits will be reported to DNS. QA Committee quarterly X2.	<i>GC accepted 3/24/11</i>
F441	Resident #39 had no negative outcome as a result of dragging fingers through pudding. The pudding was disposed of. Residents who receive food substances with their medications are at risk for the deficient practice. Food substances used during medication passes will be covered during medication administration and disposed of as appropriate after the pass. Licensed staff will be re-inserviced on covering foods during med pass by the SDC/Designee.	3/24/11	Audits will be done during med passes by Clinical Coordinator/Designee daily X1 month, weekly X4 weeks and monthly X3 months to ensure prospering covering. Results of the audit will be reported to the QA Committee quarterly X 6 months. Completion date 3-24-11.	<i>accepted GC 3/24/11</i>
F456	Residents #2, 6, 7, 9, 17, 30 and 37 sustained no negative outcome as a result of the use of a glucometer cleaned with an alcohol swab. Residents with orders for finger sticks are at risk for the deficient practice. Individual glucometers are in use for finger sticks. They are cleaned between sticks according to manufacturer's guidelines. Licensed staff will be inserviced on the cleaning policy by the SDC/Designee.	3/24/11	The process will be monitored by the DON daily X1 month, weekly X4 weeks and monthly X3. Results will be reported to the QA Committee quarterly X2.	<i>accepted GC 3/24/11</i>

F 498 483.76(f) NURSE AIDE DEMONSTRATE
SS=B COMPETENCY/CARE NEEDS

The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure that 3 applicable Licensed Nurse Aides (LNAs) demonstrated competency skills and techniques necessary to care for residents needs. Findings include:

1. Per review of personnel files on the afternoon of 02/23/11, the facility's staff development person was unable to provide evidence of competency reviews for 3 LNAs who had been employed for greater than 1 year. Per interview on 02/23/11 at 4:00 PM, the DNS stated the facility "is working on a system to do that" and confirmed the competencies were not demonstrated.

F 498 F498

The 3 LNAs have been demonstrated competency reviews. Current and future LNAs will have annual competency testing by SDC. This will be monitored by the DON who will do quarterly audits of LNA competency testing and report results to the QA Committee quarterly X2.

Completion Date 3-24-11

514 Medical records are being organized and thinned to provide a systematic process to provide resident information. The process is ongoing. The licensed staff will be re-inserviced on the order of the medical record by the SDC/Designee. Medical records will be audited monthly by the DON for organization and information. The results of the audits will be reported to the QA Committee quarterly X4. Weights will be reported in a "Weight book" with a dedicated page for each resident. The individual resident's weight sheet will be placed in a designated section of the resident's medical record at the time of discharge.

3/24/11 The licensed staff will be inserviced on the process by the SDC/Designee. The weights will be audited weekly by the Dietician/Designee. Results of the audits will be reported to the QA Committee quarterly X2.

*Accepted
3/24/11
CZ*