



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

December 2, 2011

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 and complaint investigation conducted on **October 19, 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,

A handwritten signature in black ink that reads "Pamela M. Cota".

Pamela M. Cota, RN
Licensing Chief

PC:ne
Enclosure



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 C 10/19/2011
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 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 record review, observation and interview, the facility failed to ensure that care planned monitoring, supervision and redirection was provided for one wandering resident resulting in a second altercation with another resident. This affected one (Resident #1) of two residents reviewed. Findings include:</p> <p>Review of the clinical record accumulative diagnosis list for Resident #1 revealed diagnoses of dementia with behavioral disturbances and senile depressive disorder. The Medication Administration Record (MAR) and the Behavior/Intervention flow record, indicated that Resident #1 received as needed Ativan (antianxiety medication) 0.5 milligrams by mouth three times in October 2011 for symptoms of throwing objects, hitting and kicking. The flow record did not indicate that wandering was a problem that was tracked or monitored for Resident #1. The nurses note entry dated 05/05/11 at 2300 hours, indicated that Resident</p>	F 282	<p>F282-Resident #1 injury risk care plan updated to say "All Interdisciplinary team members will redirect resident when she is getting in close proximity to R.Z."</p> <p>Resident #1care plan was updated to say she is happiest when left to herself to wander up and down halls with out impediment. We define wandering by MDS 3.0. Wandering is the act of moving (walking or locomotion in a wheelchair) from place to place with or without a specified course or known direction. May or may not be aimless.</p> <p>Her behavior care plan for wandering will be updated with accurate and relevant approaches that reflect the most effective means in providing care for her. It also reflects that too many interactions increase her agitation. That includes her hx of throwing objects at a</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *T. Garcia* TITLE *LNHA* (X6) DATE *11/9/2011*

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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PRINTED: 10/28/2011
FORM APPROVED
OMB NO. 0938-0391

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F 282	Continued From page 1 #1 hit another resident with a box of tissues with a cup of water in it. The other Resident then slapped Resident #1 on the right cheek. No injury was noted. The plan of care for Resident #1 labeled, a Resident who has assaulted, initiated on 05/05/11, indicated staff interventions of: Monitor for wandering, confused behavior and engage resident in activities; and Redirect the Resident. On 06/21/11, the nurses notes (untimed) indicated that Resident #1 was agitated with another male Resident and was throwing objects. The other Resident slapped her face. No injury was noted. Further review of the nurses notes revealed no documentation of problem wandering or monitoring and redirection from staff for the week preceding the incident. The social service notes dated 06/22/11 (untimed) revealed that Resident #1 carries objects in her wheelchair and will throw them at staff and another resident who provokes her. Per observation of Resident #1 on 10/19/11 at 12:50 P.M. the noon meal service was in progress and Resident #1 was observed to propel away from the table near the nurses station. She was asked one time by the nurse aid seated at the table assisting another Resident, if she wanted anything to eat. She said no and proceeded to propel back and forth from this area to the main dining room area at the other end of the building for the next 20 minutes. No staff were observed to acknowledge her, engage her in conversation or attempt to redirect her back to her unit or the meal during that time. The other Resident (Resident #2) involved in the incidents of 05/05/11 and 06/21/11 was observed to be in the main dining area as she wandered in the vicinity.	F 282	specific male resident when in close proximity and at staff for interacting when already agitated. The SSD and DNS will identify other residents at potential risk for wandering, as defined by MDS 3.0. The SSD and DNS will ensure proper care plans are in place to address wandering behaviors. Going forward, any resident with noted wandering, as defined by MDS 3.0, will have a care plan put into place by SSD in conjunction with nursing department. All wandering residents (as defined by MDS 3.0) will be audited bi-weekly to ensure proper care plan in place with appropriate approaches by DNS x 90days. After the 90 days the SSD will be responsible for ensuring proper care plans are in place for all residents whose MDS indicated wandering behavior and the SSD will reviewed in conjunction with Geri-psych consultations PRN. We will have this process in place no later than 11/16/2011	

Jan Hu, LNA

11/9/2011

F282 POC accepted 11/22/11
SEMURRN/PMCOARN

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F 282	Continued From page 2	F 282			
F 353 SS=D	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed</p>	F 353	<p>F353 Staffing scheduled on day of incident was sufficient for shift.</p> <p>When at all possible LNAs will not take meal breaks before 7pm and only one LNA at a time will take meal breaks from 7-8pm. After 8pm, 2 LNAs may take meal breaks at the same time.</p>		

John Hens, LNA, 11/9/2011

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F 353	<p>Continued From page 3</p> <p>nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure sufficient staffing was available to meet the needs of each resident in accordance with 1 applicable resident's care plan. (Resident #1) Findings include:</p> <p>1. On the evening of 06/21/11, Resident #1 wandered into the main dining area at approximately 6:45 PM, were another resident (Resident #2) was sitting. Resident # 1 is care planned to be monitored when wandering and to be re-directed when in close proximity to Resident #2 [who was sitting in the main dining area] as a result of past altercations between the two residents. A kitchen staff member heard a loud 'cup-falling' sound and saw Resident #2 slap Resident #1. The residents were separated at that time.</p> <p>Per record review on 10/19/11 of the staffing numbers for 06/21/11 evening shift, 3 of 6 LNA staff were not available after the dinner hour. Per the staff projection sheet and information from time sheets, which was presented to the surveyor by the Director of Nursing Services, the LNA assigned to the main dining area had left at 6:31 PM [for a supper break] and two LNA's were also away on break beginning at 6:30 PM and 6:40 PM respectively. Additionally, the Activity personnel , also assigned to that area, was in another part of the building preparing for an evening activity. There were 37 residents,</p>	F 353	<p>Charge Nurse will assign meal break times at the start of shift on the projection sheets.</p> <p>DNS will monitor meal breaks Q Thursday on the electronic timecards x 6 weeks.</p> <p>This practice will be in place by 11/10/11.</p> <p>F353 POC accepted 11/22/11 SEMMONS RN / P.M. COTURN</p>	

Patricia Horn, LNA

11/9/2011

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F 353	<p>Continued From page 4</p> <p>some who need extensive assistance with feeding, toileting or monitoring being helped by the remaining 3 LNA's. Per interview at 1:45 PM, the DNS confirmed staff were not available at that time to monitor Resident #1's wandering.</p> <p>2. Review of the clinical record accumulative diagnosis list for Resident #1 revealed diagnoses of dementia with behavioral disturbances and senile depressive disorder. The flow record did not indicate that wandering was a problem that was tracked or monitored for Resident #1. The nurses note entry dated 05/05/11 at 2300 hours, indicated that Resident #1 hit another resident with a box of tissues with a cup of water in it. The other Resident then slapped Resident #1 on the right cheek. No injury was noted. The plan of care for Resident #1 labeled, a Resident who has assaulted, initiated on 05/05/11, indicated staff interventions of: Monitor for wandering, confused behavior and engage resident in activities; and Redirect the Resident. On 06/21/11, the nurses notes (untimed) indicated that Resident #1 was agitated with another male Resident and was throwing objects. The other Resident slapped her face. No injury was noted. Further review of the nurses notes revealed no documentation of problem wandering or monitoring and redirection from staff for the week preceding the incident. The social service notes dated 06/22/11 (untimed) revealed that Resident #1 carries objects in her wheelchair and will throw them at staff and another resident who provokes her.</p> <p>Per observation of Resident #1 on 10/19/11 at 12:50 P.M. the noon meal service was in progress and Resident #1 was observed to propel away from the table near the nurses station. She</p>	F 353		
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Paul Huang, LNA, 11/9/2011

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F 353	Continued From page 5 was asked one time by the nurse aid seated at the table assisting another Resident, if she wanted anything to eat. She said no and proceeded to propel back and forth from this area to the main dining room area at the other end of the building for the next 20 minutes. No staff were observed to acknowledge her, engage her in conversation or attempt to redirect her back to her unit or the meal during that time. The other Resident (Resident #2) involved in the incidents of 05/05/11 and 06/21/11 was observed to be in the main dining area as she wandered in the vicinity. Per interview of the Assistant Director of Nursing Services (ADNS) on 10/19/11 at 1:45 P.M. revealed that the interventions of monitoring, supervision and redirection were added to the plan of care labeled, a Resident who has assaulted, on 05/05/11 after the initial resident to resident incident. She stated that staff keep track of Resident #1 and redirect him/her but did not document that anywhere other than the nurses notes. She stated that Resident #1 wandered continuously and staff were very busy during meals. She verified that Resident #1 wandered the halls in the vicinity of the dining room where Resident #2 was eating while staff were busy with other Residents.	F 353		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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.	F 514	F514- DNS/ADNS will do one on one education for all Nurses that practice at this time for the proper coding of behavior sheets and the proper way to complete MAR for PRN use.	

Pat Heav, 11/9/2011

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F 514	<p>Continued From page 6</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 interviews, the facility failed to assure that there was complete and accurate documentation for 1 applicable resident's record. (Resident #2) Findings include:</p> <p>1. Per record review and staff interviews on 10/19/11, there was incomplete documentation regarding behavior monitoring for Resident #2. The behavior monthly flow sheet located in the current medication administration record (MAR) did not have the month or year. There was also no documentation for monitoring behaviors for 3 shifts for the first 12 days on this sheet. Per interview at 1:30 PM, the staff nurse stated that the behavior flow sheet was for the month of October 2011 and "was not sure why the the behavior flow sheet was not filled out". In addition, the medication Haldol was administered on 10/05/11, however, was not accurately documented on the MAR's PRN (as needed) section. Per interview at 1:45 PM, the DNS (Director of Nursing Services) confirmed that Resident #2's record was not complete and accurate.</p>	F 514	<p>DNS / ADNS will review all in house patient Behavior sheets for accurate behavior monitoring.</p> <p>All new nurse hires will sign off on a paperwork orientation sheet that includes the proper documentation of behaviors and PRN use.</p> <p>DNS/ ADNS to review all in house behavior sheets on a weekly basis for accuracy x one month.</p> <p>ADNS or designee to double check all new admits and new MARS behavior sheets for accurate coding, dates and name labeling of resident before going into MAR for use.</p> <p>This will be in place by 11/16/2011.</p> <p>F514 POC accepted 11/22/11 SEMMONSEN / Pincoturn</p>	
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Patricia Hunt, 11/16/2011