

Division of Licensing and Protection
103 South Main Street
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

January 14, 2015

Ms. Patricia Horn, Administrator
Cedar Hill Health Care Center
49 Cedar Hill Drive
Windsor, VT 05089-9470

Dear Ms. Horn:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 17, 2014**. 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
Licensing Chief

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

JAN 14 2015

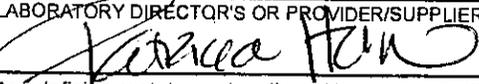
PRINTED: 12/31/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/17/2014
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 F 281 SS=D	<p>INITIAL COMMENTS</p> <p>An unannounced onsite annual recertification survey was conducted by the Division of Licensing & Protection on 12/15/14 through 112/17/14. The finding include the following: 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon staff interview and record review the facility failed to provide services that meet professional standards of quality regarding physician orders related to medications and monitoring oxygen saturation levels for one resident [Resident #9] of 36 residents in the stage 2 sample group. Findings include: Per record review, the American Medical Association Code of Medical Ethics states " One of the duties in providing reasonable care is fulfilled by a nurse who carries out the orders of the attending physician. " [http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion302.page] Per record review, the American Nurses Association Standards of Practice include " The nurse collects comprehensive data pertinent to the patient ' s health or situation " and " The nurse implements the identified plan of care " , " implements interventions " and " documents interventions " [http://www.currentnursing.com/nursing_manage</p>	F 000 F 281	<p><u>Annual Survey December 2014 Plan of Corrections</u></p> <p>F-281 §483.20(k)(3)(i) - Professional Standards of Quality Services provided or arranged by the facility must meet professional standards of quality.</p> <ol style="list-style-type: none"> 1. The Registered Nurse that withheld medication for Resident #9 was promptly disciplined. 2. By January 17, 2015, all current nursing staff will be trained and educated on the Standards sited on the website documented in the 2567 by the survey team. This training and education will ensure that the current nursing staff has a clear understanding of the Professional Standards. New Licensed Nurses will be oriented to Professional Standards and protocols during the orientation process for all new nurses hired after January 17, 2015. 	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE LTHA (X6) DATE 1/21/2015
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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 281	<p>Continued From page 1 ment/nursing_standards.html]</p> <p>1). Per record review Resident #9 ' s diagnoses include chronic pain, joint pain, osteoarthritis [a painful Degenerative Bone Disease] and has a history of pneumonia. Physician Orders for Resident #9 include " Oxycodone [an opioid pain medication] 5 milligrams by mouth at bedtime " and " Oxygen at 2 litres per minute via nasal cannula as needed to keep Sats [oxygen saturation levels] over 90% ". Resident #9 ' s Plan of Care includes " Give medications as ordered " and " monitor oxygen sats [saturation levels] and temperatures as indicated " .</p> <p>Per record review and confirmed during interview with the Director of Nursing Services [DNS] and the Unit Manager [UM] on 12/16/14 at 11:20 A.M., Resident #9 was not given the opioid pain medication on 9/16/14 as ordered. Per record review Nursing Notes for 9/16/14 record " med not given-floor was very busy. " Per interview with the DNS, the facility ' s procedure for missing a medication is to fill out an Incident Report, contact the resident ' s physician regarding the missed medication, and contact the DNS. The DNS confirmed that none of this was done regarding Resident #9 ' s missed pain medication.</p> <p>2). Per record review, Resident #9 ' s oxygen saturation levels were not monitored and/or documented as being above 90% on 11/22, 11/24, & 11/26/14 per physician ' s order. On 11/28/14 Resident #9 ' s oxygen saturation level is recorded as 89%. Per record review on 12/1 & 12/2/14 the oxygen saturation levels are documented as being ' I.C. ' [in computer]. Per review there is no record of oxygen saturation levels being taken for Resident #9 from 12/3 to 12/16/14. Per record review, Resident #9 ' s Plan</p>	F 281	<p>3. Protocol for oxygen has been updated and is attached to survey response for your review. The updated Protocol reinforces the expectation that all oxygen orders, as needed or continuous, will be checked by a nurse and the oxygen saturations levels will be recorded during every shift in the MAR/TAR. (See attached Protocol.)</p> <p>4. ADNS/ Clinical Coordinator will audit all MAR/TAR on a weekly basis to ensure that all medications were given as ordered and all oxygen saturations required were obtained and documented appropriately. Results of these audits will be tracked and discussed at the Quality Assurance Meetings.</p> <p>Compliance Date January 17, 2015</p> <p><i>F281 POC accepted 1/13/15 Mbertina P/MLC</i></p>	
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PAH 1/2/2015

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F 281	<p>Continued From page 2</p> <p>of Care also includes " Monitor/document/report to MD as needed for the following s/sx of pneumonia ". Included in the signs and symptoms [" s/sx "] is ' hypoxia ' .</p> <p>Per review of WebMD.com ' s guide to hypoxia-hypoxemia: " When your body doesn't have enough oxygen, you could get hypoxemia or hypoxia. These are dangerous conditions. Without oxygen, your brain, liver, and other organs can be damaged just minutes after symptoms start. [The word hypoxia is sometimes used to describe both problems; hypoxia-hypoxemia] . "</p> <p><http://www.webmd.com/asthma/guide/hypoxia-hypoxemia></p> <p>Per review the US National Library of Medicine National Institutes of Health reports " the human eye is poor at recognizing hypoxemia. Even under ideal conditions skilled observers cannot consistently detect hypoxemia until the oxygen saturation [O2] is below 80% " .</p> <p><http://www.ncbi.nlm.nih.gov/pmc/articles/PMC137227/></p> <p>Per review the International Primary Care Respiratory Group states " Pulse oximetry can rapidly detect changes in oxygen saturation, thus providing an early warning of dangerous hypoxemia. "</p> <p><https://www.theipcr.org/download/attachments/689660/oximetry_pocket_guide.pdf?version=1&modificationDate=1347261955000>, and per review the American Association for Respiratory Care states " Pulse oximetry is accepted as a standard of care in multiple settings. "</p> <p><http://www.aarc.org/marketplace/reference_articles/02.99.045.pdf></p> <p>Per interview with the Director of Nursing Services [DNS] and the Unit Manager [UM] on 12/16/14 at 11:20 A.M., the DNS and UM</p>	F 281		

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F 281	Continued From page 3 confirmed Physician Orders for Resident #9 included " to keep Sats [oxygen saturation levels] over 90% ". The DNS and UM confirmed oxygen saturation levels were not monitored and/or documented as being above 90% on 11/22, 11/24, & 11/26/14 , on 12/1 & 12/2/14 the oxygen saturation levels are documented as being ' I.C. ' [in computer] but were unable to be located in either Resident #9 ' s electronic medical record or written record, and there is no record of oxygen saturation levels being taken for Resident #9 from 12/3 to 12/16/14. The DNS and UM also confirmed Resident #9 ' s Plan of Care includes monitor/document/report to MD as needed for signs and symptoms of pneumonia including hypoxia, and monitor oxygen saturation levels as indicated. The DNS and UM confirmed there was no way to assure oxygen saturation levels for Resident #9 remained over 90% per physician order without taking oxygen saturation levels, and these were not done.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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 upon staff interview and record review the facility failed to provide services in accordance with the resident ' s written plan of care for one resident [Resident #9] of 36 residents in the stage 2 sample group. Findings include:	F 282	F282 §483.20(k)(3)(ii) - Qualifications of Facility Staff. Be provided by qualified persons in accordance with each resident's written plan of care. 1. Registered Nurse that withheld medication for Resident #9 was promptly disciplined. 2. ADNS/ Clinical Coordinator will audit all MAR/TAR on a weekly basis to ensure that all medications were given as	

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F 282	Continued From page 4 1). Per record review Resident #9 ' s diagnoses include chronic pain, joint pain, osteoarthritis [a painful Degenerative Bone Disease] and has a history of pneumonia. Physician Orders for Resident #9 include " Oxycodone [an opioid pain medication] 5 milligrams by mouth at bedtime " and " Oxygen at 2 litres per minute via nasal cannula as needed to keep Sats [oxygen saturation levels] over 90% ". Resident #9 ' s Plan of Care includes " Give medications as ordered " and " monitor oxygen sats [saturation levels] and temperatures as indicated ". Per record review and confirmed during interview with the Director of Nursing Services [DNS] and the Unit Manager [UM] on 12/16/14 at 11:20 A.M., Resident #9 was not given the opioid pain medication on 9/16/14 as ordered. Per record review Nursing Notes for 9/16/14 record " med not given-floor was very busy. " Per interview with the DNS, the facility ' s procedure for missing a medication is to fill out an Incident Report, contact the resident ' s physician regarding the missed medication, and contact the DNS. The DNS confirmed that none of this was done regarding Resident #9 ' s missed pain medication. 2). Per record review, Resident #9 ' s oxygen saturation levels were not monitored and/or documented as being above 90% on 11/22, 11/24, & 11/26/14 per physician ' s order. On 11/28/14 Resident #9 ' s oxygen saturation level is recorded as 89%. Per record review on 12/1 & 12/2/14 the oxygen saturation levels are documented as being ' I.C. ' [in computer]. Per review there is no record of oxygen saturation levels being taken for Resident #9 from 12/3 to 12/16/14. Per record review, Resident #9 ' s Plan of Care also includes " Monitor/document/report	F 282	ordered and all oxygen saturations required were obtained and documented appropriately in accordance with the Plan of Care. 3. ADNS/ Clinical Coordinator will audit the plans of care weekly to ensure that all problems, goals and interventions are appropriate and updated to the current resident ' s conditions. 4. All current Nurses will be re-educated to the plan of care process by January 17, 2015. All nurses hired after January 17, 2015 will have this education and training provided with orientation. Compliance Date January 17, 2015 <i>F282 POC accepted 1/13/15 M.B. and R.H.P.M.</i>	

Pen 1/8/2015

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F 282	<p>Continued From page 5</p> <p>to MD as needed for the following s/sx of pneumonia " . Included in the signs and symptoms [" s/sx "] is ' hypoxia ' .</p> <p>Per review of WebMD.com ' s guide to hypoxia-hypoxemia: " When your body doesn't have enough oxygen, you could get hypoxemia or hypoxia. These are dangerous conditions. Without oxygen, your brain, liver, and other organs can be damaged just minutes after symptoms start. [The word hypoxia is sometimes used to describe both problems; hypoxia-hypoxemia] . "</p> <p><http://www.webmd.com/asthma/guide/hypoxia-hypoxemia></p> <p>Per review the US National Library of Medicine National Institutes of Health reports " the human eye is poor at recognizing hypoxemia. Even under ideal conditions skilled observers cannot consistently detect hypoxemia until the oxygen saturation [O2] is below 80% " .</p> <p><http://www.ncbi.nlm.nih.gov/pmc/articles/PMC137227/></p> <p>Per review the International Primary Care Respiratory Group states " Pulse oximetry can rapidly detect changes in oxygen saturation, thus providing an early warning of dangerous hypoxemia. "</p> <p><https://www.theipcr.org/download/attachments/689660/oximetry_pocket_guide.pdf?version=1&modificationDate=1347261955000>, and per review the American Association for Respiratory Care states " Pulse oximetry is accepted as a standard of care in multiple settings. "</p> <p><http://www.aarc.org/marketplace/reference_articles/02.99.045.pdf></p> <p>Per interview with the Director of Nursing Services [DNS] and the Unit Manager [UM] on 12/16/14 at 11:20 A.M., the DNS and UM confirmed Physician Orders for Resident #9</p>	F 282		

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F 282	Continued From page 6 included " to keep Sats [oxygen saturation levels] over 90% ". The DNS and UM confirmed oxygen saturation levels were not monitored and/or documented as being above 90% on 11/22, 11/24, & 11/26/14 , on 12/1 & 12/2/14 the oxygen saturation levels are documented as being ' I.C. ' [in computer] but were unable to be located in either Resident #9 ' s electronic medical record or written record, and there is no record of oxygen saturation levels being taken for Resident #9 from 12/3 to 12/16/14. The DNS and UM also confirmed Resident #9 ' s Plan of Care includes monitor/document/report to MD as needed for signs and symptoms of pneumonia including hypoxia, and monitor oxygen saturation levels as indicated. The DNS and UM confirmed there was no way to assure oxygen saturation levels for Resident #9 remained over 90% per physician order without taking oxygen saturation levels, and these were not done.	F 282		
F 456 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain all essential patient care equipment in safe operating condition for 2 of 35 occupied resident beds, for resident #17 and #21 . The findings include the following: Per observation on 12/15/14 at approximately 3 PM, the mattresses (Residents #17 and	F 456	<u>F 456 §483.70 (c) (2) Essential Equipment, Safe Operating Conditions</u> The Facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating conditions. 1. New bed frames were obtained by facility in 2014. During the survey it was noted that some mattresses were short. This issue was addressed and corrected immediately during the survey using the existing bed extenders	

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F 456	<p>Continued From page 7</p> <p>#21), were found to improperly fit the bed frames securely, which could potentially lead to an incident of resident entrapment.</p> <p>Resident #4 had a gap measuring 6 inches between the mattress and the foot of the bed and/or the head board. Resident #21, had a gap measuring 7 inches between the mattress and the foot of the bed and/or the head board.</p> <p>Per interview with the Director of Nurses and the Unit Manager on 12/16/14 at 8:29 AM confirmation was made that the above measurements were correct and the mattresses did not fit the bed frame securely which could lead to the potential of resident entrapment. Administrative staff immediately placed cushioned blocks at the foot of both beds to avoid any immediate danger.</p>	F 456	<p>on the back of the head boards transferring them to be mattress extenders.</p> <ol style="list-style-type: none"> All beds were checked by DNS, ADNS and maintenance immediately to ensure all beds that needed the bed extenders for the mattresses were corrected. New bed extenders were ordered in accordance with bed specifications and will be installed to the necessary beds on the date of arrival. Expected delivery date is January 12, 2015. All currently employed Nurses, LNA's and Unit Aides will be educated by January 17, 2015 to the purpose of Bed extenders, there appropriate use and importance of them being in place to prevent potential injury. All Nurses, LNA's and Unit Aides that are hired after January 17, 2015 will have this education and training included as part of the orientation. Compliance Date January 17, 2015 	

F456 POC accepted 1/13/15 MB.../PML

PAH 1/13/2015