

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

PRINTED: 12/22/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475033</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ <b>DEC 31 2009</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/09/2009</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CRESCENT MANOR CARE CTRS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>312 CRESCENT BLVD BENNINGTON, VT 05201</b>
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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	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced recertification survey and a complaint investigation was conducted by the Division of Licensing and Protection from 12/07/09 to 12/09/09. The following deficiencies were identified.</p>	F 000		
F 152 SS=D	<p><b>483.10(a)(3)&amp;(4) EXERCISE OF RIGHTS</b></p> <p>In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf.</p> <p>In the case of a resident who has not been judged incompetent by the State court, any legal surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assure a signed legal Durable Power of Attorney for Health Care (DPOAHC) document was completed and available in the record for one resident in the targeted sample placed on comfort care measures by a relative. (Resident # 7) Findings include:</p> <p>1. Per record review, the facility failed to obtain the legal DPOAHC documentation for Resident # 7, who had been placed on Comfort Care measures by a relative upon admission to the nursing home in July 2009. Per interview on the afternoon of 12-8-09, the Social Services Director confirmed that the facility had no legal and</p>	F 152	<p><b>F152 Exercise of Rights</b></p> <p>Resident #7 remains in the facility in stable Condition.</p> <p>Resident #7 DPOA has been completed and witnessed. The Social Worker is reviewing all residents advance directives to insure legal representation is documented.</p> <p>Social worker will audit records to assure Compliance. Outcomes of the audits will Be submitted to the CQI Committee, audits Will continue until thresholds have been met. The social worker will complete Quarterly audits on new admissions to assure compliance.</p> <p><i>POC reports 1.6.10</i> <i>[Signature]</i></p>	1/6/10 On-going

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Claudia Waver Roman</i>	TITLE  <i>Administrator</i>	(X6) DATE  <i>12-29-09</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 152  F 164 SS=D	<p>Continued From page 1</p> <p>binding documentation that supported the relative making health care decisions for this Resident.</p> <p>483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility staff failed to assure privacy during treatment procedures for one of 18 residents on the</p>	F 152  F 164	<p><b>F164</b> <b>Privacy and Confidentiality</b></p> <p>Resident #7 remains in the facility in stable condition.</p> <p>The nurse that did not pull curtain was spoken to and re-educated to the importance of maintaining privacy at all times.</p> <p>Random audits/visual checks to assure privacy will be completed by the Nurse Manager. Outcomes of the audits will be submitted to the CQI Committee, audits will continue until thresholds have been met.</p> <p><i>BC [signature] 1-6-10</i></p>	1/6/10

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F 164	Continued From page 2 targeted sample. (Resident # 7) Findings include:  1. Per observation on 12-8-09 at approximately 3:05 PM, a nurse conducting gastric tube medication administration, failed to utilize Resident # 7's privacy curtain to assure the resident's privacy. The room-mate was present in the room and in full view of the procedure. In addition, the residents door to the corridor was left open, with other residents and staff in the corridor. Per interview immediately after the procedure, the nurse confirmed the failure to provide privacy for Resident # 7.	F 164		
F 250 SS=D	483.15(g)(1) SOCIAL SERVICES  The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and observation the facility failed to meet the psychosocial needs to maintain the well-being of 1 applicable resident. (Resident #5) Findings include:  1. Per record review and confirmed during the initial tour interview on 12/07/09, Resident #5's primary language is Spanish, with limited communication in English. In addition, a letter written in Spanish was in the resident's chart, however there was no interpretation nor staff aware of its meaning. Per interview on 12/08/09 at 10:30 AM Resident #5 had the opportunity to	F 250	<p><b>F250</b> <b>Social Services</b></p> <p>Resident #5 remains in the facility in stable Condition.</p> <p>Resident #5 communicates very well in English. He enjoys speaking Spanish when it's available. A Spanish interpreter is scheduled to visit with Resident twice per month. Documentation of these visits will be noted in the Social Service section of the medical record. Additionally, Social worker will keep a running log of anyone needing an interpreter and will schedule visits accordingly.</p> <p>Social worker will audit record to assure visits are occurring; outcome of audit will be presented to the CQI meeting.</p> <p><i>Be prints 1.6.10</i></p>	1/6/09 On-going

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F 250	Continued From page 3 speak to an interpreter. When asked if the Resident wanted to speak to someone in Spanish on a regular basis, the Resident smiled and stated "Si" (yes). The letter, also interpreted at this time, indicated that the resident would like to write letters (in Spanish). Per interview on 12/08/09 at 10:54 AM the Social Services director confirmed that the resident's customary language was not used to support the individuals' preferences.	F 250		
F 281	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 record review and staff interview the facility failed to adhere to professional standards of practice for 5 of 18 residents in the targeted sample (Residents # 3, 5, 6, 7, 17). Findings include:  1. Per record review and staff interview Resident #3 has a physician's order for an anti-psychotic medication that has no specific indications or targeted behaviors for its use. A physician's order dated 8/31/09 for Seroquel (an anti-psychotic medication) 25 mg (milligrams) PO (by mouth) QD (daily) PRN (as needed). No specific indications or targeted behaviors for PRN use are identified. Per interview on 12/8/09 at 12:05 PM, the Unit Coordinator confirmed that the order lacked the PRN indications required and was incomplete.  2. Per review of Resident #6's medical record on 11-28-09 and 11-30-09, facility nurses	F 281	<b>F281 Comprehensive Care Plans</b>  Resident #3, 5, 6, 7 & 17 remain in the facility in stable condition.  Resident #3 medication was discontinued on day of survey. Nurse Manager will audit the MAR and BMR for specific indications or targeted behaviors for anti-psychotic PRN medications.  Findings will be reported to the CQI committee by the Nurse Manager.  Resident # 6 MAR and BMR now indicate specific behaviors for PRN use. Nurse Manager will audit and report findings to the CQI committee.  Resident #7 received appropriate treatment, the physician orders were reviewed by the nurse manager, the physician was notified and new orders were obtained.  SDC will re-educate the nursing staff of the importance of carrying over Physician orders at the end of the month. To assure compliance an on-going audit will be completed by the Nurse Manager, outcomes will be reported to the CQI committee until thresholds are met.	

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F 281

Continued From page 4

administered an as needed (PRN) psychoactive medication; Zyprexa 2.5 milligrams 1 tablet orally for "agitation", with no specific indicators for use, failing to clarify in the Medication Administration Record (MAR) specific behaviors that were targeted that would indicate to staff this as needed, (PRN) psychoactive drug. This was confirmed on the morning of 12-9-09, by the Nurse Unit Manager.

Reference: Potter, P. A and Perry, A.G. (2001) Fundamentals of Nursing, 5th edition, p. 904. Mosby, St. Louis Philadelphia

3. Per record review, the facility staff failed to have a process in place that assured physician ordered treatments be brought forward onto the most current, monthly, signed physicians's order sheet. The treatment orders for tracheostomy care, gastric tube care and Foley catheter care for Resident # 7 were last signed by the physician on the 8-17-09. Per interview on the afternoon of 12-9-09, the Nurse Unit Manager confirmed the failure to have a process in place that would assure all current physician signed orders, including treatments, be brought forward monthly for the physician to review and sign.

4. Per record review and staff interview, the facility failed to have a process in place that assured that discontinued lab orders were not carried over onto signed physician orders. Physician orders noted on MAR for 12/01/09 indicate that PT/INR was to be drawn on Resident #17 every day (original order for daily protimes was dated 09/18/09). Physician orders signed on 10/03/09 and on 11/07/09 contained orders for daily PT/ INR to be drawn on Resident # 17. A

F 281

Resident #17 physicians ordered Lab work was not discontinued. To assure compliance the SDC will re-educated the nursing staff of the importance of carrying over physician orders at the end of the month. To assure compliance an on-going audit will be completed by the Nurse Manager, outcomes will be reported to the CQI Committee until thresholds are met.

Resident #5 orders were updated immediately to discontinue the blood sugar levels prior to giving PRN seroquel related to parameters of behaviors specified. Mineral oil is applied regularly as ordered.

Nurse Manager will continue to audit treatment records to assure compliance, the outcome of the audits will be presented to the CQI committee until thresholds are met.

On-going quarterly audits will be completed by The Nurse Manager to monitor on-going compliance.

*POC audit 1.6.10*



1/6/10  
On-going

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F 281	Continued From page 5 verbal order on 09/29/09 changed the PT/ INR frequency from every day to day-specific depending on the previous results. Coumadin was discontinued on 11/12/09 negating the need for further lab work. This was confirmed during interview with the Unit Manager on 12/08/09 at 3:05 PM.  5. Per record review staff failed to follow a physician's order for administrating medication and treatments for Resident #5. Per signed physician's orders, nursing staff was to assess blood sugar levels if Resident #5 became agitated prior to administrating an anti-psychotic (Seroquel) PRN. Per review of the MAR (Medication administration record) for the month of November 2009 PRN Seroquel was given without staff checking the blood sugar levels. In addition, Resident #5 was to be treated with mineral oil to the scalp the night prior to a bath. Per review of the treatment record, treatment was not given during the month of November 2009. Per interview on 12/08/09 at 12:15 PM the Unit Manager confirmed staff failed to follow physician's orders for medication and treatments.	F 281			
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION  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.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the	F 323			

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F 323	Continued From page 6 facility failed show evidence of supervision by consistently documenting the 15 minute safety checks of one resident in the sample (Resident #20). Findings include:  1. Per record review on 12/09/09, Resident #20 has a history of being aggressive with other residents and staff, including pushing people down, and physically assaulting others. One intervention of the plan of care to assure safety for others included the initiation of 15 minute checks on Resident #20 when she/he exhibited aggressive actions. On 6/10/09, nurse's notes state that the resident was wandering the unit, agitated, and later that same morning charging aggressively at staff and residents. Although 15 minute safety checks were initiated, there were blank spaces, the last documented check was at 2:00 PM, and the next check initialed was at 10:00 PM. On 6/19/09 the 15 minute checks were not recorded from 2:00 PM until 5:00 PM. On 6/23/09 the checks were not documented from 6:15 AM until 10:00 PM. On 8/14/09, the documentation of safety checks was not recorded from 2:00 PM until they resumed at 6:00 PM. On 9/2/09, the 15 minute checks were not documented from 6:00 PM until 10:15 PM that night. Per interview on 12/09/09 at 9:30 PM, the Administrator confirmed that the documentation of the 15 minute checks was incomplete for these dates, and there was no other evidence that the resident was supervised at those times per the plan of care.	F 323	F323 <b>Accidents &amp; Supervision</b>  <b>Resident #20 expired.</b>  The facility expects when 15 minute checks are initiated that staff will document accordingly.  The Staff Development Coordinator will re-educate staff of the importance of continuous documentation of 15 minute checks when indicated.  The nurse manager will audit this documentation to assure compliance. Outcomes will be presented at the CQI meeting, audits will continue until thresholds have been reached.  On-going quarterly audits will be completed by The Nurse Manager to monitor on-going compliance.  <i>pe amts 1.6.10</i>	1/6/10  On-going
F 329 SS=D	483.25(l) 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	F 329		

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F 329	<p>Continued From page 7</p> <p>without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure adequate indications for use of psychoactive medications for 2 of 14 Residents on the targeted sample. (Resident # 6 and #3). Findings include:</p> <p>1. Per review of Resident #6's medical record on 11-28-09 and 11-30-09, facility nurses administered an as needed (PRN) psychoactive medication; Zyprexa 2.5 milligrams 1 tablet orally for "agitation", with no specific indicators for use, failing to clarify in the Medication Administration Record (MAR) specific behaviors that were targeted that would indicate to staff this as needed, (PRN) psychoactive drug. This was</p>	F 329	<p><b>F329</b> <b>Unnecessary Drugs</b></p> <p>Residents # 6 and #3 remain in the facility in stable condition.</p> <p>The SDC will re-educate the nursing staff on the importance of obtaining adequate indications for targeted behaviors for the use of anti-psychotic PRN medications.</p> <p>The nurse manager will continue to audit PRN medications to assure compliance and thresholds are met. Outcomes will be submitted to the CQI committee.</p> <p>Random audits will be completed quarterly to assure on-going compliance.</p> <p><i>Prognosis 1.6.10</i></p>	1/6/10 On-going
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F 329 Continued From page 8 confirmed on the morning of 12-9-09, by the Nurse Unit Manager.

F 329

2. Per record review and staff interview Resident #3 has a physician's order for an anti-psychotic medication that has no specific indications or targeted behaviors for its use. A physician's order dated 8/31/09 for Seroquel (an anti-psychotic medication) 25 mg (milligrams) PO (by mouth) QD (daily) PRN (as needed). No specific indications or targeted behaviors for PRN use are identified. Per interview on 12/8/09 at 12:05 PM, the Unit Coordinator confirmed that the order lacked the PRN indications required and was incomplete.

F 431  
SS=D

F 431

483.60(b), (d), (e) PHARMACY SERVICES  
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.

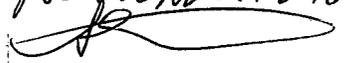
**F431  
Pharmacy Services**

Resident #24 remains in the facility in stable condition.

SDC will re-educate nursing staff of the importance of closely monitoring expiration dates of medications as well as thoroughly searching in the refridgerator (behind shelves & drawers) to assure compliance.

1/6/09  
On-going

Random Audits will be completed by the DNS; outcomes will be reported to the CQI committee Until thresholds have been reached.

*pc guntz - 1.6.10*  


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F 431	<p>Continued From page 9</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 confirmed by staff interview, the facility failed to dispose of expired, refrigerated drugs in accordance with currently accepted professional principles. Findings include:</p> <ol style="list-style-type: none"> <li>1. Based on observation of the medication refrigerator on South Wing On 12/08/09 at 3:12 PM 4 boxes containing Cubicin 500 were found with expiration dates of 12/08 and 1 box of Cubicin 500 was found to have an expiration date of 09/08. This was confirmed by the Unit Manager at 3:12 PM on 12/08/09. She indicated that the facility policy for disposing of medications that are no longer in use by residents is that the assigned nurse returns the unused vials to the pharmacy for resident credit and eventual disposition.</li> <li>2. Based on observation of the medications currently in use on the North wing medication cart on 12/08/09 at 4:40 PM, two Novolog insulin vials for Resident #8 were not labeled with the date they were opened, and Resident # 24 had an opened vial of Novolin R that was dated as</li> </ol>	F 431		
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F 431 Continued From page 10  
opened on 10/8/09, almost 30 days past the recommended discard after opening date. This observation was confirmed at 5:15 PM by the nurse administering medications and the Unit Coordinator.

F 431

F 441 483.65(a) INFECTION CONTROL  
SS=D

F 441

The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.

**F441  
Infection Control**

Resident # 7, 23 & 19 remain in the building in stable condition.

SDC has re-educated individual nurses as well as other staff nurses and LNA's on specific infection control issues and practices.

SDC and Nurse Manager have shadowed individual nurses during treatments to assure accuracy and infection control practices.

Audits are on-going to assure compliance; outcomes will be reported to the CQI committee until thresholds have been reached.

Quarterly random audits will continue, outcomes Will be presented to the CQI committee.

*Per audits 1/6/10*

This REQUIREMENT is not met as evidenced by:  
Based on observation and interview, facility staff failed to assure infection control practices for the prevention of cross contamination during medication administration and dressing change procedures for 3 of 7 residents in the targeted sample: (Resident's # 7, # 23 and #19.) Findings include:

1. Per observation conducted on 12-8-09 at 8:30 AM, the nurse failed to sanitize hands after administering and cleaning Residents # 23's inhaler and prior to handling supplies on top of the medication cart. This was confirmed through interview with the medication nurse on the morning of 12-9-09.
2. Per observation on 12-8-09 at 1:20 PM the

1/6/10  
On-going

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F 441	Continued From page 11 wound care nurse was observed conducting tracheostomy and gastric tube dressing changes for Resident# 7 and failed to remove gloves and sanitize/wash hands after the gastric tube dressing was applied and prior to touching the resident for repositioning, touching the resident's bed linens and other environmental surfaces. Per interview on the afternoon of 12-08-09, the nurse confirmed failure to remove gloves and sanitize hands immediately after the dressing change.  3. Per observation on 12-08-09 at approximately 3:30 PM, following a medication administrate for Resident # 7, the nurse failed to remove gloves and sanitize/wash hands after handling a cloth with tracheal secretions and prior to leaving the resident's room and entering the soiled utility room; potentially contaminating the door buzzer during entry. During the same observation, the nurse layed the stethoscope on the resident's bed and failed to sanitize the instrument prior to replacing it around he/r neck. Per interview on the afternoon of 12-8-09, the nurse confirmed failing to remove gloves and sanitize/wash hands prior to leaving the resident's room and failure to sanitize the stethoscope.  4. Per observation on 12/08/09, during the morning and evening hours, Resident #19's Foley drainage bag was lying on the floor without a barrier or cover for infection control practices. Per Interview on 12/09/09 8:30 AM, the Staff Development Nurse confirmed that the Foley drainage bag is not to be on the floor without a cover or barrier.	F 441			
F 456 SS=D	483.70(c)(2) SPACE AND EQUIPMENT  The facility must maintain all essential mechanical, electrical, and patient care	F 456			

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F 456 Continued From page 12  
equipment in safe operating condition.

This REQUIREMENT is not met as evidenced by:  
Based on observation, and confirmed through staff interview, the facility failed to assure that laundry equipment was maintained in safe operating condition. Findings include:

1. Per observation on 12/8/09 at 3:50 PM during the tour of the laundry area, accompanied by the Maintenance Director, there was noted to be a 1/4 inch thick collection of lint on the top of the vent pipes leading from the dryers to the outside, which become very hot during use. Also on top of the dryers in the back was a layer of dust and lint. In the front of the dryers, the bins underneath that contain the lint traps also had an accumulation of lint, especially in the corners. Per interview at the time of this observation, the Maintenance Director confirmed that the dryers were in need of cleaning in these areas, and that the cleaning was scheduled monthly. Per review on 12/9/09 at 8:40 AM, the dryer cleaning log showed a check mark for the month with no specific date recorded, and the Maintenance Director was not sure when in November they were last cleaned. Per interview with the Laundry Supervisor on 12/9/09 at 8:30 AM, the lint traps were cleaned once daily at the end of the shift around 2:30 PM each day, and no log was kept to reflect the completion of this task.

F9999 FINAL OBSERVATIONS

2.7 SPECIAL CARE UNITS

(d) Dementia units shall meet the following staffing and staff training requirements:

F 456

**F456  
Space and Equipment**

A new PM scheduled has been established to assure lint is at a minimum at all times. Posters were installed to remind staff to clean out lint draw every two hours.

Environmental Director is monitoring laundry to assure compliance with dryers, outcomes will be presented at the CQI meeting. Monitoring daily for next two weeks, then weekly to assure compliance.

*see units 1.6-10*

*[Signature]*

F9999

12/11/09  
On-going

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F9999	<p>Continued From page 13</p> <p>(1) Dementia units must provide initial training in addition to general facility training to include eight hours of classroom orientation for all employees assigned to the unit and an additional eight hours of clinical orientation to all nursing employees assigned to the unit. The eight hours of classroom work must include:</p> <p>(i) A general overview of Alzheimer's disease and related dementia; (ii) Communication basics; (iii) Creating a therapeutic environment; (iv) Activity focused care; (v) Dealing with difficult behavior; and (vi) Family issues.</p> <p>(2) Ongoing in-service training shall be provided to all nursing and non-nursing staff, including volunteers, who have any direct contact with residents of the unit. Staff training shall occur at least quarterly. The facility will maintain records of all staff training provided and the qualifications of the presenter. Training over 12 months must include the following subjects:</p> <p>(i) Alzheimer's disease and related dementias, including but not limited to, possible causes, general statistics, risk factors, diagnosis, stages and symptoms, and current treatments and research trends; (ii) Communication, including training related to communication losses that result with dementia, non-verbal techniques, techniques to enhance communication, validation as an approach, and environmental factors that affect communication; (iii) Ways to create a therapeutic environment, including safety issues, effective strategies for providing care, background noise, staff behavior,</p>	F9999	<p><b>2.7 Special Care Units</b></p> <p>The staff on the unit was re-assigned until the educational requirement was completed. Staff has since attended the 8 hours Ace Program.</p> <p>The 8 hour classroom education is scheduled for the second day of orientation for all new staff in order to assure that education is completed prior to anyone working the special program.</p> <p>Audit of compliance of education for special care will be completed by the business office manager to assure compliance. Outcomes will be reported to the CQI committee.</p> <p><i>Pre audit 1.6.10</i> </p>	12/23/09 On-going
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F9999	<p>Continued From page 14 and consistency;</p> <p>(iv) Activity focused care, including personal care, nutrition and dining, structured leisure and sexuality;</p> <p>(v) Dealing with difficult behaviors, including but not limited to, strategies to deal with common behavioral issues such as wandering, sundowning, combativeness, paranoia and ignoring self-care; and</p> <p>(vi) Family issues such as grief, loss education and support.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, the facility failed to ensure that staff working within the special care unit received required training in accordance with Vermont Licensing and Operating Rules for Nursing Homes. Findings include:</p> <p>1. Per review of staff inservice record for the Special Care Unit (SCU) 3 new employees failed to have the required initial 8 hours of initial classroom prior to working on the SCU. In addition, 1 employee failed to have the required SCU in-service training over a 12 month period. Per interview with the Staff Development Coordinator on 12/08/08 at 4:00 PM, confirmed the failure to meet the required training and inservice for staff assigned to the SCU.</p>	F9999		