

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

January 27, 2014

Mr. Dovid Glenn, Administrator
Crescent Manor Care Ctrs
312 Crescent Blvd
Bennington, VT 05201-0170

Dear Mr. Glenn:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 4, 2013**. 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

PC:jl

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

PRINTED: 12/19/2013
FORM APPROVED
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/04/2013
NAME OF PROVIDER OR SUPPLIER CRESCENT MANOR CARE CTRS			STREET ADDRESS, CITY, STATE, ZIP CODE 312 CRESCENT BLVD BENNINGTON, VT 06201	
(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 176 SS=D	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation, facility documentation and staff interviews, the facility failed to ensure that 1 of 5 sampled residents, (Resident #2) was safe for self administration of drugs. The findings include: Resident #2 was admitted to the facility on 1/4/13 with diagnoses to include COPD, Depression, Auditory Hallucinations, Failure to Thrive, Anxiety and Constipation. Per physician orders dated on 11/23/13 @ 10:18 AM identifies, ProAir HFA 90 mcg/actuation aerosol inhaler, inhale 2 puffs by oral route 4 times per day as needed, may keep at the bedside. Per Medication Administration Record (MAR) for the months of November and December 2013 identify that the resident received the inhaler on November: 2, 23, 24, 25, 26, and 27. Per nurses notes dated 8/29/13 identifies a nursing order, medication, @ bedside PRN (as</p>	F 176	<p><u>F176</u></p> <p>Resident #2 was evaluated using our "self Administration Assessment tool" and has been deemed safe to self administer inhaler. Inhaler is kept in locked box at bedside. All other meds are locked in med cart</p> <p>All residents with self administer drug orders can be affected.</p> <p>Any resident with an order for self administer drugs, will be evaluated at time of order and reevaluated during their quarterly assessments, and or sick change.</p> <p>MDS Coordinator will keep a log of all residents with order for self administer drugs</p> <p>Corrective action was completed by 12/31/13</p> <p>F176 POC accepted 11/27/14 Proctor</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator _____ (X6) DATE 1/22/14

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.

PM

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NAME OF PROVIDER OR SUPPLIER CRESCENT MANOR CARE CTRS	STREET ADDRESS, CITY, STATE, ZIP CODE 312 CRESCENT BLVD BENNINGTON, VT 05201
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F 176	Continued From page 1 needed) signed by an LPN (Licensed Practical Nurse). Per Crescent Manor Care Center Policy and Procedure for Self Administration of Medications, prior to self administration of medications, the residents cognitive, physical and visual ability to carry out this responsibility will be assessed by the interdisciplinary team. There is not evidence in the medical record identifying that an assessment for self-administration of medications was conducted. Per interview with the Unit Manager on 12/3/13 @ 1:40 PM, s/he confirms that there was no assessment conducted prior to obtaining the order for self administration of medication or prior to the resident self administering the inhaler that is kept at the bedside.	F 176		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based upon observation and interviews, the facility failed to ensure that residents had reasonable accommodations of individual needs and preferences for 1 of 30 residents in the sample (Resident #28) Findings include:	F 246	<p>F246</p> <p>Resident #28 was interviewed and assessed using call bell placement tool, and call bell placement determined. Care plan has been updated.</p> <p>All residents have the potential to be affected.</p> <p>All residents will be assessed for call bell placement.</p> <p>MDS coordinator will audit assessments during care planning.</p> <p>Corrective action was completed by 12/19/13</p> <p>F246 POC accepted 11/27/14 Pmcstarw</p>	

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F 246	Continued From page 2 1. Per observation on 12/02/13 at 4:45 PM Resident #28's call light cord was hanging up on the lamp behind the resident's bed non-accessible to the resident. Per observation the next day, 12/03/13 the cord remained hanging from the lamp behind the bed. Per interview with two LNAs present at that time, one LNA stated "I think he just comes out to the desk to ask for things", while the other LNA was not sure if the Resident "uses it". Per review of the care plan states that the Resident is able to make needs known and does not use a call bell. However, there is no documentation as per nursing assessments, social services notes, or care plan meeting notes of the resident's alleged preference. Per interview on the afternoon of 12/03/13 with the Resident and the Unit Manager present, the resident stated that he thought it would be important to have the call light cord accessible "for emergency use".	F 246			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION DEVICES 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 facility failed to ensure that 3 of 3 residents reviewed (Resident #67, #16 and #49) received	F 323			

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F 323	<p>Continued From page 3</p> <p>adequate supervision and/or assistance devices to prevent accidents. The findings include;</p> <p>1. Per record review on 12/4/13, Resident #76 was admitted to the facility with diagnoses that include, dementia, Alzheimer's and anxiety. Per review of the medical record Resident #76 has a history of wandering the unit and in and out of other residents' rooms. Per the nurses notes, Resident #76 sustained several falls from 10/13/13 thru to 11/11/13. The documentation indicates that Resident #76 falls in other residents' rooms, in the hallway, tripped over staff's feet and rolled out of bed onto floor.</p> <p>Per review of the facility fall risk assessment, the assessment indicates that Resident #76 is at high risk for falls. Per review of the comprehensive assessment dated 10/11/13, the assessment indicates that Resident #76 is a 1 person physical assist when walking in his/her room and the comprehensive assessment also indicates that Resident #76 is a physical assist of 1 when walking in the hallway.</p> <p>Per review of the nurses notes there was no evidence that Resident #76 was receiving physical assistance when walking in room or in hallway when the falls occurred. Per review of the comprehensive care plan titled falls, and last was no evidence that the care plan was reviewed and revised after the numerous falls to ensure that interventions were used to meet the specific needs of the resident and to prevent reoccurrence of falls.</p> <p>Per review of the falls committee reports dated 10/14, 10/16, 11/6 and 11/11 they indicate that under the plans and recommendations section the</p>	F 323	<p><u>F323 (1, 2, 3)</u></p> <p>Resident #76</p> <p>A) Glasses and shoes are being worn during daytime hours</p> <p>B) Ambulation reassessed – resident able to transfer and ambulate independently.</p> <p>C) Medication reduction was made</p> <p>Resident #67</p> <p>A) Change in activities to avoid unattended ambulation.</p> <p>B) Voice activated seat alarm placed.</p> <p>C) Motion sensor placed in bedroom</p> <p>Resident #0</p> <p>Staff educated to reduce environmental influences to reduce resident#0's anxiety and aggression</p>	

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F 323	<p>Continued From page 4</p> <p>facility was going to monitor and use 15 minute checks. Per interview with the UM he/she reviewed the medical record, care plan and falls committee reviews and confirmed that after the falls, there was no evidence that an evaluation of the interventions was conducted and that there was no evidence that interventions were utilized for Resident #76 to ensure s/he would remain free from falls and injuries.</p> <p>2. Per review of the medical record Resident #67 was admitted to the facility on 3/8/12 with diagnoses that include dementia. Per review of the nurses notes there were numerous incidents documented that Resident #67 fell during the time frame of 6/2/13 thru 11/9/13. Per review of the falls risk assessments, Resident #67 was noted to be at high risk of falls. Per review of the comprehensive care plan last reviewed on 5/21/13, there were numerous documented falls listed, 8/11, 10/2, 10/24 and 11/9/13. Per review of the care plan there was no evidence that the care plan was reviewed and revised with goals and interventions to meet the specific needs of Resident #67 to reduce and prevent falls.</p> <p>Per interview with the UM he/she reviewed the medical record and care plan and confirmed that after the falls there was no evidence that an evaluation of the interventions was conducted and that there was no evidence that interventions were utilized for Resident #67 to ensure s/he would remain free from falls and injuries.</p> <p>3. Per review of a facility internal investigation on 12/4/13, the investigation indicated that on 11/26/13, Resident #67 was in the activities room with other residents and while Resident #67 was</p>	F 323	<p>All residents with history of fall and combative behavior can be affected.</p> <p>All falls and combative behaviors with intervention will be kept on the 24 hour report for 7 days</p> <p>Fall committee will meet to follow up on all falls 1 week after intervention.</p> <p>Corrective action was completed by 12/31/13</p>		

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F 323	<p>Continued From page 5.</p> <p>bickering with another resident, Resident #0 walked into the activity room, walked up behind Resident #67 and punched Resident #67 in the back of the head.</p> <p>Per review of the medical record of Resident #0, he/she had diagnosis of Dementia, Alzheimer's with delusions and intermittent agitation. Per review of the medical record and comprehensive care plan of resident #0, he/she had several incident's of verbal and physical aggression toward other residents.</p> <p>Per review of the facility policy and procedure titled Abuse, the policy indicates that each resident has the right to be free from mistreatment, neglect and misappropriation of resident property. This includes resident to resident abuse.</p> <p>Per interview with the Unit Manager on 12/4/13, he/she reviewed the medical record and indicated that Resident #0 had several incidences of physical aggression toward residents and the UM confirmed that the resident care plan indicated resident #0 attempt to reduce environmental stimuli as able. The UM indicated that Resident #0 becomes agitated when around a lot of noise. The UM confirmed that Resident #67 was in the activity room at the time of the incident arguing with another resident when Resident #0 walked up behind Resident #67 and punched him in the head.</p> <p>4. During the initial tour on 12/2/13 at 11:30 AM - 11:44 AM, in the small dining room at end of the Special Care Unit, Resident #49 was observed alone and wandering about the dining room and folding a quilt. The surveyor observed 2 bottles of</p>	F 323	<p>F323 (4)</p> <p>Resident #49 unaffected</p> <p>All chemicals have been removed</p> <p>All residents can be affected</p> <p>All staff will be reeducated on procedures of chemicals</p> <p>Routine inspection of all common areas will be made by administrator.</p> <p>Corrective action will be completed by 12/31/13</p> <p><i>F323 POC accepted 11/27/14 Annotator</i></p>		

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F 323	Continued From page 6 hand sanitizer on the counter (pump bottles), several packets of anti-septic towelettes and 'yellow citrus' cleaning fluid under the sink, all of which were not secured. Per record review for Resident #49 at 1:52 PM the resident has a history of hoarding and pica (placing non-edible items in the mouth). Per interview 12/03/13 at 2:04 PM, the Unit Manager was shown the yellow citrus cleaner under the sink and the two hand sanitizer bottles plus anti-septic cleaner packets, and stated this "should not be unlocked or on the counters, I am shocked". S/he confirmed the resident's environment, especially for Resident #49, was not as free of accident hazards as is possible.	F 323			
F 329 SS-E	Also see F-280 483.25(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	F 329			

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F 329	<p>Continued From page 7</p> <p>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 record review, observation, facility documentation and interviews, for 4 of 5 sampled residents (Resident #2, 28, 35 and 76) the facility failed to ensure that each resident's drug regimen was free from unnecessary medications. The findings include:</p> <p>1. Resident #2 was admitted to the facility on 1/4/13 with diagnoses to include COPD, Depression, Auditory Hallucinations, Failure to Thrive, Anxiety and Constipation.</p> <p>Per physician order dated 1/5/13 @ 9:38 AM, identifies Senna-Genn 8.6 mg tablet give 1-2 tabs twice a day for constipation. Per review of the Medication Administration Record (MAR) the resident received tabs 2 or eight different days in the month of October 2013. In the months of November and December 2013 the resident refused the medication. Per interview on 12/3/13 @ 2:20 PM with the Unit Manager s/he confirms that there are no physician orders identifying parameters for the administration of 1 or 2 tabs of Senna-Gen.</p> <p>2. Per review of the medication record of Resident #85 on 12/4/13, he/she was admitted to the facility with diagnoses that include; Dementia,</p>	F 329	<p>F329 (1)</p> <p>Doctor for resident #2 was notified. Senna-Genn has been discontinued</p> <p>All residents can be affected.</p> <p>Nurses will be educated on how to take orders with clear parameters.</p> <p>All orders will be reviewed by unit manager monthly to insure dosage is clear.</p> <p>Corrective action will be completed by 12/31/13</p>	

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F 329	<p>Continued From page 8</p> <p>Alzheimer's and Anxiety. Per review of the physician's orders and the resident medication administration record, Resident #85 had an order for Ativan 0.25 mg by mouth and as needed, may give every 3 hours for breakthrough anxiety not to exceed 4 mg/day. Per further review of the physician's orders and the medication administration record there was also another Ativan order that indicated to give 1 tablet (0.5 mg) by mouth twice a day and as needed and every 3 hours for breakthrough anxiety not to exceed 4 mg/day.</p> <p>Per interview with the Unit Manager (UM) on 12/4/13, he/she reviewed the physician's orders for Ativan and the medication administration record for Resident #85, the UM confirmed that there were no parameters for the nurses to use to determine when Resident #85 would get 0.25 mg of Ativan and when the resident should get .50 mg of Ativan.</p> <p>3. Per review of the medical record of Resident #76 on 12/4/13, he/she was admitted to the facility on 10/26/13 with diagnoses that include Alzheimer's, Dementia and Anxiety. Per review of the physician's medication orders, Resident #76 is receiving Haldol (anti-psychotic medication) 0.5 mg by mouth twice a day.</p> <p>Per review of a fax communication between staff and the physician on 9/6/13, the fax indicates that Resident #76 is to be placed on Haldol 0.5 mg by mouth twice daily related to increases in anxiety, pacing, looking for a way home, and attempting to leave the unit.</p> <p>Per review of the diagnosis sheet for resident #76, it indicates diagnosis of dementia, anxiety and Alzheimer's. Per interview with the Unit</p>	F 329	<p><u>F329 (2)</u></p> <p>Doctor for Resident #85 was notified. Resident now has only one PRN Ativan order.</p> <p>All residents can be affected</p> <p>Nurses will be in-serviced to check previous orders when transcribing new order.</p> <p>Nurse Manager will audit all orders monthly</p> <p>Corrective action was completed by 1/14/14</p>		

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F 329	<p>Continued From page 9</p> <p>Manager on 12/4/13, he/she reviewed the medical record and was unable to provide documentation of an appropriate diagnosis from the physician for the use of the anti-psychotic medication of Haldol.</p> <p>4. Per record review and interviews Resident #28 is receiving an anti-psychotic without adequate monitoring or without adequate indications for its use. The resident was admitted on 12/18/07 with diagnoses of persistent mental disorder [dementia], Parkinson's disease/paralysis, gastric reflux disease, inflammatory and toxic neuropathy, hypertension, acute sinusitis, and anxiety/agitation/depression. Per record review on 12/03/13 Resident #28 is currently receiving Seroquel (an anti-psychotic medication) 50 mg three times a day for increased behaviors as noted per the verbal order of 11/18/13.</p> <p>Per review of the nursing note dated 11/13/13 states "outburst yelling, confusion, delusions noted to be more frequent almost daily [noted with activities]". However, per review of the nursing progress notes, activity notes, as well as the Behavior Monitoring Record for all three shifts during the month of November only two incidents on the evenings of 11/05/13 & 11/11/13 for "agitation" were noted. There is no indication that all non-pharmalogical interventions were attempted including monitoring for pain offering food or drink. Also noted during the month of November, per the MAR, the daily pain assessments were not completed on 11/05/13, 11/07/13 and 11/11/13.</p> <p>Per review of the care plan dated 06/19/13, directs staff that for increased behaviors to attempt non-pharmalogical interventions for</p>	F 329	<p>F329 (3)</p> <p>Doctor for resident #76 notified and appropriate diagnosis for Haldol established as hallucinations.</p> <p>All residents can be affected</p> <p>List of all psychotropic meds with appropriate diagnoses will be kept by the nurses' station. Nurses will check all new orders and match with documented diagnosis to insure proper diagnosis received from DR.</p> <p>SDC will audit all new orders monthly to insure proper diagnosis</p> <p>Corrective action was completed by 1/14/14</p>	

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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
F 428	<p>Continued From page 11</p> <p>by: Based on record review and staff interview the facility failed to act upon a pharmacy recommendation for 1 of 5 residents reviewed (Resident #76). The findings include;</p> <p>1. Per review of the medical record on 12/4/13 for Resident #76, the record indicated that Resident #76 was admitted to the facility on 10/26/12 with diagnoses that include; Dementia, Alzheimer and Anxiety. Per review of the pharmacy recommendations, on 7/1/2013, McClelland Health Systems notified the facility that Resident #76, who was taking a medication called Lorazepam and a medication called Valproate, and that the US, manufacturers of Lorazepam state that the dosage of Lorazepam should be reduced by 50 % in residents receiving Valproate. Per review of the medical record there was no evidence that the recommendation was acted upon by either the Physician or the Director of Nursing (DNS). Per interview with the Unit Manager (UM), he/she reviewed the medical record of Resident #76 and was unable to identify any documentation that indicates the recommendation was acted upon by the physician or the DNS. The UM confirmed it had been faxed to the physician by the fax stamp on the recommendation; however, the UM was unable to identify when it was faxed because there was no date and was unable to locate any documentation that it had been reviewed by the Physician or the DNS.</p> <p>Per interview with the Interim Director of Nursing (IDNS), he/she indicated that the expectation of the staff is that when the pharmacy sends a recommendation, that it is given to the Unit Manager who ensures that the physician reviews</p>	F 428	<p>F428</p> <p>Physician for Resident #76 was notified and recommendation to decrease Lorazepam was followed.</p> <p>All residents can be affected.</p> <p>DNS will follow up with Dr if no response to recommendation.</p> <p>DNS will keep a log of pharmacy recommendations to insure they are addressed</p> <p>Corrective action was completed by 12/24/13</p> <p>F428 POC accepted 1/27/14 pmocturp</p>	

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F 428	Continued From page 12 it and acts upon it. Per interview, the IDNS confirmed that the facility did not have a policy/procedure addressing how pharmacy recommendations are to be handled when received from the pharmacy. The IDNS indicated that the staff is educated verbally on how to handle the recommendations.	F 428		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to assure that for 1 Resident in the sample, the call system was functioning (Resident #49). Findings include: 1. During the environmental tour of the facility on 12/02/13 at 1:52 PM, the call bell cord was noted to be hanging on the wall, and when the button was pushed, there was no sound at the nursing station nor did the light above the door in the hall indicate the bell was on. Per interview on 12/03/13 at 3:00 PM, the Environmental Director stated that there is no regularly scheduled maintenance checks for the call system. S/he stated that housekeeping or nursing will let maintenance know when the call system is not working. S/he confirmed that the call system in Resident #49's room was not working.	F 463	F463 Call bell for resident #49 was replaced, and all call bells were checked. All residents can be affected by broken call bells. Maintenance will check all call bells monthly. Report will be given to Administrator Corrective action was completed by 12/17/13 F463 POC accepted 1/27/14 PmcataRN	
F9999	FINAL OBSERVATIONS	F9999		

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F9999	<p>Continued From page 13</p> <p>Vermont State Licensng and Operating Rules for Nursing Homes</p> <p>7.13 Nursing Services: 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 or as specified by the licensing agency.</p> <p>(d) Staffing Levels. The facility shall maintain staffing levels adequate to meet resident needs.</p> <p>(1) At a minimum, nursing facilities must provide:</p> <p>(i) no fewer than 3 hours of direct care per resident per day, on a weekly average, including nursing care, personal care and restorative nursing care, but not including administration or supervision of staff; and of the three hours of direct care, no fewer than 2 hours per resident per day must be assigned to provide standard LNA care (such as personal care, assistance with ambulation, feeding, etc.) performed by LNAs or equivalent staff and not including meal preparation, physical therapy or the activities program.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on review of the facility staffing patterns and interviews, the facility failed to meet the 2 hours per resident per day to provide standard LNA care for thirty-nine (39) days in a random selection of schedules reviewed, dating from</p>	F9999	<p><u>F9999</u></p> <p>Staff will be increased to meet hours</p> <p>All residents can be affected</p> <p>Facility is actively recruiting new staff, as well as utilizing LNAs from other departments for feeding & restorative nursing.</p> <p>Administrator will review staffing to insure staffing requirements are met and recorded in the proper category</p> <p>Corrective action was completed by 1/15/14</p> <p><i>F9999 POC accepted 1/27/14 pmcotafan</i></p>		

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F9999	<p>Continued From page 14</p> <p>June 1, 2013 through November 30, 2013. The findings include:</p> <p>Per interview with the staffing scheduler, on 12/4/13 @ 9:50 AM, s/he confirms that s/he was unaware of regulations regarding this requirement. Per interview on 12/4/13 @ 10:15 AM, with the Nursing Home Administrator (NHA) and the Comptroller (who enters the information for the facility staffing pattern), clarified that the hours included under the "other" category identify care attendants, feeding by other staff, escorts to physician appointments and feeding by activity staff. Per interview with the Nursing Home Administrator and the Comptroller, they could not agree on the duties carried out by the employees included in the other category. Therefore, they could not confirm that the employees in the other category did in fact provide direct resident care.</p> <p>On 12/4/13 @ 10:30 AM the NHA confirmed that the staffing pattern did identify 39 days from June 1, 2013 through November 30, 2013 that were below the required 2.0 hours for direct care staff. NHA also confirmed that she was unaware that the facility had not met the requirement for LNA staffing of a 2.0 and that the information in the staffing pattern entered in the other category did not clearly identify the actual duties carried out by the other category.</p>	F9999			