

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

July 23, 2014

Ms. Theresa Southworth, Administrator
Gill Odd Fellows Home
8 Gill Terrace
Ludlow, VT 05149-1004

Dear Ms. Southworth:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 25, 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

PC:jl

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

RECEIVED PRINTED: 07/03/2014
Division of FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	JUL 2 1 14 Licensing and Protection	(X3) DATE SURVEY COMPLETED C 06/25/2014
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NAME OF PROVIDER OR SUPPLIER GILL ODD FELLOWS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 8 GILL TERRACE LUDLOW, VT 05149
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F 000	INITIAL COMMENTS	F 000		
F 253 SS=E	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. The findings include the following:</p> <p>1. On 06/24/14 at 10:20 AM an Environmental Tour with the Nursing Home Administrator (NHA) and the Maintenance Director took place. The following observations were noted:</p> <p>a. Room #101: The floor was found to be dirty with visible grime on the walls and floor and a build-up of old yellow discolored wax is seen around the edges of the floor.</p> <p>b. Rooms #102, #104, #108 #116 and #122: Bureaus and walls in these rooms are found to be in disrepair, evidenced by numerous scratches, chips and rough surfaces.</p> <p>c. Room #103: Is found to have missing cove</p>	F 253	<p>F-253 – Housekeeping and Maintenance Services.</p> <p>Rm 101 – painted and floors waxed. Rm 102, 104, 108, 116 and 122 had bureaus repaired or replaced. Rm 103 cove base replaced/repared and closet door knobs replaced. Bathroom wall repaired. Rm 106 Bureau and sink cabinet repaired and privacy curtains with the minwax stain was thrown out and new curtain was hung. Rm 107 walls repaired and painted. Rm. 112 ceiling tiles repaired, cove base replaced and closet knob replaced. Rm. 118 Bureau repaired walls repaired and painted and wheelchair repaired. Rm. 119 ceiling tiles replaced, bureau replaced and floors waxed. Rm. 123 ceiling tiles repaired and bathroom door replaced. Dietary Dept. dry storage room light bulb and light cover replaced. Hot water temperatures are being checked at least 5x/Week in random rooms.</p> <p>(cont on pg2)</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sheresa Southworth</i>	TITLE <i>Administrator</i>	(X6) DATE 7-17-14
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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 253	<p>Continued From page 1</p> <p>base under the radiator which runs along the length of the resident room. Closet doors were found to have missing knobs, making it difficult for residents to open the doors and access their personal belongings. The bathroom towel rack has been removed evidenced by the holes still present from previous screws.</p> <p>d. Room #106: The bureaus and sink cabinet are in disrepair, evidenced by numerous scratches, chips and rough surfaces. Both bureaus have missing knobs making it difficult for the residents to open the drawers to access personal belongings. Privacy curtain was found to have smear/stain of a brown material. This was confirmed by the NHA at the time of the tour.</p> <p>e. Room #107: The chair railing at the head of the beds has been removed. A 3-5 inch width stripe of white paint is noted across the wall at the head of both beds. Primary color of the room is dark green. The wall was never repaired at the time the chair rail was removed.</p> <p>f. Room #112: Has ceiling tiles that are water stained and has missing cove base under the radiator that runs along the length of the resident room. The closet door is also missing a knob, which makes opening the door difficult for the resident to access personal belongings.</p> <p>g. Room #118: The bureau is noted to have a missing knob making it difficult for resident to access personal belongings. The walls need cosmetic repairs as noted by chipped paint and scuff marks.</p> <p>h. Room #118 is occupied by Resident #32, who sits in a wheel chair (w/c) that is vinyl covered.</p>	F 253	<p>(continued from pg 1)</p> <p>All wheelchairs were looked at and w/c arm rests replaced if needed.</p> <p>Environmental rounds will be done weekly by maintenance and/or administrative team.</p> <p>A schedule has been set up to completely renovate at least one room per week until all patient rooms are complete. Residents will be given a choice about room colors.</p> <p>Rehab staff will assess w/c with each quarterly screen to ensure every w/c is looked at at least quarterly.</p> <p>Maintenance Director and/ or designee will ensure compliance. This will be reviewed at the Quality Assurance Meetings to ensure compliance.</p> <p>Substantial compliance obtained by July 25, 2014.</p> <p>F253 POC accepted 7/23/14 AmcoRN</p>	
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Theresa Southworth 7-17-14

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F 253	<p>Continued From page 2</p> <p>The vinyl covering over the arm rests and upper body sling are peeling and cracked, all of which could cause injury to the resident's skin. Maintenance Director confirms during the tour that there is no system in place for wheelchair inspection/review.</p> <p>i. Room #119: Ceiling tiles are noted to be chipped and broken with securing screws visible. The floor has build up of dirt and grime. Room #119 has a 4 inch square piece of cardboard was observed under the left foot of the bureau, that is utilized by Resident #25. Resident #25, voices "It looks shabby and is embarrassing. It could use some polish". The bureau is also in disrepair evidenced by numerous scratches, chips and rough surfaces.</p> <p>j. Room #123: Has ceiling tiles that are water stained and the bathroom door has dried liquid splatters on the outside of the door.</p> <p>k. Dietary Department dry storage room, has a ceiling light that has a cracked plastic covering and a fluorescent bulb is not functioning.</p> <p>l. In addition, the Maintenance Director stated hot water temperatures were checked at the hot water boiler gauge in the cellar although there was no documentation of the temperatures in actual resident rooms and common areas, and confirmed that the water temperatures were not monitored through random samples in the resident rooms.</p> <p>6/24/14 at 11:15 PM the NHA and the Maintenance Director both confirm that environmental rounds do not occur consistently, just hit and miss. They also confirm resident</p>	F 253		
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F 253	Continued From page 3 rooms have not had the floors stripped of old wax, nor have the floors been thoroughly cleaned with a reapplication of wax for 1-2 years. Many resident rooms have not been painted or repaired for well over 2 years. Renovations are slow to occur primarily because of lack of financial resources. Confirmation is made by the NHA and the Maintenance Director on 6/24/14 that there is no documented plan in place to maintain, repair and/or replace furniture at present.	F 253		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the	F 280	F-280 – RIGHT TO PARTICIPATE PLANNING CARE-REVISE-CP Resident # 17 was discharge from the facility with appropriate care needs/wound care communicated to her son and VNA. All residents reviewed to ensure most accurate skin care treatments are in place. All PT/FT LPN's & RN's will be educated about care planning wounds and treatments. (LPN's will need to review any CP updates with RN). Daily wound treatment flow sheet to be initiated that will prompt CP updates. The DNS/ADNS or designee will ensure compliance. This will be reviewed at the Quality Assurance Meetings to ensure compliance. Substantial compliance obtained by July 25, 2014. <i>F280 POC accepted 7/23/14 pmeoturn</i>	

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F 280	Continued From page 4 facility failed to ensure that a comprehensive care plan was reviewed and revised for 1 of 4 Residents in the sample by a team of qualified persons to address current needs around pressure ulcers. (Resident #17) The findings include: 1. Per record review on 06/24/14, Resident #17 has multiple diagnoses which include diabetes and history of skin ulcers and wounds. The care plan upon admission 04/28/14 notes skin breakdown risk and directs staff to observe skin with daily care, conduct a weekly body audit, turn and reposition the resident every 2 hours and complete treatments per standing orders [derma spray]. Per review of nursing notes and treatment records (TAR) from 05/13/14 - 06/24/14 the resident received mepilex, honey and most recently mesalt treatments. Only the honey is noted on the current care plan dated 05/02/14. Per interview, the DON (Director of Nursing) on 06/24/14 at 1:42 confirmed the care plan was not updated to reflect the treatments provided.	F 280		
F 314 SS=E	Also see F-314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314	(see next pg)	

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F 314	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to ensure that a resident who enters the facility with a pressure ulcer or a resident who enters the facility without a pressure ulcer receives the necessary treatment and services to promote healing, or prevent new sores from developing for 2 of 4 sampled residents with pressure ulcers (Resident #17 & #27). The findings include: 1. Per record review Resident #17 was admitted on 04/28/14 without a pressure ulcer but had multiple co-morbid diagnoses. Per the comprehensive assessment the resident was identified and a care plan was developed for at risk for skin breakdown, staff failed to conduct thorough skin assessments as evident by the lack of documentation that consistently describes stage, size and characteristic. The Resident developed a pressure ulcer on 05/13/14, approximately 2 weeks after the admission. The physician was not immediately notified of the pressure ulcer which was described as 'area on coccyx 1/2 inch open'. Additionally, the care plan failed to reflect changes to treatment options or reevaluations of the effectiveness of treatment. Per staff interview on 06/23/14 at 1:15 PM the resident was identified as having an unstageable pressure ulcer. The nurse confirmed that the resident did not receive the necessary services such as accurate assessments, immediate physician notification and care plan revisions. See also F514. 2. Per record review Resident #27, whose diagnoses include a chronic left heel ulcer, was	F 314	F-314 -- TREATMENT/ SERVICES TO PREVENT/HEAL PRESSURE SORES. Resident #17 has been discharged, but at the time of discharge CP and treatment were appropriate. Resident # 27 has improved ulcer noted on 6/25/2014 and discovered a STG 2 pressure ulcer and treatment was changed to reflect improved status and care plan. All residents will have body audits completed and checked for appropriate treatment and care plan. All FT & PT Nurses will be educated on wound care and how to accurately assess wounds. New readmission body audit tool to be initiated as well as daily documentation flow sheet for wounds that will trigger CP. The DNS/ADNS or designee will ensure compliance. This will be reviewed at the Quality Assurance Meetings to ensure compliance. Substantial compliance obtained by July 25, 2014. <i>F314 POC accepted 7/23/14 pncoturn</i>	
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Theresa Southworth *7-17-14*

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F 314	Continued From page 6 transferred out of the facility for insertion of a pace maker on 06/17/14. At the time of the transfer to the hospital, the resident's heel ulcer was assessed and care planned for as an unstageable wound. The resident returned to the facility on 06/19/14. Per record review Nursing Notes on 06/19/14 record the resident returned from the hospital with a dressing covering the heel ulcer which was not removed by nursing. Resident #27's readmission assessment on 06/19/14 documents the pressure ulcer on the left heel as a "stage 2 heel wound". Per interview with the facility's Director of Nursing Service [DNS] on 06/25/14 at 8:25 A.M. h/she confirmed there was no heel ulcer assessment included in the hospital notes, and the readmitting nurse would have no way of assessing the heel ulcer without removing the dressing. The DNS reported it was h/her expectation that the heel ulcer would be assessed and measured upon readmission to facility, and would be documented on the facility's pressure ulcer tracking sheet upon readmission and was not. The DNS also confirmed Resident #27's heel ulcer had not been reassessed by the facility's wound team as of the time of the interview on 06/25/14.	F 314		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses.	F 356	(see next page)	

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F 356	<p>Continued From page 7</p> <ul style="list-style-type: none"> - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. <p>o Resident census.</p> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to insure that the daily census and staffing was posted for public view as required. Findings include:</p> <p>During the initial facility tour at 9:30 AM on 6/23/14, there was no evidence that there was a daily posting of census and staffing. The form that the facility had in place was a schedule for staffing for the week with no census completed. This was confirmed by the nurse on duty during the tour. Per interview and confirmation with the Assistant Director of Nursing (ADNS), on 6/24/14 at 10:27 AM, the form that was posted on 6/23/14, observed during the initial tour, did not</p>	F 356	<p>F-356 --POSTED NURSE STAFFING INFORMATION</p> <p>Daily staffing was posted during the survey to reflect changes in staffing and census.</p> <p>All FT & PT Nurses will be educated about the daily posting and reminded to update as they alert on-call to changes either to census or staffing.</p> <p>It will be posted daily at nursing station to allow for easy update by nursing staff.</p> <p>The DNS/ADNS or designee will ensure compliance. This will be reviewed at the Quality Assurance Meetings to ensure compliance.</p> <p>Substantial compliance obtained by July 25, 2014.</p> <p><i>F356 POL accepted 7/23/14 [signature]</i></p>	
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Aneesa Southworth 7-17-14

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F 356	Continued From page 8 reflect the staffing and census daily and that was what the facility posted for the daily census posting. S/he further confirmed that the census was blank and that changes in staffing were not reflected on a daily basis to reflect the staffing. S/he said that it was his/her responsibility to post the census and S/he did so Monday through Friday after the facility held it's morning meeting. S/he stated that the census would be changed Monday through Friday by him/her after the morning meeting and it was not changed on the weekend to reflect current staffing and census.	F 356			
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. 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. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to maintain complete and accurate clinical records for 1 applicable resident in the sample. (Resident #17) Findings include: 1. Per record review on 06/24/14 Resident #17	F 514	(see next page)		

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F 514	Continued From page 9 who had multiple skin wounds failed to have accurate and complete weekly skin audits and pressure ulcer tracking monitoring. The Weekly Body Audit (WBA) sheets, which are used for the weekly skin audits, have the diagram of the body and lists specific skin conditions such as a) no skin issues b) abrasions, c) skin tear d) wound. Per the (WBA) sheet on 05/17/14 and on 05/31/14 notes a pressure ulcer on the coccyx however there was no staging [size] of the ulcer. Per the (WBA) sheets dated 05/24, 06/07, 06/14 and 06/21/14 fails to identify specific skin issues or staging. The nurse documented the word "new" between the word 'no' and 'skin issue' to read "no 'new' skin issues", however, the resident continued to have a pressure ulcer on the coccyx and no further information regarding staging and/or size was noted. Additionally, in the wound treatment book the Pressure Ulcer Tracking sheets dated only '5', 05/28/14 and 06/05/14 have no staging of the pressure ulcer. Per interview on 06/24/14 at 1:42 P.M. the DNS stated that the expectation would be that the nurse fill out the WBA sheets completely and comprehensively with type of skin concern, locations, staging and measurements. S/he confirmed failure to have complete and accurate clinical records for resident #17. See F-314	F 514	F-514 -RES RECORDS - COMPLETE/ ACCURATE/ ACCESSIBLE Resident 17 was discharged. A body Audit will be performed on each resident to ensure accuracy by an RN. ALL FT & PT nurses will be educated on how to do a body audit. New wound care documentation flow sheets initiated to alert staff to complete and document all necessary items. Weekly wound rounds to be initiated by ADNS or DNS and a member of the nursing staff to rotate each week until all FT & PT nurses have had an opportunity to participate and provide accurate return demonstration of actual wounds without disrupting resident schedules. The DNS/ADNS or designee will ensure compliance. This will be reviewed at the Quality Assurance Meetings to ensure compliance. Substantial compliance obtained by July 25, 2014 <i>F514 POC accepted 7/23/14 mcoatarn</i>	
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Theresa Southworth 7-17-14

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475052	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 6/25/2014
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NAME OF PROVIDER OR SUPPLIER GILL ODD FELLOWS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 8 GILL TERRACE LUDLOW, VT
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 205 483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR

Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.

At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.

This REQUIREMENT is not met as evidenced by:
Based upon interview and record review, the facility failed to assure one resident [Resident #40] of 10 residents in the sample group was given written notice of the facility's bed hold policy when the resident was transferred to a hospital.
Findings include:

Per interview with the facility's Director of Nursing [DON] on 6/25/14 at 8:25 A.M. s/he confirmed Resident #40 was transferred to the hospital on 9/14/13 and the resident was expected to return to the facility. The DON confirmed it is the facility's policy to give bed hold /readmission information to residents when they are discharged to a hospital, and bed/hold readmission information was not given to Resident #40 or the resident's family. The DON also confirmed the resident and the resident's family would have no way of knowing if a bed would be available at the facility at the time of the resident's return from the hospital without receiving the required written notice.

*This is an "A" level citation.

F 387 483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT

The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to ensure that 1 resident from the Stage 2 survey sample was seen by a physician in a timely fashion, resident #49. Findings include:

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

The above isolated deficiencies pose no actual harm to the residents

JOS 7-17-14

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475052	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 6/25/2014
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NAME OF PROVIDER OR SUPPLIER GILL ODD FELLOWS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 8 GILL TERRACE LUDLOW, VT
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 387	<p>Continued From Page 1</p> <p>During record review on 6/24/14 at 2:39PM for Resident #49, there was no evidence that h/she had been seen every 60 days per regulation. Physician progress notes dated 11/10/13 and again on 2/10/14, which was 91 days since last visit. The Director of Nursing (DNS) confirmed at time of discovery that the Physician had not visited within the required 60 days. S/he stated that the doctor was away and s/he knew that the visit had not occurred. This surveyor asked the DNS if the primary physician had someone that covered for him/her and h/she stated "yes", but that the visit did not occur.</p> <p>*This is an "A" level citation.</p>
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108 7-17-14