

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

December 15, 2011

Ms.. Charlene Bedor, Administrator
Redstone Villa
7 Forest Hill Drive
St Albans, VT 05478-1615

Provider #: 475055

Dear Ms.. Bedor:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 26, 2011**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN
Licensing Chief

PC:ne

Enclosure



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

PRINTED: 11/07/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/26/2011
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NAME OF PROVIDER OR SUPPLIER REDSTONE VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 7 FOREST HILL DRIVE ST ALBANS, VT 05478
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F 253	Continued From page 1 on the floor between the bed and the wall. The observations were confirmed by the Maintenance Supervisor at the time of the facility environmental tour. He stated that the damage was caused by the movement of beds and chairs in the Resident rooms. He stated that staff did not always submit requisitions for maintenance as they should when the damage is noted.	F 253	4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? Random Audits by Administrator/Designee on wall and door surfaces. Results will be reviewed at Quarterly QA meeting. 5. Include dates when a corrective action will be completed. Administrator/Designee will be responsible for monitoring to assure with compliance with POC and regulatory requirements by 11/26/11.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure that	F 279	<p><i>F 253 POC accepted Karen Campos 12/15/11 RW</i></p> <p>F279 Comprehensive Care Plans</p> <p>1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #46 Physician's order was written for the use of alarms, placed on the treatment sheet, and care plan was updated on the use of bed and chair alarms by 11/11/11. Resident #21 care plan was updated with the risk of bleeding related to dialysis shunt with emergency procedures to follow, the location of the fistula, monitoring of the shunt for bleeding, location and contact information for the dialysis center. Care plan also was updated on amount of fluid restriction and amounts of fluids to be given at meals and with medication passes by 11/14/11.</p>	

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F 279	<p>Continued From page 2</p> <p>comprehensive care plans were developed that included the use of bed and chair alarms and emergency procedures for a resident requiring dialysis services. This affected two (Resident #46 and Resident #21) of 16 resident care plans reviewed. Findings include:</p> <p>1. Per review on 10/25/11, the clinical record accumulative diagnosis list for Resident #46 revealed diagnoses of dementia, syncope and history of falls. The admission assessment dated 09/14/11 indicated that bed and chair alarms were in place at the time of the assessment. Review of the plan of care for fall risk initiated 10/19/11 did not indicate the use of a bed or chair alarm.</p> <p>Observation of Resident #46 on 10/25/11 at 5:00 P.M. revealed a chair alarm was in use in the recliner in the community living room. Observation of the bed assigned to Resident #46 at 5:05 P.M. revealed a bed alarm pad was in place.</p> <p>Interview of Registered Nurse #1 on 10/25/11 at 4:45 P.M., confirmed that the bed and chair alarms were noted on admission on 09/14/11. She stated that the use of alarms is addressed in the facility standing orders. She indicated that when standing orders are used, a physicians order should be written to allow the standing order to be transcribed to the appropriate tracking document and to be incorporated into the plan of care. She was not able to locate a physician order that was written for the alarms since the admission on 09/14/11. This protocol was verified with the Director of Nursing Services (DNS) on 10/26/11 at 8:30 A.M. She verified that</p>	F 279	<p>2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All Residents using chair or bed alarms are at risk by this alleged deficient practice. All Residents receiving dialysis are at risk by this alleged deficient practice.</p> <p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Re education of all Licensed Nurses on protocol for use of alarms and re education of Care Plan Coordinator on updating care plans for use of alarms and residents receiving dialysis by 11/26/11.</p> <p>4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? DNS/Designee will audit all charts for Residents using alarms and care plans for Residents receiving dialysis. Random audits will be done for 6 months. Results will be reviewed at the quarterly QA meeting.</p> <p>5. Include dates when a corrective action will be completed. DNS will be responsible for monitoring to assure compliance with POC and regulatory requirements by 11/26/11.</p> <p><i>F279 POC accepted Raren Campo RN 12/15/11</i></p>	

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F 279	<p>Continued From page 3</p> <p>without the written physicians order when activating the standing order for the alarms, the treatment record and the plan of care were not updated.</p> <p>2. Review of the clinical record accumulative diagnosis list for Resident #21, revealed a diagnosis of end stage renal disease with dialysis. The physician's orders revealed dialysis services three times weekly on Monday, Wednesday and Friday and fluid restriction of 1000 milliliters daily. The Dialysis plan of care dated 7/13/11 indicated that Resident #21 had a shunt and directed staff to take no blood pressures in that arm, to assess bruit and thrill each shift, to assess the site for signs of infection, to educate Resident #21 on diet restriction and fluid limitations and medications, and to provide a binder for communication with the dialysis unit. The plan of care did not address information specific to Resident #21, his/her physician's orders related to dialysis or his/her risk for bleeding related to venous and arteriole access. The plan of care did not identify the location of the access, the location or contact information for the dialysis center, or the need to monitor the site for bleeding and the emergency procedures to follow if bleeding was noted. Review of the plans of care for dialysis, fluid volume excess, and state of nourishment, revealed no specific information related to the fluid restriction. The amount of fluid allowed, or how much fluid to provide with medications or meals was not specified.</p> <p>Interview of Registered Nurse (RN) #2 and Licensed Practical Nurse (LPN) #3 on 10/25/11 at 1:15 P.M. verified that the plan of care did not contain the specified information related to</p>	F 279		

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F 279	Continued From page 4 dialysis care for Resident #21. They stated that the information is scattered throughout the records. They were not able to produce emergency procedures for bleeding at a dialysis site. They stated the communication binder contained information related to the location, contact numbers and schedule of dialysis sessions as well as recent laboratory values. RN#2 and LPN#3 were not able to locate the communication book for review and indicated they had not seen it since his last treatment. They indicated that Resident #21 frequently did not return the book. The communication book was provided at 5:00 P.M. on 10/26/11, which was 24 hours after Resident #21 returned from dialysis.	F 279		
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