

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 5, 2012

Mr. Timothy Urich, Administrator
Rutland Healthcare and Rehabilitation Center
46 Nichols Street
Rutland, VT 05701-3275

Provider #: 475039

Dear Mr. Urich:

Enclosed is a copy of your acceptable plans of correction for the annual re-certification survey conducted on **June 7, 2012**. 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, MS
Licensing Chief

PC:ne

Enclosure



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

RECEIVED
Division of

PRINTED: 06/20/2012
FORM APPROVED
OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ Licensing and Protection	(X3) DATE SURVEY COMPLETED 06/07/2012
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NAME OF PROVIDER OR SUPPLIER RUTLAND HEALTHCARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 46 NICHOLS STREET RUTLAND, VT 05701
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F 000	<p>INITIAL COMMENTS</p> <p>An unannounced, on site annual re-certification survey was conducted by the Division of Licensing and Protection from 06/04/12 through 06/07/12. The following regulatory deficiencies were identified.</p>	F 000		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, the facility failed to review and revise the plan of care for one resident to reflect interventions to promote healing of an existing unavoidable pressure ulcer. This affected one (Resident #91)</p>	F 280	<p>Plan of Correction F 280</p> <p><u>Corrective Action:</u> The identified resident was reassessed for her skin concerns and appropriate interventions were identified and implemented. The residents Care Plan was reviewed with the IDT and updated based upon the assessment.</p> <p><u>Identify Other Potential Residents:</u> In order to identify others with the potential to be affected by the same alleged deficient practice, residents with a skin change in condition will have their care plans reviewed for possible revision.</p> <p><u>Systemic Changes:</u> Skin care plans will be reviewed and revised whenever a change in condition or orders occurs.</p> <p><u>Monitoring:</u> Skin care plans will be reviewed for accuracy weekly at CAR meetings. Audits of care plans will be done weekly x 4 then monthly x 4. Results will be reviewed at QI Committee for follow-up and further recommendations.</p> <p>Responsibility: Director of Nursing Completion Date: 7/27/2012 F280 POC accepted 7/31/12 Thymmer-Rail PML</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE **ADMINISTRATOR** (X6) DATE **6/27/12**

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 280	<p>Continued From page 1 of 18 Stage 2 sampled Residents. Findings include:</p> <p>Per record review, Resident #91 was admitted 1/24/12 with a stage 2 pressure ulcer (superficial or partial thickness open area) to the coccyx. The plan of care developed on 01/24/12 indicated Resident #91 was at risk for skin breakdown and had actual skin breakdown. The interventions included evaluate for skin risk factors per protocol, weekly skin assessment by a licensed nurse, encourage the Resident to consume all fluids during meals, evaluate the wound area daily, and provide wound treatment as ordered. On 02/07/12 an intervention was added to observe the skin condition with daily care and report abnormalities. On 05/18/12 an intervention to apply an air mattress to the bed was added. On 05/22/12 and intervention of skilled Physical Therapy (PT) for therapeutic activity, modalities for wound care and seating and positioning strategies was added.</p> <p>Review of the progress notes indicated that an air mattress was ordered on 02/02/12. On 02/09/12 a care plan meeting progress note indicated that Resident #91 had a Roho cushion to relieve pressure. The physician's orders indicated on 02/20/12 the air mattress was discontinued. The progress notes indicated that on 03/27/12 the Nurse Practitioner (NP) evaluated the wound and ordered a low air loss mattress. The 05/21/12 Enterostomal (ET) nurse (nurse wound specialist) consultation indicated that the Resident sat in a geriatric chair recliner on and off daily for four to six hours at a time and recommended that the time up in the chair be decreased to one or two hours at a time, more frequently.</p>	F 280		

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F 280	Continued From page 2 During interview on 06/06/12 at 8:30 A.M. the NP verified that the air mattress was ordered on 02/02/12 and discontinued on 02/20/12 and a low air loss mattress was ordered on 03/27/12 and was not reflected on the plan of care until 05/18/12. The Director of Nursing Services and the Nurse Consultant did not provide evidence per request, that the care plan had been updated to include the Roho cushion or the recommendations of the wound specialist to limit the amount of time up in the chair each day. The plan of care reflected no changes from 02/07/12 through 05/18/12 as the wound declined, per the weekly skin integrity reports, from a stage 2 ulcer to an unstageable ulcer.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to implement the plan of care for one resident (Resident #21) regarding monitoring for side effects of a psychotropic medication. This affected one (R#21) of three stage 2 residents sampled for psychoactive medication reviews. Findings include: Per record review, Resident #21, whose diagnoses include altered mental status, depressive disorder, dementia, and anxiety, has a	F 282	Plan of Correction F 282 <u>Corrective Action:</u> In order to correct the action for the resident noted to be affected by the alleged practice, the resident had a Behavior Monitoring Flow Sheet added which includes side effect monitoring. <u>Identify Other Potential Residents:</u> In order to identify others with the potential to be affected by the alleged deficient practice, residents that receive psychoactive medications will be audited to ensure they have a Behavior Monitoring Flow Sheet. <u>Systemic Changes:</u> Licensed staff will be educated to Genesis Policy 15.0 Behavior Monitoring regarding the monitoring of side effects of psychotropic drugs. (F 282 continued on page 4 of 17)	

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F 282	<p>Continued From page 3</p> <p>written plan of care for risk of complications related to the use of psychotropic drugs. The Care Plan, dated as reviewed by the facility on 05/30/12, contains the intervention "monitor for side effects and consult physician and/or pharmacist as needed". Per record review on 06/06/12, Resident #21 also has a Care Plan, dated 05/30/12, regarding [the resident] "exhibits distressed mood symptoms as evidenced by diagnoses of depression/anxiety". Interventions include "Monitor current medication regimen. Monitor for side effects of medication." Per record review, Resident #21's Medication Administration Record (MAR) includes an order for the psychotropic medication Zoloft (an anti-depressant) 50 milligrams by mouth daily.</p> <p>Per staff interview at 2:30 P.M. on 06/06/12 with the Nursing Manager for Resident #21's unit, an LPN on the unit, and the facility's Director of Nursing Services (DNS), medication side effects are documented on a Behavior Flow Sheet included with the resident's MAR. The 3 staff members confirmed that Resident #21 was currently on the medication Zoloft, and that Resident #21's Care Plan for psychotropic medications and for exhibiting distressed mood symptoms includes the intervention 'monitor for medication side effects'.</p> <p>Per record review on 6/6/12 Resident #21's MAR did not include a Behavior Flow Sheet. Per interview at 2:30 P.M. on 6/6/12 the DNS stated it was his/her expectation that there would be a Behavior Flow Sheet for Resident #21 to monitor for side effects, and/or monitoring for side effects would be documented in the Nursing Notes for the resident. The DNS confirmed there was no documentation regarding monitoring for side</p>	F 282	<p><u>Monitoring:</u> Audits will be completed for Residents on psychotropic drugs to ensure compliance with monitoring of side effects. These audits will be completed weekly x 4 then monthly x4. Results will be reviewed at QI Committee meeting for further evaluation and recommendation.</p> <p><u>Responsibility:</u> Director of Nursing</p> <p><u>Completion Date:</u> 7/27/2012</p> <p><i>F282 poc accepted 7/3/12</i> <i>TMynhwa RN/ Pme</i></p>	

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F 282	Continued From page 4 effects or Behavior Flow Sheet for the resident, and there was no indication medication side effects were being monitored per Resident #21's written plan of care.	F 282		
F 314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and clinical record review, the facility failed to ensure that one resident admitted with a stage 2 pressure ulcer received necessary care and services to promote healing of an unavoidable pressure ulcer. This affected one (Resident #91) of three stage 2 Residents reviewed for pressure ulcer care. Findings include:</p> <p>Per clinical record review Resident #91 was admitted on 01/24/12 with a stage 2 (partial thickness) pressure ulcer to the coccyx. The skin integrity report indicated the measurements were 3.5 centimeters (cm) long by 3.0 cm wide and no depth was indicated. A second area was noted and measured 1.5 cm by 1.0 cm with no depth. The wound appearance was described as intact/pink with minimal drainage and healthy</p>	F 314	<p>Plan of Correction F 314</p> <p><u>Corrective Action:</u> The identified resident was reassessed and now has an air mattress.</p> <p><u>Identify Other Potential Residents:</u> In order to identify others with the potential to be affected by the same alleged deficient practice, residents with pressure ulcers will be assessed to ensure the appropriate mattress is in place.</p> <p><u>Systemic Changes:</u> Licensed nursing staff will be educated on support surface management.</p> <p><u>Monitoring:</u> Support surface audits will be completed weekly x'4 then monthly x's 4 to ensure residents appropriate support surfaces are in use. Results of the audits will be reviewed at QI committee for further evaluation and recommendations'</p> <p><u>Responsibility:</u> Director of Nursing <u>Completion Date:</u> 7/27/2012</p> <p><i>F314 Poc accepted 7/31/12 Thynner RN Pmc</i></p>	

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F 314	<p>Continued From page 5</p> <p>surrounding tissue and wound edges and no odor. The plan of care developed on 01/24/12 indicated Resident #91 was at risk for skin breakdown and had actual skin breakdown. The interventions included evaluate for skin risk factors per protocol, weekly skin assessment by a licensed nurse, encourage the Resident to consume all fluids during meals, evaluate the wound area daily, and provide wound treatment as ordered. On 02/07/12 an intervention was added to observe the skin condition with daily care and report abnormalities. On 05/18/12 an intervention to apply an air mattress to the bed was added. On 05/22/12 and intervention of skilled Physical Therapy (PT) for therapeutic activity, modalities for wound care and seating and positioning strategies was added.</p> <p>Review of the progress notes indicated that the Nurse Practitioner (NP) assessed the wound on 02/02/12 and determined it had progressed to a stage 3 (full thickness wound) measuring 2.8 cm by 2.5 cm by 0.2 cm. and 25 percent of the wound was covered in slough. An air mattress was ordered on 02/02/12. The skin integrity report dated 02/02/12 indicated the wound was a stage 2 ulcer with the same measurements and description. A general progress note dated 02/04/12 at 6:55 P.M. indicated the dressing was changed and the area around the ulcer seemed to be redder than two nights ago and larger as well. A general progress note dated 02/07/12 at 4:23 P.M. stated new order: air mattress when available. A care plan meeting note dated 02/09/12 indicated a Roho cushion was in place to relieve pressure. It does not state the type of chair Resident #91 was using. The physician's orders indicated on 02/20/12 the air mattress was</p>	F 314		

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F 314	<p>Continued From page 6</p> <p>discontinued. The progress notes indicated on 03/27/12 the Nurse Practitioner (NP) evaluated the wound to be a stage 3 ulcer that was not improving and again ordered a low air loss mattress.</p> <p>The notes indicated Resident #91 was hospitalized from 03/30/12 to 04/03/12 for transient ischemic attack and urinary tract infection after being observed leaning in the wheelchair and weaker than usual. Resident #91 was also hospitalized from 04/20/12 to 04/26/12 with severe hypernatremia, mild hyperkalemia, and pneumonia. On 05/01/12, the Physician documented a meeting with the spouse and caregiver to discuss goals of care. At this time orders were written for supportive care and comfort measures. The progress notes indicated that an Enterostomal (ET) nurse (nurse wound specialist) was consulted on 05/21/12 and noted that the Resident sat in a geriatric chair recliner on and off daily for four to six hours at a time with no pressure reduction cushion and had a Span America Pressure Guard mattress in place set on alternating air and set at firm. The wound was measured by the ET nurse and was noted to be 6.0 cm by 5.0 cm with a dept of 3.0 cm. with 90 percent slough and an odor. Drainage was described as tan/yellow and moderate. The recommendations included to #1. continue the treatment; #2. continue the barrier film around the area to protect the healthy skin; #3. to get copies of the instructions for the bed for adjustment directions; #4. Physical Therapy evaluation for seating and positioning and pressure reduction; #5. Encourage protein in whatever manner the resident will take it; and #6. Decrease the time up in the chair to one or two hours at a time but more</p>	F 314		

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F 314	<p>Continued From page 7 frequently.</p> <p>Interview of Resident #91 on 06/07/12 at 8:40 A.M. revealed the Resident was positioned slightly to the left and supported by pillows, on an alternating air mattress that was set on level 2. There was an unpleasant odor noted in the room. The Resident stated the bed is comfortable. Resident #91 declined to allow observation of the wound as the dressing had been changed early in the morning. Staff verified the dressing was changed on wound rounds at shift change on 06/07/12. The nurse stated that the odor in the room was related to the wound. The nurse stated s/he had no knowledge of the events related to the air mattress as s/he had been off on medical leave.</p> <p>During interview on 06/06/12 at 8:30 A.M. the NP verified that the air mattress was ordered on 02/02/12 and discontinued on 02/20/12 and a low air loss mattress was ordered on 03/27/12. The NP was not able to state why the air mattress was ordered multiple times and could not state if the mattress was on the bed or not on the bed during that time. The Director of Nursing Services, the unit manager and the Nurse Consultant did not provide any explanation. The Nurse Consultant provided copies of the facility policies related to #1. Skin Integrity Management, revised 10/01/10, which indicates in item 4.2 Determine the need for a support surface and initiate according to policy, and #2. Support Surfaces, revised 02/01/08, which indicates support surfaces are used to provide pressure redistribution for select patients who have multiple stage II pressure ulcers on more than one turning surface; Stage III, Stage IV, deep tissue injury, and unstageable</p>	F 314		

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F 314	Continued From page 8 pressure ulcers: full thickness wounds; and select other needs in accordance with a physician's order and management approval.	F 314		
F 333 SS=G	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure that one resident was free from significant medication errors. This affected one (Resident #146) of 18 stage 2 sampled residents. Findings include:</p> <p>Per record review, Resident #146 received his/her routine morning medications in his/her room sometime during the 8:00 A.M. medication pass on 06/01/12. After s/he received his/her medications, the medication nurse prepared to administer medications to a second resident (#77) who was in one of the unit's common areas. The nurse was a traveling nurse relatively new to the facility and asked an LNA where the resident was seated and was given a location. The nurse proceeded to the area reportedly unaware that in the interim Resident #77 had been moved out to be taken to the bathroom and Resident #146 was brought into the common area and placed in approximately the same place. Both residents have diagnoses of dementia. At that time the routine medications for Resident #77, which included a calcium channel blocker, an antihypertensive, and an antipsychotic medication, were administered to Resident #146.</p>	F 333	<p>Plan of Correction F 333</p> <p><u>Corrective Action:</u> The identified resident was immediately triaged and sent to the hospital for treatment.</p> <p><u>Identify Other Potential Residents:</u> Every resident was immediately given a wrist band identifying them by name. The individual who was involved in the alleged error was required to pass a medication competency test.</p> <p><u>Systemic Changes:</u> Care givers have been educated to utilize 2 patient identifiers, including the patients name band, whenever delivering care or giving medications. All new licensed staff will be required to pass a medication competency test prior to giving medications.</p> <p><u>Monitoring:</u> New admissions will be identified with a name band and picture ID placed in the chart. Audits of patients name bands and picture ID will be completed weekly x 4, then monthly x 4. Results of audits will be reviewed at the QI Committee.</p> <p>Responsibility: Director of Nursing Completion Date: 7/27/2012</p> <p><i>F333 POC accepted 7/31/12</i> <i>TMynhocrn/PMC</i></p>	

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F 333	<p>Continued From page 9</p> <p>The error was recognized by the administering nurse shortly after and reported to the Unit Manager.</p> <p>The Unit Manager assessed the Resident and requested that a Nurse Practitioner, who was in the building, come to assess the Resident. The Resident was in rapid decline, according to the progress notes, and his/her vital signs were dropping with a blood pressure of 83/57. The Medical Doctor (MD) and Emergency Medical Services (EMS) were called and the Rescue Squad arrived to stabilize and transport the Resident to Rutland Regional Medical Center (RRMC). When Resident #146 left via ambulance s/he had a blood pressure of 63/37 and was minimally responsive to sternal rub.</p> <p>In the progress notes, the Physician states that Resident #146 was treated with Lasix (a diuretic) and intubation (mechanical ventilation) at the hospital and s/he was admitted to the hospital. The Resident was treated and returned to the facility at 2:30 PM on 06/02/12. Resident #146 was described as somnolent and more lethargic than baseline upon return.</p> <p>On 06/02/12 at 3:30 P.M. Resident #146 was found unresponsive with an oxygen saturation (SAO2) of 95% on oxygen at 2 liters per minute via nasal cannula, had a temperature of 101.1 degrees Fahrenheit and increased heart rate. Resident #146 was transported to RRMC via ambulance and remains hospitalized on 06/07/2012 although the facility anticipates his return in the next day or two.</p> <p>These events were confirmed by interview of the</p>	F 333		

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

PRINTED: 06/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/07/2012
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NAME OF PROVIDER OR SUPPLIER RUTLAND HEALTHCARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 46 NICHOLS STREET RUTLAND, VT 05701
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F 333	Continued From page 10 Administrator and Corporate Consultant on 06/05/12 at 1:45 P.M. and 4:40 P.M. and follow up interview of the Administrator and Director of Nursing Services (DNS) on 06/06/12 at 8:45 A.M. The medication nurse was also interviewed during the survey and confirmed the events as recorded in the record.	F 333		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures	F 334	Plan of Correction F 334 <u>Corrective Action:</u> <u>Identify Other Potential Residents:</u> Residents in the center during the flu season 2012-2013 have the potential to be affected. <u>Systemic Changes:</u> Residents/responsible parties will be provided with current educational materials per revised protocols beginning with the flu season 2012-2013 <u>Monitoring:</u> Signed consent with acknowledgement of education relative to immunizations will be on the residents chart prior to immunization. <u>Responsibility:</u> Director of Nursing <u>Completion Date:</u> 7/27/2012 <i>F334 POC accepted 7/27/12 Thuyhvier RN / POC</i>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 334	<p>Continued From page 11</p> <p>that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the</p>	F 334		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 334	Continued From page 12 facility failed to provide documentation of information/education provided to residents or their legal representatives regarding the benefits and risk of immunization each time the vaccine is offered. Findings include: Per record review and staff interview the facility has the resident or representative sign a consent for administration of the annual flu vaccine one time only. On an annual basis the facility provides the current year's CDC flyer to residents who are capable of their own decisions and mails the information to the representative of those who are not capable. There is no request for a signed acknowledgement of receipt of the letter and no methodology for assuring that the document was received. The Infection Control Nurse maintains a computer list based upon those letters which were mailed. There is no evidence as to the person signing the consent having received the information. The findings were confirmed with the infection control nurse in an interview at 11:55 A.M. on 06/06/12.	F 334		
F9999	FINAL OBSERVATIONS 2.7 Special Care Units (a) The facility must obtain approval from the licensing agency prior to establishing and operating a Special Care Unit. Approval will be based on a demonstration that the Unit will provide specialized services to a specific population. (b) A request for approval must include all of the following: (1) a statement outlining the philosophy and purpose of the unit, including a description of the form of care, treatment, program or scope of services to be provided that distinguishes it as	F9999	Plan of Correction 9999 <u>Corrective Action:</u> The facility has been in discussions with the Division of Licensing and Protection in order to determine an acceptable resolution to this finding. The center administrator has been in direct communication with the Division's Licensing Chief, Pamela Cota, in an effort to determine the facility's ability/inability to meet the requirements of the regulation. As such, Ms. Cota has instructed the facility to reference this collaboration in the plan of correction. <i>F9999 POC accepted 7/3/12 PML</i>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F9999	<p>Continued From page 13</p> <p>being especially applicable to or suitable for residents;</p> <p>(2) a definition of the categories of residents to be served;</p> <p>(3) a description of the organizational structure of the unit consistent with the unit ' s philosophy, purpose and scope of services;</p> <p>(4) a description and identification of physical environment;</p> <p>(5) the criteria for admission, continued stay and discharge which shall also include any criteria used for moving residents within the facility, into or out of a unit; and</p> <p>(6) a description of unit staffing to include:</p> <p>(i) staff qualifications,</p> <p>(ii) orientation,</p> <p>(iii) in-service education and specialized training, and</p> <p>(iv) medical management and credentialing as necessary.</p> <p>(c) In addition to the requirements set forth in 2.7(a) and (b), dementia units are required to have:</p> <p>(1) Secured outdoor space and walkways that allow residents to ambulate, but prevent undetected egress;</p> <p>(2) High visual contrasts between floors and walls and doorways in resident use areas. Except for fire exits, doors and access ways may be designed to minimize contrast.</p> <p>(3) Non-reflective floors, walls and ceilings to minimize glare;</p> <p>(4) Adequate and even lighting which minimizes glare and shadows;</p> <p>(5) Individualized identification of residents ' rooms that assists residents to recognize their rooms;</p> <p>(6) A public address system, if applicable, to be</p>	F9999		

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F9999	<p>Continued From page 14</p> <p>used only in the event of an emergency; and</p> <p>(7) Public or shared areas of the unit (both inside and out) that are easily monitored by caregiving staff.</p> <p>(d) Dementia units shall meet the following staffing and staff training requirements:</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;</p> <p>(ii) Communication basics;</p> <p>(iii) Creating a therapeutic environment;</p> <p>(iv) Activity focused care;</p> <p>(v) Dealing with difficult behaviors; and</p> <p>(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;</p> <p>(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;</p>	F9999		

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F9999	<p>Continued From page 15</p> <p>(iii) Ways to create a therapeutic environment, including safety issues, effective strategies for providing care, background noise, staff behavior, 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>(e) Failure to provide the care, treatment, program or scope of services set forth in the request for approval from the licensing agency shall constitute a violation of these rules.</p> <p>(f) Facilities with existing special care units shall comply with the requirements of subsections (b) and (d) on the date on which the rules take effect. Such facilities shall meet the requirements of subsection (c) as soon as practicable, but no later than six months from the effective date of the rules. Facilities that cannot come into compliance within that time period may request a variance pursuant to section 1.5 of these rules.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, the facility failed to ensure that information was available indicating the philosophy of the designated special care unit or describing the population to be served or the care to be provided. In addition, the special care unit failed to provide a secured outdoor space in</p>	F9999		

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F9999	<p>Continued From page 16 accordance with Vermont Licensing and Operating Rules for Nursing Homes. Findings include:</p> <p>Review of the documentation provided related to the designated special care unit for dementia revealed extensive staff education related to the care of residents with dementia related illnesses. No information was provided that described the philosophy and purpose of the unit, the population to be served, the organizational structure of the unit, the physical environment, the criteria for admission to, continued stay or discharge from the unit, the care and services to be provided or a description of unit staffing.</p> <p>Interview of the Administrator on 06/06/12 at 8:10 A.M. revealed that s/he was not able to locate any of the above noted documentation related to the facility's designated special care unit for dementia. The Administrator further stated that after reading the regulation, after this information was requested, s/he realized that the unit did not meet the requirements for a secured outdoor space and walkways to allow residents to ambulate, but prevent undetected egress per the Vermont Licensing and Operating Rules for Nursing Homes 2.7 Special Care Units (c)(1).</p>	F9999		