

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

Mr. Shawn Hallisey, Administrator
St Johnsbury Health & Rehab
1248 Hospital Drive
Saint Johnsbury, VT 05819-9248

Dear Mr. Hallisey:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 18, 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

JUL 18 2014

PRINTED: 06/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/18/2014
NAME OF PROVIDER OR SUPPLIER ST JOHNSBURY HEALTH & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1248 HOSPITAL DRIVE SAINT JOHNSBURY, VT 05819	
(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 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility staff failed to adhere to professional standards of quality for 3 of 23 residents in the stage 2 sample regarding identification of potential allergies to medications, timely scheduling of appointments, and consistent implementation of dietary recommendations (Residents #43, #105, #107). Findings include:</p> <p>1. Per record review on 6/18/14 at 8:30 AM, Resident # 107's clinical record indicated that h/she had an allergy to SSRIs (Selective Serotonin Reuptake Inhibitors) and that staff had been administering the SSRI Zoloft (an anti-depressant) since admission in 2012. Review of the Medication Administration Records (MARS) show that the medication has been given daily. The Physician order for Zoloft was 100 milligrams by mouth every day. The SSRI allergy is documented on physician orders, MARS, on a condition alert sheet in clinical record and on an orange sticker on the front of resident's chart. Per interview with a Unit Registered Nurse (RN), the</p>	F 281	<p><u>F 281</u></p> <p><u>How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>Resident #105 has been receiving her supplements as ordered, has assistance as needed at mealtime. She has gained several pounds. Plan of Care has been reviewed and re-implemented. Resident #43 has orders for foley catheter care parameters which have been added to the MAR and also the careplan has been updated. Resident #107 has had her drug allergies reviewed and changes have been made to reflect the current orders on her care plan.</p> <p><u>How will the facility identify other residents having the potential to be affected by the same deficient practice?</u></p> <p>All residents have had their care plans and orders reviewed for accuracy and have been updated as needed. And any changes in their Plans of Care have been reviewed with nursing staff and Social Services.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shawn T. Hallisey TITLE: Administrator (X6) DATE: 7/16/14

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.

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F 281	<p>Continued From page 1</p> <p>RN was unable to explain why the resident was receiving Zoloft despite the documented allergy. The RN was unable to find a physician's progress note or order approving administration of the SSRI medication or discontinuing the SSRI allergy alerts. Review of pharmacy consultant documentation back to November 2012 showed no irregularities were noted. On 6/18/14 at 11:40 AM, the Assistant Director of Nursing Services (ADNS) confirmed that staff nurses did administer the Zoloft and should have questioned the allergy prior to administering the medication as described above.</p> <p>2. Per 6/17/14 medical record review, Resident #43 was admitted to the facility on 6/2/14 with diagnoses of difficulty walking, a history of falls, hypertension and other chronic diseases. On 6/10/14 s/he was evaluated at the ED (Emergency Department) for right lower quadrant abdominal pain. In the ED s/he also complained of not being able to void (urinate) and was catheterized with an almost 1000 cc urine output and diagnosed with urinary retention. S/he returned to the facility with an indwelling foley catheter. Per review of a 6/10/14 fax, the resident's physician was notified of the change in medical condition. A 6/11/14 fax to the physician obtained orders for a foley [catheter] to gravity and orders for a urology consult.</p> <p>Per 6/18/14 interview at 7:52 AM, the facility Assistant Director of Nursing (ADON), confirmed that orders for the catheter did not contain parameters for the catheter size or change schedule; the resident's care plan was updated on 6/18/14 to include these parameters after brought to the nurses attention at the time of the</p>	F 281	<p><u>What measures will be put on place to ensure that the deficient practice will not occur</u></p> <p>Licensed nursing staff has been reeducated on following the Plan of Care and keeping it updated to reflect the current needs of the residents. A process to monitor MD orders has been put in place.</p> <p><u>How will the facility monitor its corrective actions to ensure that the deficient practice will not reoccur?</u></p> <p>. There will be random weekly audits for 4 weeks and monthly x's 3 regarding MD orders being carried out timely and drug allergies being verified and addressed. Results will be reported through the QA process with interventions as appropriate.</p> <p>The DNS or designee is responsible for this process</p> <p><i>F281 POC accepted 7/17/14 JHosmer RN/PMC</i></p>	07/17/14

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F 281	<p>Continued From page 2</p> <p>survey. Although the resident was reported as continent of urine prior to the 6/10/14 ED visit and a urology consult was ordered on 6/12/14, per interview on 6/18/14 with a facility scheduler, a call for a urology consult did not occur until 6/17/14 to schedule an appointment and an actual appointment (for July) was not obtained until 6/18/14 during the survey. Per interview with the facility DON (Director of Nursing), s/he reported that the nursing unit manager for this resident's unit had left his/her position abruptly and staff was working to catch up from his/her departure.</p> <p>3. Per record review on 6/18/14, Resident #105 had experienced a significant weight loss. The Registered Dietician (RD) was following him/her on a regular basis, as s/he was considered at nutritional risk, and s/he was on a weight gain and loss alternating pattern since admission in April 2013. The Registered Dietician (RD) recommended a supplement on May 26, 2014, which the doctor signed as an order for "High Protein, High Calorie 4 oz. shakes three times per day" on May 27, 2014. Per review of the Medication Administration Record (MAR), Resident #105 received the 4 oz. high protein, high calorie shake three times per day as ordered for the next four days until June 1, 2014. Per review of the June 2014 MAR, there were no supplemental shakes given to the resident until noon on June 13th. Per interview on 6/18/14 at 10:30 AM, the Unit Manager and the nurse passing medications on that wing both confirmed that the MD order had not been transcribed to the June 2014 MAR due to staff oversight, and that the supplement was not given to the resident for 12 days until the error was discovered. The MD</p>	F 281		

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F 281	Continued From page 3 was notified of the missed order, and the resident resumed the shakes on June 13, 2014. Per review of the resident's weight documentation, s/he lost an additional 9.5 lbs. between May 27 and June 7, 2014.	F 281	<u>F 282</u> <u>How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?</u> Resident #105 has been receiving her supplements as ordered, has assistance as needed at mealtime. She has gained several pounds. Plan of Care has been reviewed and re-implemented.	
F 282 SS=D	Reference: Lippincott Manual of Nursing Practice (9th ed). Wolters Kluwer Health/Lippincott Williams & Wilkins. 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 record review and staff interview, the facility failed to assure that the plan of care was implemented by qualified persons for 2 of 23 residents reviewed (Residents #105 and #115). Findings include: 1. Per record review on 6/18/14, Resident #105 had experienced significant weight loss, and on 5/27/14 was started on nutritional supplements of high calorie, high protein shakes 4 oz. three times daily by nursing. The nutritional care plan was updated to include the new intervention. Resident #105 did not receive the supplements from June 1- June 12, 2014 due to a staff oversight of transcribing the order to the June Medication Administration Record (MAR). Per interview on 6/18/14 at 11:15 PM, the Unit Manager confirmed that the nutritional care plan for supplements was	F 282	<u>How will the facility identify other residents having the potential to be affected by the same deficient practice?</u> All residents have had their care plans and orders reviewed for accuracy and have been updated as needed. And any changes in their Plans of Care have been reviewed with nursing staff and Social Services. <u>What measures will be put on place to ensure that the deficient practice will not occur</u> Licensed nursing staff and Social Services has been reeducated on following the Plan of Care and keeping it updated to reflect the current needs of the residents. <u>How will the facility monitor its corrective actions to ensure that the deficient practice will not reoccur?</u>	

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F 282	<p>Continued From page 4 not implemented during that time period due to the oversight.</p> <p>2. Per record review on 6/17/14, Resident #115 was admitted to the facility on 2/25/14 with diagnoses that included anxiety and depression. A note on the "Doctor's Order Sheet" dated 2/26/14 ordered: "Mental Health consult-depression." Per record review, the facility used the PHQ-9, a patient health questionnaire to screen for depression symptoms; scores in the 15-19 range indicate moderately severe depression. On Resident #115's 3/14/14 MDS (Minimum Data Set), a PHQ-9 mood score of 18 is listed; on 4/28/14, the 30 day MDS lists a mood score of 16 and the 5/31/14 MDS lists a mood score of 18. The above scores were confirmed by the social services staff member on 6/17/14 at 4:05 PM and s/he confirmed that the resident screened positive for depressive symptoms.</p> <p>Per review, the resident was care planned for an "alteration in mood related to [signs and symptoms] of depression" on 3/14/14. Under interventions, the care plan stated that social services made a referral to NKHS (a community mental health agency).</p> <p>On 6/17/14 at 2:40 PM, the facility's social services staff member stated that Resident #115 saw a counselor from Deer Oaks as s/he could not get into the local community mental health program. On 6/17/14 at 4:05 PM, the social services staff stated that Deer Oaks staff made 2 visits to the resident but never admitted him/her to services and that until the survey, s/he was not aware that the resident was not seen by the mental health provider. S/he added that the resident's physician was also not aware that the resident was not receiving services. The social</p>	F 282	<p>Audits will be conducted for accuracy of Plans of Care and the timely addressing of MD orders. There will be random weekly audits for 4 weeks. Then monthly audits x's 4.</p> <p>Results will be reported through the QA process with interventions as appropriate.</p> <p>The Administrator, DNS or designee is responsible for this process</p> <p><i>Faba poc accepted 7/17/14 JHormoren/PML</i></p>	07/17/14
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F 282	Continued From page 5 services person also confirmed that alternative psychological services were not pursued and that there was miscommunication between facility and the Deer Oaks staff about whether the resident was receiving services. On 6/17/14 at 4:42 PM, the social services staff member stated that Deer Oaks staff also contacted the resident on 5/13/14: the contact summary stated that Resident #115 ... "decided its not a good idea to see me, privacy is an issue..." On 6/18/14 at 9:55 AM, Resident #115 stated that s/he did not think it would work out to see the same counselor as his/her roommate [who was also being followed by the Deer Oaks counselor] and stated s/he was told that they would get me someone from "St Johnsbury" so s/he wouldn't have to see the same person. Per 6/18/14 telephone interview with the Deer Oaks provider, s/he confirmed that Resident #115 was not interested in visits with him/her as the resident did not want the same counselor as his/her roommate and was concerned about privacy. S/he stated that s/he did not see the resident in an official capacity, did not do an evaluation or bill for any visits. S/he stated that s/he reported this to a charge nurse and put it in her note; s/he felt the facility would handle finding another counselor for the resident as that was not his/her role.	F 282			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309			

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F 309	<p>Continued From page 6 accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and resident, staff and provider interviews, the facility failed to assure that services were provided to meet the highest practicable level of well-being for 1 of 23 residents in the stage 2 sample regarding assuring that the resident received psychological care and services (Resident #115). Findings include:</p> <p>Per medical record review on 6/17/14, Resident #115 was admitted to the facility on 2/25/14 with diagnoses that included anxiety and depression. A note on the "Doctor's Order Sheet" dated 2/26/14 ordered: "Mental Health consult-depression." Per record review, the facility used the PHQ-9, a patient health questionnaire* to screen for depression; scores in the 15-19 range indicate moderately severe depression. On Resident #115's 3/14/14 MDS (Minimum Data Set), a PHQ-9 mood score of 18 is listed; on 4/28/14, the 30 day MDS lists a mood score of 16 and the 5/31/14 MDS lists a mood score of 18. The above scores were confirmed by the social services staff member on 6/17/14 at 4:05 PM and s/he confirmed that the resident screened positive for depressive symptoms. On 6/17/14 at 2:40 PM, the facility's social services staff member stated that Resident #115 saw a counselor from Deer Oaks as s/he could not get in to the local community mental health program. On 6/17/14 at 4:05 PM, the social services staff stated that Deer Oaks staff made 2</p>	F 309	<p><u>F 309</u></p> <p><u>How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?</u> Resident #115 Plan of Care has been reviewed and changed as needed. . The Resident #115 was discharged on to a facility in Connecticut #115 where she could be close to her family.</p> <p><u>How will the facility identify other residents having the potential to be affected by the same deficient practice</u> All residents who are depressed and anxious have had their care plans reassessed and changes have been implemented if needed. And any changes in their Plans of Care have been reviewed with Nursing and Social Service staff</p> <p><u>What measures will be put on place to ensure that the deficient practice will not occur</u> Licensed nursing staff has been reeducated on following the Plan of Care and keeping it updated to reflect the current needs of the residents. Social Services will meet with the individual residents to ensure they receive the care and services needed to attain or maintain the highest level in accordance with their individual assessment and plan of care.</p> <p><u>How will the facility monitor its</u></p>	
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F 309	<p>Continued From page 7</p> <p>visits to the resident but never admitted him/her to services and that until the survey, s/he was not aware that the resident was not seen by the mental health provider. S/he added that the resident's physician was also not aware that the resident was not receiving services. The social services person also confirmed that alternative psychological services were not pursued and that there was miscommunication between facility and the Deer Oaks staff about whether the resident was receiving services. On 6/17/14 at 4:42 PM, the social services staff member stated that Deer Oaks staff contacted the resident on 5/13/14: the contact summary stated that Resident #115 ... "decided its not a good idea to see me, privacy is an issue..."</p> <p>Per 6/17/14 review, the MD visit note dated 4/2/14, state "Depression -worse. Continue with Remeron. Refer for psychiatric counseling." (Remeron = an antidepressant medication). The 5/6/14 note states "Depression -Appears slightly improved. Continue to pursue psychiatric consultation."</p> <p>On 6/18/14 at 9:55 AM, Resident #115 stated that s/he did not think it would work out to see the same counselor as his/he roommate [who was also being followed by the Deer Oaks counselor] and stated s/he was told that they would get me someone from "St Johnsbury" so s/he wouldn't have to see the same person.</p> <p>Per 6/18/14 telephone interview with the Deer Oaks provider, s/he confirmed that Resident #115 was not interested in visits with him/her as the resident did not want the same counselor as his/her roommate and was concerned about privacy. S/he stated that s/he did not see the resident in an official capacity, did not do an</p>	F 309	<p><u>corrective actions to ensure that the deficient practice will not reoccur</u></p> <p>An audit will be conducted for adherence Plans of Care for residents with depression and anxiety to ensure their needs are met in a timely fashion. There will be random weekly audits for 2 weeks. And monthly audits x's 2. Results will be reported through the QA process with interventions as appropriate.</p> <p>The Administrator , DNS or designee or is responsible for this process</p> <p><i>F309 POC accepted 7/17/14 JHamer RN/PMC</i></p>	07/17/14

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F 309	Continued From page 8 evaluation or bill for any visits. S/he stated that s/he reported this to a charge nurse and put it in her note; s/he felt the facility would handle finding another counselor for the resident as that was not his/her role.	F 309	<u>F 325</u> <u>How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?</u>		
F 325 SS=G	< http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf > 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that a resident with weight loss received the prescribed therapeutic diet for 1 of 23 residents in the stage 2 sample (Resident # 105). Findings include: Per record review on 6/18/14, Resident #105 had experienced a significant weight loss over the last few months. Documentation from 3/3/14 showed an increases in weight trend and good meal acceptance noted. The Registered Dietician (RD) was following him/her on a regular basis, as s/he	F 325	Resident #105 has been receiving her supplements as ordered, has assistance as needed at mealtime. She has gained several pounds. Plan of Care has been reviewed and changes made as needed. <u>How will the facility identify other residents having the potential to be affected by the same deficient practice?</u> All residents have had their care plans and orders reviewed for accuracy and have been updated as needed. And any changes in their Plans of Care have been reviewed with nursing staff. <u>What measures will be put on place to ensure that the deficient practice will not occur</u> Licensed nursing staff has been educated on the new process to track orders and make ensure they are implemented timely. Reeducated on following the Plan of Care and keeping it updated to reflect the current needs of the residents.		

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F 325	<p>Continued From page 9</p> <p>was considered at nutritional risk, and s/he was on a weight gain and loss alternating pattern since admission in April 2013. On January 31, 2014 s/he weighed 105.6 lbs. By February 24, 2014 s/he had dropped to 101.8 lbs. after an illness, however started to regain the weight, was 102.4 lbs on March 22, and was stable until March 31, 2014 when s/he had dropped down to 100 lbs. again. S/he did begin to regain the weight in April/May and was stable, however not regaining enough and the RD recommended a supplement on May 26, 2014, which the doctor signed as an order on May 27, 2014. Per review of the Medication Administration Record (MAR), Resident #105 received the 4 oz. high protein, high calorie shake three times per day as ordered for the next four days until June 1, 2014. Per review of the June 2014 MAR, there were no supplemental shakes given to the resident until noon on June 13th. Per interview on 6/18/14 at 10:30 AM, the Unit Manager and the nurse passing medications on that wing both confirmed that the MD order had not been transcribed to the June 2014 MAR due to staff oversight, and that the supplement was not given to the resident for 12 days until the error was discovered. The MD was notified, and the resident resumed the shakes on June 13, 2014. Per review of the resident's weight documentation, s/he lost 9.5 lbs. between May 27 and June 7, 2014, and was down to 89.2 lbs. Per interview on 6/18/14 at 11:30 AM, the Registered Dietician confirmed that s/he was aware of the resident's recent weight loss since June 1, 2014 as they discuss him/her weekly in care meetings; however, s/he had not been told that the resident did not receive the supplemental shakes for 12 days, and that it was important information that should have been communicated to him/her.</p>	F 325	<p><u>How will the facility monitor its corrective actions to ensure that the deficient practice will not reoccur?</u></p> <p>. There will be random weekly audits for 4 weeks and monthly x's 3 regarding MD orders being carried out timely and being verified and addressed. Random audits will be performed for ordered supplements and the appropriate documentation. Results will be reported through the QA process with interventions as appropriate.</p> <p>The DNS or designee is responsible for this process</p>	07/17/14 <i>F325 POC accepted 7/17/14 J Hosmer RN/AMC</i>
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2014
NAME OF PROVIDER OR SUPPLIER ST JOHNSBURY HEALTH & REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1248 HOSPITAL DRIVE SAINT JOHNSBURY, VT 05819		
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F 353 SS=E	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>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.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident and family interviews, the facility failed to provide sufficient staff to provide nursing and related services for 4 of 35 residents in the sample (Residents #19, 22, 90, and 93) to maintain the highest practicable physical, mental, and psychological wellbeing. Findings include:</p> <p>1. During interviews on 6/17/14 and 6/18/14, Resident #90 reported, that s/he did not feel there is adequate staffing to assure that s/he gets the care that s/he needs. S/he reported that one day, s/he slipped down by his/her chair and could not</p>	F 353	<p><u>F 353</u></p> <p><u>How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>Resident #90, #19, #93, and #22 have had no negative outcome.</p> <p><u>How will the facility identify other residents having the potential to be affected by the same deficient practice?</u></p> <p>Residents requiring assistance with ADL's, ambulation or transfers have the potential to be affected by this alleged deficient practice.</p> <p><u>What measures will be put on place to ensure that the deficient practice will not occur</u></p> <p>The staffing pattern is reviewed daily to meet the needs of the residents. There is a half hour overlap at shift change. Several LNA's work early to help nights shift. Several LNA's work till 4pm to help with the residents at change of shift. Walking rounds are also done at each change of shift.</p> <p>Staff have been re-educated on customer service and timely responses to resident's needs.</p>	

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F 353	<p>Continued From page 11</p> <p>get up as kept slipping; s/he rang for assistance, no one showed up. Finally, s/he reported, s/he was able to pull his/her self up using furniture; the incident happened in the morning. The resident stated that s/he is fairly independent and hardly ever rings for help, so staff should know that if s/he does, it is significant. S/he stated that s/he did not report the fall to the facility and was not injured. S/he expressed concern that if something serious happened, s/he might not get a response from using the call bell. When asked why s/he did not report the fall, s/he reported that other complaints have gone unanswered in the past and thought it would do no good.</p> <p>2. During an interview on 6/16/14 at 1:39 PM, Resident #19 reported that s/he did not feel there is sufficient staffing to assure the care s/he needs in a timely manner. Resident #19 (who requires staff assistance to toilet) related that at times s/he waits too long for staff to respond to his/her call light. This has on occasion been as long as 30 minutes and resulted in an episode of incontinence during the wait.</p> <p>3. During an interview on 6/16/14 at 2:54 PM, Resident #93 reported that s/he did not feel there is sufficient staffing to assure the care s/he needs in a timely manner. Resident #93 (who is chairbound and requires staff assistance to transfer to bed or toilet) related that at mealtimes or change of shift it is hard to find staff; s/he has experienced what s/he considers significant waiting for assistance during such times.</p> <p>4. During a family interview on 6/16/14 at 3:40 PM, Resident #22's family member stated that there were not enough staff primarily on the evening shift. S/he stated that there were less</p>	F 353	<p>The Administrator will attend monthly resident council meetings to listen to Residents' concerns.</p> <p><u>How will the facility monitor its corrective actions to ensure that the deficient practice will not reoccur?</u></p> <p>. There will be random weekly audits for 3 time week. Then one time a week for 3 months Results will be reported through the QA process with interventions as appropriate.</p> <p>The DNS or designee is responsible for this process</p>	07/17/14	

F353 POC accepted 7/17/14 JHsmer RN/anal

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F 353	<p>Continued From page 12</p> <p>LNAs assigned to the unit on that shift than during the day shift, and that they were extremely busy in trying to meet the needs of the residents, and often seemed very stressed out. Resident #22 often had to wait to be transferred to bed by mechanical lift until they had time for two aides to be available as opposed to when the resident may have wanted to get into bed.</p> <p>Per interview with the Director of Nursing, there are six LNA's on the day shift and four LNA's for the evening shift assigned to each of two wings. According to census and staff information provided for the period 5/11/14-6/8/14, the census ranged from 89 to 95 residents.</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the Consultant Pharmacist failed to report any irregularities to the Physician or Director of Nurses for 1 of 23 residents in the stage 2 sample (Resident # 107). Findings include:</p>	F 353	<p><u>F 428</u></p> <p><u>How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?</u> Resident # 107 Plan of Care has been reviewed and changed as needed. The Pharmacist will conduct drug regime review for the resident affected.</p> <p><u>How will the facility identify other residents having the potential to be affected by the same deficient practice?</u> All residents who have drug allergies have the potential to be affected. All residents with drug class allergies have been reviewed and the Physicians have been notified if the documentation was not in place.</p> <p><u>What measures will be put on place to ensure that the deficient practice will not occur</u> Licensed nursing staff has been in serviced on drug allergies and the process to follow when there is a question as to whether the medication should be given or not. The Licensed Pharmacist will conduct drug regime reviews for residents potentially affected by the deficient process.</p> <p><u>How will the facility monitor its corrective actions to ensure that the deficient practice will not reoccur?</u></p>
F 42B SS=D		F 428	

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F 428	Continued From page 13 Per record review on 6/18/14 at 8:30 AM, Resident #107's clinical record indicated that h/she had an allergy to SSRI's (Selective Serotonin Reuptake Inhibitor) and that staff had been administering the SSRI Zoloft (an anti-depressant medication) since admission on 8/17/12. Review of the Medication Administration Records (MARS) show that the medication has been given daily. The Physician order for Zoloft was 100 milligrams by mouth every day. The SSRI allergy is documented on physician orders, MARS, on a condition alert sheet in clinical record and on an orange sticker on the front of resident's chart. Per interview with a Unit Registered Nurse (RN), the RN was unable to explain why the resident was receiving Zoloft despite the documented allergy. The RN was unable to find a physician's progress note or order approving administration of the SSRI medication. Per review of the nursing notes since admission, there is no documentation related to the allergy. Review of pharmacy consultant documentation back to November 2012 showed no irregularities were noted or reported to the Physician or Director of Nurses. On 6/18/14 at 11:40 AM, the Assistant Director of Nurses (ADNS) confirmed that the pharmacy consultant had not reported the above irregularities.	F 428	The Pharmacist will submit a monthly report to the DNS. An audit will be conducted drug regime review for effectiveness.. There will be random weekly audits for 2 weeks. And monthly audits x's 2. Results will be reported through the QA process with interventions as appropriate. The DNS or designee or is responsible for this process	07/17/14 <i>F428 POC accepted 7/17/14 J Thomas RN/PMC</i>	