

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

May 1, 2012

Ms. Melissa Jackson, Administrator  
Vermont Veterans Home  
325 North Street  
Bennington, VT 05201-5014

Provider #: 475032

Dear Ms. Jackson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 28, 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

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Division of  
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PRINTED: 04/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475032</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	Licensing and Protection	(X3) DATE SURVEY COMPLETED  <b>03/28/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>VERMONT VETERANS HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>325 NORTH STREET BENNINGTON, VT 05201</b>
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F 000	INITIAL COMMENTS  An unannounced on-site recertification survey and complaint investigation were conducted from 03/26/2012 to 03/28/2012. There were no regulatory deficiencies identified as a result of the complaint investigation. The following regulatory deficiencies were identified as a result of the recertification survey:	F 000	Please note that the filing of this plan of correction does not constitute any admission as to any of the alleged violations set forth in this Statement of Deficiency. The POC is being filed as evidence of the Facility's continued compliance with all applicable laws	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that meal assistance was provided in a manner to preserve the dignity of Residents that required feeding assistance. Staff were observed to be standing over Residents in the B unit dining room while assisting Residents with the evening meal on two days. This affected 10 of 13 Residents requiring significant assistance with their meal in the B unit dining room. Findings include:  1. Per staff interview and observation of meal service on 03/26/12, from 4:45 P.M. to 6:00 P.M., a table at the back of the room was noted to have four Residents positioned in large, reclining, wheeled chairs. All four required extensive feeding assistance from staff. The meal trays arrived on the unit and were delivered to the back table at 5:30 P.M. The charge nurse assisted to	F 241	<b>F241</b> <u>Corrective Action:</u> Additional seating for staff has been made available and staff is being re-educated in dining with dignity whole house.  <u>Other Residents:</u> All Residents who require feeding assistance are at risk.  <u>Systemic Changes:</u> 1) Staff are being re-educated in an interactive setting whole house on dining with dignity. All staff hired within the past year will receive 1:1 education in this subject. Dining with dignity will be added as a subject during orientation.  <u>Monitoring:</u> The DNS or designee will conduct weekly dining observations of 3 random meals, x 90 days to ensure compliance. Observation findings will be reported at the bimonthly QA Meeting  <u>Compliance Date:</u> April 22, 2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Melissa A Jackson BSW, LNA* TITLE *Administrative* (X6) DATE *4/17/12*

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.

*Amc*

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F 241	<p>Continued From page 1</p> <p>set the trays up for each Resident and encouraged them to attempt to feed themselves. Three did not. One Resident was able to sip soup from a mug, but did not attempt to use the utensils to eat from the plate. The charge nurse then began to assist the Residents to eat by feeding them. The charge nurse was observed to offer several bites to one Resident, then proceeded to the next Resident, in a clockwise rotation, providing several bites to each Resident before moving to the next. The charge nurse continued to feed the four Residents in this manner for approximately 15 minutes, until a second staff member arrived and sat down to assist two Residents. The nurse then continued to feed two of the Residents while standing over them. There were 24 residents observed in the dining room, and 13 required significant feeding assistance. Six staff members were present and assisting Residents at four tables. They were frequently observed to stop feeding Residents to assist other Residents in the dining room with various requests. At one point, two staff members left the dining room to assist a Resident, leaving four staff members in the dining room.</p> <p>During interview on 3/26/12 at 5:50 P.M., the nurse indicated that the staffing level observed in the dining room was the typical staffing pattern. Interview of the B unit Clinical Care Coordinator (CCC) on 3/26/12 at 6:00 P.M., revealed that staff were expected to sit when feeding Residents "when there are enough seats". Interview of the Administrator and the Assistant Administrator on 3/26/12 at 6:10 P.M. revealed that staff should be seated when feeding Residents. They revealed that one exception was care planned for a</p>	F 241		

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F 241	Continued From page 2 Resident seated at the back table, with a tall chair and positioning that made it difficult from a seated position. They revealed that all other Residents should be fed by staff that were seated.  2. Per staff interview and observation of the B unit dining area on 3/27/12 at 5:15 P.M., three staff members were observed to be standing and feeding Residents at three different tables. A table of three in the front, center of the dining room was being assisted by one standing staff member. A table of four in the back of the room was being assisted by one seated staff member and one standing staff member. The table of three, located in the center row, just in front of the table of four, was attended by one standing staff member. Two of them were frequently called away to meet requests of other Residents in the dining room. This observation was verified at that time by the CCC, who instructed the staff members to be seated when feeding Residents.	F 241	<b>F280</b> <u>Corrective Action:</u> Veteran #4 care plan was updated on 3/29/12 to reflect that the splints had been discontinued.  <u>Other residents:</u> Residents requiring assistive devices are at risk.  <u>Systemic Changes:</u> 1)Staff education will be performed by the staff educator and unit managers on nursing staff updating the care plan at the time the order is noted by the nurse noting the order to discontinue assistive devices and/or splints. 2)Night shift will double check the care plan has been updated when performing chart checks for orders.	
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	F 280	<u>Monitoring:</u> Monthly random audits, (Attachment ?) will be performed by Clinical Care Coordinator of 20% of new orders to ensure that orders have been carried over to the care plan. DNS will report results to Quality Assurance committee bimonthly and upon 100% compliance for 3 months, will report to the Quality Assurance Committee 2 additional quarters.  <u>Compliance Date:</u> April 22, 2012	

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F 280	<p>Continued From page 3</p> <p>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 interview and record review, the facility failed to revise the care plans to reflect a change in treatment for 1 applicable resident in Stage 2 sample. (Resident #4) Findings include:</p> <p>1. Per the staff interview at 2:54 PM on 03/26/12, staff stated Resident #4, who had a history of a CVA (stroke) with left hemiparesis (left sided weakness) resulting in a contracture, did not wear a splint or have a device for either the upper or lower limb. During the unit tour on 03/26/12 at 3:45 PM, the resident was observed without the use of arm or leg splints. Per review of the current care plan for ADLs (Activities of Daily Living), the care plan indicated limited assist with ADLs, AFO left lower leg as allowed, &amp; left wrist splint for contracture as [resident] will allow, on-AM/off-PM, check skin every 2 hours while on.</p> <p>Per interview at 11:27 AM on 03/28/12, nursing staff stated "I don't know if that has been discontinued yet for the splints but pretty sure he no longer wears them". Per interview with the PT Director at 11:40 AM, s/he stated that she believes he is using a new 'holistic-type' leg device but that should be noted in the chart. Per interview on 03/29/12 at 11:56 AM, the nursing supervisor stated "not that this is an excuse or</p>	F 280		
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F 280	Continued From page 4 anything but we haven't had a CCC [Clinical Care Coordinator] here consistently for awhile but now there is a new CCC" and found an old physician order of last year discontinuing the old arm/leg splint. At that time the nursing supervisor confirmed that the care plan has not been revised to show accurate use and/or non-use of assisted devises.	F 280	<b>F353</b> <u>Corrective Action:</u> Veteran/ member's concerns addressed with change in staff assignment. Verbalized satisfaction with the changes by Veteran/member #13. DNS or designee and Social Services will monitor Veteran/member #13's satisfaction with services and timely staff response.  <u>Other Residents:</u> All Residents are at risk.  <u>Systemic Changes:</u> All facility staff will be educated regarding response to call bells and a positive and proactive customer service approach to Veterans/members.  <u>Monitoring:</u> Staffing levels on all units are evaluated daily for staffing needs based on number of Residents and acuity. Supervisors and Scheduler have staffing levels required. On-going QIS interviews and audits of Veteran/member satisfaction in regard to call bell response and needs being met will be conducted monthly. Findings will be reviewed at the bimonthly Quality Assurance committee meeting. Random weekly call bell audits by QA x 4 weeks then biweekly until 100% compliance is demonstrated.  <u>Compliance Date:</u> April 22, 2012		
F 353 SS=E	<b>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</b>  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.  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:  Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.  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.  This REQUIREMENT is not met as evidenced by: Based on interviews and observation the facility failed to have sufficient nursing staff to provide	F 353			

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F 353	<p>Continued From page 5 .</p> <p>nursing services to meet the assessed needs of the residents, both on the nursing units and in the dining areas. The findings are as follows:</p> <p>1. Per interviews during Stage 1 of the survey process, 9 of 22 residents interviewed and 1 other resident who requested to address the survey team reported that they had to wait too long for their needs to be met. Per resident interviews, wait times varied from 10 minutes to over 1 hour. Residents further indicated that on some occasions, staff would respond to call lights, shut them off and state that they "would be back in a little while" to get what the resident needed, but didn't return. There were no reported episodes of incontinence because wait times were too long, but residents reported trying to get up unassisted while waiting. During interview with Resident #13 on 03/27/2012 at 10:28 am, s/he reported that s/he has to wait longer on the day shift for call lights to be answered.</p> <p>One resident reported during an interview on 03/27/2012 that s/he became so upset with call light response time that s/he conducted an analysis over a 60 day period to prove to administration that staff have too much to do to respond to call lights in a timely manner. The longest wait on the graphs is 40 minutes except for nights when s/he indicates that there isn't enough meaningful data based on sleeping schedules. The unit manager confirms, during interview on 03/28/2012, that staff do delay response to Resident #13 on occasion.</p> <p>In interviews, throughout the three days of survey, staff report that it is not uncommon to have to be moved to other units to cover when staff call out</p>	F 353		

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F 353	Continued From page 6 or are on administrative leave.  2. During observation of meal service on 03/26/12, from 4:45 P.M. to 6:00 P.M., a table at the back of the room was noted to have four Residents positioned in large, reclining, wheeled chairs. All four required extensive feeding assistance from staff. The meal trays arrived on the unit and were delivered to the back table at 5:30 P.M. The charge nurse assisted to set the trays up for each Resident and encouraged them to attempt to feed themselves. Three did not. One Resident was able to sip soup from a mug, but did not attempt to use the utensils to eat from the plate. The charge nurse then began to assist the Residents to eat by feeding them. The charge nurse was observed to offer several bites to one Resident, then proceeded to the next Resident, in a clockwise rotation, providing several bites to each Resident before moving to the next. The charge nurse continued to feed the four Residents in this manner for approximately 15 minutes, until a second staff member arrived and sat down to assist two Residents. The nurse then continued to feed two of the Residents while standing over them. There were 24 residents observed in the dining room, and 13 required significant feeding assistance. Six staff members were present and assisting Residents at four tables. They were frequently observed to stop feeding Residents to assist other Residents in the dining room with various requests. At one point, two staff members left the dining room to assist a Resident, leaving four staff members in the dining room.	F 353			
F 362 SS=E	483.35(b) SUFFICIENT DIETARY SUPPORT PERSONNEL	F 362			

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F 362	<p>Continued From page 7</p> <p>The facility must employ sufficient support personnel competent to carry out the functions of the dietary service.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon observation, interview, and record review, the facility failed to ensure there was adequate kitchen staff necessary to prepare and serve resident meals at appropriate times and proper temperatures. Findings include:</p> <p>1). Per interview with the Dietary Manager (DM) on 3/28/12 at 11:05 A.M. and per record review of the facility's Estimated Time for Meal Cart Arrival to Neighborhoods, the estimated arrival time for the dinner meal cart for the North unit is 5:25 P.M. Per observation on 3/27/12 the dinner meal cart for the North unit arrived at 5:49 P.M. (24 minutes later than estimated time). Per interview on 3/27/12 with 3 residents of the North unit awaiting their meals, they reported that "last night [3/26/12] the trays arrived at 10 of 6 [5:50 PM]." Per interview with the DM on 3/28/12, h/she confirmed the meal carts the 'last few days' have been 'slow going out' but that the kitchen will call units if there is to be a delay in arrival of the meal carts.</p> <p>Per observation on 3/27/12 at 5:35 P.M. a Licensed Nursing Assistant (LNA #1) on the North unit called the kitchen regarding the delay in the arrival of the meal cart and was told they were "running late, due to technical difficulties". Per interview with LNA #2 on the North unit "It happens quite often. I think it's a long time to wait.</p>	F 362	<p><b>F362</b></p> <p><u>Corrective Action:</u> The facility ensures that sufficient dietary staff is employed to carry out the functions of the dietary service.</p> <p><u>Other Residents:</u> All Residents are at risk.</p> <p><u>Systemic Changes:</u> Dietary personnel have been given and educated on their specific job tasks/responsibilities to ensure the timely delivery of meals.</p> <p><u>Other Residents:</u> All Residents are at risk.</p> <p><u>Monitoring:</u></p> <ol style="list-style-type: none"> <li>1) The Dietary Manager or designee will conduct 10 weekly audits, x 90 days, of dietary department staff to ensure they are following their job tasks/responsibilities and to identify any changes in job tasks/responsibilities necessary to improve meal service.</li> <li>2) Daily times of meal deliveries x90 days will be taken to identify any issues or concerns that prevent timely meal deliveries</li> </ol> <p>Audit results will be reviewed at bimonthly QA meetings.</p> <p><u>Compliance Date:</u> April 22, 2012</p>	

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F 362	Continued From page 8 It's always a 'technical difficulty.'" Per interview with the Assistant Kitchen Manager (AKM) on 3/28/12 at 11:20 A.M., h/she assists in assembling the meal trays for distribution to the residents, but if a resident requests an alternative menu item, h/she must leave the assembling to prepare the individual item. The AKM confirmed that when this happens, the assembly of the meals is delayed and then the departure of the meal carts to the units is delayed.  Per interview with the DM h/she is aware of concerns voiced by residents regarding late arrival of the meal carts to the units, and the delay between the cart's arrival and the time the trays are distributed. The DM stated it is Nursing and LNAs who are responsible for distributing the trays to the residents. A test tray containing the alternate menu item of a reuben sandwich and vegetable soup was requested on 3/27/12 and received at 6:14 P.M. (estimated cart arrival time was 5:25 P.M., actual arrival time was 5:49 P.M.) The temperature of the soup was observed to be 118 degrees Fahrenheit. Per interview with the DM h/she confirmed that the soup temperature "should be hotter" and that the soup leaves the kitchen at 165 degrees. The DM confirmed that delays in arrival and distribution of the trays would affect the temperature of the foods being served, but that the LNAs were instructed to microwave any food per resident request. The DM also confirmed that microwaving could alter the taste and texture of certain foods served by the facility. The DM reported that the delays in the meal cart arrivals were due to new cooks, new utility people, and closer checking due to the state survey.	F 362		
F 364	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR,	F 364		

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F 364 SS=E	<p>Continued From page 9 PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that the meals served to residents were palatable, attractive, and at the proper temperature to ensure resident satisfaction. Findings include:</p> <p>1. Per resident interviews on 3/26 &amp; 3/27/12, 13 of 22 residents [59%] in the sample group responded negatively to one or both of the questions "Does the food taste good and look appetizing?" and "Is the food served at the proper temperature?". Resident comments included "bland...tasteless...no flavor...not appetizing...poorly prepared...poorly presented" and compared the appearance of some food to vomit.</p> <p>Per interview with the Dietary Manager (DM) on 3/28/12 at 11:05 A.M., h/she confirmed food complaints in the facility are wide spread, and h/she had questions him/herself regarding the palatability of certain menu items, dictated by the system of the food supplier employed by the facility. The DM explained that the facility's current food company supplies the ingredients for each specific meal, how to cook the meals, and the menu for when and what meals are served.</p>	F 364	<p><b>F364</b> <u>Corrective Action:</u> The facility ensures that all meals are prepared to conserve nutritive value, flavor, and appearance and that food is palatable, attractive, and at the proper temperature.</p> <p><u>Other Residents:</u> All Residents are at risk.</p> <p><u>Corrective Measures:</u></p> <ol style="list-style-type: none"> <li>1) Menus are developed at the facility level to reflect the preferences of the Residents.</li> <li>2) Dietary staff has been educated on presentation, palatability, and temperature of the food served.</li> <li>3) Temperatures of the food being served at any meal will be taken at the beginning, middle, and end of the service to ensure proper temperatures are maintained.</li> </ol> <p><u>Monitoring:</u></p> <ol style="list-style-type: none"> <li>1) The Dietary Manager or designee will conduct 14 weekly random interviews x 90 days, with Residents to evaluate the appearance, palatability, and temperature of the meals being served.</li> <li>2) The Dietary Manager or Designee will conduct 10 weekly audits x 90 days, of tray temperature to ensure the</li> </ol>	

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NAME OF PROVIDER OR SUPPLIER  <b>VERMONT VETERANS HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>325 NORTH STREET BENNINGTON, VT 05201</b>	
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F 364	<p>Continued From page 10</p> <p>The system utilizes a 4 week cycle, and was implemented in 'early November' 2011 with the same menu and order of what menu items are served on what day for what meal to continue until April 1st, 2012 (approximately 5 months). Per observation on 3/27/12, 4 week menus labeled 'Fall/Winter 2011' were present on the facility's units. The DM confirmed that food concerns were brought up in the previous 3 monthly resident council meetings, and that h/she responded to the food complaints by polling "most of the residents." The DM clarified this as residents who attended a meeting in the facility's Main Dining Room and a meeting of the Resident Council. The poll asked their favorite foods and disliked items. The DM stated h/she was investigating a new food supplier, and planning a new menu based on the resident poll, but arrangements were not yet made regarding a new supplier, and the new menu was still being developed.</p> <p>2. Per interview with the Dietary Manager (DM) on 3/28/12 at 11:05 A.M. and per record review of the facility's Estimated Time for Meal Cart Arrival to Neighborhoods, the estimated arrival time for the dinner meal cart for the North unit is 5:25 P.M. Per observation on 3/27/12 the dinner meal cart for the North unit arrived at 5:49 P.M. (24 minutes later than estimated time). Per interview on 3/27/12 with 3 residents of the North unit awaiting their meals, they reported that "last night [3/26/12] the trays arrived at 10 of 6 [5:50 PM]." Per interview with the DM on 3/28/12, h/she confirmed the meal carts the 'last few days' have been 'slow going out' but that the kitchen will call units if there is to be a delay in arrival of the meal carts.</p>	F 364	<p>food is maintaining proper temperature when served to the Resident.</p> <p>All audit results will be reviewed at the bimonthly QA meeting.</p> <p><u>Compliance Date:</u> April 22, 2012</p>	

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F 364	Continued From page 11  Per observation on 3/27/12 at 5:35 P.M. a Licensed Nursing Assistant (LNA #1) on the North unit called the kitchen regarding the delay in the arrival of the meal cart and was told they were "running late, due to technical difficulties". Per interview with LNA #2 on the North unit "It happens quite often. I think it's a long time to wait. It's always a 'technical difficulty'." Per interview with the Assistant Kitchen Manager (AKM) on 3/28/12 at 11:20 A.M., h/she assists in assembling the meal trays for distribution to the residents, but if a resident requests an alternative menu item, h/she must leave the assembling to prepare the individual item. The AKM confirmed that when this happens, the assembly of the meals is delayed and then the departure of the meal carts to the units is delayed.  Per interview with the DM h/she is aware of concerns voiced by residents regarding late arrival of the meal carts to the units, and the delay between the cart's arrival and the time the trays are distributed. The DM stated it is Nursing and LNAs who are responsible for distributing the trays to the residents. A test tray containing the alternate menu item of a reuben sandwich and vegetable soup was requested on 3/27/12 and received at 6:14 P.M. (estimated cart arrival time was 5:25 P.M., actual arrival time was 5:49 P.M.) The temperature of the soup was observed to be 118 degrees Fahrenheit. Per interview with the DM h/she confirmed that the soup temperature "should be hotter" and that the soup leaves the kitchen at 165 degrees. The DM confirmed that delays in arrival and distribution of the trays would affect the temperature of the foods being served, but that the LNAs were instructed to microwave	F 364		

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F 364	Continued From page 12 any food per resident request. The DM also confirmed that microwaving could alter the taste and texture of certain foods served by the facility. The DM reported that the delays in the meal cart arrivals were due to new cooks, new utility people, and closer checking due to the state survey.	F 364		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based upon observation and staff interview, the facility failed to ensure that food was properly labeled, dated, and stored to prevent food borne illness. Findings include:  1. Per observation of the facility's walk-in refrigerator on 3/26/12 at 11:04 A.M., a metal storage container holding undated strawberries with visible mold on them was observed. Additionally, there was also a metal storage container holding undated limes with visible gray, soft areas indicating rotting.  Per interview with the Dietary Manager (DM), h/she confirmed both containers should have	F 371	<b>F371</b> <u>Corrective Action:</u> The facility ensures that all food is procured, stored, serviced in a sanitary manner.  <u>Corrective Measures:</u> 1) All Dietary staff has been educated on proper labeling and dating and disposing of food. 2) All Dietary Staff have been educated on proper labeling of received and open dates for all food products.  <u>Monitoring:</u> The Dietary Manager of Designee will conduct daily audits, x 90 days of the food storage areas to ensure proper labeling, dating, and disposal of food is taking place. Audit results will be reviewed at bimonthly QA meetings.  <u>Compliance Date:</u> April 22, 2012	

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F 371	Continued From page 13 been dated and the items within 'should have been thrown out'. A container of diced pears with the date '3/17' was observed and per the DM, the fruit was good for 7 days (3/24) and should have been thrown out 2 days prior. The DM stated it was the facility's policy to mark on the container when the item was received, and again mark the date when the item was opened or first used. During a tour of the kitchen food preparation area, 2 open one gallon containers, one containing sugar free syrup with a received date of 11/24/11, the other Worcestershire sauce dated only '9/7', had no 'opened on' dates. The DM confirmed that both opened containers lacked the 'opened on' dates and therefore it was not possible to know if their contents were still usable or not, and "should be thrown out". Another opened gallon container of Catalina salad dressing had an 'opened on' date of 1/26/12. Per interview with the DM, the dressing was 'good for 4 weeks' after opening, and should have been discarded on 2/26/12.  Per interview on 3/28/12 at 11:04 A.M., the DM confirmed h/she and the kitchen staff did not know the expiration timelines for the various dry goods and perishable items used by the facility's kitchen, and that there was no facility policy regarding such. The DM confirmed that the facility policy of dating containers with a 'received' and 'opened on' date was not implemented consistently, and stated h/she had printed out FDA guidelines for food storage and would post them in the facility's kitchen, and had planned an in-service for the kitchen staff to educate them on the material, but had not done so yet.	F 371			
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428			

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F 428	<p>Continued From page 14</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 observation, record review and staff interviews the facility failed to assure that monthly pharmacy reviews were present and readily available in the records of residents in the Stage 2 sample (including but not limited to Residents #157 and #167). The facility also failed to act on pharmacy recommendations for 2 residents in the targeted sample. (Residents #90 &amp; #138) Findings include:</p> <p>1. During the Stage 2 survey, surveyors did not find evidence of pharmacy review in the records of multiple Stage 2 residents. In interview on 03/27/2012 at 2:45 PM the Director of Nursing Services and the Administrator stated that the Registered Pharmacist attends Bi-weekly Meetings with the Medical Director, themselves, and the Clinical Care Coordinators for each unit to review the medication regimes. On these days the Pharmacist also reviews the medication regimes for individual residents. The Pharmacist has created a website where the facility can view the results of these reviews and the</p>	F 428	<p><b>F428</b> <u>Corrective Action:</u> All pharmacy reviews assembled and made available to all staff on 3/28/2012. Record review was performed to assure all recommendations over the previous 6 months were addressed.</p> <p><u>Other Residents:</u> All residents are at risk.</p> <p><u>Systemic Changes:</u> Consulting Pharmacist created a quick view report generated monthly with Veteran/members last date of review, assuring a review within the last 30 days. The Consulting Pharmacist generates a comprehensive report monthly for each unit of all reviews. This report will be saved onto the facility shared drive in a designated protected folder. The Clinical Care Coordinators of each unit will access and print reports for their respective units, maintain a binder of reviews for easy access and assure follow up of any reviews requiring action.</p> <p><u>Monitoring:</u> The Pharmacy IDT will review all the recommendations within the month to assure that each recommendation has been followed up and acted upon. Pharmacy IDT will track findings and will report to bimonthly Quality Assurance Meeting.</p> <p><u>Compliance Date:</u> April 22, 2012</p>	
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F 428	<p>Continued From page 15</p> <p>recommendations. The facility physician liaison then prints out the reviews which are sent to the physician and copies are sent to each unit to be filed in resident records.</p> <p>When this surveyor informed them that medication reviews were not found in most records, they stated that the physician liaison, who was an RN (Registered Nurse), is presently on leave and that the current replacement liaison is not a nurse and is new to the temporary position. Per interview with the facility's Medical Director (MD) and a RN on the North unit on 3/28/12 at 10:00 A.M., the facility was in 'evolution' of its' Pharmacy Review process. The present process consisted of the Pharmacist entering his recommendations on the computer and the physician's to review and respond to the recommendations. These responses were processed by a RN specifically designated for the task. All the processed recommendations were to be filed in a binder on each nursing unit, with the recommendations requiring no action to remain in the binder, and a copy of all Pharmacist recommendations and Physician responses requiring action to be filed in each resident's medical chart to be acted upon by the nursing staff.</p> <p>Per interview the facility's MD and RN from the North unit confirmed there were no Pharmacist Recommendations and Physician responses filed in either Resident #157 or Resident #167's chart. The MD confirmed both residents had Pharmacist recommendations with Physician recommendations that should have been filed in the residents' charts but were not. Per record review, the North unit's binder which per the</p>	F 428	<p><i>F241, F280, F353, F362, F364, F371 + F428 POX'S accepted 4/26/12 M. Higgins RN / Amata RN</i></p>	

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F 428	<p>Continued From page 16</p> <p>facility's MD should have contained all Pharmacist's recommendations regardless if they required action or not for Residents #157 and #167, were absent of any Pharmacist review/recommendations for the months of 8/2011 thru 12/2012. Per interview with the facility's MD, Pharmacist Recommendations and the Physicians' responses were to be emailed and processed by the RN specifically designated, but that h/she was no longer working at the facility and the position had been absent for approximately 6 weeks.</p> <p>2. Per record review on 03/28/12, The facility failed to act upon pharmacy recommendations for 2 applicable residents.</p> <p>a) Per review on 03/28/12 of Resident #138's pharmacy reviews, one review was not acted upon until 3 months later and one review still has no response. The 11/13/11 pharmacy review recommends a 'Lipitor conversion' and the physician agreed on 02/06/12. A pharmacy review of 02/15/12 states "the resident continues with a clinically complex drug regimen, could a interdisciplinary meeting (IDT) be arranged to review this resident's medical record?"</p> <p>Per interview on 03/28/12 at 2:03 PM, the clinical care coordinator (CCC) and Nursing Supervisor stated that the normal process would be that the liaison would contact or send notice to the physician of the pharmacy's recommendation and set up the agenda for the IDT meetings which are held the first and third Wednesdays of the month. They acknowledged that here was a change in personnel "and we're trying to catch up and work</p>	F 428		

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F 428	Continued From page 17 out the bugs, but the expectation would be response within a month". They confirmed at that time that the pharmacy reviews were not acted upon.  b) Resident #90's MAR indicates that the resident has received PRN (as needed) Pyridium for urinary burning twice in the last 4 months 10/24/11 & 12/07/12. A pharmacy review dated 10/19/11 states "nursing- review PRN use and administration of Pyridium with MD". There is no evidence that nursing staff spoke to the the physician during the monthly visits on 11/17/11, 12/2/11, 01/2/12, 03/05/12. Per interview on 03/28/12 at 3:15 PM, the (CCC) stated that the physician would've written whether or not there was to be a change in the medication regime, in the progress notes. Additionally s/he would expect to find documentation in the nursing note of the conversation with the physician. The CCC confirmed at that time that the facility failed to act upon the pharmacy review recommendations.	F 428		