



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
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Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

July 21, 2010

Ms. Devida Deluca, Administrator
Living Well A Community Care Home
71 Maple Street
Bristol, VT 05443

Dear Ms. Deluca:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **May 25, 2010**. 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,

A handwritten signature in black ink that reads "Pamela M. Cota, RN". The signature is cursive and fluid.

Pamela M. Cota, RN
Licensing Chief



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0543	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/25/2010
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NAME OF PROVIDER OR SUPPLIER LIVING WELL A COMMUNITY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 71 MAPLE STREET BRISTOL, VT 05443
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(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) COMPLETE DATE
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R100 Initial Comments:

An unannounced on-site visit to investigate 3 complaints was initiated on 5/13/10 and completed on 5/25/10. The following regulatory violations were found.

R126 V. RESIDENT CARE AND HOME SERVICES
SS=G

5.5 General Care

5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to provide necessary services to meet each resident's nursing and medical care needs for 5 of 10 residents in the applicable sample. (Residents # 5, 7, 8, 9 & 10) Findings include:

1. Per record review on 5/14/10 and 5/24/10, staff failed to inform the physician of on-going symptoms of a possible respiratory infection for Resident #5 and the resident was subsequently admitted to the hospital for treatment of a respiratory infection. Progress notes for the resident dated 3/21/10 described "not feeling well at all, congested, throat still scratchy...hoarse..back to bed..ate very little". The next progress note dated 3/25/10 stated "still has a nasty cough, slept in the chair all night..Blood Pressure B/P high at

Action:
ACTION

Change:

→ Administrator reviewed details of the survey with Home Nurse (HN) and Client Care Coordinator (CCC) and specifically this deficiency.

→ Both HN and CCC understand they must report symptoms to PCP both orally & written in a timely manner

6/1/10

6/1/10

Division of Licensing and Protection

Al DeLuca

TITLE Administrator (X6) DATE

7/7/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

VZOJ11

If continuation sheet 1 of 25

Division of Licensing and Protection

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R126	<p>Continued From page 1</p> <p>180/86....seems so exhausted". A note from 3/27/10 stated "still not feeling well, exhausted...depressed about being sick so long..". Another note from later on 3/27/10 at 1 PM stated "still discouraged about being sick for a week..". At 1400 (2 PM), the same day the resident complained about feeling dizzy and was transported to the Emergency Room for evaluation and subsequently admitted to the hospital for treatment of a respiratory infection. The failure to provide timely physician notification of the resident's symptoms was confirmed with the RN on the afternoon of 5/25/10.</p> <p>2. Per record review on 5/14/10 and 5/24/10, Resident #5, who had orders for twice daily medication to treat gastric secretions (Nexium), did not receive this medication as ordered due to it being "out of stock" for a total of 9 days (from 5/3/10 - 5/11/10). During interview on the afternoon of 5/24/10, the clinical manager confirmed that although the medication was unavailable, she had not notified the physician to see if another medication could be used in the interim. A progress note of 5/11/10 stated "not feeling well...stomach hurting, out of (medication)".</p> <p>a. Per record review on 5/14/10, a progress note dated 4/17/10 for Resident #5 indicated that the resident "wasn't feeling well again" and had a "low grade fever this AM" and staff failed to record the fever in the note or on the Vital Signs Flow Sheet and there was no evidence of follow temperatures taken.</p> <p>b. Per record review on 5/14/10, Resident #5 had physician orders for a daily antihypertensive medication which stated to "hold if B/P <90 or pulse <50. Per review of the Vital Signs Sheets</p>	R126	<p><u>Monitor</u> → HN and CCC monitor residents daily. ongoing</p> <p><u>Action</u> → Administrator reviewed this deficiency with Clinical Manager (CM) 6/1/10</p> <p><u>Changes</u> → CM understands a written notice to RP of "out of stock" med and request for substitution is required. 6/1/10</p> <p><u>Monitor</u> → HN reviews resident records weekly. HN meets with CM weekly ongoing</p> <p><u>Action</u> → Administrator reviewed this deficiency with HN 6/1/10</p> <p><u>Changes</u> → HN reviewed proper temp/fever charting and follow-up with staff. 6/1/10</p> <p><u>Monitor</u> → HN reviews resident records weekly ongoing</p> <p><u>Action</u> → Administrator reviewed this deficiency with HN and CM 6/24/10</p>

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R126	<p>Continued From page 2</p> <p>for March and April, 2010, there were a total of 9 days that did not include any documentation regarding the resident's B/P and pulse. This was confirmed with the RN and the Clinical Manager at 4 PM the same day.</p> <p>3. Per closed record review and confirmed during a telephone interview with a family member on 5/27/10 at 1:20 PM, Resident #7 experienced multiple falls while living at the home and staff failed to document notification to family of falls on 3/16/10, 4/9/10, and 4/10/10. The resident was admitted to the hospital after the 4/11/10 fall for evaluation for the 3rd fall in 3 days. In addition, a family member stated that a nurse at the hospital informed her that the resident arrived from the facility in an unclean state, without evidence of recent personal hygiene. The resident's RCH admission assessment dated 2/9/09 coded him as requiring extensive assist of 1 staff with bathing.</p> <p>4. Per record review and confirmed during staff interview on 5/24/10, Resident #9, who was not assessed to be responsible by the RN, was allowed to take another dependent resident on unsupervised outings away from the home on 3 occasions. Progress notes dated 5/20/10, 5/22/10 and 5/23/10 stated "— took — (Resident #10) for a walk". This was confirmed with the RN and the Clinical Manager on the afternoon of 5/25/10.</p>	R126	<p><u>Changes</u> → H/N and CM understand VITALS need to be recorded at time and are administered + have reviewed with staff. 6/29/10</p> <p><u>Monitoring</u> → H/N reviews VITALS weekly, ongoing</p> <p><u>Action</u> → Administrator reviewed this deficiency with H/N and CM 6/29/10</p> <p><u>Changes</u> → H/N has reviewed falls policy with staff, stress requirement to always complete written report AND a post fall analysis. Also, staff understand written documentation of resident non-compliance as records personal care is absolutely necessary. 6/29/10</p> <p><u>Monitoring</u> → H/N reviews resident documentation weekly ongoing</p> <p><u>Action</u> → Administrator reviewed this deficiency with H/N + CM 6/11/10</p> <p><u>Change</u> → Residents are no longer allowed to be with another resident without staff supervision 6/11/10</p>
R128 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.5 General Care</p> <p>5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders.</p>	R128	<p><u>Monitoring</u> → All staff understand they must be present when residents who are unresponsive leave the building. RN, CM + Administrator monitor for compliance. ongoing</p> <p>R126 - POC Accepted 7/19/10 [Signature]</p>

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R128	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that each resident's medications were consistent with physician orders for 2 of 8 applicable records in the sample. (Resident #2) Findings include: 1. Per record review on 5/14/10, Resident #2's current signed physician orders for an antihypertensive (Benicar) dated 2/22/10 did not match the dose on the May, 2010 Medication Administration Record (MAR). The resident was admitted on 2/20/10 without original signed and dated physician orders for medications. A medication list was provided upon admission that listed Benicar 40 mg. daily, and that was what was listed on the current MAR (May). The signed physician orders in the medical record dated 2/22/10 state Benicar 40 mg tablet - 1 PO BID (twice daily). This discrepancy had not been resolved as of 5/25/10. 2. Per record review on 5/14/10, Resident #4's MAR is incompletely transcribed regarding physician orders for sliding scale insulin; there are no times stated for checking of BS and drawing up sliding scale insulin as needed per orders. This was confirmed with the RN on 5/25/10 at 3:45 PM.	R128	6/29/10 <u>Action</u> → Administrator reviewed details of this deficiency with CCC (CM) <u>Change</u> → CM understands signed orders from physicians must match MARS. This discrepancy corrected on 6/14/10 also, Neuroform by used since 5/25/10 as per CM and study nurse agreement. <u>Monitor</u> → HN directed must recent office visit form signed & dated by physician placed just in front of each resident's MAR. HN reviews weekly ongoing <u>Action</u> → Administrator reviewed this deficiency with HN + CM. 7/7/10 <u>Change</u> → MAR now includes times for check BS. 6/1/10
R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a	R136	<u>Monitor</u> → HN + CM review MARS weekly and FAX physician weekly BS for sliding scale client. R128 on going POL Accepted 7/19/10 [Signature] RN

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R136	Continued From page 4 change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the 1 of 9 applicable residents in the sample was not reassessed after a change in physical functioning. (Resident #4) Findings include: Per record review on 5/25/10, Resident #4's most recent assessment dated 7/27/09, did not accurately reflect the resident's current levels of physical functioning. The resident was coded as needing extensive assist of 1 staff for mobility and unable to self transfer. Per observation on 5/24/10 and confirmed during interview with the RN at 2:45 PM, the resident has improved and now is able to ambulate independently with a walker and can self transfer.	R136	<u>Action</u> → Administrator reviewed this deficiency with HN. 7/7/10 <u>Change</u> → HN understands improvements as well as declines require reassessment. 7/7/10 <u>Monitor</u> → Administrator to monitor for compliance. ongoing R136 POC Accepted 7/19/10 AMCATARN	
R144 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c.(1) Complete an assessment of the resident in accordance with section 5.7; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the nurse failed to reassess 1 of 9 applicable residents in the sample who developed new issues after admission. (Resident #3) Findings include: Per record review and staff interview, Resident #3	R144	<u>Action</u> → Survey nurse reviewed this deficiency with HN and Administrator. 5/25/10 <u>Change</u> → HN amended assessment and care plan. 6/1/10 <u>Monitor</u> → Administrator to monitor for compliance ongoing	

Division of Licensing and Protection
STATE FORM

6899

R144
V2011

If continuation sheet 5 of 25

POC Accepted 7/19/10 AMCATARN

Division of Licensing and Protection

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R144: Continued From page 5
developed problems with constipation and socially inappropriate behaviors, first noted in the progress note of 3/5/10. As of 5/14/10, there was no reassessment by the RN nor care plan developed to address these on-going needs. This was confirmed with the RN on the afternoon of 5/25/10. Refer also to R145

R144

R145 V. RESIDENT CARE AND HOME SERVICES
SS=D
5.9.c (2)
Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being;
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the RN failed to assure that the care plans for 3 of 9 residents in the total sample addressed all of the resident's identified needs. (Residents #4, 2 & 3)
) Findings include:
1. Per record review on 5/14/10, Resident #4's care plan did not include interventions regarding monitoring for symptoms of high or low blood sugars, nor monitoring for bleeding risk due to use of an anticoagulant medication daily, and common adverse side effects of psychotropic medications.
2. Per record review on 5/14/10, Resident #2's care plan did not address symptoms/risks of hypo/hyper glycemia and the history of and risk for falls due to a medical condition.
These issues were confirmed with the RN on

R145

Action → Survey Nurse + Administrator reviewed this deficiency with HN + CM. 5/25/10

Changes → RN to update all care plans + bring into compliance 7/30/10

Monitor → Administrator monitors for compliance on going.
R145
POC Accepted 7/19/10 DM Cotar RN

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R145	Continued From page 6 5/25/10 at 3:30 PM. 3. Per record review on 5/14/10, Resident #3's care plan did not address the following issues: monitoring for side effects of psychotropic medications, occasional incontinence, and socially inappropriate behaviors. These concerns were confirmed with the RN on 5/25/10 at 3:30 PM. Refer also to R144	R145		
R147 SS=C	V. RESIDENT CARE AND HOME SERVICES 5.9.c (4) Maintain a current list for review by staff and physician of all residents' medications. The list shall include: resident's name; medications; date medication ordered; dosage and frequency of administration; and likely side effects to monitor. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility RN failed to assure that each resident had a complete current list of medications, with the required elements included, for staff and physician review. (Residents #1-9) Findings include: Per reviews throught the 4 days of survey (5/13/10-5/14/10 & 5/24/10-5/25/10), the medical record physician orders were not systematically organized and periodically updated and signed and dated by the physician as required. Review of physician orders for Residents #1 - 9 revealed of out sequence by date orders as well as unsigned lists of 'current medications' with no recent physician signatures. During interviews with the manager and the RN on the afternoons of	R147	<i>Action</i> → Administrator reviewed this deficy with HN + CM. 7/7/10 <i>Changes</i> → CM and Sur. Nurse designed a new doctor visit form which meet 5 regulatory requirement. There is a separate binder with all meds and their likely side effects. ongoing <i>Monitor</i> → RN to monitor for compliance ongoing R147 POC Accepted 7/19/10 P. M. RN	

Division of Licensing and Protection

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R147	Continued From page 7 5/14/10 and 5/25/10, the lack of signed and dated current physician orders was confirmed.	R147		
R150 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (7) Assure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the nurse failed to assure that staff recorded all accidents at the time of their occurrence and included the action taken for 2 of 8 applicable residents reviewed. (Resident #2 & 6) Findings include: 1. Per reviews on the 5/14/10 and 5/24/10, an incident report dated 3/12/10 at 2 PM stated that Resident #2 fell in his/her room and was found lying beside the bed. The left ankle was noted to be swollen. There was no progress note in the medical record regarding this accidental fall and there was no evidence that the resident's physician and guardian had been notified. This was confirmed with the RN Consultant and the Clinical Coordinator during interviews on 5/24/10. 2. Per record review on 5/25/10, Resident #6 had 2 choking episodes during breakfast on 8/1/09 and also vomited. The progress note dated 8/1/09 stated "blue in the face and unable to breathe at all - I turned him around and did the Heimlich and cleared his airway." There was no evidence that the physician or RN were notified. There were no follow up progress notes until	R150		

Action → Administrator reviewed this deficy with RN. 7/7/10

Changes → RN understands accidents require: ① incident report ② notify PCP/guardian ③ notation in medical notes. RN to review @ next LW Staff meety on 7/14/10

Monitor → Administrator to monitor for compliance. ongoing

Action → Administrator reviewed deficy with RN 7/9/10

Changes → RN to review @ staff necessary areas of symptoms, signs of illness or accident as well as notification to RN on PCP.

Division of Licensing and Protection

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R150	Continued From page 8 8/22/09.	R150	<i>Monitoring → Administrator to monitor for compliance. ongoing</i> R150 POC Accepted 7/19/10 Amstar RN	
R160 SS=A	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.a Each residential care home must have written policies and procedures describing the home's medication management practices. The policies must cover at least the following: (1) Level III homes must provide medication management under the supervision of a licensed nurse. Level IV homes must determine whether the home is capable of and willing to provide assistance with medications and/or administration of medications as provided under these regulations. Residents must be fully informed of the home's policy prior to admission. (2) Who provides the professional nursing delegation if the home administers medications to residents unable to self-administer and how the process of delegation is to be carried out in the home. (3) Qualifications of the staff who will be managing medications or administering medications and the home's process for nursing supervision of the staff. (4) How medications shall be obtained for residents including choices of pharmacies. (5) Procedures for documentation of medication administration. (6) Procedures for disposing of outdated or unused medication, including designation of a person or persons with responsibility for disposal. (7) Procedures for monitoring side effects of psychoactive medications. This REQUIREMENT is not met as evidenced	R160		

Division of Licensing and Protection

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R160	Continued From page 9 by: Based on staff interview and record review, the facility failed to have a policy for monitoring for side effects of psychoactive medications affecting 7 of 9 residents reviewed. (Residents #1-6 & 9) Findings include: Per review of the facility's policies regarding medication management, there was no policy to direct staff in the monitoring of side effects for psychoactive medications. Of the 9 resident medication regimes reviewed, 7 received regular or as needed (PRN) psychotropic medications. There were no potential adverse side effects listed in the PRN psychoactive medication plans or MARs nor were any DISCUS/AIMS tests being done as appropriate to detect possible Tardive Dyskinesia or other undesired effects. This was confirmed during interview with the RN on 5/25/10 at 3:45 PM.	R160	<u>Action</u> → Administrator reviewed this deficiency with RN + CM. 7/7/10 <u>Changes</u> → Administrator, RN + CM to create policy for monitoring side effects of psychoactive meds. 8/30/10 <u>Monitor</u> → Administrator to monitor for compliance ongoing	
R161 SS=C	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.b The manager of the home is responsible for ensuring that all medications are handled according to the home's policies and that designated staff are fully trained in the policies and procedures. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the manager of the home failed to assure that all medications were handled properly and that all staff administering or drawing up injectable medications for 1 applicable resident, had evidence of training in the procedures.	R161	R160 PDC accepted 7/19/10 from RN	

Division of Licensing and Protection

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R161	Continued From page 10 (Resident #4) Findings include: Per observation on 5/14/10 at 11:50 AM, Caregiver #1 drew up 12 units of Novolin N-100 (a type of insulin) for Resident #4 to self administer, per physician's sliding scale orders. Based on a review of the list of RN insulin trained and delegated staff at 2:45 PM the same day, Caregiver #1 had no documented training to administer/draw up insulin. This was confirmed with the Clinical Manager and the RN at the time. Refer also to R168	R161	<u>Action</u> → Administrator reviewed this deficiency with RN + CM 7/7/10 <u>Changes</u> → RN has documented training for all med certified staff to administer draw up insulin ongoing <u>Monitor</u> → Administrator to monitor for compliance. ongoing... R161 POC accepted 7/19/10 DMCO RN	
R162 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that all medications administered by staff have signed and dated physician orders and supporting diagnosis or problem statement in the record. (Residents #1 - 9) Findings include: 1. Per record review on 5/14/10, for Residents #1 - 9, the facility had copies of 'standing orders' from a naturopathic doctor and there were no individual orders in each resident's record and there was no evidence that residents and/or their primary physicians were aware of, or agreed with, the potential use of these remedies. The orders	R162	<u>Action</u> → Administrator reviewed this deficiency with RN + CM 7/7/10 <u>Changes</u> → CM to obtain individual orders for all residents by 8/30/10 → <u>Monitor</u> → RN to monitor for compliance ongoing	

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0543	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/25/2010	
NAME OF PROVIDER OR SUPPLIER LIVING WELL A COMMUNITY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 71 MAPLE STREET BRISTOL, VT 05443		
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R162	<p>Continued From page 11</p> <p>included topical treatments for fungal nails, elderberry syrup for boosting of immune system and symptoms of common cold, propolis spray at first signs of sore throat and wild cherry bark syrup as directed for cough or expectorant. Supplement orders included whey to put in smoothies and Goatein to put in smoothies. When the Operations Manager, who is in charge of food service was asked if resident are aware of the use of the supplements, she indicated that they were not. The supplements were used to boost protein. The orders, one dated 11/21/08 stated "order stands for all residents with toe or fingernail fungus, no date.."house order for cough/cold symptoms", no date.."supplement order for residents". This was confirmed with the manager and the administrator on the morning of 5/25/10.</p> <p>2. Per review on 5/14/10, the MAY 2010 MAR for Resident #5 stated the give APAP (acetaminophen) 325 mg., 2 tabs PO QID PRN pain and the most recent physician order in the medical record dated 10/20/09 stated Tylenol 325, 2 tabs PO BID-TID PRN pain.</p> <p>3. Per record review on 5/14/10, Resident #2 was admitted to the home without current signed, dated physician orders. During interview the manager showed the surveyor a list of the resident's medications that had accompanied her home from a recent hospital stay. There was no physician dated signature on the form. Per review, the facility's Admission Policy states newly admitted residents or legal representatives must provide "an original script of all medications routine or as needed." The lack of complete admission orders was confirmed with the RN and the manager at 2:45 PM the same day.</p>	R162	<p><u>Action</u> → Administrator reviewed defing with RN and CM 7/7/10</p> <p><u>Changes</u> → CM to update MAR day new med arrives. ongoing</p> <p><u>Monity</u> → RN monitors for compliance ongoing</p> <p><u>Action</u> → Administrator reviewed defing with RN and CM 7/7/10</p> <p><u>Changes</u> → CM understands all admission/readmission orders <u>MUST</u> be signed on goy</p> <p><u>Monity</u> → RN monitors for compliance ongoing</p>	

Division of Licensing and Protection
STATE FORM

6889 VZOJ11

If continuation sheet 12 of 25

R162
POC Accepted 7/19/10 Administrator

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0543	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/25/2010
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R165 SS=F	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.10 Medication Management</p> <p>5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:</p> <p>(3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for:</p> <ul style="list-style-type: none"> i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects; ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications; iii. Assessing the resident's condition and the need for any changes in medications; and Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions. <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the registered nurse failed to assure that all staff administering medications received teaching in potential adverse side effects of all medications being administered and failed to provide monitoring and evaluation of the designated staff performance in carrying out the nurse's instructions. (Resident #8) Findings include:</p> <p>1. Per interviews with the RN regarding staff teaching in medication administration on 5/14/10 at 2:45 PM and 5/24/10 at 3:30 PM, the RN confirmed that she had not included a return</p>	R165		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0543	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/25/2010
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R165	Continued From page 13 demonstration of medication administration with staff prior to delegated them as "cleared" for medication administration. Per record review on 5/14/10, the RN certified Staff #2 as of 5/6/10, yet also confirmed during interview at 2:45 PM that she still required supervision for administering medications. (Staff #2 worked the overnight 10:45 PM - 7 AM shift alone.) A review of the medication delegation forms revealed that current staff had been medication certified (delegated) by the RN between the dates of 11/07 to 5/18/10. Three current caregivers who were listed as medication certified each told the surveyor that the RN had not required them to demonstrate their competence of the task. The interviews included Staff #1 on 5/14/10 at 11:50 AM, Staff #3 on 5/24/10 at 4:55 PM, and Staff #4 on 5/25/10 at 3:15 PM. All 3 staff stated, and the RN confirmed, (5/14/10 at 2:45 PM) that neither completion of a written test, nor a return demonstration, was required prior to being certified to administer medication to residents of the home. Regulations require that the RN "monitor and evaluate the designated staff performance in carrying out the nurse's instructions. The facility policy "Staff Training for Health-Related Services" states regarding medication assistance training, (3) "The RN should conduct an annual review and retraining for all employees responsible for medication assistance" (administration). There were no records of any yearly evaluations and retraining for staff and the RN confirmed that this was not being done during interview on 5/24/10 at 2:30 PM. Refer also to R.N. 2. Per review of a closed record on 5/24/10, Resident # 8 was administered another resident's physician ordered medications in error on 9/22/09. During a telephone interview on 5/24/10 at 12 PM, former staff member (#5) stated that	R165	<u>Action</u> : Administrator reviewed deficiency with RN 7/7/10 <u>Changes</u> : Med Certification now includes: ① written test ② return demonstration ③ annual evaluation and re-training ongoing <u>Monitoring</u> : Administrator to monitor for compliance ongoing R165 POC accepted 7/19/10 from RN See above for ? Action Changes, Monitoring	
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Division of Licensing and Protection

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R165	Continued From page 14 she had received some training in medication administration although she was not required to demonstrate competency in the tasks, nor was competency testing done annually. She said that she had worked at the home for more that 1 year.	R165		
R168 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (6) Insulin. Staff other than a nurse may administer insulin injections only when: i. The diabetic resident's condition and medication regimen is considered stable by the registered nurse who is responsible for delegating the administration; and ii. The designated staff to administer insulin to the resident have received additional training in the administration of insulin, including return demonstration, and the registered nurse has deemed them competent and documented that assessment; and iii. The registered nurse monitors the resident's condition regularly and is available when changes in condition or medication might occur. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the RN failed to assure that staff administering/drawing up insulin medication received the required training and failed to assure	R168		

Division of Licensing and Protection

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R168	<p>Continued From page 15</p> <p>that 1 of 2 residents whose insulin was drawn up by staff was medically stable. (Resident #4) Findings include:</p> <p>Per observation on 5/14/10 at 11:50 AM, Staff #1 drew up regular insulin per physician's sliding scale order for blood sugar values for Resident #4 without written evidence of the required additional training per state regulations. Although the staff correctly drew up the ordered amount, there was no record of the training provided to her for insulin administration. When she was asked if she received training from the RN, she stated that she thought she had, but wasn't sure when and she stated that she was not required to take a written test or do a return demonstration of the skill. During a review of the medication certification forms with the RN and Clinical Manager, only 1 staff member was certified for insulin administration (Staff #3). The RN confirmed she had no evidence of training for insulin administration for the other staff who routinely draw up this medication for the resident to self administer. She had not completed additional training as required, including return demonstration. This was verified with Staff #3 at 4:55 PM on 5/24/10 and Staff #4 at 3:15 PM on 5/25/10.</p> <p>In addition, Resident #4's medication regime was not stable. The resident has been on changing sliding scale insulin orders since before July of 2009. Recently, orders were changed on 4/8/10, 4/23/10 and 5/13/10, due to "noted high blood sugars" per physician note during a visit 5/13/10. Per review of the flow sheets, during April blood sugars measured by FS (finger stick) were over 300, 22 times; 2 times FS were over 400. During May, 2010, FS measured over 300 a total of 13 times; over 400, 1 time.</p>	R168	<p><u>Action</u> → Administrator reviewed deficiency with RN. 7/7/10</p> <p><u>Changes</u> → Insulin Med certification now includes: (1) written test (2) return demonstration (3) annual evaluation and retraining ongoing</p> <p><u>Monitoring</u> → Administrator to monitor for compliance. ongoing</p> <p><u>Action</u> → Administrator reviewed defcy with RN + CM 7/7/10</p> <p><u>Changes</u> → CM to request a post on MARS guidelines for BS fluctuations 7/30/10</p> <p><u>Monitoring</u> → RN to monitor for compliance ongoing</p>	

Division of Licensing and Protection
STATE FORM

0999 2011
 If continuation sheet 16 of 25
 R168
 POC Accepted 7/19/10 [Signature]

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0543	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/25/2010
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R171 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.10 Medication Management</p> <p>5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include:</p> <p>(1) Documentation that medications were administered as ordered;</p> <p>(2) All instances of refusal of medications, including the reason why and the actions taken by the home;</p> <p>(3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect;</p> <p>(4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and</p> <p>(5) For residents receiving psychoactive medications, a record of monitoring for side effects.</p> <p>(6) All incidents of medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that there was a evidence of monitoring of for side effects of psychoactive medications for 1 of 9 residents in the total sample. (Resident #9) Findings include:</p> <p>Per record review on 5/24/10, there was no evidence of monitoring of side effects of anti psychotic medication for Resident #9. The resident takes an antipsychotic medication daily and the RN does not complete assessments</p>	R171	<p><u>Action</u> → Administrator reviewed defici with RN + CM 7/7/10</p> <p><u>Changes</u> → RN to admin PCP with any evidence of TD ongoing</p> <p><u>Monitoring</u> → Administrator to monitor for compliance. ongoing</p> <p>R171 POC Accepted 7/19/10 [Signature]</p>	

Division of Licensing and Protection

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R171	Continued From page 17 such as the AIMS or DISCUS Assessment to monitor for Tardive Dyskinesias. This was confirmed with the RN on 5/24/10 at 4 PM.	R171		
R177 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.10 Medication Management</p> <p>5.10.h</p> <p>(5) Narcotics and other controlled drugs must be kept in a locked cabinet. Narcotics must be accounted for on a daily basis. Other controlled drugs shall be accounted for on at least a weekly basis.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to assure that controlled medications were accounted for as required for a medication ordered for Resident #1 . Findings include:</p> <p>Per observation of a count of the controlled medication, Clonazepam, on 5/14/10 at 11 AM, 1 dose for Clonazepam was missing from the count at 11 PM the previous night and no staff had signed out that the medication had been given at 8 AM on 5/14/10. Per interview with the day shift Caregiver #1, she stated that the medication had been given by the night shift caregiver. Per telephone call to the night shift Caregiver #2 at 5:15 PM on 5/14/10, she stated to the Clinical Manager that Caregiver #1 had administered the 8 AM medications that morning. During a return visit to the home on 5/25/10, the MAR, which was not documented for the 8 AM dose of</p>	R177		

Division of Licensing and Protection

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NAME OF PROVIDER OR SUPPLIER LIVING WELL A COMMUNITY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 71 MAPLE STREET BRISTOL, VT 05443	

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R177	Continued From page 18 Clonazepam on 5/14/10 as of the end of the day, was initiated as given by Caregiver #1 for that day. During interview on 5/25/10 at 9:45 AM., she (#1) again denied giving the medication to Resident #1 as documented. When the discrepancy in the controlled medication count was discussed with the manager, she explained the system in use and it did not include a review of documentation of medication administration comparison to the actual medication count. The system being used would not note discrepancies in medication counts during the shift to shift process. The issue was also discussed and confirmed with the RN and the home's administrator on morning of 5/25/10.	R177	<u>Action</u> → Administrator reviewed this deficiency with CM+RN <u>Changes</u> → Pharmacy provided form now used for narcotic documentation / count ongoing	7/7/10
R178 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that sufficient qualified staff were on duty to provide necessary care to 2 residents requiring daily injections on all days of the survey, 5/13/10 - 5/25/10. (Residents #4 & 5) Findings include: 1. Per record reviews for Residents #4 & #5 on 5/14/10, both residents self administer insulin daily subcutaneous injections of insulin which	R178	<u>Monitor</u> → RN to monitor for compliance. R177 POC Accepted 7/11/10 & Monitor RN <u>Action</u> → Administrator reviewed this deficiency with RN <u>Changes</u> → All med certified staff are also in compliance with insulin administration guidelines ongoing <u>Monitor</u> → Administrator to monitor for compliance. ongoing	7/7/10

R178
POC Accepted 7/11/10 & Monitor RN

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0543	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/25/2010
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R178	Continued From page 19 must be drawn up by staff, based on daily and/or sliding scale physician orders. Per review of the medication delegation training list, only 1 current staff member was trained to administer these medications as of 5/14/10. There were shifts on days each week during the previous 4 weeks (prior to May 14, 2010) that there were no insulin medication delegated staff scheduled. Per interview with 2 current caregivers (5/24/10) and 1 former caregiver via telephone interview on 5/24/10, all 3 stated that the RN had not observed them administer/draw up insulin for a resident to determine competency prior to their independent administration/drawing up of insulin for these residents. Refer also to R188	R178		
R188 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(2) A record for each resident which includes: resident's name; emergency notification numbers; name, address and telephone number of any legal representative or, if there is none, the next of kin; physician's name, address and telephone number; instructions in case of resident's death; the resident's assessment(s); progress notes regarding any accident or incident and subsequent follow-up; list of allergies; a signed admission agreement; a recent photograph of the resident, unless the resident objects; a copy of the resident's advance directives, if any completed; and a copy of the document giving legal authority to another, if any. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, there	R188		

Division of Licensing and Protection

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R188	Continued From page 20 was no signed admission agreement for 1 of 9 residents in the applicable sample. (Resident #9) Findings include: Per record review on 5/24/10, Resident #9 was a resident of the home since the day the current owners took ownership. The only admission agreement in the medical record was with the previous owners. The Clinical Manager verified on the morning of 5/24/10 that they had forgotten to complete a new admission agreement with this resident at the change over in ownership of the home.	R188	<u>Action</u> → Administrator reviewed deficiency with CM + RN. 7/7/10 <u>changes</u> → CM reports Resident #9 has signed admission agreement as of → 6/15/10 <u>Monitor</u> → Administrator to monitor for compliance. ongoing	
R189 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b. (3) For residents requiring nursing care, including nursing overview or medication management, the record shall also contain: initial assessment; annual reassessment; significant change assessment; physician's admission statement and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of physician visits, signed telephone orders and treatment documentation; and resident plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, staff failed to assure that each resident's medical record included documentation of all treatments for 1 of 9 residents reviewed. (Resident #4) Findings include: Per record review at 2:45 PM on 5/24/10, staff failed to document/perform TID before meal	R189	R188 PDC Accepted 7/19/10 P.Mcota RN <u>Action</u> → Administrator reviewed deficiency with CM + RN 7/7/10 <u>changes</u> → ① BS on MARS ongoing ② further staff in service 8/30/10 <u>Monitor</u> → Administrator to monitor for compliance ongoing	

R189

PDC Accepted 7/19/10 P.Mcota RN

Division of Licensing and Protection

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R189	Continued From page 21 blood sugar testing via FS per physician orders multiple times during the months of January (6xs), February (5xs), and March (4xs). The resident is a diabetic who has frequent high blood sugars managed by sliding scale insulin. These omissions were confirmed with the Clinical Coordinator the same day.	R189		
R194 SS=G	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.14 Restraints</p> <p>5.14.a Mechanical restraints may be used only in an emergency to prevent injury to a resident or others and shall not be used as an on-going form of treatment. The use of a mechanical restraint shall constitute nursing care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, mechanical restraints were used on a non-emergency basis as an ongoing treatment for 1 of 9 residents in the sample. (Resident #7) Findings include: Per record review on 5/24/10, Resident #7, whose diagnoses included cognitive impairment, physical impairment, and unsteady gait, was restrained while in bed with a side rail to help prevent falls from bed, per interview with the manager at 3:20 PM the same day. The resident was in a weakened state and required general supervision and physical assist of 1 staff for most ADLs. The resident had a history of multiple falls, including falls from bed. The manager got an order on 2/16/10 for "bed rails to be applied to the bed for fall prevention". The manager stated that she was not aware that the side rail was a</p>	R194	<p><u>Action</u> → Administrator reviewed deficiency with RN + C.M. 7/7/10</p> <p><u>Changes</u> → RN + CM now understand ongoing use of restraints are not permitted in RCH. We do understand, in special circumstances, i.e., Hoopie, the state considers granty a variance. ongoing</p> <p><u>Monitor</u> → Administrator to monitor for compliance: R194 PDC Accepted 7/19/10 [Signature]</p>	

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0543	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/25/2010
NAME OF PROVIDER OR SUPPLIER LIVING WELL A COMMUNITY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 71 MAPLE STREET BRISTOL, VT 05443		
(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) COMPLETE DATE
R194	Continued From page 22 restraint and that it could not be used as an on-going form of treatment. Per telephone interview with the former resident's family member, she stated that the resident tried to slid down the bed and pushed on the side rail and it fell off and he fell on top of it. The family member said that they were not apprised of potential harm that could be caused by the use of a restraint (bedrails). In addition, a note from a home health agency RN stated on 3/310, "about his bedrail, I think that he is... agreeable to use a bell....and the rail could be removed so he's not crawling off the end of the bed". Refer also to R197	R194		
R197 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.14 Restraints 5.14.d The home shall notify the licensing agency and the resident representative within 24 hours when a restraint is used, and within 72 hours must complete a reassessment of the resident to determine if the resident's needs can be met within the residential care setting. The reassessment shall include consultation with the physician and the resident or the resident's representative. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to notify the licensing agency within 24 hours of restraining a resident and failed to conduct an assessment to determine if the resident's needs could be met within the residential care home setting. (Resident #7). Findings include: Per record review on 5/24/10, Resident #7, who	R197	<i>Action → Administrator reviewed these findings with RN and CM 6/1/10</i> <i>Change → RN and CM understand state must be notified within 24 hours, as well as resident representative, when there is a doctor's order and need for use of restraint(s). In addition, within 72 hours RN must complete reassessment to determine placement appropriateness in the RC+H. Reassessment must include consultation with physician and resident or resident representative.</i>	6/1/10

Division of Licensing and Protection
STATE FORM

6869

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If continuation sheet 23 of 25

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0543	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/25/2010
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NAME OF PROVIDER OR SUPPLIER LIVING WELL A COMMUNITY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 71 MAPLE STREET BRISTOL, VT 05443
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R197 Continued From page 23
had a history of falls with injuries, was admitted to the home for a short term stay and was restrained by use of bed side rails daily after physician orders were obtained on 2/16/10. During interview the same day, the Clinical Manager stated that she was not aware that use of on-going restraints was against the RCH regulations, nor was she aware of the requirement to notify the licensing agency within 24 hours. There was no assessment regarding the use of the restraints and the resident did have a fall with minor injuries trying to get out of bed with the side rails on the bed. Refer also to R194

R197
Monitor → Administrator to monitor for compliance ongoing
R197
PDC Accepted 7/20/10 *PN*

R247 SS=E VII. NUTRITION AND FOOD SERVICES
7.2 Food Safety and Sanitation
7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to ensure staff's completion of refrigeration temperature logs to assure that all perishable food and drink was held at the proper temperature. Findings include:
Per review of the refrigeration logs in a food storage area of the basement on 5/13/10 at 4:30 PM, accompanied by the Operations Manager, there were multiple daily gaps in the recording of refrigerator/freezer twice daily temperatures. In addition, one of the freezers had a container of leftover carrot soup labeled 5/10/09, which the

R247
Action: Administrator reviewed these finds with Operations Manager. 6/1/10
Changes: Operations Manager reviewed refrigerator with staff on 6/1/10

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0543	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/25/2010
NAME OF PROVIDER OR SUPPLIER LIVING WELL A COMMUNITY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 71 MAPLE STREET BRISTOL, VT 05443		
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R247	Continued From page 24 manager said would be discarded. The manager confirmed the findings at the time of the observations.	R247	<i>stress the importance of complete food temperature documentation</i>	
R266 SS=E	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to assure that all exits from the facility were in safe functional condition. Findings include: Per observations of the home on 5/14/10 at 10:35 AM, the upstairs outside resident emergency exit stairway had loose, spongy floor boards in some areas and a walk way from the emergency exit to the upstairs business office had a very loose, wobbly hand rail which needed replacement. These issues were observed with the Clinical Coordinator, who agreed the boards needed replacement.	R266	<i>Monitor → Shift check list requires about temperature documentation. Operations Manager is reporting any non-compliance to Administrator for disciplinary action - ongoing POC Accepted 7/19/10 PmcotARN</i>	
			<i>Action → Administrator reviewed these observations with our Operations Manager 6/1/10</i>	
			<i>Change → C/M advised boards and railing are repaired 6/1/10</i>	
			<i>Monitor → Operations Manager arranged for seasonal checks by our Maintenance person 6/1/10</i>	

Division of Licensing and Protection
STATE FORM

6899

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If continuation sheet 25 of 25

R266

POC Accepted 7/19/10 PmcotARN