

November 23, 2009

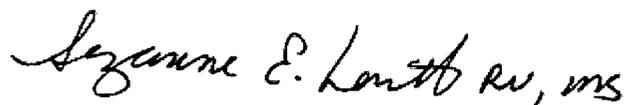
Mr. Steven Doe, Administrator
Our Lady Of The Meadows
1 Pinnacle Meadows
Richford, VT 05476

Dear Mr. Doe:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **August 31, 2009**. 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,



Suzanne Leavitt, RN, MS
Licensing Chief



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0197	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/31/2009
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NAME OF PROVIDER OR SUPPLIER OUR LADY OF THE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1 PINNACLE MEADOWS RICHFORD, VT 05476
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R100	Initial Comments: A Complaint investigation was initiated on 7/13/09 and was completed on 8/31/09. Deficiencies cited at R126 are directly related to the complaint allegations.	R100	SEE ATTACHED	9/11/09
R126 SS=D	V. RESIDENT CARE AND HOME SERVICES 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 record review and interview, the facility failed to demonstrate that services were provided to meet the personal, nursing and medical needs of 2 applicable residents reviewed (Resident #1, 6). Findings include the following: 1. Per review of a comprehensive assessment completed by the facility, Resident #1, admitted in 6/09, had long and short term memory loss, required extensive assistance with all activities of daily living (ADLS), management of occasional incontinence, medication administration, and was noncompliant with diet/nutrition and at risk for weight loss due to poor oral intake. Per review on 7/13/09 and 7/29/09, there were only 2 entries by licensed nursing staff: Resident #1's admission to the facility in 6/09 and discharge 2 weeks later in 6/09. There were no additional progress notes regarding the resident's status during the 2 week stay despite the resident's risk for nutritional deficit /weight loss and refusal	R126		

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *AL - STEVEN A. JOE* TITLE: *ADMINISTRATOR* (X6) DATE: *9/11/09*

Division of Licensing and Protection

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R126	Continued From page 1 of medications on several occasions as well as staff decision to withhold anti-hypertensive medication based on a pulse rate checked daily. a. Per record review and interview of direct care staff on 7/13/09, an 'S' recorded on a flow chart for intake indicated that Resident #1 consumed some portion of a high protein/carbohydrate shake, the resident's preferred food. Directions on the flow chart instruct staff to document the percentage of food/fluid consumed. Per on-site interviews on 7/13/09, direct care staff stated that the 'S' meant that some or the entire shake was consumed but were unable to explain why the percentage of intake was not recorded. Per interviews on 7/13/09 and subsequent telephone interviews of staff from other shifts, direct care staff confirmed that the resident frequently pushed the shake, and other items offered, away and only consumed small amounts at any one time after much encouragement. There was no evidence of nursing oversight to assess the resident's intake or evaluate staff's documentation of the information. b. Resident #1 intermittently refused medications, including anti-hypertensive and antidepressant drugs. Anti-hypertensive medication was withheld based on a low pulse rate on four separate days (6/11, 6/12, 6/17, 6/18/09). There was no evidence of nursing oversight/evaluation of the pulse rate that was below the facility threshold for administering the drug. There was no evidence that the resident's physician was notified of the resident's pulse rate and the decision to withhold the drug, as well as the resident's intermittent refusal of medications. c. Per review of documentation of ADL care, Resident #1 received only one full bath/shower (which includes a shampoo and nail care) on	R126	SEE ATTACHED 9/11/09

SAD

Division of Licensing and Protection

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R126 Continued From page 2

6/13/09 during the 2-week stay. According to the flow sheet, a shower/bath was due 6/20/09. Although the resident received personal care each morning and evening there was no documentation or other evidence that the resident received a full bath/shower/shampoo and nail care on 6/20/09. Per interview on 7/13/09, direct care staff confirmed that a bath/shower was due on 6/20/09.

d. Per record review, Resident #6 had physician 's orders for an anti-hypertensive medication to be administered on a daily basis. The Medication Administration Record (MAR) directed staff to withhold the medication if Resident #6 ' s pulse rate was below [the facility threshold for administering the medication]. Per review of the 6/2009 MAR, the medication was withheld on 6/30/09 due to a decreased pulse rate. Per record review, there was no physician ' s order authorizing staff to do this nor was there any evidence that the physician was notified of the pulse rate and that the resident ' s medication was withheld.

R126

SEE ATTACHED

9/11/09

R126 11-23-09 attached POC (revision #1) accepted as written. 11-20-09 C. Baraway, RN

R128 V. RESIDENT CARE AND HOME SERVICES
SS=D

R128

5.5 General Care

5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to obtain written signed orders from the physicians of 2 applicable residents reviewed, who were receiving anti-hypertensive

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R128 Continued From page 3

medications, to administer or withhold the medication based on each resident ' s pulse rate (Residents #1, 6). Findings include the following:

- Per review of the June 2009 Medication Administration Records (MARs) on 7/13/09 and 7/29/09, Residents #1 and #6 received an anti-hypertensive medication. Each resident ' s MAR directed staff to withhold the medication if the residents ' pulse was below the facility ' s threshold for administering the medication. Per review of each resident ' s physician ' s orders, there were no written signed physicians ' orders authorizing staff to do this. This was confirmed with the nurse on 7/29/09.

R128

SEE ATTACHED 9/11/09

R128 11-23-09 Attached POC (revision #1 rec'd 11-20-09) accepted as written C. Laraway, RN

R134 V. RESIDENT CARE AND HOME SERVICES
SS=D

5.7 Assessment

5.7.a An assessment shall be completed for each resident within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The resident's abilities regarding medication management shall be assessed within 24 hours and nursing delegation implemented, if necessary.

This REQUIREMENT is not met as evidenced by:

Per record review and interview, the facility failed to complete the required assessments for 2 of 4 applicable residents reviewed who were admitted to the facility in 2009 (Residents #1, 2). Findings include the following:

- Per record review on 7/13/09, no assessment was done for Resident #2, admitted in 6/09. This was confirmed with the nurse on 7/29/09.

R134

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R134 Continued From page 4

2. Per record review on 7/13/09 the assessment done on Resident #1 was inaccurate. In Section L1, Medications, (listing 5 categories of medications), the facility failed to document that the resident was administered a diuretic and an anti-depressant on 6 of the previous 7 days, and instead indicated that the resident took none of the categories of medications listed. This was confirmed with the nurse on 8/27/09.

3. Per review of the assessment done on Resident #1 on 7/13/09, the resident's weight was not obtained even though the resident had a history of poor oral intake and was at risk for weight loss. This was confirmed with direct care staff on 7/13/09.

R134

SEE ATTACHED 9/11/09

R134 11-23-09 Attached POC (revision #1 rec'd 11-20-09) accepted as written. C. Haraway, RN

R151 V. RESIDENT CARE AND HOME SERVICES
SS=D

5.9.c (8)

Ensure that the resident's record documents any changes in a resident's condition;

This REQUIREMENT is not met as evidenced by:
Based on record review, the nurse failed to assure that changes in resident condition were documented for 2 of 3 applicable residents reviewed (Residents #3, 7). Findings include the following:

1. Per review of the June 2009 MAR on 7/13/09, Resident #3 was administered cough syrup on 15 occasions between 6/2/09 and 6/16/09. There were no nursing progress notes regarding the resident's condition nor was there any evidence that the resident's physician was informed, per the direction of standing physician's orders that state to contact the physician after four days of

R151

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R151	Continued From page 5 cough syrup administration. 2. Per review on 7/13/09, a single nursing progress note of 4/12/09 stated that Resident #7 developed a cough and congestion. An entry on 4/13/09 stated that the resident's responsible party was called and informed of the resident's condition but there were no notes describing the resident's condition. Notes on 4/14/09 indicate an increase in the resident's symptoms and subsequent hospitalization.	R151	<i>SEE ATTACHED 9/11/09</i> <i>R151 11-23-09 Attached PC (revision #1 rec'd 11-20-09) accepted as written. - C. Lowrey, RN</i>
R153 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (10) Monitor stability of each resident's weight; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to monitor the body weight of 2 of 5 applicable residents reviewed (Residents #1, 2). 1. Per review of records of Residents #1 and #2 on 7/13/09, neither resident was weighed after admission to the facility in 6/09. This was confirmed with direct care staff and the nurse on 7/13/09 and 7/29/09.	R153	
R200 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request.	R200	

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R200 Continued From page 6

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to develop policies and procedures governing the use of a pulse oximeter. Findings include the following:

1. Based on record review, there were no policies and procedures governing the use of a pulse oximeter. Per interview of direct care staff the licensed nursing staff, a pulse oximeter was used to obtain pulse rates of residents who were administered anti-hypertensive medication. The pulse rate determined whether or not the medication was administered or withheld. This was confirmed per interview with the nurse on 7/29/09.

R200

SEE ATTACHED 9/11/09

R200 11-23-09 Attached POC (revision #1 rec'd 11-20-09) accepted as written. —
C. Laraway, RN

R249 VII. NUTRITION AND FOOD SERVICES
SS=D

7.2 Food Safety and Sanitation

7.2.d The home shall assure that food handling and storage techniques are consistent with safe food handling practices.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to discard the remainder of an electrolyte solution within an appropriate time frame per the directions on the label. Findings include the following:

1. An open container of Pedialyte, an electrolyte solution, was observed in the refrigerator in the kitchen on the St. Joseph 's unit on 7/13/09. The date ' 4/09 ' was written on the label, indicating when it was opened. Directions on the label

R249

892

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0197	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/31/2009
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R249	Continued From page 7 stated to use within 48 hours of opening. The caregiver present acknowledged the directions and discarded the solution.	R249	<i>SEE ATTACHED 9/11/09 R249 11-23-09 Attached POC (revision #1 rec'd 11-20-09) accepted as written. — C. Laraway, RN</i>
R268 SS=A	IX. PHYSICAL PLANT 9.2 Residents' Rooms 9.2.a Each bedroom shall have at least 100 square feet of useable floor space in single rooms and at least 80 square feet per bed in double-bed rooms, exclusive of toilets, closets, lockers, wardrobes, alcoves or vestibules. These specifications may be waived for beds licensed prior to the adoption of the 1987 regulations. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide sufficient bedroom space for 2 applicable residents. Findings include the following: 1. Per interview, the manager stated that a private room was converted to a semi-private room to accommodate the admission of Resident #1. Per observation on 7/13/09 and subsequent measurement by the facility, the room contained 135.4 sq. feet of usable space, 25 square feet short of the required minimum of 160 square feet necessary for double-bed rooms. This was confirmed with the manager of the facility on 8/27/09.	R268	<i>R268 11-23-09 Attached POC (Revision #1 rec'd 11-20-09) accepted as written. — C. Laraway, RN</i>
R302 SS=D	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness	R302	

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Division of Licensing and Protection

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R302 Continued From page 8

9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to conduct fire drills on all three shifts as required. Findings include the following:
1. Per review of fire drill records of 5/08 - 5/22/09, eight drills were conducted between the hours of 7 AM and 7 PM, but none were conducted on the night shift This was confirmed with the manager on 7/29/09.

R302

SEE ATTACHED

9/11/09

R302 11-23-09 Attached POC (revision #1 rec'd 11-20-09) accepted as written.
C. Loraney, RN

SAD

Our Lady Of The Meadows
Plan Of Correction
Residential Care Home State Survey
August 31, 2009

NOV 20 2009

R126

5.5.a

Action: Actions to correct the deficiencies pertaining to Resident #1 are not possible at this time as Resident #1 was discharged on June 20, 2009.

Physician order to withhold Beta Blocker medication obtained for Resident #6 on 8/7/09

Medication Administration Procedure for Beta Blockers have been adopted and are in currently in place. (See Attachment A)

A revised Resident Monitoring/Observation by Staff Policy and Procedures has been adopted to specifically include "Refusal to eat and or Drink" and "Refusal of Bathing or showering for more than seven days".(See Attachment B) The RN will review this policy with all direct care staff by no later than September 18, 2009.

R126-11-23-09 POC accepted as written. — C. Laraway, RN

The RN will review the Medication/Treatment Orders/Transcriptions Policy (Attachment D) with all direct care staff by no later than November 19, 2009 to insure that all Physician orders are transcribed accurately.

Measures: Administrator and Licensed Nursing Staff will insure that all documentation will reflect that all necessary services have been provided or arranged to meet the Resident's personal, psychosocial, nursing and medical care needs, by taking the following measures:

Licensed Nursing Staff will educate all direct care staff authorized for medication administration on the written policies and procedures regarding Beta-Blockers and will review the revised Resident Monitoring/Observation policy with all direct care staff by no later than September 18, 2009. The RN will also review with all direct care staff the Medication/Treatment Orders/Transcriptions policy no later than November 19, 2009.

Monitoring: The RN will provide overview to insure compliance

R126

11-23-09 POC accepted as written. — C. Laraway, RN

R128

5.5.c

Action: Actions to correct the deficiencies pertaining to Resident #1 are not possible at this time as Resident #1 was discharged on June 20 , 2009.

Physician order to withhold Beta-Blocker medication due to low pulse obtained for resident #6 on 8/7/09

Medication Administration Procedure for Beta Blockers have been adopted and are in currently in place. (See Attachment A)

Measures: The RN will insure that each resident's medication, treatment and dietary services shall be consistent with the physician's orders.

Monitoring: RN will educate all direct care staff authorized for medication administration on the written policies and procedures regarding Beta Blocker medication and monitor that procedures are followed to insure that this deficient practice does not recur.

R-128 11-23-09 POC accepted as written. — C. Laraway, RN

R134

5.7.a

Action: Actions to correct the deficiencies pertaining to Resident #1 are not possible at this time as Resident #1 was discharged on June 20 , 2009.

A written assessment was completed on 07/23/09 for Resident #2 consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency.

Measures: The RN will complete the written assessment for each resident within 14 days of admission and at least annually thereafter or at anytime that there is a significant change. The resident's abilities regarding medication management shall be assessed by the RN within 24 hours and nursing delegation will be implemented, if necessary.

Monitors: The RN and Administrator will monitor this practice to insure that this deficiency will not reoccur.

R134 11-23-09 POC accepted as written. — C. Laraway, RN

R151

5.9.c (8)

Action: No appreciable action can take place on this specific deficiency as the Nurse Progress notes are part of the resident's permanent record and cannot be altered.

Measures: The RN will ensure that each resident's record documents any changes in a resident's condition and determine what action, regarding the specific condition, should be taken.

Monitors: The RN will monitor this practice to insure that this deficiency will not reoccur.

R151 11-23-09 POC accepted as written. — C. Laraway, RN

R153

5.9.c (10)

Action: Actions to correct the deficiencies pertaining to Resident #1 are not possible at this time as Resident #1 was discharged on June 20, 2009.

Resident #2 was weighed by the RN on 07/01/09. This was documented in the Resident #2's Medication Administration Record.

Measures: The RN will ensure that each resident will be weighed within 24 hours of admission and at the first of each month thereafter or as directed by the physician.

Monitors: The RN will monitor this practice to insure that this deficiency does not reoccur.

R153 11-23-09 POC accepted as written. — C. Laraway, RN

R200

5.15

Actions: A written policy and procedure was established regarding the usage of a pulse oximeter was developed on 9/11/09. (See Attachment C)

Measures: The RN will educate all direct care staff authorized for Medication Administration on the written policies and procedures regarding the use of the pulse oximeter by no later than 9/18/09.

Monitors: The RN will monitor this practice to insure that this deficiency does not reoccur.

R200 11-23-09 POC accepted as written. — C. Laraway, RN

R249

7.2.d

Actions: As noted on the survey Statement dated 8/31/09, the Pedialyte was promptly discarded.

Measures: All staff will assist in monitoring the expiration dates on food items/ Supplements and assure that food handling and storage techniques are consistent with safe food handling practices.

Monitoring: The Administrator and RN will provide oversight to assure compliance.

R249 11-23-09 POC accepted as written. — C. Laraway, RN

R268

9.2.a

Actions: As of 6/20/09 the room in question resumed being a private room meeting the requirement of having at least 100 square feet of useable floor space.

Measures: The Administrator has clearly identified which rooms are suitable for double-bed rooms and which rooms are strictly private.

Monitors: The Administrator will provide oversight to assure that all room assignments are in compliance with regulations.

R268 11-23-09 POC accepted as written. — C. Laraway, RN

R302

9.11.c

Actions: On 8/20/09 a fire drill was conducted at 12:35am during the night shift.

Measures: Four fire drills have been conducted thus far this year. One at 11:15am, one at 4:15pm, one at 3:10pm and one at 12:35am. The Administrator will arrange for two more fire drills to take place before December 31, 2009. One will be in the morning and one will be at night.

Monitors: The Administrator will provide oversight to assure compliance.

R302 11-23-09 POC accepted as written. — C. Laraway, RN

(Attachment A)

Medication Administration Procedures for BETA-BLOCKERS

What is a BETA-BLOCKER?

Beta blockers (sometimes written as β -blocker) are a class of drugs used for various indications, but particularly for the management of cardiac arrhythmias, cardioprotection after myocardial infarction (heart attack), and hypertension. Propranolol was the first clinically useful beta adrenergic receptor antagonist. Invented by Sir James W. Black, it revolutionized the medical management of angina pectoris and is considered to be one of the most important contributions to clinical medicine and pharmacology of the 20th century.[1] Beta blockers may also be referred to as beta-adrenergic blocking agents, beta-adrenergic antagonists, or beta antagonists.

Examples of beta-blockers include: acebutolol, bisoprolol, esmolol, propranolol, atenolol, labetalol, carvedilol, metoprolol, and nebivolol.

Reference: *www.Wikipedia.org*

For those residents on a Beta Blocker the procedure will be as follows:

1. The Resident's pulse will be monitored weekly manually using the radial pulse or as directed by the resident's physician, by a Licensed Nurse or authorized individuals and the results will be documented on the Medication Administration Record.
2. The RN will follow up with the resident's physician as needed and document as appropriate.

(Attachment B)

Resident Monitoring/Observation by Staff

POLICY: The Direct Care Staff shall monitor for changes in resident status, report any changes observed to the RN and provide appropriate documentation in a timely manner according to established procedures.

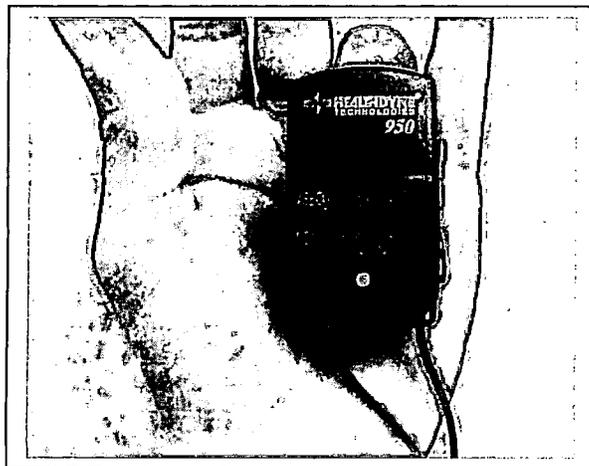
PROCEDURES:

1. All Direct Care Staff will, on an ongoing basis, observe for changes in the status of residents.
2. Examples of resident changes that staff may observe include:
 - a. Increased swelling in the ankles, fingers, feet and/or hands
 - b. Rashes, bruising, skin tears, or a change in the condition or color of the skin
 - c. A change in appetite, fluid intake, or weight loss/gain.
 - i. Refusal to eat and/or drink
 - ii. Difficulty swallowing and/or eating
 - d. A change in mood, emotion or daily habits.
 - e. A change in sleeping patterns.
 - f. A change in the color, odor, and/or consistency of urine or bowel movements
 - g. A change in the resident's normal temperature, pulse or blood pressure.
 - h. Refusal of bathing or showering for more than seven days.
 - i. Difficulty breathing/shortness of breath
 - j. Change in skin color
 - k. Change in vital signs
3. All Direct Care Staff will report any changes to the RN along with the interventions that have occurred to help to resolve the issue. When staff report changes in a resident's condition to the RN, the RN must determine what action should be taken. Interventions that might be appropriate include:
 - a. Assisting the resident with administration of a PRN medication.
 - b. Continued observation/monitoring by staff.
 - c. Additional evaluation by the RN and/or other health care professional.
 - d. Informing the resident's physician of the concern and follow any instructions provided by him/her.
 - e. Scheduling an appointment for the resident with his/her physician.
 - f. Calling 911 for emergency assistance.

(Attachment C)

Procedures for using a Pulse Oximeter

1. The Pulse Oximeter may only be used by the Direct Care Staff for evaluating the resident's oxygen saturation level. **The Pulse Oximeter is not to be used for determining a resident's pulse.** (*For determining the resident's pulse, use the radial or apical method.*)
2. Examples of when the Pulse Oximeter may be utilized include:
 - a. If the resident is having difficulty breathing
 - b. There is a change in the resident's skin color
 - c. There is a change in the resident's vital signs
 - d. The resident is complaining of shortness of breath
3. If one of these conditions occurs the Direct Care Staff will report the resident's condition to the RN, the RN must determine what action should be taken. Interventions that might be appropriate include:
 - a. Assisting the resident with administration of a PRN medication.
 - b. Continued observation/monitoring by staff as directed by RN
 - c. Additional evaluation by the RN and/or other health care professional.
 - d. Informing the resident's physician of the concern and follow any instructions provided by him/her.
 - e. Scheduling an appointment for the resident with his/her physician.
 - f. Calling 911 for emergency assistance.
4. The Licensed Nursing Staff will document any intervention taken in the resident's nursing notes, along with any follow-up action taken and continue routine documentation until resolution of the concern is noted



MEDICATION/TREATMENT ORDERS/TRANSCRIPTIONS

STANDARD: Proper channels of communication are used to ensure accurate delivery of medications and treatments to all residents. This is achieved by using the order sheet, medication administration record, and treatment administration record

POLICY: 1. Medications and treatments ordered by the physician, including telephone orders, may be taken by a LNA or DS but must be signed by the physician within 15 days.

2. All new orders must be reviewed by the RN/LPN

PRACTICE: 1. Receiving a written order:

- a. Order must be written by the physician on
 - i. physician order sheet
 - ii. prescription pad
- b. Check to see that the order is complete
 - i. Time and date of the order
 - ii. If medication; the drug dose, route, frequency, number of days or doses to be given, and the reason for medication (supporting diagnosis)
 - iii. Physician's signature
- c. Order is then transcribed to the physician's order sheet (if not already on) exactly as written on the prescription pad
- d. Staple a copy of prescription or note in the order section of the chart.

2. Receiving a telephone order (T/O)

- a. Record on a physician's order form and T/O sheet/physician's order sheet
- b. Immediately write on the order exactly as it is given (no abbreviations)
- c. Before termination of the telephone call with the physician, repeat the order (s) to clarify and ensure that the following necessary information is included:
 - i. If medication: drug, dosage, route, frequency, number of days or doses to be given, reason for medication (supporting diagnosis)
 - ii. If medication is ordered PRN make sure the reason for giving the medication and frequency that it can be given is documented.
- d. Advise Physician to call the pharmacy with the new order. If after hours encourage physician to fax prescription to pharmacy if possible.
- e. Order is labeled with
 - i. Date and time
 - ii. T/O (telephone order)
 - iii. Name of Physician/Name of LNA/DS taking the order

- f. T/O slip (white copy) is
 - i. Placed in nurse communication book
 - ii. AFTER the nurse views it, it is then mailed/faxed to the physician's office to be signed/or placed on physician order sheet in chart and the spine of chart is tagged for physician to sign on his next visit to the home. The order must be signed in 15 days.
 - iii. Returned signed copy is placed in the chart.