VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street
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

January 7, 2015

Mr. Jay Grimes, Administrator
Meadows At East Mountain
157 Heritage Hill Place
Rutland, VT 05701-8811

Dear Mr. Grimes:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 25, 2014.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

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Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1002	A. BUILDING: _____ B. WING _____	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS AT EAST MOUNTAIN	157 HERITAGE HILL PLACE RUTLAND, VT 05701

(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
R100	Initial Comments: An unannounced onsite re-licensing survey and investigation of a self report was completed by the Division of Licensing and Protection on 11/24/14 through 11/25/14. For the self report review, the facility was found to be in substantial compliance with Vermont Residential/Assisted Living Regulations. The following regulatory findings were found regarding the re-licensing survey.	R100		
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 change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to reassess each resident annually and/or at any point there is a change in the resident's physical or mental condition, for 1 of 10 residents sampled. For Resident #2 the findings include the following: Per medical record review, Resident #2 who was admitted on 5/31/06 with diagnoses to include Dementia, Aphasia both reactive and expressive, Arteriosclerotic Cardiac Vascular Disease, Hypertension, Agitation, Anxiety and Depression. Per medical review for Resident #2 the State required Resident Assessment was last completed on 9/17/13. Unit Manger confirms on	R135	**Tag 136, 5.7** Resident #2 has had an assessment completed since the survey. All resident records are being reviewed by Resident Care staff to insure assessments are up to date. Any resident that has not had an assessment completed as necessary will have one completed. All resident records will be audited for assessment compliance monthly for three months. If deemed appropriate by	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X5) DATE: 12/30/14

R136 → R266 Plans of correction accepted 1/6/15 MBertrand RN/PMC

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R136	Continued From page 1 11/25/14 at approximately 9:30 AM that there is no evidence that Resident #2 has been reassessed since the last assessment located in the medical record dated 9/17/13.	R136	the QI team these audits will be made quarterly.	
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 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 record review and staff interview the facility failed to assure that a written plan of care was developed for Resident #7, one resident of 9 residents reviewed, to describe the care and services necessary to assist the resident to maintain well-being. Findings include: Per record review Resident #7 was admitted to the hospital for cellulitis, where s/he was diagnosed as having open wounds with MRSA (Methicillin Resistant Staph Aureus). Upon return to the facility the plan of care did not contain any specifics regarding wound monitoring, reporting, or precautions for infection control. In an interview on 11/25/14 the Director of Nursing Services (DNS) confirmed that the plan of care did not contain interventions for wounds with MRSA.	R145	This will be completed by 1/1/15.	
R155 SS=D	V. RESIDENT CARE AND HOME SERVICES	R155		

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R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 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 record review and staff interview the facility failed to assure that a written plan of care was developed for Resident #7, one resident of 9 residents reviewed, to describe the care and services necessary to assist the resident to maintain well-being. Findings include: Per record review Resident #7 was admitted to the hospital for cellulitis, where s/he was diagnosed as having open wounds with MRSA (Methcillin Resistant Staph Aureus). Upon return to the facility the plan of care did not contain any specifics regarding wound monitoring, reporting, or precautions for infection control. In an interview on 11/25/14 the Director of Nursing Services (DNS) confirmed that the plan of care did not contain interventions for wounds with MRSA.	R145	**Tag 145,5.9.c (2)** Resident #7 has had his care plan updated to include interventions for wounds with MRSA. All other resident care plans are being audited by Resident Care Staff to insure the care plan adequately addresses the residents needs. Care plans will be audited on a monthly basis for three months and changes made as needed. Audits will be reviewed by the QI team. If the QI team feels it appropriate care plan audits will be moved to quarterly. This will be completed by 1/1/15.	
R155 SS=D	V. RESIDENT CARE AND HOME SERVICES	R155		

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R155	Continued From page 2 5.9.c. (12) Assume responsibility for staff performance in the administration of or assistance with resident medication in accordance with the home's policies. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and policy review, the facility failed to assure staff handled medication in accordance with the home's policies, for Resident #1. The finding includes the following: Per tour of the Special Care Unit on 11/24/14 at approximately 10:15 AM, a medicine cup containing two white tablets was observed at the bedside of Resident #1. The bedroom door is observed wide open, residents on the unit ambulate freely as able and the room is easily accessed. Per The Meadows Unit Dose Drug Distribution System policy dated and initialed on 6/2012, item #7 evidences "Medications may not be left at bedside or table setting for any resident. All medication must be delivered directly to each individual". Per interview with Unit Manger on 11/24/14, confirmation is made at 11:04 AM that medication was left unattended on Resident #1's bed side table and that the bedroom door is observed wide open, making the room easily accessed by wandering residents. (See also R266)	R155	**Tag 155, 5.9** The pills near Resident #7 were removed. Staff that distribute medication will be educated on policies related to medication administration. This will be monitored by The Administrator and Director of Resident Care on weekly rounds. A report on the findings will be presented to the QI team monthly. This will be completed by 1/1/15.	
R160 SS=F	V. RESIDENT CARE AND HOME SERVICES	R160		

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R160	Continued From page 3	R160		

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 by:
Based on record review the facility failed to assure that written policies described the medication delegation process. Findings include:

Tag 160, 5.1

The Director of Resident Care has written a new policy for medication management that includes the facility delegation process,training, monitoring, and re-delegation.

The Administrator and the Director of Resident Care will review current policies to insure all policies are up to date and make changes as necessary.

All staff involved in administering medication will be educated on the new policy.

This will be completed by 1/1/15.

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R160	Continued From page 4 Per record review of the facility's Medication Management policies, the policy does not contain any information regarding the facility's delegation process to include who is responsible for providing professional nursing delegation and how the process will be carried out, including training, monitoring and re-delegation. In an interview at 3:15 PM on 11/26/14 the Director of Nursing Services (DNS) confirmed that there was no policy available with the required information.	R160		
R167 SS=D	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: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure that a PRN (used as needed) Psychotropic Plan was developed for Resident #8, one of 9 residents reviewed, who	R167		

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R167	Continued From page 5 was receiving a PRN psychoactive medication. Per record review R#8 is prescribed Seroquel 25 mg PO (by mouth) daily PRN. In the two weeks prior to survey he is recorded as receiving the medication on 3 days. Per interview with the Director of Nursing Services (DNS) on 11/25/14 at 11:20 AM, medications are administered to R#8 at times by delegated medication techs (unlicensed staff who have been delegated by a Registered Nurse to administer specific medications to specific residents). During the interview the DNS confirmed that there was no PRN Psychotropic med plan available for R#8.	R167	issue, the audits will be done quarterly thereafter. This will be completed by 1/1/15.	
R171 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 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: (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, including the reason why and the actions taken by the home; (3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect; (4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and (5) For residents receiving psychoactive	R171		

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R171 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 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: (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, including the reason why and the actions taken by the home; (3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect; (4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and (5) For residents receiving psychoactive	R171		

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R171	Continued From page 6 medications, a record of monitoring for side effects. (6) All incidents of medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, for 2 of 10 sampled residents (Resident #4 and #5) the facility failed to monitor side effects for those residents receiving psychoactive medications. The findings include the following: 1. Per medical record review, Resident #4 is located on the Special Care Unit and was admitted on 10/2/12 with diagnoses to include Alzheimer's Disease, Depression, Asthma, Narcolepsy and Prostate Cancer. Per medical record review Resident #4, physician's orders prescribe Abilify 2 mg by mouth (po) daily, originally ordered on 3/5/2014. Resident #4 remains on the antipsychotic medication that requires monitoring for adverse side effects such as difficulty speaking, muscle spasms, restlessness, the need to keep moving, shuffling gait, stiffness of the arms and legs and other muscular symptoms that require monitoring to determine if the mediation should be continued or dosage adjusted. Per medical record review, behaviors are monitored 24 hours a day and resident has received medication as ordered. Per The Meadows policy regarding antipsychotic medication administration dated and initialed 1/17/11 evidences "Any resident who is taking Antipsychotic medication will be tested as per the AIMS testing scale quarterly". Per medical record review and interview with the Unit Manger on 11/25/14 at 11:30 AM, confirmation was made that monitoring for side effects of psychoactive medication screening (AIMS), was last completed	R171	antipsychotic medications to insure compliance. The QI team will review these audits and make suggestions accordingly. This will be completed by 1/1/15.	

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R171	Continued From page 7 on 4/16/14 and the facility policy has not been followed. 2. Per medical record review for Resident #5 who had been located on both the Traditional and Special Care Units, was admitted on 1/2/10 with diagnoses to include Prostrate and Bladder Cancer, Hypertension, Diabetes, Carotid Artery Stenosis, Osteomyletis and Arthritis. Per medical record review Resident #5, physician orders prescribe Seroquel 25 mg by mouth (po) twice a day as needed (PRN) for increased agitation/behavioral episodes, was originally ordered on 5/29/2014. Resident #5 received the medication 2-3 times a week at various times of the day, evening and night shifts. Antipsychotic medication requires monitoring for adverse side effects such as difficulty speaking, muscle spasms, restlessness, the need to keep moving, shuffling gait, stiffness of the arms and legs and other muscular symptoms that require monitoring to determine if the mediation should be continued or dosage adjusted. Per medical record review, behaviors were monitored 24 hours a day and the resident received the medication as ordered. Per The Meadows policy regarding antipsychotic medication dated and initialed 1/17/11 evidences "Any resident who is taking Antipsychotic medication will be tested as per the AIMS testing scale quarterly". Per medical record review and interview with the Director of Nurses on 11/25/14 at approximately 12:43 PM, confirmation was made that monitoring for side effects of psychoactive medication screening (AIMS), can not be located in Resident #5's medical record therefor the resident was not monitored for adverse side effects as per facility policy.	R171		

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R206	Continued From page 8	R206	**Tag Number R206, 5.18**	
R206 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.a The licensee and staff shall report any case of suspected abuse, neglect or exploitation to the Adult Protective Services (APS) as required by 33 V.S.A. §6903. APS may be contacted by calling toll-free 1-800-564-1612. Reports must be made to APS within 48 hours of learning of the suspected, reported or alleged incident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to report an allegation of abuse by Resident #10 to Adult Protective Services. Findings include: Per record review on 11/24/14 of incidents investigated by the facility, R#10 complained of his Right hand hurting. When questioned at the time s/he alleged that a staff member pushes her/him; grabs her/his hand, and is rough with her/him . The facility investigated the incident and concluded that R#10's hand was "hurting" due to it being under her/him during care and not the result of a willful or intentional act by the staff member. Resident #10 has Dementia and is unable to remember or describe the incident. The staff member denied the allegations. In an interview on 11/23/14 at 2:50 PM the Administrator confirmed that the facility had not reported the alleged incident to the licensing agency/APS. (See also R208)	R206	The incident involving Resident #10 has been reported to the licensing agency. After a review no other issues were discovered that should have been reported to the licensing agency. The Administrator will complete an educational session on Abuse to reduce the risk of this reoccurring. All future incidents will be reviewed by The Administrator and if there is any allegation or potential that abuse could have occurred the incident will be reported to the licensing agency. This item will be reviewed at managers meeting weekly and at the Quality Improvement Meeting monthly. Items to be completed by 1/15/15.	

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R208	Continued From page 9	R208	**Tag Number R208, 5.18**	
R208 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.c Incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse, or if an injury requiring physician intervention results, or if there is a pattern of abusive behavior. All resident-to-resident incidents, even minor ones, must be recorded in the resident's record. Families or legal representatives must be notified and a plan must be developed to deal with the behaviors This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to report an allegation of abuse by Resident #10 to the licensing agency. Findings include: Per record review on 11/24/14 of incidents investigated by the facility, R#10 complained of his Right hand hurting. When questioned at the time s/he alleged that a staff member pushes her/him, grabs her/his hand, and is rough with her/him . The facility investigated the incident and concluded that R#10's hand was "hurting" due to it being under her/him during care and not the result of a willful or intentional act by the staff member. Resident #10 has Dementia and is unable to remember or describe the incident. The staff member denied the allegations. In an interview on 11/23/14 at 2:50 PM the Administrator confirmed that the facility had not reported the alleged incident to the licensing agency.	R208	The incident involving Resident #10 has been reported to the licensing agency. After a review no other issues were discovered that should have been reported to the licensing agency. The Administrator will complete an educational session on Abuse to reduce the risk of this reoccurring. All future incidents will be reviewed by The Administrator and if there is any allegation or potential that abuse could have occurred the incident will be reported to the licensing agency. This item will be reviewed at managers meeting weekly and at the Quality Improvement Meeting monthly. Items to be completed by 1/15/15.	

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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 observation and staff interviews, the facility failed to ensure that all perishable food and drink are labeled and 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. The finding include the following: 1. Per observation/inspection of the Special Care Unit (SCU) refrigerator on 11/24/14 at 12:30 PM, which stores nourishments, snacks, liquids and has an attached freezer containing ice cream, does not evidence a thermometer to monitor temperatures. Per interview with the Food Service Supervisor, the Unit Manger and the Resident Care Attendant, confirmation was made that the refrigerator does not have a thermometer nor does the unit staff or the dietary staff monitor the SCU refrigerator for proper temperatures. 2. Per observation/inspection of the Special Care Unit (SCU) on 11/24/14 at 12:30 PM, the following items were found to be open and not labeled as required: Multiple packages of home-made cookies wrapped in plastic wrap with no date. One opened squirt bottle containing brown liquid (3/4 full) with no cap and no identification as to	R247	**Tag 247, 7.2** A thermometer was placed in the SCU refrigerator and is being monitored daily. All food items found to be unlabeled were discarded. All other food storage areas were also inspected and food removed if not properly labeled. A new labeling system has been put into place to insure food is discard. All food items not immediately used will be labeled with a a "throw out" date. If the food is not used by the the "throw out" date then it will be thrown out.	

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R247	Continued From page 11 what the bottle contained or date the item began to be utilized. Two multiple gallon plastic containers storing dried cereal, that is not labeled as to the type of cereal and no date the item began to be utilized. Two boxes of dry Maypo hot cereal mix open, not secure and partially used with no date as to when the item began to be utilized. Two plastic bags of dry cereal with no date as to when the item began to be utilized. Per interview with the Food Service Supervisor, the Unit Manger and the Resident Care Attendant, at the time of the dining room observation/inspection, confirmation was made that the above listed items were not stored properly to avoid various sources of contamination, not were the dated and labeled as required.	R247	All food storage areas will be inspected by the Food Service Manager or designee. A weekly report will be reviewed at managers meeting for one month. If daily inspection are successful the reports will then be reviewed monthly at The Quality Improvement Committee Meeting. The facility administrator will inspect all food storage areas weekly for a month and if inspections go well these inspections will be done monthly. This plan will be completed by January 15th, 2015.	
R248 SS=E	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.c. All work surfaces are cleaned and sanitized after each use. Equipment and utensils are cleaned and sanitized after each use and stored properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that all work surfaces are cleaned and sanitized after each use. The findings include the following: Per observation/inspection of the Special Care Unit (SCU) dining room, on 11/24/14 at 12:30 PM	R248		

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R248 SS=E	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.c. All work surfaces are cleaned and sanitized after each use. Equipment and utensils are cleaned and sanitized after each use and stored properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that all work surfaces are cleaned and sanitized after each use. The findings include the following: Per observation/inspection of the Special Care Unit (SCU) dining room, on 11/24/14 at 12:30 PM	R248		

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R248	Continued From page 12 the following conditions were evidenced: Multiple kitchen cabinet surfaces, utilized for dry food storage, cooking utensils, silver-ware and dishes were observed to have old dried liquid spills, dried caked food and sticky substances felt when touched. Microwave oven, toaster and blender were found to have multiple visible caked on food, dried liquid spills and crumbs on the surfaces. The dining room floor was very sticky and made a crackling sound as individuals walked across the preparation area. Per interview at the time of the observation/inspection of the SCU dining room, with the Food Service Supervisor, the Unit Manger and the Resident Care Attendant, confirmation was made that the floor was sticky and that the cabinets/counter tops and above listed equipment were not clean and needed much attention. Confirmation was also made that there is no schedule for cleaning in the SCU. (See also R252)	R248	After three months of this routine the review will be moved to quarterly if deemed by the QI team to be appropriate. This plan of correction will be completed by 1/1/15.	
R251 SS=E	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.a All food and drink shall be stored so as to protect from dust, insects, rodents, overhead leakage, unnecessary handling and all other sources of contamination. This REQUIREMENT is not met as evidenced	R251		

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R251 SS=E	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.a All food and drink shall be stored so as to protect from dust, insects, rodents, overhead leakage, unnecessary handling and all other sources of contamination. This REQUIREMENT is not met as evidenced	R251		

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R251	Continued From page 13 by: Based on observation and interview, the facility failed to protect stored dried food from dust, insects, rodents, unnecessary handling and all other sources of contamination. The findings include the following: Per observation/inspection of the Special Care Unit (SCU) dining room, to include storage cabinets, on 11/24/14 at 12:30 PM, this dry storage area contained the following: Multiple bags of potato chips open, not secured. One opened squirt bottle containing brown liquid (3/4 full) with no cap and no identification as to what the bottle contained. One multiple gallon plastic container storing dried cereal with a visible crack along the side of the containiner approximately 3 inches in length. Two boxes of dry Maypo hot cereal mix open, partially used and not secured. Two plastic bags of dry cereal open and not secure. Per interview with the Food Service Supervisor, the Unit Manger and the Resident Care Attendant, at the time of the dining room observation/inspection, confirmation was made that the above listed items were not stored properly to avoid various sources of contamination.	R251	The Food Service Supervisor, or her designee, will conduct a daily inspection of all food storage areas to insure all food is stored properly. Daily inspections will go for a month and if there is adequate improvement the inspections will be moved to monthly. Inspections will be reviewed by the QI team and adjusted accordingly. This will be completed by 1/1/15.	
R252 SS=E	VII. NUTRITION AND FOOD SERVICES 7.2 Food Storage and Equipment 7.3.b Areas of the home used for storage of food, drink, equipment or utensils shall be	R252		

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R252 SS=E	VII. NUTRITION AND FOOD SERVICES 7.2 Food Storage and Equipment 7.3.b Areas of the home used for storage of food, drink, equipment or utensils shall be	R252		

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R252	Continued From page 14 constructed to be easily cleaned and shall be kept clean This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed assure that equipment in the Special Care Unit (SCU) dining room is and shall be kept clean. The findings include the following: Per observation/inspection of the Special Care Unit (SCU) dining room, on 11/24/14 at 12:30 PM the following conditions were evidenced: Multiple kitchen cabinet surfaces, utilized for dry food storage, cooking utensils, silver-ware and dishes were observed to have old dried liquid spills, dried caked food and sticky substances felt when touched. Microwave oven, toaster and blender were found to have multiple visible caked on food, fried liquid spills and crumbs on the surfaces. The dining room floor was very sticky and made a crackling sound as individuals walked across the preparation area. Per interview at the time of the observation/inspection of the SCU dining room, with the Food Service Supervisor, the Unit Manger and the Resident Care Attendant, confirmation was made that the floor was sticky and that the cabinets/counter tops and the above listed equipment were not clean and needed much attention. Confirmation was also made that there is no schedule for cleaning in the SCU. (See also R248)	R252	also inspect food storage areas weekly and report his findings at Weekly managers meeting and monthly at The Quality Improvement meeting. After three months of this routine the review will be moved to quarterly if deemed by the QI team to be appropriate. This plan of correction will be completed by 1/1/15.	

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R266	Continued From page 15	R266		
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 observation and staff interview the facility failed to provide and maintain a safe environment. The findings include the following: 1. Per tour of the Special Care Unit on 11/24/14 at approximately 10:15 AM, a medicine cup containing two white tablets was observed at the bedside of Resident #1. The bedroom door was observed wide open, residents on the unit ambulate freely as able and the room is easily accessed. Per The Meadows Unit Dose Drug Distribution System policy dated and initialed on 6/2012 item #7 evidences "Medications may not be left at bedside or table setting for any resident. All medication must be delivered directly to each individual". Per interview with Unit Manger on 11/24/14, confirmation is made at 11:04 AM that medication has been left unattended on Resident #1's bed side table and that the bedroom door is observed to been wide open, making the room easily accessed by wandering residents. (See also R155) 2. Per tour of the facility on 11/24/14 at 10 AM	R266	**Tag 266, 9.1** All items identified during the survey as unsafe were corrected. A facility tour was completed by The Administrator and Resident Care Director and any similar or other potentially dangerous situations, were identified. These items were given to The Maintenance Director for immediate correction. Weekly environmental rounds will be completed by The Administrator and the Director of Resident Care. Any items found	

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R266	Continued From page 16 with the Associate Administrator the following Resident Rooms were found to have oxygen cylinders stored free standing and insecure in an upright position: Room #8 had one small cylinder, Room #11 had one small cylinder, Room #26 had one small cylinder and Room #58 had five medium sized cylinders. Confirmation was made by the Associate Administrator at 10:30 AM on 11/24/14 that the cylinders are not secure and are free standing and are not stored properly. 3. Per facility tour on 11/24/14 at 10 AM with the Associate Administrator on the Traditional Unit, Room #54's bathroom was found with the baseboard heater uncovered with numerous sharp metal objects exposed. This room is shared by two residents (#9 and #11). Resident #9 is transferred via mechanical lift on and off the toilet and Resident #11 is assisted with ambulation/transfer with one staff member. Both residents are at risk for injury due to exposed sharp metal edges if contact is made. Confirmation that the heater was uncovered and in disrepair was made by the Maintenance Director on 11/24/14 at 11:58 AM.	R266	to be unsafe will be given to the Maintenance Director for immediate action. Results of the weekly environmental rounds will be reviewed monthly at the Quality Improvement Committee. The QI team will look for common issues that may be addressed to prevent them from happening in the future. Staff will be educated on not leaving medication at bedside, insuring all oxygen containers are secured and to report any potentially dangerous situations for correction. This will be completed by 1/1/15.	