

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

July 21, 2016

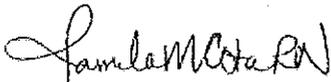
Ms. Susan Biondolillo, Administrator
Starr Farm Nursing Center
98 Starr Farm Rd
Burlington, VT 05408-1396

Dear Ms. Biondolillo:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on June 22, 2016. 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

JUL 18 2016

PRINTED: 07/05/2016
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475030 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 06/22/2016 |
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| NAME OF PROVIDER OR SUPPLIER STARR FARM NURSING CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 98 STARR FARM RD BURLINGTON, VT 05408 |
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F 000 INITIAL COMMENTS

F 000

An unannounced onsite investigation of 1 complaint concerning care and services was conducted by the Division of Licensing and Protection on 6/22/16. The following regulatory violations were identified:

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP
SS=D

F 280 Ftag 280

07/21/16

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

- Resident # 1 resident profile sheet has been revised and updated to current plan of care.
- House audit on resident profile sheets has been completed to ensure no other residents affected.
- The SDC/designee has re-educate staff on the facility requirements of updating resident profile sheets to resident's current plan of care.
- The DNS/Designee will complete random resident profile sheet audits on residents weekly x 30 days then monthly x 60 days. The results of these audits will be reviewed with the QAPI committee monthly x 3 months to ensure compliance.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

F280 POC accepted 7/21/16 Amcotaran

This REQUIREMENT is not met as evidenced by:

Based on staff interview and record review, the facility failed to revise the care plan used by LNAs (Licensed Nursing Assistants) for 1 of 2 residents to reflect the resident's current care needs (Resident #1). Findings include:

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Susan B. Bondolillo</i> | TITLE Executive Director | (X6) DATE 7-14-16 |
|---|-----------------------------|----------------------|

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 280 Continued From page 1

F 280

On 6/22/16 at 12 noon, the LNA caring for Resident #1 confirmed that the "Resident Profile" sheet that was posted in the resident's bathroom was the current care plan that the LNA staff use to determine the care they will provide to the resident. Per review, the Resident Profile was last updated 3/2/15 and stated that the resident transfers with maximum assistance "using transfer pole" and walks "5 x per week with nursing staff" using a "platform walker." The LNA stated that Resident #1 now pivdt transfers with 2 assist from bed to chair or chair to bed and s/he could not remember when the resident last walked with the platform walker. The resident's nursing care plan for "ADL [Activities of Daily Living] Self Care Performance Deficit" states to refer to the resident profile and was initiated on 11/4/13.

Per interview on 6/22/16 at 12:10 PM, the ADNS (Assistant Director of Nursing) confirmed that the transfer pole was no longer in use and that the resident is not walking with a platform walker. S/he confirmed that the care plan/Resident Profile needed to be updated.
(Refer to F281, F282, F323, and F514)

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

F 281

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to provide services

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F 281 Continued From page 2

that meet professional standards of quality by not obtaining a physician's order or completing a restraint evaluation for the use of a lapbelt restraint prior to its use and for failure to provide notice to the resident's responsible party of the use of the restraint for 1 of 2 residents (Resident #2); the facility also failed to ensure that the Interdisciplinary Team reviewed the use of restraints quarterly or following significant change in condition for 1 of 2 residents (Resident #1). Findings include:

1. Per record review, Resident #2 was admitted to the facility on 5/13/16 with a diagnosis of Huntington's Disease, a progressive neurodegenerative condition characterized by involuntary movements. Per interview with the Unit Manager (UM) on 6/22/16 at approximately 2:25 PM, s/he reported that Resident #2 uses a lapbelt restraint when sitting up in a chair as his/her involuntary movements increase when out of bed posing a safety risk. Per review of the medical record with the UM, s/he confirmed that there was no physician's order for the use of the lapbelt restraint; the UM also confirmed that a Physical Restraint Evaluation was not completed for the resident and was not started until the day of this survey. The UM also confirmed that the Acknowledgment of Physical Restraint Use form, which lists potential risks and benefits of the use of restraints and the facility's review process for restraint use was not signed by the resident's responsible family member (RP).

Per review of the facility procedure, titled Restraint Use (10/31/10 R), Step 4. states to obtain physician's order as necessary. Step 5. Review rationale for the use of the restraints including the risk and benefits or [sic] restraint

F 281

Ftag 281

- Resident #2 has a physician order for use of a lap belt; a physical restraint assessment has been completed as well as a signed acknowledgement of physical restraint/supportive device use form signed by the residents' guardian.
- Resident # 1 has a physician order for use of thigh belt and enclosure bed; a physical restraint assessment has been completed as

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F 281 Continued From page 3

use. Obtain patient and/or family signature on the acknowledgment form (Acknowledgment of Physical Restraint Use). Step 12. Complete restraint assessment.

2. Per record review, Resident #1 has a diagnosis of Huntington's Chorea, a progressive neurodegenerative condition characterized by involuntary movements. A chest harness and lap belt restraint were ordered by the residents' physician and used for positioning and safety while the resident was up in his/her wheelchair. On 6/6/16, the nursing progress note documented that Resident #1's family member approached the nurses station to report that s/he found the resident slipped down in his/her chair with harness straps pressing on [his/her] neck and chin. The resident had been repositioned in the chair several times by staff during the shift due to moving [her/himself] in the chair. Per interview on 6/22/16 at 3:15 PM, with an LNA (Licensed Nursing Assistant) on duty at the time of the incident, s/he reported that she observed that the resident had slid down in his/her chair and the strap (from the chest harness) was at the resident's neck; she reported that "we had pulled [him/her] up three times in the chair that day."

Per review, Resident #1's POA-HC (Power of Attorney for Health care) and a facility representative signed a form titled, Acknowledgement of Physical Restraint Use (for the use of a chest harness and velcro seatbelt) on 9/11/15. The form states that "The use of the physical restraint will be reviewed at least quarterly by the Interdisciplinary Team (IDT) or more frequently as necessary." Per interview with the facility ADNS (Assistant Director of Nursing), s/he confirmed that there was no evidence that

F 281

well as a signed acknowledgement of physical restraint/supportive device use form for both thigh belt and enclosure bed signed by the power of attorney for health care.

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- House audit completed on residents with physical restraints/ supportive seating devices (seat belts, lap belts, harnesses etc.) to ensure no other residents were affected by this practice.
- The SDC/ designee has Re-Educated staff on the policy/procedure for restraints/ supportive seating devices.
- The DNS/designee will complete random weekly audits of residents with physical restraints/supportive seating devices x 1 month then monthly x 2 months. The results of these audits will be reviewed monthly with the QAPI committee x 90 days to ensure substantial compliance.

F281 POC accepted 7/21/16 pncostuRN

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F 281 Continued From page 4
an IDT team had reviewed the use of restraints quarterly or more frequently. Per 6/22/16 at 4:44 PM interview with the facility DNS (Director of Nursing), s/he confirmed that there was no evidence that restraints were reviewed by an IDT or at the quarterly case management meetings. The facility policy titled Restraint Use states in Section 16 and 17, "Assess patient quarterly, annually, and/or significant change in the patient's status." There is no evidence of a reassessment following the resident's admission to the hospice program on 3/25/16 and weight loss from 118.5 pounds on 12/28/15 to 106.4 pounds on 6/6/16. (Refer to F280, F282, F323, and F514)

F 281

F 282 This is a repeat citation.
483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

F 282

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to provide services in accordance with the plan of care for 1 of 2 residents (Resident #1). Findings include:

Per record review, the facility failed to implement the care plan for Resident #1 related to use of supportive devices and physical restraints. Resident #1 has a diagnosis of Huntington's Chorea, a chronic, progressive neurodegenerative condition characterised by

Ftag 282

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- Resident # 1 has a current physical restraint assessment completed for use of a thigh belt in wheelchair and for enclosure bed per current plan of care.
- House audit completed on residents with physical

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| F 282 | Continued From page 5 involuntary movements. A care plan was established on 4/15/15 for "Supportive device/Physical restraint Safe enclosure bed.... and positional harness in shower chair, wheelchair seatbelt and harness." The plan stated to "complete the Restraint evaluation, reassess quarterly or as needed for continued necessity and appropriateness." Per record review on 6/22/16 at approximately 12:15 PM, the facility ADNS (Assistant Director of Nursing), confirmed that the last time the Restraint Evaluation was completed was on 9/1/15 and confirmed that the Restraint Evaluation tool had not been reassessed/completed quarterly as per care plan. S/he also confirmed that there was no evidence that an IDT (Interdisciplinary Team) had reviewed the use of restraints quarterly or more frequently as necessary. Per 6/22/16 at 4:44 PM interview with the facility DNS (Director of Nursing), s/he confirmed that there was no evidence that restraints were reviewed by an IDT or at the quarterly case management meetings. (Refer to F280, F281, F323, and F514) This is a repeat citation | F 282 | restraints/ supportive seating devices (seat belts, lap belts, harnesses etc.) to ensure no other residents were affected by this practice. <ul style="list-style-type: none"> The SDC/ designee has Re-Educated staff on the policy/procedure for restraints/ supportive seating devices. The DNS/designee will complete random weekly audits of residents with physical restraints/supportive seating devices x 1 month then monthly x 2 months. The results of these audits will be reviewed monthly with the QAPI committee x 90 days to ensure substantial compliance. <i>FABA poc accepted 7/21/16 Amestarn</i> |
| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. | F 323 | |

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| F 323 | <p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that the environment was free of accident hazards and that each resident received adequate supervision to prevent accidents for 1 applicable resident in the sample. (Resident #1) Findings include:</p> <p>The facility failed to assess the use of physical restraints quarterly, annually and/or following a significant change in patient's status per policy or per care plan. Per record review, Resident #1 has a diagnosis of Huntington's Chorea, a progressive neurodegenerative condition characterized by involuntary movements. A chest harness and lap belt were ordered by the resident's physician and used for positioning and safety while the resident was up in his/her wheelchair. On 6/6/16, the nursing progress note documented that Resident #1's family member approached the nurses station to report that s/he found the resident slipped down in his/her chair with harness straps pressing on [his/her] neck and chin. The resident had been repositioned in the chair several times by staff during the shift due to moving [her/himself] in the chair. Per interview on 6/22/16 at 3:15 PM, with an LNA (Licensed Nursing Assistant) on duty at the time of the incident, s/he reported that the resident had slid down in his/her chair and the strap (from the chest harness) was at the resident's neck; she reported that "we had pulled [him/her] up three times in the chair that day."</p> <p>Per review of pictures taken at the time of the incident, Resident #1 was observed to be sliding down in his/her wheelchair; chest harness straps</p> | F 323 | <p>Ftag 323</p> <ul style="list-style-type: none"> Resident # 1 has a current physical restraint assessment completed for use of thigh belt in wheelchair and enclosure bed. House audit completed on residents with physical restraints/ supportive seating devices (seat belts, lap belts, harnesses etc.) to ensure no |
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F 323 Continued From page 7
were observed positioned at the residents neck; a side view photograph showed the right harness strap pressing into the right side of the residents' neck. A picture taken after the harness was removed, showed a linear red mark on the resident's right neck.

Per review of Physical Therapy notes, the last documented Physical Therapy admission was from 12/9-12/29/15 when the resident was seen for positioning. At the start of the evaluation, the resident's head, trunk and feet were not well supported, but on discharge, the resident was positioned "good in the tilt in space wheelchair from head to feet."

Per 6/22/16 at 1:35 PM interview with the Program Director (PD) of the rehab department, s/he reported that the facility does not have a routine schedule to reassess harness and lapbelt fit. S/he reported that if restraints are in use, they are looked at each time a resident is admitted for therapy. Since the 12/29/15 assessment, the resident was admitted to the hospice program on 3/25/16. The resident's weight declined from 118.5 pounds on 12/28/15 to 106.4 pounds on 6/6/16. Per rehab staff, there was no documentation of Physical Therapy visits after 12/29/15.

The PD reported seeing Resident #1 after the 6/6/16 incident and reported changing the resident's seat cushion to one that has a wedge and saddle fit with a position "bump" to decrease slippage. S/he reported that s/he also made adjustments to the seat belt and had maintenance change the fastening points of the belt to the chair to make it the right tightness. S/he reported that this visit was not a formal

F 323 other residents were affected by this practice. 07/21/16

- The SDC/ designee has Re-Educated staff on the policy/procedure for restraints/ supportive seating devices.
- The DNS/designee will complete random weekly audits of residents with physical restraints/supportive seating devices x 1 month then monthly x 2 months. The results of these audits will be reviewed monthly with the QAPI committee x 90 days to ensure substantial compliance;

F323 POC accepted 7/21/16 matarn

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| F 323 | <p>Continued From page 8</p> <p>evaluation and s/he did not document the assessment or changes that were made to the chair or lapbelt. The chest harness was removed immediately following the 6/6/16 incident and was no longer in use; the PD reported that s/he did not reassess the chest harness after the incident.</p> <p>Per review, Resident #1's POA-HC (Power of Attorney for Health care) and a facility representative signed a form titled, Acknowledgement of Physical Restraint Use (for the use of a chest harness and velcro seatbelt) on 9/11/15. The form states that "The use of the physical restraint will be reviewed at least quarterly by the Interdisciplinary Team (IDT) or more frequently as necessary." Per interview with the facility ADNS (Assistant Director of Nursing), s/he confirmed that there was no evidence that an IDT team had reviewed the use of restraints quarterly or more frequently. Per 6/22/16 at 4:44 PM interview with the facility DNS (Director of Nursing), s/he confirmed that there was no evidence that restraints were reviewed by an IDT or at the quarterly case management meetings. The facility policy titled Restraint Use states in Section 16 and 17, "Assess patient quarterly, annually, and/or significant change in the patient's status." There is no evidence of a reassessment following the resident's admission to the hospice program and weight loss.</p> <p>(Refer to F280, F281, F282, F514)</p> | F 323 | | |
| F 441 SS=D | <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and</p> | F 441 | | |

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| F 441 | <p>Continued From page 9</p> <p>to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <ol style="list-style-type: none"> (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. <p>(b) Preventing Spread of Infection</p> <ol style="list-style-type: none"> (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review, the facility failed to implement proper infection control measures during a dressing</p> | Ftag 441 F 441 | <p>Resident # 1 is receiving dressing changes per facility policy/ procedures for clean dressing changes. Resident # 1 fan was cleaned on 6/22/16.</p> <ul style="list-style-type: none"> • All residents have the potential to be affected by this deficient dressing change practice. House audit on fans completed to ensure no other dirty fans. • The SDC / designee has re-educated the nursing staff on policy/procedure for clean dressing changes. The housekeeping manager has re-educated the house keeping staff on cleaning resident personal fans. • The DNS/ designee will complete weekly audits mon-fri x 30 days then monthly x 90 days. The Housekeeping manager will audit fan cleanliness weekly x 30 days then monthly x 90 days. The results of these audits will be reviewed monthly with the QAPI committee x 90 days to ensure compliance. <p><i>F441 POC accepted 7/21/16 P. M. O. T. A. W.</i></p> | 07/21/16 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475030 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 06/22/2016 |
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F 441 Continued From page 10 F 441

change for 1 resident and for the same resident, failed to ensure that a sanitary environment was maintained per infection control standards (Resident #1). Findings include:

1. Per observation, a staff nurse failed to follow infection control measures during dressing changes on 2 open wounds. On 6/22/16 at approximately 8:45 AM, a staff nurse was observed to place dressing supplies directly on the surface of Resident #1's over the bed table without cleaning the surface or using a clean barrier. After completing the first dressing change on an open area of the right elbow (which involved removing a soiled dressing and cleaning the wound with normal saline), the nurse did not wash or sanitize his/her hands prior to changing gloves and starting the second dressing procedure on an open area between the 4th and 5th toes of the resident's right foot. Following the observation, the nurse confirmed the failure to set up a clean barrier for supplies and to sanitize hands between the 2 dressing changes.

Per review, the facility policy Clean Dressing Change states in step 6. "Create clean field with paper towels or drape." Under Step 12, there is a note that states "If resident has multiple wounds, wash hands in between wounds and cleanse the least contaminated to the most contaminated wound." On 6/22/16 at 9:00 AM, the facility ADNS (Assistant Director of Nursing) confirmed that the dressing change as described above did not follow infection control practices.

2. Per 6/22/16 at 8:20 AM observation in Resident #1's room, a heavily dust soiled fan was observed blowing in the direction of the resident. Per interview with the LNA who was providing care at

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| F 441 | Continued From page 11 the time of the observation, s/he confirmed that the fan was on and had been blowing in the direction of the resident while s/he was in his/her bed earlier in the morning and now while up and seated in the room. Per medical record review, Resident #1 has a diagnosis of asthma as well as other chronic medical conditions. On 6/22/16 at 8:55 AM, a staff nurse confirmed that the dust soiled fan posed an infection control issue and stated that s/he would speak to the Unit Manager (UM) about setting up a plan to clean the fan on a regular basis as there was no cleaning schedule established for the fan at this time. | F 441 | | |
| F 514 SS=D | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: The facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are | F 514 | | |

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| F 514 | Continued From page 12 complete; accurately documented; readily accessible; and systematically organized for 1 of 2 residents (Resident #1). Findings include: Per record review, Resident #1 has a diagnosis of Huntington's Chorea, a progressive neurodegenerative condition characterized by involuntary movements. A chest harness and lap belt were ordered by the residents' physician and used with the resident for positioning and safety while s/he was up in his/her wheelchair. On 6/6/16, the nursing progress note documented that Resident #1's family member approached the nurses station to report that s/he found the resident slipped down in his/her chair with harness straps pressing on [his/her] neck and chin. The resident had been repositioned in the chair several times by staff during the shift due to moving [her/himself] in the chair. Per 6/22/16 at 3:15 PM interview with an LNA (Licensed Nursing Assistant) on duty at the time of the incident, s/he reported that the resident had slid down in his/her chair and the strap (from the chest harness) was at the resident's neck; she reported that "we had pulled [him/her] up three times in the chair that day." Per 6/22/16 at 1:35 PM interview with the Program Director (PD) of the rehab department, s/he reported seeing Resident #1 after the 6/6/16 incident and reported changing the resident's seat cushion to one that has a wedge and saddle fit with a position "bump" to decrease slippage. S/he reported that s/he also made adjustments to the seat belt and had maintenance change the fastening points of the belt to the chair and took measurements for a new chair for the resident. The PD reported that this visit was not a formal evaluation so s/he did not document the | F 514 | Ftag 514 <ul style="list-style-type: none"> Resident #1 had a current therapy evaluation and treatment and it is documented in medical record. All residents have the potential to be affected by this practice. The District director of Clinical Operations re-educated the program director on documenting screens and evaluation per policy. The Program Director has re-educated the therapists on the documentation requirements per policy. The Rehab Program Director/designee will complete random monthly audits on the rehab screen documentation x 3 months. The results of these audits will be reviewed by the QAPI committee monthly x 90 days to ensure compliance. | 07/21/16 | |

F514 POC accepted 7/21/16 direct care

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| F 514 | Continued From page 13 assessment or changes that were made to the chair or lapbelt. S/he confirmed that documentation in Resident #1's record was complete. (Refer to F280, F281, F282, and F323) | F 514 | | |