

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

October 21, 2014

Mr. Dane Rank, Administrator
Thompson House Nursing Home
80 Maple Street
Brattleboro, VT 05302-6551

Dear Mr. Rank:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 17, 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

PC:kc

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

OCT 13 2014

PRINTED: 09/23/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/17/2014
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NAME OF PROVIDER OR SUPPLIER THOMPSON HOUSE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 80 MAPLE STREET BRATTLEBORO, VT 05302
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{F 000} INITIAL COMMENTS

{F 000}

F 157

An unannounced follow up visit for a complaint investigation [on 07/07/14] and a recertification survey [on 07/24/14] was conducted by the Division of Licensing and Protection on 09/16/14 - 09/17/14. The following are regulatory violations.

Resident #2
MD notified and catheter order clarified.

9/18/14

{F 157} 483.10(b)(11) NOTIFY OF CHANGES SS=D (INJURY/DECLINE/ROOM, ETC)

{F 157}

Resident #50
MD notified of pressure ulcer. Orders remained the same.

9/16/14

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

DNS or designee will audit resident records to ensure notifications have been made for current orders and conditions.

10/14/14

Policies regarding Notification of changes reviewed and updated as necessary.

10/10/14

DNS or designee will educate nursing staff regarding Notification of changes.

10/14/14

DNS or designee will monitor 24 report sheets weekly to ensure that notification of changes is done.

Ongoing

DNS or designee will perform audits of 5 resident records per quarter to ensure that Notification of changes is done.

Ongoing

Results will be reported at QA meetings. DNS to monitor for compliance.

Ongoing

F157 POC accepted 10/16/14 SEMMONS RN/PML

The facility must record and periodically update the address and phone number of the resident's

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Administrator

(X6) DATE

10/10/14

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 157}	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to consult with a physician or notify the family regarding a significant change in medical condition or a potential clinical complication for two of six residents in the sample group. (Resident #2 and #50). Findings include: 1. Per record review on 09/17/14, Resident #2 has a history of urinary infections and an indwelling catheter, in which the wrong size catheter was used and the physician was not notified. Per signed physician orders from May 2014 through August 2014 states " 18Fr 10 cc Foley". A physician order dated 08/18/14 states "discontinue 18 Fr. 10 cc balloon use 18 Fr. 30 cc balloon catheter with only 20 cc balloon [filled]". Per a telephone order on 08/19/14 notes "may wait until 18 Fr balloon cath comes out to change 18 Fr with 30 cc balloon". Per a nursing note on 08/26/14 states the LNA [licensed nursing assistant] found the catheter pulled out with the balloon inflated and a " 16 Fr 10 cc balloon reinserted". Per review of the August 2014 TAR [treatment administration record] notes "Foley cath 18 Fr. 30 cc but use 20 cc" and shows on 08/26/14 a Foley was inserted. On 09/17/14 at 9:45 AM a 16 Fr 10 cc catheter was observed in Resident #2. Per interview the nurse stated "it has always been a 16 Fr. but I did let [supply department] we needed a 18Fr one". Per record review of the supply order, a 18 Fr 30 cc Foley had not been ordered nor was any 18Fr Foley found in the supply room. The DNS [Director of Nursing] confirmed the physician was not notified	{F 157}		

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{F 157}	Continued From page 2 that a wrong catheter was inserted nor the availability of the 18Fr. Foley catheter. Also see F-281 2. Resident #50 developed a pressure ulcer in which the physician and family was not notified. Per a nursing assessment upon admission on 08/11/14 the skin exam shows bruising on the top of the feet and a right hip incision. The TAR for August 2014 directs staff to apply a barrier dressing (Allyum) to the sacrum and to apply skin prep to bilateral heels plus 'booties when in bed". Per a nursing note on 08/20/14 states red area heels/toes, skin prep applied. On 08/27/14 a nursing notes states "eschar to left heel and bruising... skin prep applied" with measurements of 1.5 cm x 1.7 cm. Per observation on 09/16/14 at 2:25 PM the nurse measured the eschar wound at 2 cm x 1.8 cm. The DNS confirmed the physician was not notified of a worsening skin condition. Also see F-314	{F 157}	F 221 Resident #41 Seat belt restraint discontinued after discussion with MD. Policies regarding the use of a restraint were reviewed and updated as necessary. DNS or designee will educate nursing staff regarding use of restraints. DNS or designee with monitor resident records to ensure appropriate use of restraints, if necessary. Results will be reported at QA meetings. DNS to monitor for compliance.	10/10/14 10/10/14 10/14/14 Ongoing Ongoing	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to insure freedom from restraints not required to treat a medical symptom for one of one resident in the sample, Resident #41. Findings include:	F 221	<i>F221 POC accepted 10/16/14 Semmons RA/PMC</i>		

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F 221	Continued From page 3 On 9/16/14 during record review of care plans for Resident #41, it was noted that s/he had a restraint. Physician orders dated 07/23/14, a telephone order, presents that s/he is to have a wheelchair seatbelt restraint with alarm per a Thompson House Policy secondary to safety. There is no evidence of a physician progress note to support medical justification for a restraint. Diagnoses of resident includes Alzheimer's Dementia with agitation, syncope and Hypothyroidism. Review of falls for Resident #41 presents that h/she had a fall on 7/6 and 7/12 and both were from the bed. On 7/22/14 a fall occurred from the wheelchair and resident had minor injuries. Observation of the resident on 9/16/14 from 1:30PM to 3:00PM presented him/her in wheelchair with restraint device in place. When resident was asked at 2:15PM if h/she could remove the belt, there was no evidence of comprehending what was asked as h/she just stared and fidgeted with hands. Observation of resident on 9/17/14 at 10:30AM presented in wheelchair with seatbelt restraint in place and when asked if h/she could remove the restraint, the response was the same as 9/16/14. Per review of the medial record on 9/17/14 presents with a nurse progress note dated 7/24/14 that indicates the restraint was applied per family request. Per confirmation from the Director of Nurses (DON) on 9/17/14 at 10:35AM, there is no evidence of medical justification for the restraint and that it was from a family request. Confirmation also made by the Minimum Data Set coordinator that there are no nurse progress notes, physician notes or social service notes nor a signed consent for the restraint from the family to indicate reason for restraint.	F 221		

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{F 280}	Continued From page 4 {F 280} 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP SS=D The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to make revisions of care plans for 3 of 6 residents in the sample, Resident #11, #41 and #3. Findings include: 1. On 09/16/14 at 9:30 AM while touring facility, the call bell was not observed during interview with Resident #11. During medical record review on 09/17/14 at 1:50 PM, the nurse progress notes for Resident #11 presented that the resident had sustained a fall on 07/24/14 with minor injuries resulting. Review of the care plan dated 07/24/14	{F 280}	F 280 Resident #11 Care Plan updated to include alarms and bed cradle. Resident #41 Edge sensor alarm replaced. Resident #3 Care plan updated to discontinue use of sling. All resident care plans were reviewed to ensure resident specific issues are included. Policies regarding care planning were reviewed and updated as necessary. DNS/SDC provided education to staff involved in care planning. DNS or designee will perform audits of 5 resident care plans per quarter to ensure that all identified needs are addressed Results will be reported at QA meetings. DNS to monitor for compliance.	9/17/14 9/17/14 9/17/14 10/14/14 10/10/14 10/14/14 Ongoing Ongoing

F280 PDC accepted 10/16/14 Semmons RN/pmc

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{F 280}	Continued From page 5 stated that Resident #11 was to have call bell in place as indicated and to utilize chair and bed alarms. Observation of the room on 09/17/14 at 2:00 PM did not present that resident had bed alarm in place nor did the resident have a chair alarm in place. Care plan review at this same time presented that resident to have bed cradle secondary to potential for skin breakdown. During observation on 09/16 and 09/17/14, there was no presence of a bed cradle. Per confirmation with the Licensed Practical Nurse on 09/17/14 at 2:05 PM, the care plan reflects that bed/chair alarms are to be used and that a bed cradle is to be on the bed. S/he stated at this time that the resident does not use the bed or chair alarm anymore and the care plan has not been revised. S/he also confirmed that Resident #11 periodically has pressure areas on her toes, but s/he does not currently have any. Confirmed that there was no bed cradle use and that the care plan had not been revised to reflect the change. 2. On 09/16/14 at 3:55 PM review of medical record presents that care plan for Resident #41 to include a edge sensor alarm to be utilized on bed. There is no date to indicate when added to care plan and per interview with the Licensed Practical Nurse (LPN), it was added a 09/11/14 Falls review for this resident presents that he fell from bed on 07/06/14, 07/12/14 and 08/09/14. The LPN stated that a bed alarm was being used and this surveyor inquired as to the difference between the alarms and s/he stated that the edge sensor alarm alerts staff to when the resident places a leg over the edge of the mattress and a bed alarm doesn't alarm until the resident is off the mattress and the edge sensor is a better device. Observation of the alarms, presents that	{F 280}		

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{F 280}	Continued From page 6 there is a bed alarm and no an edge sensor alarm in place. Per the LPN the resident tore the wires out of the edge sensor alarm the first night it was put on and it hasn't been replaced. S/he confirmed at this time that the care plan has not been revised to accurately reflect the need of the resident. 3. Resident #3's care plan was not updated to reflect the current treatment modality. The care plan presents for ADL's [activity of daily living] issues, history of falls, behaviors and pain. It directs staff to provide safety items such as floor mat, recliner for restlessness, monitoring for anxiety and to provide comfort measures as ice packs or a sling. Per the recent physician order dated on 09/15/14 was to discontinue the sling. Per record review on 09/17/14 the care plan did not reflect the discontinuation of the sling. Per interview at 9:35 AM the nurse stated "all nurses should be hard-wired to change the care plans, TARs and MARs [treatment and medication administration records]". S/he confirmed that the care plan was not revised.	{F 280}	F 281 Resident #2 MD notified and catheter order clarified. Resident #50 Resident expired. All resident records were reviewed to ensure MD orders are accurate. Policies regarding MD orders and Initial assessments were reviewed and updated. DNS/SDC provided education to staff involved in order transcription and incident monitoring. DNS or designee will perform audits of 5 resident records per quarter to ensure that orders are properly transcribed, and monitoring following an incident is complete.	9/18/14 9/27/14 10/14/14 10/10/14 10/14/14 Ongoing
{F 281} SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview the nurse failed to follow physician's orders for 1 of 4 applicable residents. (Resident #2) Findings include:	{F 281}	Results will be reported at QA meetings. DNS to monitor for compliance. <i>F281 PDC accepted 10/16/14 SEMMONS RN/PMC</i>	Ongoing

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{F 281} Continued From page 7

1. Per record review on 09/17/14 at 8:30 AM, Resident #2 had a physician order for a change in the Foley catheter. The physician order dated 08/18/14 states "discontinue 18 Fr. 10 cc balloon use 18 Fr. 30 cc balloon catheter with only 20 cc balloon [filled]". Per a nursing note on 08/26/14 states the LNA [licensed nursing assistant] found the catheter pulled out with the balloon inflated and a "16 Fr 10 cc balloon reinserted". Per review of the August 2014 TAR [treatment administration record] presents "Foley cath 18 Fr. 30 cc but use 20 cc" and shows on 08/26/14 a Foley was inserted. On 09/17/14 at 9:45 AM a 16 Fr 10 cc catheter was observed in Resident #2. Per interview at that time, the nurse stated "it has always been a 16 Fr. but I did let [supply department] we needed a 18Fr one". The DNS, who was present during the observation, confirmed the nurse failed to follow the physician's order.
Also see F-157

2. Resident #50 who had skin issues, failed to receive a comprehensive initial assessment by the registered nurse and complete dated and signed nursing notes. On 08/11/14 the initial comprehensive assessment was not signed nor dated and not all areas of the assessment were completed. Per interview on 09/16/14 at 2:45 PM the DNS identified the handwriting as (the LPN). The DNS confirmed at that time that the assessment was not complete, signed or dated and that the registered did not review and/or co-signed the comprehensive initial assessment.
Also see F-157, F-314 and F514

*Reference: Based on Standards of Professional Nursing Practice, Lippincott Manual of Nursing

{F 281}

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{F 281}	Continued From page 8 Practice 19th edition, Wolters Kluwer Health/Lippincott Williams & Wilkins. {F 282} 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN SS=E 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 record review and staff interview, the facility failed to insure that services were provided by qualified persons to implement plans of care for 2 of 6 residents, Resident #12 and #6. Findings include: 1. The facility failed to provide services in accordance to Resident's #6 care plan. Resident #6, who is taking an antipsychotic, has a care plan to monitor changes in cognition, side effects, lethargy hallucination or delusions. Per review of the TARs, two Behavior Monitoring Sheets were found in the chart. One Behavior sheet had no indication of the month and presents as the behavior to monitor as "11/12". Dnly one day [the 15th] during the the unknown month was documented as being monitored. The Behavior Monitoring Sheet dated September 2014 notes the behavior as 'anxiety'. Per interview on 09/16/14 at 4:45 PM the DNS stated "there would be notes documenting noting [behaviors]" and acknowledged that the Behavior Monitoring Sheet were not clear to the type of behaviors. S/he confirmed that staff failed to consistently monitor behaviors per the care plan.	{F 281}	F 282 Resident #6 Behavior Monitoring sheet was updated. Resident #12 Skin assessment completed. All resident care plans were reviewed to ensure interventions are in place. All residents on antipsychotic medication were reviewed to ensure Behavior Monitoring sheets are in place. Policies regarding care plans, behavior monitoring, and weekly skin assessments were reviewed and updated as necessary. DNS/SDC provided education to staff involved in care planning, Behavior Monitoring, and skin assessments DNS or designee will perform audits of 5 resident records per quarter to ensure that care plan interventions, Behavior Monitoring sheets and weekly skin assessments are in place. Results will be reported at QA meetings. DNS to monitor for compliance.	9/17/14 10/10/14 10/14/14 10/14/14 10/10/14 10/14/14 Ongoing Ongoing

Faba PDC accepted 10/16/14 Semmon R/PMC

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{F 282}	Continued From page 9 2. Per record review on 9/16/14 for Resident #12, a care plan dated 12/11/12 directs staff to do weekly skin assessments and there is no evidence in the record to present that these assessments have been done. Resident #12 currently presents with Stage 2 pressure ulcers on his/her feet. Per nursing progress notes the wounds were measured on 8/3/14 with notation that they were still improving and no further mention of the wounds being assessed until 9/8/14. There is evidence that the wounds were measured or assessed and this was confirmed by the Licensed Practical Nurse (LPN). Per the LPN at 2:35 PM, there are no "official" skin assessment trackers that are used. H/she further stated that when the resident is getting a shower, h/she tells the Licensed Nursing Assistant to get him/her if there are any areas of concern. H/she then stated that h/she will go to look at the resident if it is reported. The LPN further stated that h/she did not know what the other nurses do. Per Minimum Data Set (MDS) Registered Nurse (RN) coordinator at this time, h/she confirmed that there is no tool to assess skin weekly and that there is no evidence that it is consistently done.	{F 282}	F 314 Resident #50 expired. Resident #12 Wound assessment and Braden scale assessment completed. Policies regarding Pressure Ulcer Risk Assessment and documentation were reviewed and updated as necessary. DNS/SDC will provide education to all nursing staff regarding Pressure Ulcer Risk Assessment and documentation. DNS or designee will audit 5 resident records each quarter to ensure that assessments are complete. Results will be reported at QA meetings. DNS to monitor for compliance.	9/27/14 10/10/14 10/10/14 10/14/14 Ongoing Ongoing
{F 314}	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and	{F 314}	F314 PDC accepted 10/16/14 SEMINONS RN/PMC	

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{F 314}	Continued From page 10 prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed insure residents receive necessary treatment and services to promote healing and prevent new sores from developing for 2 of 4 residents in the sample (Resident #50 and #12). Findings include: 1. Resident #50 developed an unstageable pressure ulcer within one month of admission. Per a nursing assessment upon admission on 08/11/14 the skin exam shows only bruising on the top of the feet and a right hip incision. The 08/12/14 Braden Assessment Score was '12' - High Risk' for skin breakdown. The admission care plan directs staff to provide air mattress, booties in bed, hip precautions, encourage turning, treatment as ordered, abduction pillow, monitor incision right hip and heels up when in bed. The TAR (Treatment Administration Record) for August 2014 directs staff to apply a barrier dressing (Allyum) to the sacrum and to apply skin prep to bilateral heels plus 'booties' when in bed". Per a nursing note on 08/20/14 states red area heels/toes, skin prep applied. On 08/27/14 a nursing notes states "eschar to left heel and bruising...skin prep applied" with measurements of 1.5 cm x 1.7 cm.. The Weekly Wound assessment dated 09/05/14 [3 days late] notes the heel measurement as 1 cm x 1.8 cm. Per observation on 09/16/14 at 2:25 PM the nurse measured the eschar wound, which increased, at 2 cm x 1.8 cm. Per review of Thompson's House Pressure Ulcer and Treatment Guidelines and Treatment option	{F 314}		

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{F 314}	<p>Continued From page 11</p> <p>presents that debridement is indicated if there are signs and symptom of infection and may be contradicted in some situations as well as using products such as Hypergel or Mepitx. The Guidelines further states that the wound team is a collaboration of several disciplines, the physician leads the team and orders the treatments and if not improved in 2 weeks consult the team. Per review of the chart there is no indication that the physician had been notified. During interview at 2:50 PM on 09/16/14 the DNS (Director of Nursing Services) stated "I think it [heel] was red and then turned into eschar". The DNS confirmed that the facility failed insure residents receive necessary treatment and services to promote healing and prevent new sores from developing.</p> <p>Also see F-157 and F-281</p> <p>2. Per record review on 09/16/14 for Resident #12, the care plan presents with a care plan dated 12/11/12 to do weekly skin assessments and there is no evidence in the record to present that these assessments have been done. Resident #12 currently presents with Stage 2 pressure ulcers on his/her feet and there is no evidence that the wounds were measured or assessed consistently and this was confirmed by the Licensed Practical Nurse (LPN). Per the LPN at 2:35 PM, there are no "official" skin assessment trackers that are used. S/he further stated that when the resident is getting a shower, s/he tells the Licensed Nursing Assistant to get him/her if there are any areas of concern. S/he then stated that s/he will go to look at the resident if it is reported. The LPN further stated that s/he did not know what the other nurses do. Per Minimum Data Set (MDS) Registered Nurse (RN)</p>	{F 314}		

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{F 314}	Continued From page 12 coordinator at this time, s/he confirmed that there is no tool to assess skin weekly and that there is no evidence that it is consistently done. Measurements of the wounds presented in the nurse progress note indicate that areas on heels were first presented to the physical on 07/18/14 but on 07/05/14 s/he presented to have large macerated area on heel of right foot and it was measured on 07/07/14. On 07/08/14 the resident presented with a need for skin prep to left heel. Evidence of measuring not done again until 07/25/14 and 08/03/14 with a notation that the area was 2.0 x 3.0 cm and still improving. The next measurement and assessment was not done until 09/05/14 at which time the wound to the right heel was 2.0 x 3.0 cm. Measurements documented on 09/08/14 presents that left heel resolved and right heel was 4.0 x 1.2 cm which is larger. There was also confirmation from the RN on 09/17/14 at 9:18 AM that there is no evidence that a Braden Skin Risk assessment was completed for Resident #12, per facility policy of completing upon admission and then every week for four weeks and then quarterly and if skin conditions arise.	{F 314}	F 428 Resident #9 Recommendation sent to MD. All resident records were reviewed to ensure pharmacy recommendations are complete. Policies regarding pharmacy recommendations were reviewed and updated as necessary. DNS/SDC provided education to staff involved pharmacy recommendations. DNS or designee will perform audits of 5 resident records per quarter to ensure that recommendations are complete. Results will be reported at QA meetings. DNS to monitor for compliance.	9/16/14 10/14/14 10/10/14 10/14/14 Ongoing Ongoing	
{F 428} SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	{F 428}	F428 POC accepted 10/16/14 summons RN/PMC		

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{F 428}	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to act on the Pharmacy Consultant's report of recommendations for 1 of 2 residents in the sample (Resident #9). Findings include: 1. Per review of Resident #9's chart, the Pharmacy had suggested a GDR {gradual dose reduction} for three psychotropic medications which have not been acted upon. Per the Pharmacy review dated June 25, 2014 the pharmacist suggested that the physician review the orders for Klonopin, Ambien and Lexapro and attempt a GDR. The pharmacist review dated 07/22/14 notes "still pending" regarding the GDR. Again on 08/28/14, the pharmacy review notes still pending for the GDR. There is no evidence of the physician's review with explanation to reduce or keep the same doses. Per interview on 09/16/14 at 1:20 PM the DNS stated a fax, which is sent to the physician, had not been returned but stated "[s/he] signed the current orders". However, the DNS confirmed that the pharmacist's recommendations/report had not been acted upon.	{F 428}	F 514 Resident #50 expired. Resident #12 Wound assessment and Braden scale assessment completed. Policies regarding clinical records were reviewed and updated as necessary. DNS/SDC provided education to staff involved in maintaining clinical records. DNS or designee will perform audits of 5 resident records per quarter to ensure that clinical records are complete.. Results will be reported at QA meetings. DNS to monitor for compliance.	9/27/14 10/10/14 10/10/14 10/14/14 Ongoing Ongoing
{F 514}	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.	{F 514}	FS14 POC accepted 10/16/14 SEMMONS/RH/AME	

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{F 514}	Continued From page 14 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: Based on record review and staff interview, the facility failed to insure accurate and completed records for 2 of 6 residents in the sample, Resident #12 and #50. Findings include: 1. Review of record for Resident #12 on 09/16 and 09/17/14 presents that the resident has pressure ulcerations of bilateral heels. There was no evidence of Braden Skin assessments being completed for this resident. There was also confirmation from the RN on 09/17/14 at 9:18 AM that there is no evidence that a Braden Skin Risk assessment was completed for Resident #12, per facility policy of completing upon admission and then every week for four weeks and then quarterly and if skin conditions arise. 2. Per record review on 08/11/14, Resident#50's chart had an incomplete record. The initial comprehensive assessment was not signed nor dated and not all areas of the assessment were completed. Per interview on 09/16/14 at 2:45 PM the DNS identified the handwriting as (the LPN). The DNS confirmed at that time that the assessment was not complete, signed nor dated. Also see F-157, F-281 and F514	{F 514}	
{F 520}	483.75(o)(1) QAA	{F 520}	

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{F 520} SS=F	<p>Continued From page 15</p> <p>COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: The facility failed to have a quality assessment and assurance committee that develops and implements appropriate plans of action to correct identified quality deficiencies. Findings include:</p> <p>Based on interview with the Administrator and the facility Quality Assurance (QA) coordinator on 09/17/14 at 11:00 AM, the facility failed to identify or correct repeated deficient practices with</p>	{F 520}	<p>F 520</p> <p>Systems developed for QAA process to include identifying quality issues, developing action plans, implementing action plans and revising plans if found to be ineffective.</p> <p>Audits will be performed routinely for active action plans and reported to the DNS or designee for follow up.</p> <p>DNS and Administrator will review audits and action plans monthly to determine if revisions or modifications are necessary.</p> <p>Results will be reported quarterly at QA meetings. Administrator to monitor for compliance.</p> <p><i>FSaD POC accepted 10/16/14 Semmons RN/PMC</i></p>	<p>10/10/14</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>

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{F 520}	Continued From page 16 inadequate assessment of root causes. During the follow up visit on 09/16/14 - 09/17/14 there were repeated quality deficiencies. Several of the deficiencies that were found have the potential for more than minimal harm to the residents. Although the QA committee had implemented some changes, needed action plans and audits, there were no revisions of clinical protocols implemented at this time.	{F 520}		