



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
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March 14, 2011

Linda Phypers, Administrator
Wake Robin-Linden Nursing Home
200 Wake Robin Drive
Shelburne, VT 05482

Provider ID #:475056

Dear Ms. Phypers:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 14, 2011**.

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,

A handwritten signature in black ink that reads "Pamela M. Cota RN". The signature is written in a cursive style.

Pamela M. Cota, RN
Licensing Chief

PC:jl

Enclosure



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

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Division of
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Licensing and
Protection

PRINTED: 02/23/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/14/2011
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NAME OF PROVIDER OR SUPPLIER WAKE ROBIN-LINDEN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 200 WAKE ROBIN DRIVE SHELBURNE, VT 05482
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F 000	INITIAL COMMENTS	F 000		
F9999	<p>FINAL OBSERVATIONS</p> <p>Licensing and Operating Rules for Nursing Homes</p> <p>6.3 Services Provided Under a Care Plan, The services provided or arranged by the facility must: (b) be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on staff interview and record review, facility nursing staff failed to consistently implement care plan interventions regarding assessment after an injury for 1 applicable resident in the targeted sample. (Resident #1) Findings include:</p> <p>Per record review on 2/14/11, nurses failed to consistently assess and/or document findings for the left lower extremity for Resident #1 after placement of a leg cast due to a fracture, as directed by the care plan intervention dated 2/3/11. The care plan directed staff to 'monitor CSMT [Color, Sensation, Movement, Temperature]... monitor swelling'. Review of the nurses notes for the period from 2/5/11 to 2/10/11 reveal there were no documented findings of assessment of CSMTs for 9 shifts (out of 18 total shifts for the 6 days included). This was confirmed during interviews with the RN CCC</p>	F9999	<p>6.3 Nurses have been reeducated on the importance of assessing/evaluating CSMT's on residents with compromised extremity circulation. Assessment skill of checking CSMT's has been added to the orientation skills check list for all new nurses and for annual competencies. The Cast Care and CSMT policies and procedures have been revised for educating nursing staff. We have modified ECS (electronic medical record) to prompt nursing to document assessment of CSMT's upon signing in treatment record. CSMT checks will continue to be added by the nurse to the treatment record upon the care plan addition of this assessment. The nurses "to do list" will also include that this assessment is needed on the resident and checked off as completed for the oncoming shift. Weekly audits will occur by the Direct Care Coordinator for compliance that those who have CSMT's ordered are completed on all three shifts until d/c'd by the physician. Weekly audits beginning the week of 3/6/11 will occur for the next 3 months and reported at CQI meeting in April 2011 and July 2011.</p> <p><i>b.3 POC Accepted 3/14/11 M. Bolton RN Pmcotarn</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Randa Pappas* TITLE *Director Health Services* (X6) DATE *3-4-11*

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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F9999	Continued From page 1 (Clinical Care Coordinator) and the DON (Director of Nursing) on the afternoon of 2/14/11. 7.8 Accidents The facility must ensure that : (a) the resident's environment remains as accident free as is possible; This REQUIREMENT is NOT MET as evidenced by: Per staff interview and record review, the facility failed to assure that nursing staff implemented the policy/procedure for completion of an incident report after a resident accident. (Resident #1) Findings include: Per record review and confirmed by staff interview, a nurse who discovered bruising of unknown origin on the left lower leg/foot of Resident #1 on 2/1/11 failed to complete an incident report and notify the resident's family in a timely manner. During interview on 2/14/11 at 11:05 AM, the Registered Nurse (RN) who observed the bruising on 2/1/11 after breakfast stated that s/he did notify the nurse supervisor but did not think it was their responsibility to complete the incident report. During interview with the RN CCC and the DON later the same day, each stated that , per policy, the nurse who finds the injury of unknown origin must do an incident report. The policy stated that the physician and family/legal representative must be notified of the injuries. The resident's family was not notified of the injuries until 9:34 AM on 2/2/11 per review of	F9999	7.8 All nursing staff either have attended or will attend in-service training "Incident Assessment, Reporting and Documentation" on 2/25/11, 3/8/11, 3/11/11, and 3/19/11. This training emphasizes the areas of not only assessing, documenting and reporting but family and physician notification as well as investigative steps that should occur if unknown origin. The Incident/Accident policy and procedure has been revised and included in in-service training. The DNS, Medical Director and DHS continue to review all and note Incident/Accident reports routinely. The nurse who discovered the bruise was counseled on 2/14/11 with a follow up Corrective Action plan due to not completing the I&A, notifying the family and verifying that the doctor received the fax communication sheet. This nurse was also reassigned to another unit where additional nursing training is taking place. The communication sheet has been revised to include that verification is received that the physician has been notified. All Incident/Accident reports are now included for review during weekly Falls Rounds with unit staff to ensure that that all avenues of the investigative process have been pursued. Daily nursing documentation is reviewed by the MDS RN as well as the Direct Care Coordinators for any follow up that is needed in assessment or documentation. Weekly audit beginning the week of 3/6/11 of Incident/Accident reports is completed by the Direct Care Coordinator for family, and physician contact as well as status of investigation process related to bruising, redness, skin tears of unknown origin.		

7.8 POC Accepted 3/14/11 M. Bolton RN / J. McCort RN

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F9999	<p>Continued From page 2</p> <p>the progress notes and interview with the RN CCC on 2/14/11 at 11:25 AM.</p> <p>13.1 Records Maintenance and Retention (a) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are: (1) complete; (2) accurately documented; (3) readily accessible; and (4) systematically organized</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on staff interview and record review, the facility failed to assure that each resident's medical record was completely and accurately documented for 1 applicable resident in the targeted sample. (Resident #1) Findings include:</p> <p>Per record review and confirmed during interviews with nursing staff on 2/14/11, including 2 staff RNs and the LPN day supervisor, the medical record for Resident #1 did not contain complete and accurate information regarding an accident which occurred on 1/31/11, and remained unknown to staff on duty on 2/1/11 who discovered injuries from the accident of the previous night. During interview on 2/14/11 at 3 PM, RN #1 stated that s/he failed to include a progress note in the medical record and failed to report to the 11-7 shift an accident that had occurred at 7:30 PM on 1/31/11. RN #2 confirmed (on 2/14/11 at 10:20 AM) that s/he failed to</p>	F9999	<p>13.1 Licensed nursing staff are receiving education regarding documentation in electronic medical record. Compliance with facility policies and procedures for documenting incidents/Accidents will be audited weekly with results reported to the DNS. Monthly results will be reported to CQI Committee. Clinical Coordinator will monitor for trends, work with staff as necessary and document education sessions.</p> <p><i>13.1 PDC Accepted 3/14/11 M. Bolton RN / P. McT...</i></p>		

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F9999	Continued From page 3 document an incident report regarding the injuries of unknown origin observed on 2/1/11. The LPN supervisor stated during interview at 12:20 PM that although she did observe the injuries with RN #2 s/he did not write a note in the medical record of the findings on 2/1/11.	F9999	Preparation and submission of this plan of correction is required by state and federal law. This plan of correction does not constitute as admission for the purposes of general liability, professional malpractice or any other court proceeding.	