VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

May 11, 2018

Mr.. Mike Rivers, Administrator
Crescent Manor Care Ctrs
312 Crescent Blvd
Bennington, VT 05201-0170

Dear Mr.. Rivers:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 18, 2018.** 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475033	A. BUILDING ______ B. WING ______	04/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESCENT MANOR CARE CTRS	312 CRESCENT BLVD BENNINGTON, VT 05201

(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
E 000	Initial Comments An unannounced onsite Emergency Preparedness survey was completed by the Division of Licensing and Protection on 4/18/18. The facility was found to be in substantial compliance with the regulations.	E 000	The following constitutes the Facility's response to the findings Of the Department of Licensing and Does not constitute an admission of Guilt or agreement of the facts alleged or conclusions set for the summary statement of deficiencies	
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced onsite annual recertification survey 4/16/18 - 4/18/18. The following regulatory deficiencies were cited as a result.	F 000		
F 585 SS=C	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a	F 585		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mike Rives
TITLE: Administrator
(X6) DATE: 5/7/18

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.

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

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F 585	Continued From page 1 grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;	F 585	F585 1. Resident Counsel members updated on new policy and forms. At next resident meeting. Policy and forms are posted in main lobby and on each unit; The new policy includes: contact information of the grievance official, who can file, expected time frame for completing the review of grievance; right to obtain a written decision regarding grievance and contact information of independent entities with whom grievances may be filed: state agency, QIO, state survey agency and state long-term care ombudsman 2. All resident's and responsible parties provided copy of new grievance policy and form, in-house and mailed. 3. NHA re-educated the Grievance officer the correct process and ADON/Educator will educate all staff on new grievance policy and form 4. Administrator will audit residents' on new grievance policy and forms daily x1 week through 5/8/2018 Then weekly times 4 weeks through 6/5/2018 Then Monthly times 3 months. Results of these audits will be reported by Administrator at the QI meetings. These meetings are composed of the Nursing Home administrator, Director of Nursing, and Medical Director. Date of Compliance 5/8/2018	

F585 POC accepted 5/8/18 RTremblay RN/PMC

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F 585	Continued From page 2	F 585		

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on resident and staff interview and record review, the facility failed to establish a procedure for residents to file a grievance per CMS (Centers for Medicaid and Medicare Services) requirements. Findings include:

On 4/17/18 during the Resident Council Meeting, the residents discussed that they were not aware

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 585	Continued From page 3 of who the grievance official was. Further discussion at the meeting, with those in attendance, presented that they were not aware of how long it takes to have someone get back to them. It was also stated by the council members that they were unaware that they had the right to file an anonymous grievance. Review of the facility's current Grievance Policy, dated and signed 8/11/17 does not provide information regarding the grievance official's name and contact information, nor does it have information regarding the right to obtain a written decision. There was no evidence that the grievance procedure was provided to the residents, other than a review of the grievance form during resident council meetings. There was no posting of the grievance procedure for residents or visitors to review. Per interview with the social worker on 4/17/17 at 2:25 PM, s/he stated that staff was asked if the information was posted on the unit, but confirmed that s/he had not looked for the postings. On 04/17/18 at 2:32 PM a review of the grievance policy and the regulations was conducted with the social worker by this surveyor and confirmation was made by the social worker at this time that the grievance procedures did not meet CMS requirements and they were not posted.	F 585		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Surveyor: Bertrand, Maureen Based on staff interview and record review, the	F 641		

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F 641 Continued From page 4

facility failed to ensure the accuracy of assessing 4 of 16 sampled residents, utilizing the Minimum Data Set (MDS), for Residents #9, #13, #21 and #33. The findings include the following:

1. Per medical record review, Resident #21 has a completed MDS assessment (a mandated assessment tool used to evaluate/screen for residents health and emotional needs), dated 3/4/18 and signed by the Registered Nurse. The assessment indicates Resident #21 utilizes a physical restraint of a bed rail daily. Interview with the MDS Coordinator confirms on 4/16/18 at approximately 4:15 PM, that the resident does not utilize the side rail as a restraint, but as an enabler for independent positioning in bed. The Coordinator confirms that this is a coding error.

2. Observation on 4/16/18 at 11:32 AM presented Resident #9 utilizing bilateral upper half side rails on the bed to assist with positioning. S/he stated that they had never used a restraint and that the rails are to help him/her to position self in bed. During review of resident record on 4/17/18, the MDS presents that Resident #9 uses side rails daily as a restraint. Siderail assessment completed by the facility on 7/28/17 indicated that the resident uses the side rails as assistive devices and not as a restraint. Confirmation from the MDS coordinator on 4/17/18 at 12:10 PM that the MDS dated 10/16/17 and 1/19/18 were coded inaccurately and stated the resident does not use restraints.

3. Resident #13 record review on 4/16/18, presented that the MDS dated 11/27/17, 12/27/17 and 1/26/18 that the resident used siderails daily as a restraint. Per interview with the resident on 4/16/18 at 1:20 PM, s/he stated that they had

F 641

F641

1. Resident #21, #9, #13, and #33 affected by the deficient practice, all records immediately updated by MDS coordinator and sent

2. All residents that have the potential to be effective by this deficient practice have been audited, and corrected as needed

3. DON re-educated MDS coordinator on regulation of importance of accurately documenting on restraint section

4. Administrator will audit residents' MDS for accuracy daily x1 week through 5/8/2018

Then weekly times 4 weeks through 6/5/2018

Then Monthly times 3 months.

Results of these audits will be reported by the Administrator at the QI meetings. These meetings are composed of the Nursing Home administrator, Director of Nursing, and Medical Director.

Date of Compliance 5/8/2018

F641 POC accepted 5/8/18 RTrembley RN/PMC

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F 641	Continued From page 5 never used a restraint. Interview at 1:45 PM on 4/16/18 with the MDS coordinator, s/he confirmed that several resident's had restraints coded as a restraint and no one has restraints and the MDS was coded inaccurately for the referenced dates. 4. Resident #33 uses siderails for positioning in bed and per record review on 4/16/18, the MDS dated 12/5/17, 12/10/17 and 3/9/18 presented that siderails were used daily for a restraint. The resident stated that s/he does not have a restraint of any kind. Per confirmation with the MDS coordinator on 4/16/18 at 12:09 PM, the MDS was inaccurately coded.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State	F 645		

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F 645 Continued From page 6

intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).

F 645

F 645

1. Resident #44 was affected by the deficient practice, Social Worker requested level II, completed on 4/25/18

2. All residents that have the potential to be effective by this deficient practice have been audited, and no others identified

3. ADON/Educator re-educated social worker on regulation of importance of accurately screening new residents for level II PASAAR

4. Administrator will audit new resident's charts daily x1 week through 5/8/2018

Then weekly times 4 weeks through 6/5/2018

Then Monthly times 3 months.

Results of these audits will be reported by the Administrator at the QI meetings. These meetings are composed of the Nursing Home administrator, Director of Nursing, and Medical Director.

Date of Compliance 5/8/2018

F645 POC accepted 5/8/18 RTremblay RN/PMC

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F 645	Continued From page 7 (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to assure that a PASARR (Pre-Admission Screening and Resident Review) was conducted for 1 applicable Resident (Resident #44), who was admitted with a 30 day exemption and has exceeded the expected 30 day stay. The findings include the following: Per record review, Resident # 44 has a PASARR screening dated 3/2/18. Part A checked "yes" signed by the physician identifying that the resident is being admitted to the facility for less than 30 days. There is no evidence of further screening after the 30 days exemption. Resident #44 has diagnoses including, but not limited to, Bipolar Disease. On 04/16/18 at 3:20 PM, the Social Services Director confirmed that the PASARR screening has not been updated since the initial 30-day period and still remains in the facility.	F 645		
F 655 SS=B	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.	F 655		

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F 655 Continued From page 8

The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to provide the resident and/or resident's representative with a summary of the baseline

F 655

F655

1. Resident #35 and #55 affected by the deficient practice, both provided a copy of their baseline care plan and agreeable to plan

2. All new residents that have the potential to be effective by this deficient practice have been audited, and provided copy as needed

3. ADON/Educator to educate all IDT on provided a copy of the baseline care plan to new and re-admitted residents

4. Social Worker will audit new & readmitted resident's charts daily x1 week through 5/8/2018

Then weekly times 4 weeks through 6/5/2018

Then Monthly times 3 months.

Results of these audits will be reported by the Administrator or Designee at the QI meetings. These meetings are composed of the Nursing Home administrator, Director of Nursing, and Medical Director.

F655 POC accepted 5/8/18 RTremblay RN/PMC

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F 655	Continued From page 9 care plan for 2 of 16 residents in the applicable sample (Resident #35 and Resident #55). Findings include: 1. Per record review Resident #35, who was admitted on 1/30/18 had a baseline care plan initiated on 1/31/18. There was no evidence in the record that a summary of the baseline care plan was provided to the resident and/or resident's representative. Per interview on 4/17/18 at 3:29 PM with a Licensed Practical Nurse (LPN), s/he confirmed that there was no indication in the record that a summary of the baseline care plan was provided to the resident and/or resident's representative. 2. Per record review Resident #55 was admitted on 3/22/18. The baseline care plan was initiated on 3/23/18. There was no evidence in the record that a summary of the baseline care plan was provided to the resident and/or resident's representative. Per interview on 4/18/18 at 8:45 AM with the Social Worker, s/he confirmed that there was no process in place that ensured the resident and/or resident's representative was provided a summary of the baseline care plan.	F 655		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 657		

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resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to assure that the comprehensive plan of care was revised to reflect the resident's needs for 4 of 16 residents, Residents #46, 9, 33, and 35; and to assure that the InterDisciplinary Team (IDT) required members participated in the quarterly care planning and revision meetings for 8 of 16 residents, Residents #46, #31, #13, #9., #44, #34, #21, #35. Findings include:
1). Per record review Resident #46 has a pressure ulcer on his/her right ankle, which was identified on 3/28/18. Resident #46 is on Palliative Care since January of 2018, and the wound may be considered unavoidable. There is a Wound Notification sheet dated 3/28/18 that describes the wound as a Stage I pressure ulcer measuring Length (L) 3 cm, Width (W) 3cm and Depth (D) 0 cm. A Skin/Wound Sheet that is dated 4/5/18 describes the wound as unchanged.

Provider's Plan of Correction:

F 657

1. Resident #46, #9, 33 and #35 affected by the deficient practice, all care plans reviewed by IDT

2. All residents that have the potential to be effective by this deficient practice were audited to identify any missing focuses and updated were completed by IDT

3. ADON/Educator to educate all nursing staff on care plan updates to reflect patient needs

4. Nurse Manager will audit care plans daily x1 week through 5/8/2018

Then weekly times 4 weeks through 6/5/2018

Then Monthly times 3 months.

Results of these audits will be reported by the DON or Designee at the QI meetings. These meetings are composed of the Nursing Home administrator, Director of Nursing, and Medical Director.

Date of Compliance 5/8/2018

F657 POC accepted 5/8/18 RTremblay RN/PMe

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475033	A. BUILDING ______ B. WING ______	04/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESCENT MANOR CARE CTRS	312 CRESCENT BLVD BENNINGTON, VT 05201

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F 657	Continued From page 11	F 657		

There are no other wound assessments with staging and measurements in the record. There is a skin/wound note dated 4/11/18 stating that the R Malleolus (ankle) now has serosanguinous drainage and current treatment is no longer appropriate and a nurses note stating that the wound is now open (which would make it a Stage II pressure ulcer). There is no staging or wound measurement found in these notes. The care plan states that there is a Stage I pressure ulcer and still calls for skin prep application on 4/18/18. The Memory Care Coordinator confirmed, in an interview on 4/18/18, that there was no update to the plan of care.

2.) Per review of medical record for Resident #33, the resident care plan dated 10/26/17 and revised 12/4/17 for oxygen therapy related to respiratory illness indicates that s/he is to have an Aflo vest two to four times a day. Per interview with the Licensed Practical Nurse at 9:08 AM on 4/18/18, the resident hadn't worn the Aflo vest in at least six months and at this time that the care plan has not been revised to reflect the current status of the Aflo vest.

Further review of the medical record for Resident #33 presented that the MDS (Minimum Data Set), a mandated assessment tool used to evaluate/screen for residents health and emotional needs), dated 3/9/18, indicates that the resident is always incontinent with no episodes of continence. Care plan dated 1/3/18 reflects that the resident is independent with urinal use and is occasionally incontinent. Per interview with the resident on 4/18/18 at 12:30 PM, s/he stated that they wear incontinent briefs and he is rarely continent. Per the Licensed Nursing Assistant at 12:35 PM, the staff will place the urinal for the resident when they turn him/her, but the resident

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F 657	Continued From page 12 has already been incontinent. During interview with the MDS coordinator at 1:03 PM, s/he confirmed that the care plan does not accurately reflect the resident's current condition. 3.) Per record review, Resident #9 has a diagnosis of idiopathic sleep apnea and has orders for full-face Bi-Pap (Bi-level Positive Airway, a machine to push air into your lungs while allowing air to be exhaled), and orders for oxygen via nasal cannula at 3 L/M at night only. Resident #9 has a care plan for altered respiratory status/difficulty breathing related to sleep apnea, dated 3/30/17 and revised on 1/10/18. The interventions include the use of the full-face mask Bi-Pap and that the resident is to have oxygen via nasal prong at 3 L/M (liters per minute), dated and revised 3/30/17. Per physician orders dated 2/15/18 the resident is to have humidified oxygen at 3 L/M and per confirmation by the Registered Nurse on 4/17/18, the care plan does not reflect the oxygen usage accurately. 4). Per record review the care plan meetings held were reviewed and it was found that there is no evidence of the Licensed Nursing Assistants' (LNA's) participation in the quarterly care planning and revision process for the 11 residents listed above. Additionally in reviewing the documentation it was found that there was no evidence of Physician participation for Residents #46, #34, #21, #44. There was also no evidence that a Registered Nurse (RN) participated in one planning and revision process for Residents #46 and #34. In an interview on the afternoon of 4/18/18 the Medical Social Worker (MSW) stated that the	F 657	F 657 (continued) 1. Resident #46, #34, 21 and #44 affected by the deficient practice. The entire IDT met and updated care plans. 2. All residents that have the potential to be effective by the care plans needing to be updated have been audited and IDT updated as needed 3. ADON/Educator to educate all nursing staff /interdisciplinary team on care plan meetings on importance of who is required to attended/review the care plan 4. DON will audit care plans daily x1 week through 5/8/2018 Then weekly times 4 weeks through 6/5/2018 Then Monthly times 3 months. Results of these audits will be reported by the DON at the QI meetings. These meetings are composed of the Nursing Home administrator, Director of Nursing, and Medical Director. Date of Compliance 5/8/2018 F657 PoC accepted 5/8/18 RTremblay RN/ pmc	

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F 657	Continued From page 13	F 657	F657 (continued)	

only available evidence of the participation of the required members of the InterDisciplinary Team (IDT) is the paper sign in sheets found in the residents' records. In addition an RN and a Licensed Practical Nurse (LPN) confirmed that there was no evidence of participation of all required IDT members for Residents #21 and #44.

5. Confirmation was made by the Registered Nurse Manager and the Licensed Practical Nurse on 4/18/18, that for Resident # 21, the required members of the Interdisciplinary Team (IDT) were not in attendance during the care plan meetings that took place on 3/8/18. Licensed Nurse Aide staff also confirm on 4/18/18, that they do not consistently attend meetings or provide input to changes to the care plan.

6. Confirmation was made by the Registered Nurse Manager and the Licensed Practical Nurse on 4/18/18, that for Resident # 44, the required members of the Interdisciplinary Team (IDT) were not in attendance during the care plan meetings that took place on 3/22/18. Licensed Nurse Aide staff also confirm on 4/18/18, that they do not consistently attend meetings or provide input to changes to the care plan.

7. Per record review Resident #35's care plan was initiated on 2/5/18, and it read, "I have a dwelling catheter due to morbid obesity and taking a diuretic. I am on oxygen therapy related to ineffective gas exchange." Per observation on 4/16/18 at approximately 1:00 PM, Resident #35 was not wearing oxygen. Per interview with Resident #35 on 4/16/17 at approximately 1:00 PM, s/he stated that s/he did not have a catheter and did not use oxygen. Per interview on 4/18/18 at 12:19 PM with a LPN, s/he confirmed that the care plan for Resident #35 was not updated and

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F 657	Continued From page 14 should have been updated as soon as the resident's problems had resolved. 8. Per record review there was no evidence of LNA participation in the quarterly care planning and revision process for Resident #35. Per interview on 4/17/18 at 3:21 PM with the Nurse Manager, s/he confirmed that not all required members of the IDT have been participating in the care planning and revision process for Resident #35 and other residents.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that services provided meet professional standards of quality for three of 16 applicable residents Residents #46, 13 and 9, regarding wound documentation/assessment and implementation of physician's orders. Findings include: 1). Per record review, Resident #46 has a pressure ulcer on his/her Right ankle, which was identified on 3/28/18. Resident #46 is on Palliative Care since January of 2018, and the wound may be considered unavoidable. There is a Wound Notification sheet dated 3/28/18 that describes the wound as a Stage I pressure ulcer measuring Length (L) 3cm, Width (W) 3cm, and Depth (D) 0cm. The Wound/Skin Healing Sheet that is	F 658	F 658 1. Resident #46 affected by the deficient practice, patient immediately assessed, MD aware, updated by registered nurse 2. All residents that have the potential to be effective by this deficient practice, all treatment assessment records were audited to assure that weekly skin checks and wound assessments/observation were completed 3. ADON/Educator to educate all nursing staff on importance of wound documentation assessment/observations 4. Manager or designee will audit documentation daily x1 week through 5/8/2018 Then weekly times 4 weeks through 6/5/2018 Then Monthly times 3 months. Results of these audits will be reported by the Manager or Designee at the QI meetings. These meetings are composed of the Nursing Home administrator, Director of Nursing, and Medical Director. Date of Compliance 5/8/2018	

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F 658	Continued From page 15	F 658		

dated 4/5/18 describes the wound as unchanged. There are no other wound assessments with staging and measurements in the record. There is a skin/wound note dated 4/11/18 stating that the R Malleolus (ankle) now has serosanguinous drainage, current treatment is no longer appropriate and a nurses note stating that the wound is now open (which would make it a Stage II pressure ulcer). There is no staging or wound measurement found in these notes. The care plan states that there is a Stage I pressure ulcer and still calls for skin prep application on 4/18/18. The Memory Care Coordinator confirmed, in an interview on 4/18/18, that there were no further skin assessment notes available in the record.

The facility Skin and Wound Protocol Policy states: "A patient/resident with a pressure injury, non-healing wound, surgical wound, or wound requiring a wound vacuum will be seen on weekly wound rounds. The "Wound/Skin Healing Record" will be completed each week by an RN during these rounds. The information on this record-the size, drainage, treatment, etc, will be reviewed with the previous weeks' information to determine effectiveness of the current treatment and the need for continuation or change of that treatment."

The Wound, Ostomy, and Continence Nurses Society's Position Statement contains the following statement:
"5. Role of documentation
·Accurate and thorough documentation is essential for effective prevention and management of pressure ulcers. "Good documentation must be comprehensive, consistent, concise, chronological, continuing and also reasonably complete" (Ayello et al., 2009).

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F 658 Continued From page 16

·According to Dahlstrom et al. (2011), initiation of appropriate treatment of pressure ulcers is dependent on the identification and complete documentation of the ulcer (i.e., location, stage, size), and ongoing measurements and descriptions are necessary to monitor the progression of the wound and effectiveness of interventions. However, based on a retrospective chart review, Dahlstrom et al. found documentation of the characteristics of pressure ulcers was frequently missing key descriptors, such as the stage, location, and size; and therefore, was not meeting quality guidelines. The investigators suggested that the first step to improving pressure ulcer care is to improve the identification and documentation of the ulcer, which is necessary for treatment, communication within the healthcare team, and reimbursement."

Reference: Wound, Ostomy and Continence Nurses Society. (2017). WOCN Society position paper: Avoidable versus unavoidable pressure ulcers (injuries). Mt. Laurel, NJ: Author. Copyright© 2017 by the Wound, Ostomy and Continence Nurses Society (Trademark) (WOCN®). Date of Publication: February 22, 2017.

2.) Per record review Resident #9 has diagnoses of idiopathic sleep apnea and heart failure and has physician orders dated 2/15/18 to have humidified oxygen at 3 Liters per Minute (L/M) during the day, evening and night shift. Per observation on 4/16/18 at 11:36 AM, the oxygen concentrator was on and set for 4 L/M with confirmation from the Licensed Nursing Assistant at this time that it is supposed to be at 3 L/M. Per observation on 4/17/18 at 12:57 PM, the oxygen delivery was set for 2 L/M. Per confirmation from

F 658

F 658

1. Resident #9 affected by the deficient practice, the patient was assessed and provider notified by registered nurse

2. All residents that have the potential to be effective by this deficient practice of oxygen orders audited, patients assessed and MD aware of any changes

3. ADON/Educator to educate all nursing staff on importance of O2 documentation assessment/observations

4. Manager or designee will audit documentation daily x1 week through 5/8/2018

Then weekly times 4 weeks through 6/5/2018

Then Monthly times 3 months.

Results of these audits will be reported by the Manager or Designee at the QI meetings. These meetings are composed of the Nursing Home administrator, Director of Nursing, and Medical Director.

Date of Compliance 5/8/2018

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F 658 Continued From page 17

the Registered Nurse (RN) at 1:00 PM, the oxygen is to be set at 3 L/M because s/he has cardiac and respiratory issues and that it was incorrectly set.

3.) Per record review Resident #13 tested positive for MRSA (Methcillin-Resistant Staphylococcus aureus) and has a physician order written 3/30/18 to use Mupirocin to nares three times a day for fourteen days. Review of the medication administration record (MAR) on 4/18/18 presented that there is no evidence that the medication treatment was administered on the evening shift on April 6, 9 and 10 on the evening shift. Per review with the RN at 11:56 AM, s/he confirmed that there was no evidence that the medication treatment was refused by the resident and no evidence to support that it was administered. Resident #13 also has diagnosis of hypertension requiring a hypertensive medication. S/he has orders to receive Atenolol 25 mg (milligrams) daily with supper. Further review of the MAR on 4/18/18 indicates Resident #13 had not received his/her ordered doses of Atenolol 25 mg (milligrams) with supper on 4/6, 9 and 14, 2018. Confirmation was made by the RN at this time that there was no evidence that the resident had received the prescribed medication.

Reference: Based on standards of professional nursing practice, Lippincott Manual of Nursing Practice 19th edition, Wolters Kluwer Health/Lippincott Williams, page 17 Standards of Practice was deviated with failure to follow to physician orders.

F 730 Nurse Aide Peform Review-12 hr/yr In-Service
SS=E CFR(s): 483.35(d)(7)

F 658

F 658 (continued)

1. Resident #13 affected by the deficient practice, notified MD, and all nursing staff re-educated on hour of administration times and omissions reports

2. All residents that have the potential to be effective by this deficient practice medication administration records have been audited and notification sent as needed

3. ADON/Educator will re-educate all nursing staff on hour of administration times and omissions reports.

4. Manager will audit documentation daily x1 week through 5/8/2018

Then weekly times 4 weeks through 6/5/2018

Then Monthly times 3 months.

Results of these audits will be reported by the DON at the QI meetings. These meetings are composed of the Nursing Home administrator, Director of Nursing, and Medical Director.

Date of Compliance 5/8/2018

F658 POC accepted 5/8/18 RTremblay RN/[illegible]

F 730

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F 730 Continued From page 18

§483.35(d)(7) Regular in-service education.
The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g).
This REQUIREMENT is not met as evidenced by:
Based on record review and confirmed by the Administrator and the Registered Nurse Manager, 2 of 5 Licensed Nurse Aides (LNA) reviewed, do not meet the required twelve hours of in-service education annually. The findings include the following:

1. Review of LNA #1's employee in-service record, evidences that s/he has been on staff since 2004. The records for the 2017-2018 to date identify, h/she has completed 10.95 of 12 required hours of in-service education. The record identifies the following mandatory programs have been completed: Resident Dignity and Fire Safety.

2. Review of LNA #2's employee in-service record, evidences the s/he has been on staff since 2013. The records for the 2017-2018 identify to date, h/she has completed 8 of the 12 required hours of in-service education. The record identifies the following mandatory programs have been completed: HIPAA (Health Insurance Portability and Accountability Act), Fire Safety and hand washing.

The facility annual Mandatory Educational requirements are identified as follows: Resident Rights and Abuse, HIPPA privacy Act, Fire Safety

F 730

F730

1. 2 LNAs affected by this deficient practice, Both completed mandatory education.

2. All LNA staff that have the potential to be effective by this deficient practice have been audited and notification sent as needed

3. DON to re-educate ADON/Educator on importance of completing mandatory education. ADON/Educator to educate all LNA staff.

4. ADON/Educator will audit staff education daily x1 week through 5/8/2018

Then weekly times 4 weeks through 6/5/2018

Then Monthly times 3 months.

Results of these audits will be reported by the DON at the QI meetings. These meetings are composed of the Nursing Home administrator, Director of Nursing, and Medical Director.

Date of Compliance 5/8/2018

F730 POC accepted 5/8/18 RTremblayRN/PMC

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F 730	Continued From page 19 and Emergency Preparedness, Infection Control and Blood Borne Pathogens. In addition programs that must be completed are Behavioral Management, Huntington's Disease Program, Fall Prevention and Continence Management. Confirmation was made by the Administrator and the Medical Records/Education Tracker on 4/18/18 at approximately 1:15 PM, that both LNA's have not meet the facility policy nor the federal guidelines for annual in-service education.	F 730		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by:	F 757		

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F 757	Continued From page 20 Based on staff interview and record review, the facility failed to ensure that 1 applicable resident reviewed for unnecessary medications, was adequately monitored for side effects from the administration of Psychotropic drugs. (These medications are defined to affect brain activity associated with mental processes and behaviors.) The findings include the following: Per record review, Resident #44 was admitted in early March 2018 with a diagnosis to include, but not limited to Bipolar Disease. Physician orders since admission, are for the administration of Seroquel twice a day to treat Bipolar Disease. (Seroquel is an antipsychotic medication.) The medication may cause permanent nerve and muscle problems and requires monitoring. There is no evidence in the electronic medical record (EMR) or in the paper chart, identifying that any screening/testing has been completed since admission or at all. Per facility policy dated 2/8/18 "AIMS Testing Guidelines", identify the purpose of the testing is to identify adverse reactions to antipsychotic drug therapy and is performed on admission and in the months of March and September. Unit Manager confirms on 4/18/18 at approximately 8 AM that a completed AIMS testing form can not be located in the medical record and therefore it has not been completed per policy or as required.	F 757	F 757 1. Resident #44 affected by the deficient practice AIMS assessment completed and no changes identified 2. All 47 residents that have the potential to be effective by this deficient practice have been audited and no others identified 3. ADON/Educator will re-educate all nursing staff on importance of completing AIMS testing when due. 4. Manager or designee will audit documentation daily x1 week through 5/8/2018 Then weekly times 4 weeks through 6/5/2018 Then Monthly times 3 months. Results of these audits will be reported by the DON at the QI meetings. These meetings are composed of the Nursing Home administrator, Director of Nursing, and Medical Director. Date of Compliance 5/8/2018 F757 POC accepted 5/8/18 RTremblay RN/PM	