

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 16, 2016

Ms. Patricia Horn, Administrator
Cedar Hill Health Care Center
49 Cedar Hill Drive
Windsor, VT 05089-9470

Dear Ms. Horn:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 19, 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

PRINTED: 04/28/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2016
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NAME OF PROVIDER OR SUPPLIER CEDAR HILL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 49 CEDAR HILL DRIVE WINDSOR, VT 05089
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F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced on-site complaint investigation on 4/19/16. The findings include the following:	F 000	F225- Investigate/Report Allegations/Individuals	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance	F 225	1. The charge nurse did not notify family and ensure safety of resident #1 at the time of the incident, evidenced by her written statement for the investigation. The Charge Nurse that was on for the 4/4/16 incident was given back her written statement from the investigation and instructed to do a late entry for the date of the incident to add to the record of events of the evening including who was contacted and what interventions were put into place. Education by the DNS was provided at that time as well as to the proper procedure for incidents in regards to the nurse's note. 2. On 4/5/16, DNS requested that Bayada Hospice have the social worker see the resident in regards to the incident to ensure no psychological harm or emotional harm was done to Resident #1. The RN from hospice spoke to the resident on the 5 th of April and this was documented in the Bayada documentation. A request for Springfield group to have psychological visit for Resident #3 was done on 4/8/16 to ensure all behavioral modifications were being addressed. 3. Cedar Hill's ADNS and Social Services Director did speak to Resident #1 on 4/5. The Social Services Director was not available on the morning of 4/5 and asked	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Patricia R. Quinn TITLE
Community Administrator (X6) DATE
5/10/2016

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 225	<p>Continued From page 1</p> <p>with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and confirmed by staff interview the facility failed to ensure that potential abuse towards 1 of 3 residents in the sample group (Resident #1), was reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State Survey and Certification Agency). The findings include the following:</p> <p>Per internal investigation report dated 4/4/16, identifies that Resident #3 "(around 2130) last evening got into bed with the room mate, began to yell at [him/her] and open hand hit [him/her]. [Resident #1] came out to get staff. Today the resident will not talk to Cedar Hill staff about it, but did speak to Hospice and verified the story."</p> <p>Per internal investigation the Administrator was notified on 4/5/16 of the incident between Resident #1 and #3. However, the internal investigation does not evidence that the occurrence was reported to Adult Protective Services and the Licensing Agency. The medical record for Resident #1 and #3 has no evidence that the incident occurred, that any follow up with Resident #1 was conducted regarding residual effects after the incident or that it was reported to MD and family.</p>	F 225	<p>the ADNS to speak to Resident #1 about the incident. The resident did not wish to speak about the incident with the ADNS but did agree to move permanently to the room he was moved to immediately following the incident. The Social Services Director spoke to Resident #1 that afternoon. The Social Services Director did not note this conversation in the clinical record timely.</p> <p>4. The Social Services Director will attend huddles and meet with the DNS or ADNS each morning to review any updates on residents. She has been added to the call list for potential abuse incidents. She has created her own checklist for resident-to-resident encounters. For three months, the Administrator will audit social services notes after incidents.</p> <p>5. ADNS/Evening Nurse supervisor will follow up on all incidents the next business day to ensure that all appropriate documentation is in place and referrals to appropriate departments are complete and documented in the records. If any steps are missing the information will immediately be updated to the record and the staff member responsible will be disciplined accordingly.</p> <p>6. A new resident-to-resident and abuse allegation report packet and protocol was implemented for all abuse allegations/resident-to-resident incidents to ensure that the nurse has a check off sheet of what needs to be addressed in the</p>	

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F 225	<p>Continued From page 1 with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and confirmed by staff interview the facility failed to ensure that potential abuse towards 1 of 3 residents in the sample group (Resident #1), was reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State Survey and Certification Agency). The findings include the following:</p> <p>Per internal investigation report dated 4/4/16, identifies that Resident #3 "(around 2130) last evening got into bed with the room mate, began to yell at [him/her] and open hand hit [him/her]. [Resident #1] came out to get staff. Today the resident will not talk to Cedar Hill staff about it, but did speak to Hospice and verified the story."</p> <p>Per internal investigation the Administrator was notified on 4/5/16 of the incident between Resident #1 and #3. However, the internal investigation does not evidence that the occurrence was reported to Adult Protective Services and the Licensing Agency. The medical record for Resident #1 and #3 has no evidence that the incident occurred, that any follow up with Resident #1 was conducted regarding residual effects after the incident or that it was reported to MD and family.</p>	F 225	<p>record and steps to be taken for such cases.</p> <p>7. Mandatory education was provided the weeks of May 5, 2016 thru the week of May 16, 2016 to all staff regarding the new Protocol for abuse allegation and resident-to-resident incidents, as well as an overview of the new Abuse policy to ensure that the all staff are aware and able to follow through all expected steps required in the future. All current staff that does not have the education before May 18, 2016 will be removed from the schedule and put on unpaid administrative leave until the educations are completed. All new staff hired after May 18, 2016 will be educated on the Protocol and incident packet as part of the new hire orientation process.</p> <p>8. DNS or substitute will track any deviation from the required steps in the Protocol and the results of these audits will be discussed at Quality Assurance Meetings.</p> <p>Compliance Date May 18, 2016</p> <p><i>F225 POC accepted 5/16/16 Pmctarw</i></p>	
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F 225 Continued From page 2
Per interview with the Director of Nurses, the Social Service Director and the Director of Hospice all confirm that Resident #1 reported to staff that s/he was yelled at and hit in the face by Resident #3. They also confirm that the incident was not reported as required to the licensing agency. Cedar Hill staff confirm that discussion did take place with the Nursing Home Administrator who determined the incident did not need to be reported, and concluded that this was a true misunderstanding.

F 225

F 226
SS=E 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES

F 226

F226-483.13(c) Development of Abuse/Neglect, Etc. Policies

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

1. Cedar Hill Health Care's administrative version of its written policies to prevent abuse, neglect and exploitation did have the correct time of 24 hours. Its Employee Handbook did not. The nursing home administrator and the DNS have revised the policies and protocols for all staff and made the administrative and employee handbook policies the same. All Nursing Home Department Heads were educated on May 5th to the new policies and each department head must educate all their staff by May 18th. Any staff, including contract, not educated by May 18th, will be removed from the schedule and may not work until they receive the education.
2. All managers and staff must sign off on the education, citing the time and

This REQUIREMENT is not met as evidenced by:
Based on policy review and confirmed by staff interview the facility failed to develop accurate written policies and procedures to report all alleged violations and all substantiated incidents to the state agency as required. The findings include the following:

Per review of Cedar Hill Continuing and Care Community (CCC) policy and procedure for "Resident Protection from Abuse, Neglect and Exploitation" Dated 6/12 identifies the following:
1) All Cedar Hill CCC Employees, contractors or volunteers are mandated reporters of suspected abuse, neglect or exploitation. It is the duty of all employees to report to the supervisor

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F 226 Continued From page 3

immediately any case of suspected or actual abuse, neglect or exploitation of Cedar Hill CCC residents by any other person, including staff, families, guardians or responsible parties, volunteers and visitors.

3) The DNS and/or the Administrator is to report to Adult Protective Services within 48 hours of the occurrence of the incident. TO COMPLY WITH THE STATE REGULATION, REPORTS MUST BE MADE WITHIN 48 HOURS OF THEIR OCCURRENCE."

Per requirements of Federal Centers for Medicare and Medicaid Services (CMS) (42 C.F.R. 483.13(c)(2) - (4)) the Affordable Care Act and Vermont Licensing and Operating Rules for Nursing Homes, identifies that alleged violations must be reported immediately to the administrator of the facility, other officials in accordance with state law, and the state survey and certification agency. Immediately is interpreted by CMS to mean as soon as possible, but not to exceed 24 hours, unless serious bodily injury has occurred then there is a two (2) hour limit.

Per interview with the Director of Nurses (DNS), confirmation was made that the facility policy does not match the federal requirement.

(See F 225)

F 250 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE

The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

F 226

date of the education and employees must take a quiz to show their understanding. These two documents will be kept on file in the HR office. The Nursing Home Administrator and HR and Training Director will monitor compliance with this until all staff are signed off and will remove staff from the schedule on May 19th if they have not had the education. Compliance to this policy will be tracked for one year in the Quality Assurance Meetings to make sure staff are not only educated to the policy but following it.

3. Educations will be completed by May 18, 2016 with compliance review ongoing for one year.

F226 POC accepted 5/16/16 Pmestara

F 250 F250- 483.15 Provisions of Medically related social services.

I. The charge nurse did notify family and ensure safety of resident #1 at the time of the incident, evidenced by her written statement for the investigation. The Charge Nurse that

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F 250

Continued From page 4

F 250

This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interview the facility failed to ensure that medically-related social services was provided for 1 of 3 sampled residents, to attain or maintain the highest practicable physical, mental, and psychosocial well-being. For resident #3 the findings include the following:

Per medical record review for Resident #3, progress notes do not evidence that a Resident to Resident altercation occurred on 4/4/16 as verified by Resident #1. There is no evidence that demonstrates that the family and was notified of the incident and there is no evidence identifying that Social Services provided support for either resident, after the incident of 4/4/16.

Per interview with the Director of Nurses and Social Service Director confirmation is made that there is no documentation in the medical record identifying the resident to resident altercation, family notification and/or confirmation that any support or social services was provided to Resident #3.

F 280
SS=D

483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

F 280

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

was on for the 4/4/16 incident was given back her written statement from the investigation and instructed to do a late entry for the date of the incident to add to the record the events of the evening and who was contacted as well as what interventions were put into place. Education by the DNS was provided at that time as well to the proper procedure for incidents in regards to the nurse's note.

2. The Social Services Director and the Assistant Director of Nursing both spoke to Resident #1 on 4/5. Since the Social Services Director could not speak to Resident #1 the morning of 4/5, she asked the ADNS to speak to Resident #1 for her. The ADNS did and finalized a permanent room change. When Resident #1 did not feel comfortable speaking to the ADNS about the incident, the DNS asked Bayada Hospice to have the social worker see the resident in regards to the

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F 280	<p>Continued From page 5</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and staff confirmation the facility failed to revise the care plan for 1 of 3 sampled residents after an allegation of physical and verbal abuse by Resident #1's roommate. The findings include the following:</p> <p>Per medical record review, Resident #1 was admitted for 5 days of respite care on 4/4/16. Initial Admission Care plan identifies risks/problems related to pain, cardiopulmonary deficits, risk for decreased nutrition and hydration, anticoagulant therapy and risks related to bleeding, skin integrity, bowel and bladder elimination, risk for falls, needed assistance with activities of daily living, is receiving hospice services and identifies advanced directives.</p> <p>Per internal investigation report dated 4/4/16, identifies that Resident #3 "(around 2130) last evening got into bed with the room mate, began to yell at [him/her] and open hand hit [him/her].</p>	F 280	<p>F280- 433.20- Right to participate in planning of care and revise CP..</p> <ol style="list-style-type: none"> 1. At the time of survey, a care plan was placed in to record from SSD in regards to Resident #3's new behavior noted at the time of the incident. 2. ADNS/Evening Nurse supervisor will follow up on all incidents the next business day to ensure that all appropriate care planning is in place and referrals to appropriate departments are in place and documented in the records. If any steps are missing the information will immediately be updated to the record and the staff member responsible will be disciplined accordingly. 3. A new resident- to- resident and abuse allegation report packet and protocol was implemented for all abuse allegations/resident-to-resident incidents. To ensure this is followed, the charge nurse and Social Services Director have check off lists of steps to take and documentation requirements. A short term care plan is included in this packet that the nurse will initiate immediately for these types of events. These will be updated accordingly as the investigation continues. 4. Mandatory education is being provided the weeks of May 5, 2016 	

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F 280	Continued From page 5	F 280	<p>thru the week of May 16, 2016 to all staff regarding the new Abuse policy and the new Protocol for abuse allegation and resident-to-resident incidents to ensure all staff are aware and able to follow through all expected steps required in the future. All current staff that does not have the education before May 18, 2016 will be removed from schedule and put on unpaid administrative leave until the education is completed. All new nursing staff hired after May 18, 2016 will be educated on the Protocol and incident packet as part of the new hire orientation process.</p> <p>5. DNS or substitute will track any deviation from the required steps in the Protocol and the results of these audits will be discussed at Quality Assurance Meetings.</p> <p>Compliance Date May 18, 2016</p> <p><i>FABO PDC accepted 5/16/16 pmc-stapw</i></p>		

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F 280 Continued From page 6
[Resident #1] came out to get staff. Today the resident will not talk to Cedar Hill staff about it, but did speak to Hospice and verified the story."

Per interview with the Director of Nurses, confirmation is made that the resident to resident incident of 4/4/16 was not updated on the initial care plan nor is there documentation directing staff as to the management of such occurrences with this resident or the monitoring of any residual effects of the altercation.

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 staff interview and record review, the facility failed to adhere to professional standards of care for 1 applicable resident regarding neurological assessments following an unwitnessed fall. For Resident #2 the findings include the following:

Per medical record review for Resident #2, had an unwitnessed fall on 4/17/16 at approximately 10:25 AM. Resident was found on the floor in his/her room with the wheel chair behind him/her as the chair alarm was sounding. Resident #2 stated "I fell". Per medical record review, Resident #2 had a neurological check list completed one time at 10:48 AM.

Per facility policy titled "Post Fall Neurological Assessment Protocol" dated 10/15 "identifies that

F 280

F 281 F281- 483.20 Services provided met professional standards.

1. The Nurse responsible for not documenting in the Nurses note that the neurological assessment of the Hospice patient was not done due to instructions given by hospice was reeducated to the policy as were all Nurses on duty the day of the survey were immediately given the current Neurological assessment policy and it was reiterated that all patients that fall that hit head or that are unwitnessed must have neurological assessment completed, even Hospice patients, unless the Physician gives an order stating otherwise and then it is to be documented as a verbal order and documented in the nurses notes as such. It was reiterated that Hospice staff could not discontinue the Neurological assessments unless they are a physician, Nurse

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F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to adhere to professional standards of care for 1 applicable resident regarding neurological assessments following an unwitnessed fall. For Resident #2 the findings include the following:</p> <p>Per medical record review for Resident #2, had an unwitnessed fall on 4/17/16 at approximately 10:25 AM. Resident was found on the floor in his/her room with the wheel chair behind him/her as the chair alarm was sounding. Resident #2 stated "I fell". Per medical record review, Resident #2 had a neurological check list completed one time at 10:48 AM.</p> <p>Per facility policy titled "Post Fall Neurological Assessment Protocol" dated 10/15 "identifies that</p>	F 281	<p>practitioner or a Physician Assistance.</p> <ol style="list-style-type: none"> ADNS/Evening Nurse supervisor will follow up on all incidents no later than the next business day, if occurring after hours, to ensure that all appropriate assessments and documentations in place and referrals to appropriate departments were done and documented in the records. If any steps are missing the information will immediately be updated to the record and the staff member responsible will be disciplined accordingly. Mandatory education was provided the weeks of May 5, 2016 thru the week of May 16, 2016 to all Nursing Staff regarding Professional Standards, Neurological Assessment Policy that was initiated in October of 2015, as well as an overview of the Falls Management Program and status post falls assessments to ensure that Nursing staff are aware and able to follow through on all expected steps required in the future. <p>All current Nursing staff that do not have the education before May 18, 2016 will be removed from schedule on unpaid administrative leave until the educations are completed. All new nursing staff hired after May 18, 2016 will be educated on the Professional Standards, Neurological</p>		

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F 281

Continued From page 7
when a resident falls the nurse will initially complete a neurological assessment if the fall is unwitnessed. When the Medical Doctor (MD) is notified of fall, it will be at the MD's discretion whether or not the assessment will be continued. The MD statement regarding the assessment must be clearly in the nurses notes in progress note section." Per policy, Standard Neurological assessment time frames are as follows: every 15 minutes x's 1 hour, every 30 minutes x's 1 hour, every hour x's 4 hours and every shift x's 3 days.

Per interview with the Director of Nurses confirmation is made that there is no documentation in the nurses notes indicating that the MD discontinued the neurological assessment for the unwitnessed fall.

(Lippincott Manual of Nursing Practice 19th Edition. Wolters Kluwer Health/Lippincott Williams and Wilkins, Chapter 2 Standard of Care page #16 and #17.)

F 356
SS=C

483.30(e) POSTED NURSE STAFFING INFORMATION

The facility must post the following information on a daily basis:

- o Facility name.
- o The current date.
- o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
 - Registered nurses.
 - Licensed practical nurses or licensed vocational nurses (as defined under State law).
 - Certified nurse aides.
- o Resident census.

F 281

Assessments Protocol, Falls management Program and status post falls assessments as part of the new hire orientation process.
4. DNS or substitute will track any deviation from the required steps in the Protocol and the results of these audits will be discussed at Quality Assurance Meetings

Compliance Date May 18, 2016

F281 POC accepted 5/16/16 Pmatara

F 356

F356 §483.30 (e) Nursing Staff information

1. A new daily staffing information sheet was created to ensure RN/LPN/LNA's were more clearly differentiating for each shift.
2. ADNS/Evening Supervisor will ensure that the daily Onshift projections sheets are printed daily with all outlined items noted for the day.
3. ADNS/ Evening Supervisor will audit the previous days Onshift Projection sheets and daily staffing information sheet to

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F 356	<p>Continued From page 8</p> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff the facility failed to post the daily staffing and census for public view as required by regulation. The findings include the following:</p> <p>Per observation through the initial facility tour and throughout the 6 hour investigation by 2 State Surveyors, the daily staff posting was unable to be located.</p> <p>Per interview with the Director of Nurses (DNS) confirmation is made that the posting form was removed earlier in the day to make corrections/adjustments. At approximately 3 PM, the DNS located the Direct Care Nursing Staff form that was resting on a cart directly below a sign that identified the current census. Per review with the DNS, confirmation is made that the posting does not include the necessary</p>	F 356	<p>ensure that the Nurses updated them accordingly if any changes occurred.</p> <p>4. Mandatory education was provided the weeks of May 5, 2016 thru the week of May 16, 2016 to all Nursing Staff regarding the Protocol for Nursing Staff Information Posting in accordance with F 356.. All current Nursing staff that did not have the education before May 18, 2016 will be removed from schedule and placed on unpaid administrative leave until the educations are completed. All new nursing staff hired after May 18, 2016 will be educated on the Protocol for Nursing Staff Information Posting in accordance with F 356. As part of the new hire orientation process.</p> <p>5. This information will be tracked for accuracy by the ADNS/ Evening supervisor and results discussed at Quality Assurance Meetings</p> <p style="text-align: right;">Compliance Date May 18, 2016</p> <p style="text-align: right;"><i>F356 PDC accepted 5/18/16 [signature]</i></p>	

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F 356 Continued From page 9
information identified in the regulation. There is no evidence of the total number and actual hours worked for both licensed and unlicensed staff on the posting form used.

F 356

F 514 483.75(l)(1) RES
SS=B RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

F 514

F 514 §483.75 (l) Clinical Records

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:

Based on staff interview and medical record review, the facility failed to maintain complete and accurate clinical records in accordance with acceptable professional standards of practice for 2 of 3 residents (Resident #1 and #3) of the sampled group. The findings include the following:

1. Per medical record review for Resident #1, has no evidence that a resident to resident altercation took place on 4/4/16 at 2130.

Per interview with the Director of Nurses, Social Service Director and Director of Bayada Home

1. The charge nurse did notify family and ensure safety of resident #1 at the time of the incident, evidenced by her written statement for the investigation. The Charge Nurse that was on for the 4/4/16 incident was given back her written statement from the investigation and instructed to do a late entry for the date of the incident to add to the record the events of the evening and who was contacted as well as what interventions were put into place. Education by the DNS was provided at that time as well to the proper procedure for incidents in regards to the nurse's note.
2. The Social Services Director and the Assistant Director Nursing both spoke to the Resident #1 on 4/5. Since the Social Services Director could not speak to him the morning of 4/5, she asked the ADNS to speak to him for her.

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F 514
SS=B

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:
Based on staff interview and medical record review, the facility failed to maintain complete and accurate clinical records in accordance with acceptable professional standards of practice for 2 of 3 residents (Resident #1 and #3) of the sampled group. The findings include the following:

1. Per medical record review for Resident #1, has no evidence that a resident to resident altercation took place on 4/4/16 at 2130.

Per interview with the Director of Nurses, Social Service Director and Director of Bayada Home

F 514

The ADNS did speak to him and permanently changed his room to the room he was moved to immediately following the 4/4/16 incident. On 4/5/16, when Resident #1 did not feel comfortable speaking to the ADNS about the incident, the DNS asked Bayada Hospice to have its social worker see the resident in regards to the incident to ensure no psychological harm or emotional harm was done to Resident #1. The RN from hospice spoke to Resident #1 the 5th of April and this was documented in the Bayada documentation.

3. The Social Services Director did see Resident #1 that afternoon.
4. The Social Services Director did see Resident #3 on 4/5 and requested on 4/8 Springfield Behavioral Team to have psychological visit with Resident #3 to ensure all behavioral modifications were being addressed.
5. The Social Services Director did not make timely notes in the

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F 514 SS=B	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to maintain complete and accurate clinical records in accordance with acceptable professional standards of practice for 2 of 3 residents (Resident #1 and #3) of the sampled group. The findings include the following:</p> <ol style="list-style-type: none"> Per medical record review for Resident #1, has no evidence that a resident to resident altercation took place on 4/4/16 at 2130. <p>Per interview with the Director of Nurses, Social Service Director and Director of Bayada Home</p>	F 514	<p>medical record. The Administrator has educated her and instructed her to do a late entry to add to the record of events and what interventions were put in place.</p> <ol style="list-style-type: none"> ADNS/Evening Nurse supervisor will follow up on all incidents the next business day to ensure that all appropriate documentation is in place and referrals to appropriate departments are in place and documented in the records. If any steps are missing the information will immediately be updated to the record and the staff member responsible will be disciplined accordingly. The Social Services Director will attend huddles and meet with the DNS or ADNS each morning to review any updates on residents. She has been added to the call list for when alleged abuse incidents happen. She has created her own checklist for resident-to-resident encounters. For three months, the Administrator will audit social services notes after incidents. A new resident-to-resident and abuse allegation report packet and protocol was implemented for all abuse allegations/resident- 	

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F 514 Continued From page 10
Health and Hospice Services confirmation is made that the resident verified that he was yelled at and hit by his roommate.

2. Per medical record review for Resident #3, progress notes do not evidence that a resident to resident altercation occurred on 4/4/16 as verified by Resident #1. There is no documentation that demonstrates that the family was notified of the incident, there is no evidence identifying that Social Services provided for either resident, or evidence demonstrating that support was offered to Resident #3 after the incident of 4/4/16.

Per interview with the Director of Nurses and Social Service Director confirmation is made that there is no documentation identifying the resident to resident altercation, family notification and/or confirmation that any support was provided to Resident #3.

F 514
2016 thru the week of May 16, 2016 to all staff regarding an overview of the new abuse policy and the new protocol for abuse allegation or resident-to-resident incidents to ensure that all staff are aware and able to follow through all expected steps required in the future. All current staff that do not have the education before May 18, 2016 will be removed from schedule on unpaid administrative leave until the educations are completed. All new staff hired after May 18, 2016 will be educated on the Protocol and incident packet as part of the new hire orientation process.

10. DNS or substitute will track any deviation from the required steps in the Protocol and these results of these audits will be discussed at Quality Assurance Meetings.

Compliance Date May 18, 2016

F514 POC accepted 5/16/16 P.McGowan