

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

February 27, 2014

Ms. Christine Scott, Administrator
Mayo Healthcare Inc.
71 Richardson Ave
Northfield, VT 05663-5644

Dear Ms. Scott:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 5, 2014**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN
Licensing Chief

PC:jl

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

RECEIVED PRINTED: 02/14/2014
Division of FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	FEB 26 14 Licensing and Protection	(X3) DATE SURVEY COMPLETED C 02/05/2014
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NAME OF PROVIDER OR SUPPLIER MAYO HEALTHCARE INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 71 RICHARDSON AVE NORTHFIELD, VT 05663
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F 000	INITIAL COMMENTS An unannounced on-site complaint investigation was initiated by the Division of Licensing and Protection on 2/4/14 and completed on 2/5/14. Regulatory findings were cited. They are as follows:	F 000	F 000 The submission of this plan of correction does not imply agreement with the existence of a deficiency. It is submitted in the spirit of cooperation, to demonstrate our commitment to continued improvement in the quality of our Residents lives.	
F 222 SS=D	483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility documentation and staff interview for 2 of 3 sampled residents (Resident #1 and Resident #2), the facility failed to ensure that residents are free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. The findings include: 1. Resident #1 was admitted on 12/26/13 with diagnoses to include Congestive Heart Failure, Hypertension, Diabetes, Chronic Kidney Disease, Atrial Fibrillation, Anorexia, Depression, Dementia and Stage 3 Pressure Ulcer. Per medical record review on 2/4/14, Resident #1's physician orders dated 1/3/14 identifies the administration for Morphine Sulfate 1 mg every hour for mild pain as needed (prn), Morphine Sulfate 2 mg every hour for moderate pain prn and Morphine Sulfate 3 mg every hour for severe	F 222	F 222 *Resident # 1 and Resident #2 – The nurse involved in this deficient practice has been formally counseled and educated regarding the correct Standards of Practice for administering PRN medications for the reason prescribed. *Since all Residents have the potential to be affected by the same deficient practice, all RN/LPNs will receive Mandatory In-Service education by DNS, Staff Development Coordinator or designee on the importance of following Medication Administration Practice Standards. *To ensure that all RN/LPNs remain aware of the potential for this deficient practice MARs will be audited weekly by the DNS or designee.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Christine Scott</i>	TITLE <i>Administrative</i>	(X6) DATE <i>2/24/14</i>
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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.

AMC

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F 222	<p>Continued From page 1 pain prn.</p> <p>Per medical record review on 2/4/14 nurses note dated 1/3/14 evidences that Resident #1 became weepy and family requested Resident #1 to be medicated with Morphine to calm her down and allow for a restful sleep. Nurse documented that she did not feel comfortable administering the medication when Resident #1 did not show signs of pain, discomfort or dyspnea. Nurse informed the family s/he would administer the Morphine per their request. Morphine 1 mg PO was administered at 1945.</p> <p>Per interview on 2/4/14 at 3:10 PM nurse confirms that she medicated Resident #1 with Morphine at the family request. "I wanted it documented that I did not see signs of pain, but medicated the resident as family requested."</p> <p>2. Resident #2 admitted on 10/14/13 with diagnosis to include Fracture of the Left Femur, Vascular Dementia, Depression, Anxiety, Osteoarthritis and Hyperlipidemia.</p> <p>Per medical record review for Resident #2, on 2/4/14 physician orders dated on admission identifies Haloperidol 0.5 mg by month (PO) every 4 hours as needed (prn) for moderate agitation, nausea and vomiting, hallucinations and paranoia; and Haloperidol 1 mg PO every 4 hours prn for severe agitation, nausea and vomiting, hallucinations and paranoia.</p> <p>Per medical record review, a nurses note dated 10/18/13 state that Haldol 0.5 mg was given at 1930 prior to the resident's bath with positive effects as she exhibited no signs and symptoms of anxiety or agitation this shift.</p>	F 222	<p>*Any evidence of medication administration that could be identified or interpreted as a Chemical restraint will be immediately addressed, including disciplinary action up to and including termination of any RN/LPN involved.</p> <p>*Results of these audits will be reviewed by the Quality Assurance Committee. The frequency & duration of further audits will be determined by the committee.</p> <p><i>F222 POC accepted 2/25/14 M Bertrand RN/PMC</i></p>	3/14/14
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F 222	Continued From page 2	F 222		
F 279 SS=D	<p>Per interview with the DNS on 2/5/14 at 3:15 PM confirmation is made that the nurses notes identify that the resident was medicated for bathing purposes with no evidence identifying that resident has signs or symptoms of anxiety as indicated for use per physician orders.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, facility documentation and staff interviews for 1 of 3 sampled residents (Resident #1), the facility failed to develop, review and revise the resident's</p>	F 279	<p>F279</p> <p>*Resident #1 – The comprehensive care plan reflecting the most recent developments in the Residents status lack documentation of evidence of review and revision. Physician Orders for management of a left hip hematoma, MRSA from a draining pressure ulcer (acquired prior to admission) located on the Resident's coccyx requiring contact precautions, a blood blister of left buttocks & the indwelling Foley catheter, were followed and carried out as ordered.</p> <p>*Since all residents are potentially at risk for this same deficient practice the DNS, Staff Development Coordinator or designee will require all nursing staff involved in ICP review & revision receive Mandatory In-Service education.</p> <p>* To ensure that all RN/LPNs remain aware of the potential for this deficient practice the DNS, Unit Manager or designee will conduct weekly audits to be sure all ICPs reflect the current status of all residents.</p>	

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F 279	Continued From page 3 comprehensive care plan. The findings include: Resident #1 was admitted on 12/26/13 with diagnosis to include Congestive Heart Failure, Hypertension, Diabetes, Chronic Kidney Disease, Atrial Fibrillation, Anorexia, Depression, Dementia and Stage 3 Pressure Ulcer. Per medical record review Physician Orders dated 1/13/14 document End of Life Orders. Interdisciplinary Care Plan (ICP) initiated on 1/16/14 does not reflect Resident #1's status and management of a left hip hematoma, Methicillin-Resistant Staphylococcus Aureus (MRSA) from draining pressure ulcer located on the resident's coccyx requiring contact precautions, blood blister of left buttocks or the indwelling foley catheter care. Per interview with Director of Nurses on 2/5/14 at 11:35 AM s/he confirms that the ICP does not reflect the current status of Resident #1 at the time the End of Life orders were obtained.	F 279	*Any evidence of missing documentation will be immediately addressed & corrected. *Results of these audits will be reviewed by the Quality Assurance Committee. The frequency & duration of further audits will be determined by the committee. <i>F279 POC accepted 2/25/14 MBertrand RN PNC.</i>	<i>3/14/14</i>	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323	F323 *Resident # 1 and Resident #3 -- Mayo's Fall Prevention Policies have been reviewed and revised to reflect more proactive measures to prevent unavoidable falls.		

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F 323	<p>Continued From page 4</p> <p>Based on medical record review, observation and staff interviews for 2 of 3 sampled residents (Resident #1 and Resident #3), the facility failed to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. The findings include:</p> <p>1. Resident #1 was admitted on 12/26/13 with diagnosis to include Congestive Heart Failure, Hypertension, Diabetes, Chronic Kidney Disease, Atrial Fibrillation, Anorexia, Depression, Dementia and Stage 3 Pressure Ulcer.</p> <p>Per medical record review on 2/4/14 of Resident #1 has a known history of falls that occurred at the Mayo Assisted Living (3 falls in November, 5 falls in December 2013). Documented falls at the nursing home occurred on 12/30/13 at 11 AM, 1/1/14 at 6 AM, 8:30 AM, and 9:15 AM. Falls that occurred 1/1/14 resulted in transfer to the acute hospital for evaluation and treatment. Resident #1 was found to have a soft tissue injury of the left hip with a hematoma 7+ centimeters in size.</p> <p>Interdisciplinary Care Plan initiated on admission 12/27/13 identifies Fall Risk with approaches to manage falls to include frequent safety checks.</p> <p>Per medical record review on 1/4/14 nurses noted dated 1/1/14 at 0600 Resident #1 was found on the floor on her back, 0800 Resident #1 was sitting on the edge of her bed, at 0830 the resident was found on the floor in her room, and at 0915 Resident #1 was left unattended in the hallway in a wheelchair when she attempted to stand, staff witnessed fall to the floor.</p>	F 323	<p>*Since all residents are potentially at risk for this same deficient practice the DNS, Staff Development Coordinator or designee will require all staff to receive Mandatory In-Service education by DNS, Staff Development Coordinator or designee on the revised Fall Prevention Policy.</p> <p>*To ensure that all staff remains aware of the revisions in the Fall Prevention Policy and to prevent the potential for this deficient practice from reoccurring the DNS, Unit Manager or designee will conduct daily walking rounds to assure that all Fall Prevention strategies are being practiced.</p> <p>*Any discrepancies in following policy will be immediately addressed & corrected and recorded on the audit tool.</p> <p>*Results of these audits will be reviewed by the Quality Assurance Committee. The frequency & duration of further audits will be determined by the committee.</p> <p><i>F323 POC accepted 2/25/14 M.Bertrand RN/PAC</i></p>	<i>3/14/14</i>

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F 323	<p>Continued From page 5</p> <p>Per interview with Director of Nurses on 2/5/14 at 3:45 PM, s/he confirms that the fall that occurred on 1/1/14 at 8:30 AM was avoidable, the resident was left sitting on the edge of her bed in her room unattended after falling at 6 AM.</p> <p>Per review on Incidents with Detail Report dated 1/1/14 evidences Resident #1's fall on 1/1/14 at 6 AM identifies the resident's bed alarm was not plugged in, staff stated no box available and resident is a known fall risk. Second fall at 0830 resident found on the floor beside her recliner, the alarm sounded. Third fall 0915 identifies resident left unattended in sitting in the hallway, staff witnessed resident attempting to stand.</p> <p>Falls of 1/1/14 determined to be avoidable, resident was known to be a fall risk and safety checks were not assigned until 1/6/14 after return from hospitalization.</p> <p>2. Per medical record review, Resident #3 was hospitalized on 1/17/14 and readmitted on 1/22/14 with diagnoses to include Urinary Tract Infections, Myocardial Infarct, Pneumonia, Congestive Heart Failure, Diabetes, Macular Degeneration, Osteoporosis and Depression.</p> <p>Per medical record review Resident #3 fell 1/4/14 after assisting another resident get a drink of water. Per medical record review Resident #3 was found on the floor on 2/4/14 after sliding out of her recliner. Interview with Resident #3 on 2/5/14 confirms she slid out of her chair.</p> <p>Per Interdisciplinary Care Plan review (ICP), it was updated on 1/4/14 with no new initiatives noted. Confirmed by Unit Manager (UM) on</p>	F 323		

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F 323	Continued From page 6 interview on 2/5/14 at 2 PM. Per observation with the UM on 2/5/14 at 2 PM Resident #3 is lying in she/her recliner with legs elevated. To the left of the recliner is a wheel chair and rolling walker. To the right of the recliner is a bedside table with the surface covered with personal items and directly on the floor are multiple pairs of shoes/slippers and a plastic bag that has personal items that returned with the resident from hospitalization. UM confirms at this time that there is a lot of clutter at the bedside. Per ICP dated 8/7/13 and updated 1/4/13 identifies an approach for Impaired Mobility/Fall Risk, to keep walkways free from clutter and spills. Fall of 2/5/14 is determined to have been avoidable.	F 323		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to ensure that 1 of 3 sampled residents (Resident #1), are free of any significant medication errors. The findings include: Resident #1 was admitted on 12/26/13 with diagnoses to include Congestive Heart Failure, Hypertension, Diabetes, Chronic Kidney Disease, Atrial Fibrillation, Anorexia, Depression, Dementia	F 333	F 333 *Resident #1 – The resident was assessed and found to have no ill effects from the medication errors. The Nurse Practitioner was notified and NP stated “continue current orders at this time but call back if further dose adjustments are needed”. The nurse involved in the Medication errors has been formally counseled, has been instructed to have a second nurse oversee & confirm that she has drawn up the correct dosage of all Scheduled Two liquid medications for a minimum of 30 days or until such time that it has been deemed capable of correct practice. Furthermore, this same nurse has received a Formal referral to EAP to assure that no outside influences have affected her practice. Review of Mayo’s Policy of Transcribing Physician Orders is found to be correct.	

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F 333	<p>Continued From page 7 and Stage 3 Pressure Ulcer.</p> <p>Per medical record review physician orders dated 1/15/14 identify pain medication to be administered as follows: Morphine Sulfate 1 milligram (mg) by mouth (po) every hour as needed (PRN) for mild pain Morphine Sulfate 2 mg po every hour PRN for moderate pain Morphine Sulfate 3 mg po every hour PRN for severe pain</p> <p>Transcription error on Medication Administration Record dated 1/1/14 through 1/31/14 indicates the following: Morphine Sulfate 0.5 milliliters (ml's) 1mg po every hour PRN mild pain Morphine Sulfate 1ml (2mg) po every hour PRN moderate pain Morphine Sulfate 1.5 ml (3mg) po every hour PRN severe pain</p> <p>Per nurses note dated 1/15/14 RN documents administration of Morphine Sulfate (MSO4) 30 mg po prn at 1650 and 15 mg MSO4 po prn at 2000. Medication error written and submitted to Director of Nurses (DNS).</p> <p>Per interview on 2/4/14 at 3:10 PM with RN confirmation was made that the medication error did occur as documented. RN confirms that she looked at the MAR that identified ml's and did not calculate the dose that she needed to administer. RN confirmed that s/he administered 30 mg of Morphine po at 1650 and 10 mg po Morphine at 2000.</p> <p>Per interview on 2/4/14 at 3:10 PM with the DNS also confirms that the error was made by the RN.</p>	F 333	<p>* Since all Residents have the potential to be affected by the same deficient practice, all RN/LPNs will receive Mandatory In-Service education by DNS, Staff Development Coordinator or designee on the importance of following Mayo's Policy of Transcribing Physician Orders as well as following Medication Administration Practice Standards.</p> <p>* To ensure that this deficient practice does not recur all MARS will be audited weekly by the DNS or designee.</p> <p>* Any evidence of medication administration errors will be immediately addressed, including disciplinary action up to and including termination of any RN/LPN involved.</p> <p>* Results of these audits will be reviewed by the Quality Assurance Committee. The frequency & duration of further audits will be determined by the committee.</p> <p><i>F333 POC accepted 2/25/14 M. Bertrand, RN, J. P. M.</i></p>	3/14/14

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F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>F 441 *Resident #1 – The wound culture was obtained and sent to the lab on Friday, 01/10/14. The results of the wound culture showing MRSA were faxed to the facility on Saturday, 01/11/14. Mayo Rehabilitation & Continuing care follows Standard Precautions for all Residents. Contact Precautions were initiated on Monday, 01/13/14, but not documented in the Medical Record. Drainage from the wound was contained in the dressing & staff used Personal Protective Equipment during dressing changes as per Standard Precautions Protocol.</p> <p>* Since all Residents have the potential to be affected by the same deficient practice, all RN/LPNs will receive Mandatory In-Service education by DNS, Staff Development Coordinator or designee on the importance of following Contact Precautions as soon as lab results are received & to look for lab results within 24 hours of sending out a specimen.</p>	

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F 441	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record review and staff interview, for 1 of 3 sampled residents (Resident #1) the facility failed to isolate a resident to prevent the spread of infection. The findings include:</p> <p>Per medical record review, Resident #1 was admitted on 12/26/13 with diagnoses to include Congestive Heart Failure, Hypertension, Diabetes, Chronic Kidney Disease, Atrial Fibrillation, Anorexia, Depression, Dementia and Stage 3 Pressure Ulcer.</p> <p>Per medical record review for Resident #1, an Advanced Practice Registered Nurse (APRN) documents that a wound culture of draining Stage III coccyx pressure ulcer was obtained using sterile technique. Sent to the lab pending results. Per medical record review on 2/4/14 Resident #1, the APRN documents that laboratory studies from the wound culture dated 1/10/14 grew Methicillin-Resistant Staphylococcus Aureus (MRSA).</p> <p>Per medical record review on 2/4/14 there are no nurses noted evidencing that contact precautions were initiated or maintained from the time the culture results were obtained on 1/10/14 through the time the resident expired on 1/16/14.</p> <p>Per telephone interview with the Director of Nurses on 2/6/14 at 10 AM s/he confirms that Standard Precautions were in place. However, contact precautions were not initiated until 1/13/14. Contact precautions includes signage on the door alerting visitors and staff to see Nurse before entering the room and access to personal</p>	F 441	<p>* To ensure that this deficient practice does not recur all nursing staff will be instructed to check the fax machine every shift to look for any information that effects Resident's needs.</p> <p>*All faxed information received over the weekend will be reviewed every Monday morning by the DNS, Unit Manager or designee to assure that any necessary action has taken place in a timely fashion.</p> <p>*Results of these reviews will be documented as audits & will be reviewed by the Quality Assurance Committee. The frequency & duration of further audits will be determined by the committee.</p> <p><i>F441 POC accepted 2/25/14 M Bertrand RN PMC</i></p>	3/14/14
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/05/2014
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NAME OF PROVIDER OR SUPPLIER MAYO HEALTHCARE INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 71 RICHARDSON AVE NORTHFIELD, VT 05663
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F 441	Continued From page 10 protective equipment which was placed outside the resident's room for staff use during personal care and dressing changes.	F 441		
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 medical record review, facility documentation and staff interviews for 1 of 3 sampled residents (Resident #1), the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented. The findings include: Per medical record review, Resident #1 was admitted on 12/26/13 with diagnoses to include Congestive Heart Failure, Hypertension, Diabetes, Chronic Kidney Disease, Atrial Fibrillation, Anorexia, Depression, Dementia and Stage 3 Pressure Ulcer.	F 514	F 514 *Resident #1 -- the MDS Coordinator has been counseled about documenting information that is complete and accurate. *Since all Residents Medical Records have the potential to be affected by the same deficient practice, the MDS Coordinator has been instructed to double check all documentation of all Pressure Ulcer measurements with the Unit Manager before recoding those measurements on the MDS to assure that length and width are documented in the appropriate MDS coding boxes. *To ensure that all Pressure Ulcer measurements are accurate an audit tool has been developed, including the Standardized PUSH tool. These audits will be conducted by the QAA Coordinator on a weekly basis. *Results of these audits will be reviewed by the Quality Assurance Committee. The frequency & duration of further audits will be determined by the committee.	3/14/14

F514 POC accepted 2/25/14 mbertrand RN/pmc

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F 514	<p>Continued From page 11</p> <p>Per medical record review on 2/4/14 identifies the following: Minimum Data Set (MDS) assessment identifies on 1/1/14 a Pressure Ulcer (PU) 2 Centimeters (cm) by 1.8 cm by 0.5 cm in depth with granulation tissue. Nursing Wound Healing Chart documents 1/1/14 length 1.8 cm, width (nothing documented) and depth 0.5 cm. Fax communication dated 12/27/13 to physician documents measurements at 1.8 cm x 0.5 cm area with a circumference of 5.5 cm. Coding on the MDS does match the faxed document.</p> <p>MDS identifies on 1/10/14, PU 2 cm by 2 cm with depth of 0.5 cm with eschar present. APRN identifies the above measurements. Measurements on the Nursing Wound Healing Chart measure wound on 1/6/14 with a length of 3 cm, width of 2 cm and depth unable to measure with no exudate. Nurses Notes dated 1/8/14 identifies "old dressing 4 cm. x 4 cm. saturated with brownish drainage with foul odor".</p> <p>MDS identifies on 1/15/14 one unstagable PU and that was present on admission. Measures 4 cm by 4 cm with no depth documented. Eschar present. APRN identifies on 1/13/14 wound Stage III, likely stage IV pressure ulcer on the coccyx. There is no Nursing Wound Healing Chart evidencing further measurements taken by the nursing department. Nurses notes document dressing changes, drainage from wound and identification on 1/14/14 a 3 cm. x 3 cm. blood blister on left buttocks near the thigh (blister in tact), cleansed and left open to the air.</p> <p>Interview with MDS Coordinator on 2/4/14 at 2:02 PM confirms s/he does not measure pressure</p>	F 514		

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F 514	Continued From page 12 ulcers and s/he obtains all measurements from the medical record. Medical record reviewed with the MDS Coordinator and confirmation was made that measurements are inconsistent and incorrectly coded.	F 514			
F9999	<p>Interview with Director of Nurses on 2/5/14 at 11:53 confirms that the medical record does have inconsistencies with wound measurements.</p> <p>FINAL OBSERVATIONS</p> <p>Licensing and Operating Rules for Nursing Homes</p> <p>2.9 Reports to the Licensing Agency</p> <p>The following reports must be filed with the licensing agency:</p> <p>(a) At the time a fire occurs in the home, regardless of the size or damage, the licensing agency and the Department of Labor and Industry must be notified by the next business day. A written report must be submitted to both departments by the next business day. A copy of the report shall be kept on file in the facility.</p> <p>(b) An untimely death that occurs as a result of an untoward event, such as an accident that results in hospitalization, equipment failure, use of restraint, etc., shall be reported to the licensing agency by the next business day, followed by a written report that details and summarized the event.</p> <p>(c) Any unexplained or unaccounted for absence of a resident for a period of more than 30 minutes shall be reported promptly to the licensing</p>	F9999	<p>F 999</p> <p>FINAL OBSERVATIONS</p> <p>*Mayo Rehabilitation & Continuing Care's Policy for reporting untimely deaths has been revised to accurately reflect the Licensing & Operating Rules for Nursing Homes, including death that occurs as a result of an untoward event, such as an accident (such as a fall) that results in hospitalization, equipment failure, use of restraint, etc. shall be reported to the licensing agency by the next business day, followed by a written report that details and summarized the event.</p> <p>*Since all Residents have the potential to be affected by this same deficient practice, all Nursing Staff will receive Mandatory In-Service education by DNS, Staff Development Coordinator or designee on the revised Policy.</p>		

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F9999	<p>Continued From page 13 agency. A written report must be submitted by the close of the next business day.</p> <p>(d) Any breakdown or cessation to the facility's physical plant that has a potential for harm to the residents, such as a loss of water, power, heat, or telephone communications, etc., for four hours or more, shall be reported within 24 hours to the licensing agency.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on medical record review, facility documentation and interviews for 1 of 3 sampled residents, (Resident #1), the facility failed to report to the licensing agency an untimely death that resulted after a fall and a significant medication error.</p> <p>Resident #1 was admitted on 12/26/13 with diagnosis to include Congestive Heart Failure, Hypertension, Diabetes, Chronic Kidney Disease, Atrial Fibrillation, Anorexia, Depression, Dementia and Stage 3 Pressure Ulcer.</p> <p>Per medical record review Resident #1 has documented falls dated 12/30/13 at 10 AM; 1/1/14 at 6 AM, at 8:30 and 9:15 AM. Resident was transported on 1/1/14 to the acute care hospital for evaluation. After diagnostic testing and assessment Resident #1 was admitted to the acute hospital with a soft tissue injury to the left hip with hematoma. On 1/3/14 Resident #1 returned to the nursing facility.</p> <p>Per medical record review of Resident #1 on 2/4/14, documented physician orders dated 1/3/14 identify an order for Morphine Sulfate 1 mg</p>	F9999	<p>* All resident deaths will be reviewed by the Administrator to determine whether any death falls into the category of untimely & if so, that the death has been reported to the Licensing agency accordingly.</p> <p>*An audit tool has been developed to record all Resident deaths & indicate whether any death falls into the category of untimely.</p> <p>*Results of these reviews will be documented as audits & will be reviewed by the Quality Assurance Committee. The frequency & duration of further audits will be determined by the committee.</p> <p>F9999 POC accepted 2/25/14 M. Bertrand RN / PML</p>	3/14/14

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F9999	<p>Continued From page 14</p> <p>every hour for mild pain as needed (prn), Morphine Sulfate 2 mg every hour for moderate pain prn and Morphine Sulfate 3 mg every hour for severe pain prn. Per medical record review, Resident #1 was administered by the Registered Nurse Morphine Sulfate 30 mg by mouth (po) on 1/15/14 at 4:50 PM and Morphine Sulfate 15 mg po again on 1/15/14 at 8:15 PM. Resident expired on 1/16/14 at 0906.</p> <p>Per interview with the Nursing Home Administrator (NHA) and the Director of Nurses on 2/4/14 at 4:30 PM confirmation was made that they were unaware of the need to report to the Licensing Agency and the Medical Examiner's Office an untimely death after a resident had a fall that did not result a fracture. The NHA confirmed the death was not reported to the Licensing Agency or the Medical Examiner's Office.</p>	F9999		
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