

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

November 6, 2012

Ms. Jessica Jennings, Administrator  
Saint Albans Healthcare And Rehabilitation Center  
596 Sheldon Road  
Saint Albans, VT 05478-8011

Dear Ms. Jennings:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 3, 2012**. 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

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Division of  
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PRINTED: 10/17/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____  <b>Licensing and Protection</b>	(X3) DATE SURVEY COMPLETED  C 10/03/2012
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NAME OF PROVIDER OR SUPPLIER  SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 596 SHELDON ROAD SAINT ALBANS, VT 05478
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F 000	INITIAL COMMENTS  An unannounced on-site complaint survey was conducted by staff from the VT Division of Licensing and Protection on 10/2/12 and completed on 10/3/12. The following regulatory violations were found.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update the address and phone number of the resident's	F 157	<p><b>St. Albans Health and Rehabilitation Center Provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. This plan of correction is prepared and executed solely because it is required by federal and state law.</b></p> <p><b>F157</b></p> <p><b>The nurse responsible for the care of this resident on the evening of this incident was provided with a performance improvement plan per center policy on 10/3/12. After shave was removed from this resident's belongings as to prevent further incidents.</b></p> <p><b>Residents with cognitive impairment are at risk to be affected by this alleged deficient practice.</b></p> <p><b>Nursing staff was educated on the Center's Policy and Procedure regarding Accident's, Incidents, and Adverse Events (P&amp;P 1.1) and Physician Notification (P&amp;P 2.16).</b></p> <p><b>Audits of the nursing documentation will be reviewed to ensure that the proper procedure for MD notification occurs if a resident ingests a non-food item weekly for 4 weeks and then monthly x 3 by the DON and/or her designee.</b></p> <p><b>Findings and trends will be reviewed at the Quality Assurance meeting for a minimum of 3 months.</b></p> <p><b>Corrective actions will be completed November 9, 2012.</b></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 10/30/12
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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.

*PM*

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F 157	Continued From page 1 legal representative or interested family member.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to immediately inform the physician and responsible family member after 1 of 4 residents in the total sample was observed ingesting a potentially harmful non-food substance. (Resident #1). Findings include:  Per record review on 10/2/12, a nurse found Resident #1 drinking aftershave lotion on 9/4/12 and there was no evidence of notification of the incident to the physician and the responsible family member by the nurse and there was no evidence of monitoring and assessment to determine if the resident (who has dementia) was harmed by ingestion of this non-food substance. Per progress notes dated 9/2/12 at 2223 hours, the nurse wrote "this nurse checking on resident and found [him/her] drinking aftershave so nurse threw away aftershave". There was no documented assessment nor evidence of monitoring the resident after the incident. No incident report was completed per interview with the Director of Nurses (DNS). The facility's policy entitled "Accidents, Incidents and Adverse Events" reviewed at 4 PM with the DNS stated "All accidents, incidents or adverse events occurring on Genesis Healthcare Center premises should be reported, reviewed, and, if indicated, investigated without fear or reprisal. An incident is defined as any occurrence not consistent with the routine operation of the Center or normal care of the resident/patient."	F 157	F157 POC accepted 10/3/12 11/1/12 MBH/TURN/PMC		

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F 157	Continued From page 2 The DNS confirmed at 4 PM that an incident report should have been completed by the nurse, that the physician and family should have been notified and that there should be documented evidence of assessment and on-going monitoring of the resident after the ingestion of the aftershave. Per review of all progress notes from 9/5/12 - 9/12/12 at 1137 hours, there was no mention of the incident regarding ingestion of the aftershave on 9/4/12. The notes reviewed included a provider summary/assessment of a visit on 9/10/12 and notes from a care plan meeting documented on 9/12/12.	F 157		
F 226 SS=D	Refer also to F281 483.13(c) DEVELOP/IMPLMENT 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.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to operationalize their abuse policies regarding investigation of alleged resident mistreatment and reporting to the State Agency within the required timelines for 1 of 4 residents in the applicable sample. (Resident #3) Findings include:  Per investigation of an anonymous complaint on 10/2/12, Resident #3 sustained an injury alleged to occur during personal care by 2 Licensed	F 226	<b>F226</b>  <b>The Nurse responsible for completing the incident report is no longer employed at this center.</b>  <b>Residents throughout the center have the potential to be affected by this alleged deficient practice.</b>  <b>Nursing staff was educated in regards to the Center's Abuse Policy (P&amp;P 1.0) and Accidents, Incidents, and Adverse Events (P&amp;P 1.1).</b>  <b>Documentation audits will be completed to ensure that an investigation is completed for injuries of unknown origin weekly for 4 weeks and then monthly x 3 by the DON and/or her designee.</b>  <b>Findings and trends will be reviewed at the Quality Assurance meeting for a minimum of 3 months.</b>  <b>Corrective actions will be completed November 9, 2012.</b>	

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F 226	<p>Continued From page 3</p> <p>Nursing Assistants (LNAs) on 8/27/12 and the facility failed to conduct an appropriate investigation, per it's "VT Abuse Prohibition Policy". Resident #3 was interviewed at 11:40 AM on 10/2/12 and stated that 'a while ago (some weeks ago)' while 2 LNAs were pulling h/her up in bed, they slammed her left shoulder into the bed frame. S/he said that s/he got a large bruise on the left shoulder that was very painful. S/he said that the physician ordered multiple X-rays after the injury. The surveyor observed a bluish/black/yellow bruise, approximately 7 inches by 5 inches on the upper left arm/shoulder area. The resident said that staff were supposed to always use the Ergoslide (a slippery blue blanket) when boosting residents up in bed. It helps them to move people more easily. The resident said that the staff didn't use the slide and when they boosted her up, she was slammed into the bed/headboard, causing the injury. When asked if it was still painful, the resident said it was better but still hurt sometimes. When asked if any facility staff had interviewed her after the incident or had informed her of any results of their investigation into the alleged incident, s/he replied "no".</p> <p>Per interviews with the DNS and the unit manager on 10/2/12 at 12 noon and 2:45 PM, each was aware of the alleged incident, however, there was no incident report completed, nor was there an interview conducted with the resident regarding her allegations. The DNS stated that she was aware that the resident said that 2 LNAs failed to use the Ergoslide when boosting h/her up in bed on the evening/night of 8/27/12. The DNS said that one of the LNAs was interviewed by the nurse on duty on the night in question and that</p>	F 226	<p><i>Facility accepted 11/11/12 medication/PMC</i></p>	
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F 226	Continued From page 4 the LNA denied the allegation and said that they used the Ergoslide. The DNS confirmed that no other investigative actions were completed. No one interviewed the resident to obtain a statement regarding their account of the incident. The DNS said that she is the one who usually tracks and trends resident injuries of unknown origin. She was not aware of the fact that the resident sustained a large, painful bruise until the surveyor informed her of the fact on 10/2/12. The unit manager stated that he thought that an incident report had been completed, however, it was not found during the survey on 10/2/12 and the DNS had no knowledge of it. The physician visited the resident on 8/28/12 and the resident reported the injury to the physician, who ordered X-rays be done. The X-rays did not show a fracture. The physician wrote that it was possibly "a deep tissue injury". The bruise appeared shortly after the incident but it was never documented in the medical record. Per review of progress notes, there was no mention of the bruise, no wound report sheet started, no evidence of continued monitoring of the bruise, including size, color, pain present. etc. The DNS also confirmed that the alleged mistreatment was not reported to the Vermont State Agency (Adult Protective Services) within 48 hours, as required.	F 226			
F 281 SS=E	Refer also to F281 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	F 281			

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F 281	<p>Continued From page 5</p> <p>by: Based on staff interview and record review, the facility failed to assure that nurses met professional standards of nursing practice regarding the areas of physician orders for treatments, and monitoring and assessment of residents after a change in medical symptoms for 2 of 4 resident in the applicable sample. (Residents #1 &amp; 3) Findings include:</p> <p>1. Per record review and confirmed by nursing staff interview, there was no evidence of assessment and on-going monitoring of Resident #1 after the resident was observed drinking aftershave lotion on 9/4/12. A LPN (licensed practical nurse) documented in a progress note dated 9/4/12 at 2223 hours "this nurse checking on resident and found him drinking aftershave so nurse threw away aftershave...". During a telephone interview conducted by the DNS on 10/2/12 at 5:25 PM regarding the progress note, the LPN confirmed the events and confirmed s/he had not completed an incident report per facility policy and s/he had not notified the physician and family of the event. Refer also to F157</p> <p>2. Per record review and interview, Resident #3 sustained an injury on 8/27/12 and there was no documentation in the medical record regarding the large bruise sustained by the resident including evidence of assessment and ongoing monitoring of the bruise. Although the physician ordered X-rays and the resident required medication (for a period of weeks) to alleviate the pain in the left shoulder area, no nurses documented assessment and monitoring of the bruise, still visible on 10/2/12. The bruise was</p>	F 281	<p><b>F281</b></p> <p><b>Resident #1 had the after shave removed from the resident's belongings to prevent further incidents.</b></p> <p><b>Resident #3 received a complete investigation regarding this resident's bruise per the center's policy. In addition, Resident #3's blisters had re-solved by 10/2/2012 not requiring a dressing.</b></p> <p><b>Residents throughout the facility have the potential to be affected by this alleged deficient practice.</b></p> <p><b>Nursing staff was educated in regards to the Center's Abuse Policy (P&amp;P 1.0), Accidents, Incidents, and Adverse Events (P&amp;P 1.1), Safe Resident Handling P&amp;P and Dressings (P&amp;P 14.1) requiring a physician's order.</b></p> <p><b>Audits of documentation will be reviewed to ensure that monitoring occurs if a resident consumes a non-food item. Audits will also be completed to ensure that injuries will be monitored and documented. Audits will be conducted to ensure that the MD is notified and treatment orders are obtained for residents who have newly acquired wounds. These audits will be completed weekly for 4 weeks and then monthly x 3 by the DON and/or her designee.</b></p> <p><b>Findings and trends will be reviewed at the Quality Assurance meeting for a minimum of 3 months.</b></p> <p><b>Corrective actions will be completed November 9, 2012.</b></p>	
<p><i>FABi POL accepted 11/1/12 MBohannon R/AME</i></p>				

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F 281	<p>Continued From page 6 approximately 7 inches long and 5 inches wide, per observation on 10/2/12 at 11 AM.</p> <p>Resident #3 also developed 2 blood blisters on the left buttock area on 9/20/12. The RN documented in a progress note dated 9/20/12 at 1500 that a hydrocolloid dressing was applied to the area and that the on-call physician was called to obtain an order for treatment. During interview with the RN who wrote the note, s/he stated that s/he faxed the physician a paper with concerns for several residents on one paper, requesting orders to treat be faxed back to the facility later. The physician did not send any orders to treat the wound.. As of the date of survey, 10/2/12, the dressing was still in use for this resident; however, there was no current physician order to treat the wound with the hydrocolloid dressing. The RN confirmed at 3 PM that s/he had not faxed appropriate documentation to request treatment orders for Resident #3's wounds and that no current orders for treatment were obtained.</p> <p>Refer also to F226</p> <p>Reference: Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Williams &amp; Wilkins.</p>	F 281		
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p>	F 323		

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F 323	Continued From page 7  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that the environment was free of accident hazards and that each resident received adequate supervision to prevent accidents for 1 applicable resident in the sample. (Resident #1) Findings include:  Per record review on 10/2/12, the Licensed Practical Nurse (LPN) wrote on a progress note dated 9/4/12 at 2223 hours that s/he found Resident #1 drinking after shave solution. Per interview with the DNS on 10/2/12 at 5:25 PM, s/he confirmed that the resident had a history of conflict with the roommate on the east unit and recently transferred to the west unit from the locked east wing dementia unit. The resident's behaviors included a history of wandering, exit seeking and agitated, sundowning behaviors. During a telephone call to the LPN who found the resident drinking the aftershave (conducted by the DNS in the presence of the surveyor), the nurse stated that the resident's aftershave was found with his belongings in his room (east wing at that time). She stated she took the bottle away from him and confirmed that she did not notify the physician to obtain possible further orders. The nurse failed to document an assessment after the incident and failed to complete an incident report, per facility policy. The DNS was not previously aware of this incident until it was brought to her attention by the surveyor.	F 323	<b>F323</b>  <b>Resident #1 had the after shave removed from his room.</b>  <b>Residents with cognitive impairment have a potential to be affected by this deficient practice.</b>  <b>Nursing staff have been educated on the storage of aftershave and on completing an assessment and proper documentation when a resident consumes a non-food item.</b>  <b>The DON and/or her designee will perform random checks of resident's rooms to ensure that aftershave is maintained in a secured manner and that residents are assessed and proper documentation occurs if a resident consumes a non-food item. These audits will be completed weekly for 4 weeks and then monthly x 3.</b>  <b>Findings and trends will be reviewed at the Quality Assurance meeting for a minimum of 3 months.</b>  <b>Corrective actions will be completed November 9, 2012.</b>  <i>F323 POC accepted 11/1/12 mBatten RN/ Pme</i>		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441			

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F 441	Continued From page 8  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.  (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.  (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.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	<b>F 441</b>  <b>For the residents identified during this survey as being affected by this alleged practice Ergo-slides have been ordered.</b>  <b>Residents who require the use of an ergo-slide for bed mobility have the potential to be affected by this alleged deficient practice.</b>  <b>Nursing staff have been educated on the use of the ergo-slides, and that they are not to be used between residents without being cleaned. In addition, 25 ergo-slides have been ordered.</b>  <b>The DON and/or her designee will complete audits to ensure that each resident who requires an ergo-slide has their own device, or is cleaned between residents. These audits will be completed weekly x 4 and then monthly x 3.</b>  <b>Findings and trends will be reviewed at the Quality Assurance meeting for a minimum of 3 months.</b>  <b>Corrective actions will be completed November 9, 2012.</b>  <i>F441 POC accepted 11/1/12 mbl/houran/pmc</i>	

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

PRINTED: 10/17/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475021</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/03/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>596 SHELDON ROAD</b> <b>SAINT ALBANS, VT 05478</b>
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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 interview and record review, the facility failed to assure that a special blanket used to reposition residents with impaired mobility in bed, was handled and processed so as to prevent the possible spread of infection and maintain a safe and sanitary environment. The practice affected residents dependent on staff for bed mobility on all units. (Up to 30 residents per the Resident Roster) Findings include:</p> <p>Per interview with 2 LNAs, a unit manager and the DNS throughout the day on 10/2/12, each room where a resident resided who required assistance from staff with bed mobility, had an Ergoslide stored on a hook on the back of the door to the room. LNAs interviewed on 10/2/12 stated that they use the Ergoslide for multiple residents in some rooms. When asked how the Ergoslides are cleaned between each resident use, staff stated they have been instructed to use them for residents without cleaning as long as the Ergoslide is not wet or visibly soiled. When soiled, they are sent to the laundry for washing. During interview at 2:45 PM, the DNS stated that the slides are used for any residents in the room needing repositioning in bed; it is placed directly under the resident and sides easily on the bed and can be used for other resident's in the room. The DNS stated that as needed, 1 Ergoslide is provided to each room.</p> <p>Per review of the facility's policy/procedure "Ergoslide: Use of" on 10/2/12 at 2:30 PM, after use, "return Ergoslide to patient's drawer or, if used for multiple patients, clean according to manufacturer's instructions". The DNS confirmed</p>	F 441		
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F 441	Continued From page 10 that they should be cleaned by laundering. When asked if there was a schedule for laundering the Ergoslides, the DNS stated that there was no washing schedule. It was confirmed that an Ergoslides could be used for a long period of time with no regular cleaning. LNAs indicated that the resident may often be dressed only in a Johnnie during use of the slide blanket, and that often some skin would be in direct contact with the Ergoslides.	F 441		
F 514 SS=D	<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 record review, the facility failed to maintain medical records that were complete and accurately documented for 1 of 4 residents in the applicable sample. (Resident #3) Findings include:  Per record review and confirmed by interview on 10/2/12, Resident #3 sustained an injury to the</p>	F 514	<p><b>F514</b></p> <p><b>Resident #3's bruise was assessed and documented during the weekly skin check on 10/8 and weekly there after.</b></p> <p><b>Residents throughout the facility have the potential to be affected by this alleged deficient practice.</b></p> <p><b>Nursing staff have been educated on the Center's Policy and Procedure for VT Abuse Prohibition (1.0), Accidents, Incidents, and Adverse Events (1.1), and Nursing Documentation (2.21).</b></p> <p><b>The DON and/or her designee will complete audits to ensure that injuries will be monitored and documented weekly x 4 and then monthly x 3.</b></p> <p><b>Findings and trends will be reviewed at the Quality Assurance meeting for a minimum of 3 months.</b></p> <p><b>Corrective actions will be completed November 9, 2012.</b></p>	

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F 514	Continued From page 11 left shoulder during the provision of care and nursing staff failed to document evidence of observation and monitoring of the large bruise that developed after the alleged incident. The resident alleged to a nurse on 8/27/12 that "[s/he] knew how [s/he] got hurt". The resident reported to the surveyor at 11 AM on 10/2/12 that 2 LNAs failed to reposition her in bed properly and caused her to hit the headboard/bedrail which caused significant pain. Although the allegation was mentioned in the progress note on 8/27/12, there was no documentation to reflect the large bruise that developed subsequent to the incident. The resident was noted to have stated pain in the left shoulder area during the weeks after the incident. The provider saw the resident on 8/28/12 and 9/5/12 and ordered X-rays. He stated that the resident 'had a contusion, likely a deep bruise...LUE (left upper extremity) shows evidence of of a 10 cm. elliptical echymotic area.'  Review of the nursing progress notes from 8/28/12 - 10/1/12 showed no mention of the bruise, including no assessment and no evidence of monitoring during that time period. There was no wound flow sheet started per interview with the DNS at 2:45 PM on 10/2/12. The DNS stated that she had not received any incident report regarding the incident and was not aware of the development of the bruise until the surveyor brought it to her attention.	F 514	F514 POC accepted 11/1/12 MBoitman/PMC		