

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

August 19, 2013

Ms. Rachael Parker, Administrator
Starr Farm Nursing Center
98 Starr Farm Rd
Burlington, VT 05408-1396

Dear Ms. Parker:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 18, 2013**. 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
Division of
AUG 14 13
PRINTED: 08/01/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	Licensing and Protection	(X3) DATE SURVEY COMPLETED C 07/18/2013
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NAME OF PROVIDER OR SUPPLIER STARR FARM NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 98 STARR FARM RD BURLINGTON, VT 05408
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS An unannounced onsite complaint investigation was conducted on 7/17 and 7/18/13 by the Division of Licensing and Protection. There were regulatory deficiencies identified. The findings include:	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 281 SS=E	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 record review and staff interview the facility failed to provide or arrange services that meet professional standards of quality for 1 of 3 residents identified, regarding following physician orders and physician ordered protocols (resident #1) The findings include: 1. Per record review conducted on 7/17/13, the medical record for Resident #1 indicated that Resident #1 was admitted to the facility on 6/21/13, with diagnoses that include; Parkinson's, senile dementia and constipation. Per review of the Physician's orders dated 6/20/12, the orders indicate that Resident #1 is supposed to receive assistance when he/she eats meals. Per review of the daily ADL documentation sheets, the LNA's signed that on the day shift from 6/22 thru 6/30/13, the LNA's documented that Resident #1 eats the days meals (breakfast and lunch) independently with no supervision or assistance. Per the medical record, Resident #1 was evaluated by Speech	F 281	<u>F281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</u> Resident #1 no longer resides at the facility. MD orders and ST recommendations were reviewed for other residents to ensure adequate assistance is provided during meals. Bowel records were reviewed to ensure compliance with bowel protocol if ordered by the MD. SDC/Designee will provide re-education about ADL flowsheet documentation to ensure meal assistance given, is captured on the flowsheets. SDC/Designee will provide education to nursing staff about bowel protocol. DNS/Designee will complete monthly x3months flowsheet audits to ensure appropriate assistance is documented for meals. DNS/Designee will complete monthly x3 months audits of bowel records/medication sheets to ensure bowel protocol is followed. Evidence of audits will be reviewed by the PI committee and changes made as needed.	8/18/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Rachael Parker TITLE
Executive Director (X6) DATE
8/12/13

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 281	<p>Continued From page 1</p> <p>Therapy on 6/25/13 and noted to not hold saliva and fluids in mouth well, needing assistance with meals and noted to be at risk of aspiration (inhaling food and fluid into lungs during eating).</p> <p>Per review of the Physician's orders dated 6/20/13, the orders indicated that Resident #1 could be given the facility bowel regimen when the resident did not have a bowel movement for more than 3 days. Per the medical record Resident #1 had a chronic diagnosis of Constipation. Per review of the bowel monitoring sheets, Resident #1 in the month of June did not have a bowel movement from 6/22/13 to 6/30/13 (7 days). Review of the progress note and medication administration record there was no evidence that the facility bowel protocol was instituted for Resident #1 per physician orders. Further review of the bowel monitoring sheets for July indicates that from 7/2 to 7/8 (when Resident #1 was transferred to the hospital) Resident #1 did not have a bowel movement. Per review of the progress notes and medication administration record there was no evidence that Resident #1 received the facility bowel protocol per physicians orders.</p> <p>Per interview with the ADNS and UM on 7/18/13, they confirmed after review of the Bowel monitoring record, progress notes and physicians orders that there was no evidence that Resident #1 who had a diagnosis of constipation received the facility bowel protocol per physicians order. The UM and ADNS also reviewed the Physicians orders and progress notes and the ADL daily documentation sheets for Resident #1 and confirmed that on the day shift on 6/22 thru 6/30/13 the LNA's documented that Resident #1 ate the days meals (breakfast and lunch)</p>	F 281	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><i>F281 POC accepted 8/14/13 mcullivan RW/AMC</i></p>	
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F 281	Continued From page 2 independently with no supervision or assistance and that Resident had physicians orders to receive assistance with all meals related to possibility of aspiration of food.	F 281	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide or arrange services by qualified persons in accordance with each resident's written plan of care for 1 of 3 residents identified (Resident #1). The findings include: 1. Per record review conducted on 7/17/13, the medical record for Resident #1 indicated that Resident #1 was admitted to the facility on 6/21/13, with diagnoses that include; Parkinson's, senile dementia and constipation. Per review of the skin report dated 7/2/13 indicates blister located on the right rear knee area measured 11 cm x 7 cm. Per skin report dated 7/5/13 skin report indicates area were blisters were is now open and area measures 5 cm in diameter. Per record dated 7/6/13 the right front knee has cluster area measuring 15 cm x 11 cm, large area lateral back knee measuring 5 cm x 3 cm, all areas open and draining. Per review of the pressure report dated 7/8/13 the report indicates a right elbow new onset pressure area	F 282	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> F282 SERVICES BY QUALIFIED PERSON/PER CARE PLAN Residents #1, #2, #3 no longer reside at the facility. Residents that have protection devices were reviewed with LNA's and education provided to ensure documentation of these devices on ADL flowsheets. SDC/Designee will provide education to LNA's for documentation on ADL flowsheets for protective devices. DNS/Designee will complete monthly audits x3months of ADL flowsheets to ensure protective devices are documented. Evidence of audits will be reviewed at PI committee and changes made as needed.	8/18/13

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F 282	Continued From page 3 measuring 11 cm x 1 cm x 1 cm, a new onset stage 2 coccyx pressure area measuring 1 cm x 4-16 sq cm with noted undermining of area, and a new onset right buttock suspected deep tissue injury 2 cm x 1 cm. Per review of the comprehensive care plan titled Actual Alteration in skin integrity (non pressure related) r/t fluid filled blisters initiated 7/2/13 indicates staff is to keep heels off loaded when in bed, positioning devices under knees/between knees, and maintain pressure redistribution to wheelchair. The care plan titled Actual alteration in skin integrity (Pressure Ulcer) indicates that staff is to complete the daily monitoring pressure ulcer report, turn and position as needed and heels off loaded when in bed. Per review of the Licensed Nurses Assistants daily documentation sheets, under the section of protection devices there was no documentation that the any pressure reducing devices for heels or elbows were utilized. Per interview with the LNA Coordinator on 7/18/13 he/she reviewed the LNA daily documentation sheets for Resident #1 and confirmed that the LNA's only documented (via code) that skin moisturizers/lotions were used ion the resident, no devices were documented to have been used as per the care plan and the daily documentation sheet.	F 282	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> F282 POC accepted 8/14/13 McCubhan RNL/mc		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312	F312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS Resident #1 no longer resides at the facility.	8/18/13	

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F 312	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to carry out activities of daily living necessary to maintain good nutrition, grooming and personal and oral hygiene for 3 of 3 residents identified (Resident #1, 2, 3). The findings include:</p> <p>1. Per record review conducted on 7/17/13, the medical record for Resident #1 indicated that Resident #1 was admitted to the facility on 6/21/13, with diagnoses that include; Parkinson's, senile dementia and constipation. Per review of the comprehensive assessment (MDS) dated 6/28/13 Resident #1 was a total care and needed assistance with all areas of daily living (bed mobility, transfers, eating, dressing, bathing, personal hygiene.) The medical record indicated that Resident #1 had communication issues and was difficult to understand at times. The medical record also indicated that Resident #1 had upper and lower extremity impairment. Per review of the Physician's orders dated 6/20/13, the orders indicate that Resident #1 is supposed to receive assistance when he/she eats meals. Per the medical record Resident #1 was evaluated by Speech Therapy on 6/25/13 and noted to not hold saliva and fluids in mouth well, needing assistance with meals and noted to be at risk of aspiration (inhaling food and fluid into lungs during eating).</p> <p>Per review of the ADL documentation sheets signed by the Licensed Nurses Assistants for June and July there was no indication that Resident #1 had received assistance with eating</p>	F 312	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>MD orders and ST recommendations were reviewed for other residents to ensure adequate assistance is provided during meals. Residents that have protection devices were reviewed with LNA's and education provided to ensure documentation of these devices on ADL flowsheets. Re-education completed to capture baths and showers on flowsheets.</p> <p>SDC/Designee will provide re-education about ADL flowsheet documentation to ensure meal assistance given, is captured on the flowsheets, protective devices are recorded and baths are documented as well as showers.</p> <p>DNS/Designee will complete monthly x3months flowsheet audits to ensure appropriate assistance is documented for meals, protective devices are captured and bathing section is accurate. Evidence of audits will be reviewed by the PI committee and changes made as needed.</p> <p><i>F312 POC accepted 8/14/13 McLellan RNF/PMC</i></p>	
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F 312	<p>Continued From page 5</p> <p>from 7/22-7/30 (the LNA's indicated on the ADL daily sheet that Resident #1 was independent with eating on the day shift requiring no assistance for breakfast or lunch) as per MD order dated 6/21/13. Per review of the ADL documentation sheets signed by the LNA for June and July under the section of protection devices there was no documentation that the any pressure reducing devices for heels or elbows were utilized as indicated on Resident #1's comprehensive care plan.</p> <p>2. Per record review Resident #2 was re-admitted to the facility after hospitalization related to a fall. Per review of the medical record Resident #2 developed pressure area on the right heel requiring the use of pressure relieving devices when in bed, per the care plan. Per review of the comprehensive assessment (MDS) dated 6/4/13, it indicates that Resident #2 needed extensive assistance and total assistance with all ADL areas except eating.</p> <p>Per review of the LNA daily documentation sheet for July, under the section of protection devices, there was no documentation that the any pressure reducing devices for heels or elbows were utilized. There was no documentation for the month of June provided. Per review of the LNA daily documentation sheet for July, under the section Bathing (how a resident takes a full body bath/shower/sponge bath and transfers in and out of tub/shower, excluding washing back and hair) the documentation indicated the activity did not occur for 15 days documented on all three shifts. There was no documentation for the month of June.</p>	F 312	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>		

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F 312	<p>Continued From page 6</p> <p>3. Per record review of Resident #3, he/she was admitted to the facility on 5/15/13 related to a recent hospitalization for pneumonia and falls.</p> <p>Per review of the progress notes the notes indicate that on 6/13/13 Resident #3 has a new area, intact blister on back of right heel. The progress notes dated 6/14/13 indicate that the right heel blister is unstageable, measuring 2.4 cm x 1 cm. Per review of the Licensed Nurses Aides daily documentation sheets for May, June and July, under the section of protection devices there was no documentation that the any pressure reducing devices for heels or elbows was utilized.</p> <p>Per interview with the LNA Coordinator on 7/18/13 he/she reviewed the LNA daily documentation sheets for Resident #1, #2 and #3 and confirmed that the LNA's only documented (via code) that skin moisturizers/lotions were used on the resident, no devices were documented to have been used as per the care plans and the daily documentation sheet.</p> <p>Per interview with the Assistant Director of Nursing and Unit Manager on 7/18/13, they reviewed the ADL documentation sheets for Resident #2 and confirmed that the LNA's documented that Bathing did not occur. The ADNS and UM after reviewing the medical records for Resident #2 indicated that there was no ADL documentation sheet for June. Per interview on 7/18/13 the UM and ADNS also reviewed the Physicians orders and progress notes and the ADL daily documentation sheets for Resident #1 and confirmed that on the day shift on 6/22 thru 6/30/13 the LNA's documented that Resident #1 ate the days meals (breakfast and</p>	F 312	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>		

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F 312	Continued From page 7 lunch) independently with no supervision or assistance and that Resident had physicians orders to receive assistance with all meals related to possibility of aspiration of food.	F 312	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview the facility failed to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individuals clinical condition demonstrates that they were unavoidable and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sore from developing for 3 of 3 resident's reviewed (#1, #2, and #3) identified. The findings include: 1. Per record review on conducted on 7/17/13, the medical record for Resident #1 indicated that Resident #1 was admitted to the facility on 6/21/13, with diagnoses that include; Parkinson's, senile dementia and constipation.	F 314	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> F314 TREATMENT/SVCSTO PREVENT*HEAL PRESSURE SORES Residents #1, #2, #3 no longer reside at the facility. Residents with pressure areas will be reviewed to ensure MD notification of the area and orders are present for treatment. Residents with pressure areas will have daily monitoring sheets reviewed for completeness. Residents that have protection devices were reviewed with LNA's and education provided to ensure documentation of these devices on ADL flowsheets and nursing profile implemented to augment ADL profile. SDC/Designee will provide education to licensed nursing staff about MD notification of new pressure areas and obtaining treatments orders for those areas. SDC/Designee will provide education to LNA's for nursing profile information and	8/18/13

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F 314	<p>Continued From page 8</p> <p>Per review of the medical record, the physician summary dated 6/20/13 by the referring physician indicated that Resident #1 had history of 2 healed stage 3 pressure areas on both right and left outer ankle and currently had no open skin areas.</p> <p>Per review of the progress notes dated 6/21/13, the notes indicated on admission Resident #1 skin was intact with no open areas. The progress notes dated 6/24/13 indicate no areas of irritation on the coccyx or bilateral buttocks. Per review of the progress notes dated 6/25/13 small area on bilateral ankles, heels/ankles elevated off bed with mat per OT orders to relieve pressure area sites. Per review of the progress note dated 6/29/13 left outer ankle measures .5 cm x .8 cm, surrounding area is blanchable pink, area on right ankle measures .9 cm x .9 cm surrounding area is blanchable pink.</p> <p>Per review of the progress notes dated 7/2/13 weekly pressure area report indicated that Resident #1 has no new onset pressure areas, there is an "unstageable" area on the right ankle measuring 0.8 cm x 0.6 cm. Per review of the skin report dated 7/2/13 indicates blister located on the right rear knee area measured 11 cm x 7 cm. Per skin report dated 7/5/13 skin report indicates area were blisters were is now open and area measures 5 cm in diameter. Per record dated 7/6/13 the right front knee has cluster area measuring 15 cm x 11 cm, large area lateral back knee measuring 5 cm x 3 cm, all areas open and draining.</p> <p>Per review of the pressure report dated 7/8/13 the report indicates a right elbow new onset pressure area measuring 11 cm x 1 cm x 1 cm, a new onset stage 2 coccyx pressure area</p>	F 314	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>documentation on ADL flowsheets for protective devices.</p> <p>DNS/Designee will complete monthly audits x3months of ADL flowsheets to ensure protective devices are documented. DNS/Designee will randomly audit pressure ulcers monthlyx 3months for MD notification and treatments. Evidence of audits will be reviewed at PI committee and changes made as needed.</p> <p><i>F314 POC accepted 8/14/13 MaulhanRNL/PMC</i></p>	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	<p>Continued From page 9</p> <p>measuring 1 cm x 4-16 sq cm with noted undermining of area, and a new onset right buttock suspected deep tissue injury 2 cm x 1 cm.</p> <p>Review of the progress notes indicated that there was no documentation that indicated that the primary physician was notified of facility acquired pressure areas identified by staff on 7/8/13 on the coccyx or the right buttock. There was no documentation that orders were obtained for treatment of the coccyx and buttock wounds.</p> <p>Per review of the daily monitoring/pressure ulcer sheets they indicated that only the right outer ankle and right outer heel were being monitored and the sheets noted that the right outer heel was monitored 5 days out of a possible 23 days and the right outer ankle was monitored 6 times since the area was noted on 6/24/13. There was no monitoring noted in the documentation for the elbows, coccyx or buttock areas.</p> <p>Per review of the comprehensive care plan titled Actual Alteration in skin integrity (non pressure related) r/t fluid filled blisters initiated 7/2/13 indicates staff is to keep heels off loaded when in bed, positioning devices under knees/between knees, and maintain pressure redistribution to wheelchair. The care plan titled "Actual alteration in skin integrity (Pressure Ulcer) indicates that staff is to complete the daily monitoring pressure ulcer report, turn and position as needed.</p> <p>Per review of the ADL profile sheet there was no indication that Resident #1 had any needed preventative devices to reduce pressure, or that Resident #1 was to be turned and positioned as needed.</p>	F 314		

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F 314	<p>Continued From page 10</p> <p>Per review of the Licensed Nurses Aides daily documentation sheets, under the section of protection devices there was no documentation that the any pressure reducing devices for heels or elbows were utilized.</p> <p>Per review of the facility policy and procedure "Prevention and Treatment of Pressure Ulcers and Non-Pressure Related Wounds" last revised on 8/31/12 and educated to staff on 2/20/13, the policy indicates that "the attending physician is notified of pressure ulcers and a treatment plan is determined."</p> <p>2. Per record review Resident #2 was re-admitted to the facility after hospitalization related to a fall. Per review of the Admission examination form dated 5/20/13 and signed by the referring physician Resident #2 did not have any skin integrity issues upon admission.</p> <p>Per review of the comprehensive assessment (MDS) dated 6/4/13 Resident #2 was at risk for pressure areas. Per review of the progress notes dated 6/3/12, the notes indicate Resident #2 has a sheer area on the left buttock and deep tissue pressure injury to right heel. Per review of the Licensed Nurses Aides daily documentation sheets , under the section of protection devices there was no documentation that the any pressure reducing devices for heels or elbows was utilized. Per review of the Daily monitoring/pressure ulcer sheets for June and July there were 17 days in June that there was no documentation that Resident #2's heels were monitored.</p> <p>Per review of the daily monitoring/pressure ulcer</p>	F 314		

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F 314	<p>Continued From page 11</p> <p>sheet 13 days documented that the pressure area either remained the same or deteriorated. Per review of the facility policy and procedure titled Prevention and Treatment of Pressure Ulcers and Non-Pressure relayed wounds dated 8/31/12 indicates that the attending physician be notified if a wound or ulcer does not show signs of healing in 2 weeks. Review of the medical record indicates that there was no documented evidence the attending physician was notified that Resident #2's wound was not healing and had deteriorated on several occasions.</p> <p>3. Per record review of Resident #3, he/she was admitted to the facility on 5/15/13 and per the physicians admission examination dated 5/15/13, Resident #3 had no skin integrity issues upon admission.</p> <p>Per review of the progress notes 5/15/13, no pressure areas seen. A 5/22/13 assessment indicates resident is at risk for skin integrity issues and pressure ulcers. The progress notes indicate that on 6/13/13 Resident #3 has a new area, intact blister on back of right heel. The progress notes dated 6/14/13 indicate that the right heel blister is unstageable, measuring 2.4 cm x 1 cm.</p> <p>Per interview on 7/18/13 with the LNA Coordinator, he/she confirmed that the ADL profile sheet was utilized by the LNA's to know what specific care is to be provided to the resident. After review by the LNA Coordinator of the ADL profile sheet he/she confirmed that the ADL profile sheet did not reflect that any pressure relieving devices needed to be were utilized, did not reflect any positioning requirements were utilized, and did not reflect the need to turn and</p>	F 314			

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F 314	<p>Continued From page 12 position Resident #1.</p> <p>Per interview with the LNA Coordinator on 7/18/13 he/she reviewed the LNA daily documentation sheets for Resident #1, #2 and #3 and confirmed that the LNA's only documented (via code) that skin moisturizers/lotions were used on the resident, no devices were documented to have been used on the daily documentation sheet.</p> <p>Per interview with the ADNS and Unit Manager on 7/18/13, they reviewed the documentation and confirmed that Resident #1, #2 and #3 were admitted to the facility without pressure areas and developed pressure areas during their admissions and were avoidable. The UM and ADNS also confirmed that after review of the documentation that the primary physician had not been notified of the coccyx and buttock pressure areas for Resident #1 and that there was no treatment obtained for these pressure areas. Per interview the ADNS indicated that the blisters on the right knee of Resident #1 were pressure related to the utilization of a hoyer pad and the seat cushion of Resident #1's wheelchair created pressure on the back of the knee.</p>	F 314			