VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

June 13, 2014

Ms. Linda Phypers, Administrator
Wake Robin-Linden Nursing Home
200 Wake Robin Drive
Shelburne, VT 05482-7569

Dear Ms. Phypers:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 21, 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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475056 | | 05/21/2014 |

NAME OF PROVIDER OR SUPPLIER: WAKE ROBIN-LINDEN NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE: 200 WAKE ROBIN DRIVE, SHELBURNE, VT 05482

| (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 000 | INITIAL COMMENTS | F 000 | | |
| | An unannounced onsite recertification survey was conducted on 5/19/14 & 5/20/14 by the Division of Licensing & Protection. While the facility was found to be in substantial compliance with regulatory requirements, the following issues were identified. | | F280<br>Resident #2 care plan updated to reflect that the skin tear's treatment is present and ongoing until resolved<br><br>Resident #3 care plan updated on 5/20/14 to include a recurring skin lesion on chin as well as to be assessed every day during care.<br><br>QAPI study initiated on 5/21/14-Care plans will be written/updated/reviewed in a timely manner for any new problem or significant change in condition.<br><br>Policy and Procedures related to Wound/Skin Integrity were reviewed and revised 5/20/14.<br><br>EMR charting process modified on 5/21/14 to prompt the nurse to review, update, and/or create care plan/s while they are documenting in assessments.<br><br>All nursing staff will receive individual notification regarding the modification to the EMR-<br><br>Staff Training began on 5/20/14 on care plan revisions.<br><br>All nursing staff are receiving instruction in utilizing the 24 hour report for their neighborhood, and daily. This will identify issues requiring nurse follow up related to significant changes that will require nursing interventions.<br>*MD Family notification<br>* Notification of skin/wound team<br>* Any ongoing routine treatments will require a care plan revision for temporary problem. | 5/24/14<br><br>completed by 6/6/14 |
| F 280<br>SS=B | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP | F 280 | | |
| | The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. | | | |
| | A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. | | | |
| | This REQUIREMENT is not met as evidenced by:<br>Based upon observation, interviews and record review, the facility failed to revise the Care Plan for 2 of 2 residents [Resident #2, #3] of the sample group for non-pressure skin issues. | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda Phillips | TITLE: Director Health Services | (X6) DATE: 6-11-14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475058 | | 05/21/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WAKE ROBIN-LINDEN NURSING HOME | 200 WAKE ROBIN DRIVE SHELBURNE, VT 05482 |

| (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 280 | Continued From page 1<br>Findings include:<br><br>1. Resident #2, whose diagnoses include senile dementia, dysphasia, intracerebral hemorrhage, and generalized osteoarthritis was observed on 05/19/14 with a small bruise on the right forearm. Per review of the the care plan dated 02/23/14, it states skin integrity/risk, at risk related to incontinence and decreased mobility, assist with incontinence care, on toilet program to promote dryness, monitor skin every shift. There is no care plan noted for a dressing change or other wound protocols. Per the Nursing Assessment Note dated 04/23/14 states "New area outer right lower arm...length 1...width 1...surface area 0.7-1.0 cm...depth 0.1 cm...epithelial tissue reddened...light drainage...surrounding tissue reddened...applied Versatel and non-adherent dressing on elbow." Per review of the TAR [Treatment Administration Record] nursing has changed the dressing to the elbow every day since 04/23/14. Per the Nursing Assessment Note, nearly three weeks later dated 05/14/14, it states that the resident has a healing skin tear on right outer lower arm, scab present no signs or symptoms of infection, surrounding skin WNL[Within Normal Limits], area scabbed over [continues with dressing change]. Per interview on 5/20/14 at 1:49 PM the Clinical Coordinator confirmed there was no care plan revision for the dressing change to the elbow.<br><br>2. Resident #3 was admitted on 03/07/13 with PVD [peripheral vascular disease], mobility issues and dementia with memory deficits. Although the care plan dated 03/07/13, is noted for dementia, mobility issues and general skin integrity/risks, the care plan was not revised to address any abrasions or wounds. The care plan | F 280 | Method of Monitoring:<br>QAPI Study by QA Nurse-Staff Education — 5/20/14 completed by 6/5/14<br>All staff implementation QA Nurse will monitor in an ongoing manner. — 6/9/14-7/7/14<br>One on one spontaneous reviews and reinforcement of training — weeks of 6/16/14 & 6/23/14.<br>Benchmark measuring — week of 7/7/14<br><br>QA nurse will monitor monthly for 1 quarter And then quarterly and report to CQI/QAPI committee meeting.<br><br>Preparation and submission of this plan of correction is required by state and federal law. This plan of correction does not constitute as admission for the purposes of general liability, professional malpractice or any other court proceeding.<br><br>F280 POC accepted 6/12/14<br>Mitiggins RN/PMC | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475056 | | 05/21/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WAKE ROBIN-LINDEN NURSING HOME | 200 WAKE ROBIN DRIVE<br>SHELBURNE, VT 05482 |

| (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 APPRDPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 280 | Continued From page 2<br>for skin integrity risk states the resident will have no breakdown and to assess skin condition and apply lotion, inform MD/family of changes and monitor skin every shift.<br><br>Per observation during interview on 05/19/14 at 1:32 PM, Resident#3 had a open red abrasion/sore on the chin. The Resident stated "oh I had that for awhile" and noted that it will occasionally itch from time to time. Per review of the protocols and guidelines for wound care/skin care team, notes that the care plan will be updated and/or developed to address any skin concerns, wound or open area from any cause. Furthermore, it states weekly assessments and documentation. Per interview on 05/20/14 at 12:13 PM the DNS stated that the resident has a chronic lesion and although there is no documentation of the daily monitoring, s/he stated that "I am sure they are monitoring it". S/he confirmed that the care plan was not updated to reflect the lesion, its treatments or monitoring.<br><br>ALSO SEE TAG F-278 | F 280 | | |

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

AH
"A" FORM

| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # 475056 | MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____ | DATE SURVEY COMPLETE: 5/21/2014 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: WAKE ROBIN-LINDEN NURSING HOME | STREET ADDRESS, CITY, STATE, ZIP CODE 200 WAKE ROBIN DRIVE SHELBURNE, VT | | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES |
|---|---|
| F 278 | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED |

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on record review, observation and interview the facility failed to accurately reflect one applicable resident's status in the stage two sample. (Resident #3) Findings include:

1. Per observation during interview on 05/19/14 at 1:32 PM, Resident#3 had an open red abrasion/sore on the chin. Per record review of the MDS [Minimum Data Set/comprehensive assessment] no lesions or abrasions were noted for section M1040. (other ulcers, wounds and skin problems - D. open lesions other than ulcers, rashes, cuts [e.g. cancer lesion]) The admission MDS of 03/14/13 as well as the quarterly MDS of 12/16/13, the 03/20/14 and significant change MDS of 04/29/14 failed to note a cancer lesion. Per telephone interview with the MDS coordinator on 05/21/14 at 2:38 PM s/he stated that the process for gathering information for the MDS is obtained through review of the nursing assessments, progress notes, TAR/MAR review and occasional face to face visits. The MDS coordinator stated that [s/he] was unable to find nursing skin assessment notes with information regarding the lesion until the the most recent nursing note of 3/13/14. Furthermore, s/he stated "I should've picked up on [the lesion] from the TAR (Treatment Administration Record) but the cream was used as needed for itching. The MDS coordinator at that time confirmed that the MDS since admission for skin lesion section M 1040(D) was coded inaccurately.

*This is an "A" level citation.
Also see tag F-280

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

The above isolated deficiencies pose no actual harm to the residents

F278

MDS Coordinator will follow the below noted process for MSD completion, to include:

Full review of all documentation for the resident during the previous quarter (prior to ARD), to assist in identifying medical changes and or trends.

*DNS will work with MDS Coordinator to strengthen the charting review process he uses for MDS completion. Completion date 6/5/14

*Former MDS Coordinator (now QA Nurse) will complete a random audit of 2 MDS's every quarter and will track and report data to CQI/QAPI.