

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

PRINTED: 06/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475049</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>07/08/2014</b>
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NAME OF PROVIDER DR SUPPLIER  <b>BELAIRE QUALITY CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>35 BEL-AIRE DRIVE NEWPORT, VT 05855</b>
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F 000 INITIAL COMMENTS

F 000

An unannounced onsite complaint investigation regarding care and services and an investigation of a facility self report were completed by the Division of Licensing and Protection on 7/8/14. Regulatory violations were cited as follows. These regulatory violations represent "past non-compliance", which means at the time of the investigation, the facility had already identified and corrected the violations.

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

F 281

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and record and policy review, the facility failed to ensure services provided met professional standards of quality for 2 of 3 residents in the sample regarding assessing and monitoring residents who sustained unwitnessed falls and/or had indications of head injury (Resident #1 and #2). Findings include:

1. Per record review on 7/8/14, nursing staff failed to properly assess and monitor Resident #1 after sustaining a fall on 5/28/14. Resident #1 was admitted to the facility on 4/8/14 for rehab following a fall at home. Diagnoses included recent closed fractures of the femur and humerus, cerebral vascular disease, chronic atrial fibrillation, chronic kidney disease, osteoarthritis, generalized muscle weakness and other chronic medical issues. Per record review, fall risk was identified on admission and a care plan was

Past noncompliance: no plan of correction required.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE <b>08/08/2014</b>
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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.

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F 281	Continued From page 1 developed on 4/9/14 to address the risk. Per review of the 5/6/14 MDS (Minimum Data Set), Resident #1 required extensive assist for bed mobility and transfers; was totally dependent for dressing, toileting and personal hygiene; and was listed as not steady. On 7/8/14 at 10:40 AM the facility rehab manager stated that since the time of the May MDS assessment, Resident #1 had made progress and was walking with a walker with assistance; however, s/he stated the resident was not supposed to ambulate independently in his/her room. S/he stated that the resident had plans to be discharged in June to live with family. Per review of the nursing progress notes, on 5/28/14 Resident #1 was found lying on the floor after getting out of bed. The facility's risk management report lists the fall as unwitnessed with a head injury. Per 7/8/14 at 1:25 PM interview, the staff nurse on duty at the time of the fall, stated that Resident #1 fell at the change of shift and had a "couple of lacerations on [his/her] outer ear; it was obvious that [s/he] hit [his/her] head; [s/he] was bleeding from [his/her] outer ear." The resident was described as alert and talking after the fall. The nurse reported calling the resident's physician and obtained orders to transport the resident to the Emergency Room (ER) for evaluation. On 5/29/14 at 1:30 AM, nursing staff documented in a progress note that the resident returned to the facility; notes documenting observations and care were recorded at 3:30, 5:30 and 7:45 AM. On 5/29/14 at 9:00 AM the resident was pronounced dead. Per 7/8/14 review, the facility policy related to falls, titled "Assessment: Neurological" states that "Neurological assessment will be performed as indicated or ordered. When a patient sustains an injury to the head and/or has an unwitnessed fall, neurological assessment will be performed:	F 281		

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F 281	<p>Continued From page 2</p> <p>every 30 minutes x two hours, then every one hour x four hours, then every four hours x 24 hours." Neurological assessment is an evaluation by a licensed professional that includes assessing level of consciousness, pupil response, motor functions, pain response and vital signs. Per record review, there is no evidence that neurological assessments were done for Resident #1 following his return to the facility from the ER. On 7/8/14 at 3:43 PM the facility administrator confirmed that neurological assessments were not completed for Resident # 1, stating that "neuro should have been done."</p> <p>2. Per record review, Resident #2 was readmitted to the facility on 11/11/13 with the following diagnoses: pneumonia, congestive heart failure, COPD (chronic breathing problems), diabetes, a history of falls, muscle weakness, difficulty walking and other chronic medical problems. Per record review, fall risk was identified on admission and the resident had a care plan in place for fall prevention strategies. Per review, Resident #2's 2/18/14 quarterly MDS states that the resident required extensive assistance for bed mobility, transfers, dressing, personal hygiene and toileting and used a walker and wheelchair for mobility.</p> <p>On 4/19/14, nursing progress notes document that the resident had an unwitnessed fall. The facility was not able to provide evidence that neurological assessments were performed on this resident and on 7/8/14 at 4:36 PM, the facility administrator confirmed that neurological assessments were not completed for Resident #2 and that they were not done on a routine basis prior to in-service training done in May and June 2014.</p> <p>(Refer F309)</p> <p>During the 7/8/14 survey, the facility administrator</p>	F 281		

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F 281	Continued From page 3 and Director of Nursing reported that they identified that staff needed training regarding patient care related to falls after completing an investigation related to Resident #1's 5/28/14 fall. They scheduled two in-services (5/30/14 and 6/2/14); licensed nurses, licensed nursing assistants (LNAs) and activities personnel attended the training. Education was provided around facility policies and procedures, protocols, assessment and care planning around falls. Per record review of 3 falls that occurred after the training dates, neurological assessments were completed and care plans were reviewed and updated. Interviews with nursing and LNA staff confirmed awareness of fall protocols and interventions.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that each resident receives the necessary care and services to maintain the highest practicable physical well-being for 2 of 3 sampled residents (Resident #1 and #2) regarding assessment and monitoring after an unwitnessed fall and potential head injury. Findings include:	F 309	Past noncompliance: no plan of correction required.	

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F 309	Continued From page 4 1. Per record review on 7/8/14, nursing staff failed to properly assess and monitor Resident #1 after sustaining a fall on 5/28/14. Resident #1 was admitted to the facility on 4/8/14 for rehab following a fall at home. Diagnoses included recent closed fractures of the femur and humerus, cerebral vascular disease, chronic atrial fibrillation, chronic kidney disease, osteoarthritis, generalized muscle weakness and other chronic medical issues. Per record review, fall risk was identified on admission and a care plan was developed on 4/9/14 to address the risk. Per review of the 5/6/14 MDS (Minimum Data Set), Resident #1 required extensive assist for bed mobility and transfers; was totally dependent for dressing, toileting and personal hygiene; and was listed as not steady. On 7/8/14 at 10:40 AM the facility rehab manager stated that since the time of the May MDS assessment, Resident #1 had made progress and was walking with a walker with assistance; however, s/he stated the resident was not supposed to ambulate independently in his/her room. S/he stated that the resident had plans to be discharged in June to live with family. Per review of the nursing progress notes, on 5/28/14 Resident #1 was found lying on the floor after getting out of bed. The facility's risk management report lists the fall as unwitnessed with a head injury. Per 7/8/14 at 1:25 PM interview, the staff nurse on duty at the time of the fall, stated that Resident #1 fell at the change of shift and had a "couple of lacerations on his/her outer ear; it was obvious that [s/he] hit [his/her] head; [s/he] was bleeding from [his/her] outer ear." The resident was described as alert and talking after the fall. The nurse reported calling the resident's physician and obtained orders to transport the resident to the Emergency Room (ER) for evaluation. On 5/29/14 at 1:30	F 309		

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F 309	<p>Continued From page 5</p> <p>AM, nursing staff documented in a progress note that the resident returned to the facility; notes documenting observations and care were recorded at 3:30, 5:30 and 7:45 AM. On 5/29/14 at 9:00 AM the resident was pronounced. Per 7/8/14 review, the facility policy related to falls, titled "Assessment: Neurological" states that "Neurological assessment will be performed as indicated or ordered. When a patient sustains an injury to the head and/or has an unwitnessed fall, neurological assessment will be performed: every 30 minutes x two hours, then every one hour x four hours, then every four hours x 24 hours." Neurological assessment is an evaluation by a licensed professional that includes assessing level of consciousness, pupil response, motor functions, pain response and vital signs. Per record review, there is no evidence that neurological assessments were done for Resident #1 following his return to the facility from the ER. On 7/8/14 at 3:43 PM the facility administrator confirmed that neurological assessments were not completed for Resident # 1, stating that "neuro should have been done."</p> <p>2. Per record review, Resident #2 was readmitted to the facility on 11/11/13 with the following diagnoses: pneumonia, congestive heart failure, COPD (chronic breathing problems), diabetes, a history of falls, muscle weakness, difficulty walking and other chronic medical problems. Per record review, fall risk was identified on admission and the resident had a care plan in place for fall prevention strategies. Per review, Resident #2's 2/18/14 quarterly MDS states that the resident required extensive assistance for bed mobility, transfers, dressing, personal hygiene and toileting and used a walker and wheelchair for mobility. On 4/19/14, nursing progress notes document</p>	F 309		

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F 309	<p>Continued From page 6</p> <p>that the resident had an unwitnessed fall. The facility was not able to provide evidence that neurological assessments were performed on this resident and on 7/8/14 at 4:36 PM, the facility administrator confirmed that neurological assessments were not completed for Resident #2 and that they were not done on a routine basis prior to in-service training done in May and June 2014.</p> <p>(Refer 281)</p> <p>During the 7/8/14 survey, the facility administrator and Director of Nursing reported that they identified that staff needed training regarding patient care related to falls after completing an investigation related to Resident #1's 5/28/14 fall. They scheduled two in-services (5/30/14 and 6/2/14); licensed nurses, licensed nursing assistants (LNAs) and activities personnel attended the training. Education was provided around facility policies and procedures, protocols, assessment and care planning around falls. Per record review of 3 falls that occurred after the training dates, neurological assessments were completed and care plans were reviewed and updated. Interviews with nursing and LNA staff confirmed awareness of fall protocols and interventions.</p>	F 309		