

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 5, 2012

Mr. Thomas Rice, Administrator
Brookside Health And Rehabilitation
1200 Christian Street
White River Junction, VT 05001-9267

Provider #: 475010

Dear Mr. Rice:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **April 18, 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, MS
Licensing Chief

PC:ne

Enclosure - This version replaces the existing Accepted POC with cover letter dated **May 29, 2012**.



FORM 802/07/346

MAY 8 2012 03:48PM P004/012

PRINTED: 06/08/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/18/2012
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NAME OF PROVIDER OR SUPPLIER BROOKSIDE HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 CHRISTIAN STREET WHITE RIVER JUNCTION, VT 05001
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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

F 000

An unannounced onsite complaint investigation was conducted by the Division of Licensing and Protection on 04/18/2012. The following are regulatory violations.

Please replace existing Accepted POC with this version. (contains different dates)

F 225
SS=0

483.13(c)(1)(ii)-(iii), (c)(2) - (4)
INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

F 225

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property, and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

F225

Disclaimer

The filing of this plan of correction is filed as the facility's does not constitute the fact that deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply the requirements and provide High quality care

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance

1. Resident #2 received reimbursement for missing funds.
2. Variance obtained for employee#6
3. All residents have the potential to be effected by this alleged deficient practice.

-Pam

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 30 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 15 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.

Pmc

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F 225	<p>Continued From page 1</p> <p>with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure that employees hired have appropriate background checks prior to being hired and failed to report suspected exploitation and neglect within required time frames. Findings include:</p> <p>1. Per record review and staff interview, the facility became aware of missing resident funds on 12/01/2011, upon the discharge of Resident #2 from the facility. Several facility employees were identified as having access to the resident's funds during the time frame in which the funds went missing. Upon record review, a staff nurse working during this time, and on the list of employees with access to the funds, had a positive criminal record background check. Employee #6 (E#6) was employed by the facility on 11/10/2011. S/he had a criminal record check which revealed a conviction for Petit Larceny (theft). A request for a variance to employ E#6 was in the record and was dated 12/06/2011 (indicating the facility wished to employ this person). The response from the Division of Licensing and Protection was dated 12/13/2011 and was stamped as received by the facility on 12/15/2011 (all after the date the incident was discovered).</p>	F 225	<ol style="list-style-type: none"> 4. Audit to be performed of employee files to ensure background checks are in place and current. 5. Audit of resident funds to ensure all are accounted for. 6. Re-educate staff for timeframes to report suspected abuse, neglect, or mistreatment. 7. Random weekly audits x4 to ensure continued compliance. 8. Results to be reported to QAA for determination of continued surveillance. 9. Plan completed by 5/20/12 6/15/12 Administrator or designee responsible for implementation <p><i>F225 POC accepted 6/11/12 Amesturn</i></p>	
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Fax 802-412-348

May 8 2012 03:49pm P006/017

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F 225	<p>Continued From page 2</p> <p>2). Per record review for two self-reports, the facility failed to report suspected neglect or misappropriation of property within the required time frames.</p> <p>a). In Incident #1 the facility was aware of the alleged misappropriation of resident money on 12/01/11, when the resident was discharged from the facility, the facility did not report the allegations until 12/06/11.</p> <p>b). In Incident #2 the facility became aware of the alleged neglect of the resident on 01/16/12, the day the resident was discharged from the facility. The facility did not report the allegations until 01/20/12.</p> <p>The above information was confirmed with the present Director of Nursing Services on 04/18/12 at 4 PM.</p>	F 226		
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to assure that services provided by the facility meet professional standards of quality for 1 of 3 residents (Resident #1) reviewed during the investigation, regarding assessment of an area of impaired skin and regarding implementing physician orders. Findings include:</p> <p>1. Per record review and staff interviews, the facility failed to assure that, for Resident #1,</p>	F 281	<p>F281 Disclaimer The filing of this plan of correction is filed as the facility's does not constitute the fact that deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply the requirements and provide High quality care</p>	

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F 281	<p>Continued From page 3</p> <p>pertinent assessments relating to the potential for impaired skin were conducted, Resident #1 was admitted to the facility on 12/09/11 for rehabilitation following a hospitalization for pneumonia. The admission was intended for rehabilitation with a possible Long Term Care stay depending on his course of rehabilitation. He was discharged home in the care of his wife on 01/16/12 at 3:45 PM. At approximately 9:30 PM the facility received a telephone call from the resident's wife, who was reportedly (per documentation) very upset. The report states that the wife stated that she had been providing care to her husband when she noted that his scrotum had reddened open skin which was bleeding and had a foul odor.</p> <p>The facility Complaint/Concern Report Form stated that two nurses from the facility were sent to the resident's home on 01/17/12 to assess the area. The note written by one of the two nurses (Employee #2) during the investigation stated that the visit revealed the scrotum to be reddened and rashy with a 0.5 cm open area on the left scrotum and a "yeasty" odor. The note states that the two nurses provided the wife with the ordered topical medication and instructed her on its proper use.</p> <p>The reddened area was first noted on 01/06/12, according to investigative documentation, when an LNA (Licensed Nursing Assistant) reported reddened groins to an on duty RN (Registered Nurse) (Employee #1). The RN investigative statement is that s/he received a telephone order from the physician for Nystatin but that s/he was busy and "forgot" to transcribe the order. There is a telephone order in the record dated 01/08/2012 at 11 AM for Nystatin Cream to groins BID (twice</p>	F 281	<ol style="list-style-type: none"> 1. Resident #1 discharged home. 2. Employee 1 no longer employed at this facility. 3. All residents have the potential to be effected by this alleged deficient practice. 4. Audit all residents' skin to ensure all skin conditions are accounted for. 5. Audit all MD order to ensure proper implementation. 6. Re-educate nursing staff for process of skin checks and carrying out MD orders. 7. Random weekly audits x4 to ensure continued compliance. 8. Results to be reported to QAA for determination of continued surveillance. 	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 281	<p>Continued From page 4</p> <p>per day) until resolved. There is no evidence of the order being transcribed to the Medication Administration Record (MAR) or the Treatment Administration Record (TAR). There is no update to the care Plan for Potential Impaired Skin Integrity for either the rash or the ordered treatment.</p> <p>There are Skilled Daily Nurses Notes dated 01/09/12 to 01/18/12 which reflect, by check marks, under the skin section that the resident had a rash. On 01/09/12 through 01/14/12 the section additionally reflects either groin or bilateral groins as the rashy area. There are no notes in the record associated with the noted rashy areas nor is there any evidence of a nurse completing a skin assessment or assessing the rashy area from 01/08/12 to discharge home on 01/18/12.</p> <p>The investigative note written by the nurse who obtained the physician order states that "I did not visualize the redness myself as the resident was already back in his wheelchair." In interview, on 04/18/12 at 3:45 PM, two nurses were interviewed who had indicated at some time, in the Skilled Daily Nurses Note, that the resident had a rash. Employee #5, the Primary Nurse on Unit B, indicated a rash present by checkmark on 01/11 and 01/15/12. When interviewed s/he stated that s/he had never assessed or seen the rashy areas and that checking the boxes had been a mistake. Employee #4 who was Unit B Manager at the time of the incident, indicated by checkmark on 01/10/12 that there was rash in the groin. In interview s/he stated that s/he may have noted a reddened area when assisting the resident to use the urinal but s/he had not</p>	F 281	<p>9. Plan completed by 6/15/12 - Director of Nursing or designee responsible for implementation</p> <p>F281 POC accepted 6/14/12 - Amstar RN</p>	

FAX 0024472340

MAY 0 2012 03:00PM F0037012

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 281	<p>Continued From page 5</p> <p>performed a skin assessment related to the rash.</p> <p>2. Per record review and staff interview the facility failed to assure that physician's orders were implemented for Resident #1. Resident #1 had an area of reddened and rashy groins which, by the time of discharge, had extended to the resident's scrotum. The reddened area was first noted on 01/08/12, according to investigative documentation, when an LNA reported reddened groins to an on duty RN (Nurse #1). The RN investigative statement is that s/he received a telephone order from the MD for Nystatin but that s/he was busy and "forgot" to transcribe the order. There is a telephone order in the record dated 01/08/2012 at 11 AM for Nystatin Cream to groins BID until resolved. There is no evidence of the order being transcribed to the Medication Administration Record (MAR) or the Treatment Administration Record (TAR). There is no update to the care Plan for Potential Impaired Skin Integrity for either the rash or the ordered treatment. There is no evidence present in the record that the order for Nystatin was carried out and the staff nurses interviewed stated that they were not aware of the order and had not applied the medication as ordered.</p> <p>The above information, from documentation and interviews was confirmed by the present Director of Nursing Services in an interview 04/18/12 at 4 PM.</p>	F 281	
F 309 SS-MD	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,</p>	F 309	

FAX 8022612340

MAY 6 2012 05:51PM F010/012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 309	<p>Continued From page 6</p> <p>mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure that care and services were provided to attain the highest practicable physical well-being of 1 applicable resident for treatment of a skin-condition. (Resident #1) Findings include:</p> <p>1. Per record review and staff interviews, the facility failed to assure that, for Resident #1, pertinent assessments relating to the potential for impaired skin were conducted. Resident #1 was admitted to the facility on 12/08/11 for rehabilitation following a hospitalization for pneumonia. The admission was intended for rehabilitation with a possible Long Term Care stay depending on his course of rehabilitation. He was discharged home in the care of his wife on 01/16/12 at 3:45 PM. At approximately 9:30 PM the facility received a telephone call from the resident's wife, who was reportedly (per documentation) very upset. The report states that the wife stated that she had been providing care to her husband when she noted that his scrotum had reddened open skin which was bleeding and had a foul odor. The facility Complaint/Concern Report Form stated that two nurses from the facility were sent to the resident's home on 01/17/12 to assess the area. The note written by one of the two nurses (Employee #2) during the investigation stated that</p>	F 309	<p>F309 Disclaimer The filing of this plan of correction is filed as the facility's does not constitute the fact that deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply the requirements and provide High quality care</p> <ol style="list-style-type: none"> 1. Resident #1 discharged home. 2. Employee 1 no longer employed at this facility. 3. All residents have the potential to be effected by this alleged deficient practice. 4. Audit all residents' skin to ensure all skin conditions are accounted for. 5. Audit all MD order to ensure proper implementation.

Fax 802/472348

MAY 8 2012 03:51:00 PULL/012

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F 309	<p>Continued From page 7</p> <p>the visit revealed the scrotum to be reddened and rashy with a 0.5 cm open area on the left scrotum and a "yeasty" odor. The note states that the two nurses provided the wife with the ordered topical medication and instructed her on its proper use.</p> <p>The reddened area was first noted on 01/08/12, according to investigative documentation, when an LNA (Licensed Nursing Assistant) reported reddened groins to an on duty RN (Registered Nurse) (Employee #1). The RN investigative statement is that s/he received a telephone order from the physician for Nystatin but that s/he was busy and "forgot" to transcribe the order. There is a telephone order in the record dated 01/08/2012 at 11 AM for Nystatin Cream to groins BID (twice per day) until resolved. There is no evidence of the order being transcribed to the Medication Administration Record (MAR) or the Treatment Administration Record (TAR). There is no update to the care Plan for Potential Impaired Skin Integrity for either the rash or the ordered treatment.</p> <p>There are Skilled Daily Nurses Notes dated 01/09/12 to 01/18/12 which reflect, by check marks, under the skin section that the resident had a rash. On 01/09/12 through 01/14/12 the section additionally reflects either groin or bilateral groins as the rashy area. There are no notes in the record associated with the noted rashy areas nor is there any evidence of a nurse completing a skin assessment or assessing the rashy area from 01/08/12 to discharge home on 01/16/12.</p> <p>The Investigative note written by the nurse who</p>	F 309	<ol style="list-style-type: none"> 6. Re-educate nursing staff for process of skin checks and carrying out MD orders. 7. Random weekly audits x4 to ensure continued compliance. 8. Results to be reported to QAA for determination of continued surveillance. 9. Plan completed by 5/20/12. Director of Nursing or designee responsible for implementation <p style="text-align: right;">6/15/12 [Signature]</p> <p style="text-align: right;">F309 POC accepted 6/4/12 [Signature]</p>	
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FAX 802/242303

MAY 8 2012 03:51PM P012/012

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F 309	Continued From page 8 obtained the physician order states that "I did not visualize the redness myself as the resident was already back in his wheelchair." In interview, on 04/18/12 at 3:45 PM, two nurses were interviewed who had indicated at some time, in the Skilled Daily Nurses Note, that the resident had a rash. Employee #5, the Primary Nurse on Unit B, indicated a rash present by checkmark on 01/11 and 01/15/12. When interviewed s/he stated that s/he had never assessed or seen the rashy areas and that checking the boxes had been a mistake. Employee #4 who was Unit B Manager at the time of the incident, indicated by checkmark on 01/10/12 that there was rash in the groin. In interview s/he stated that s/he may have noted a reddened area when assisting the resident to use the urinal but s/he had not performed a skin assessment related to the rash.	F 309			