

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
<http://www.dail.vermont.gov>
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

August 8, 2016

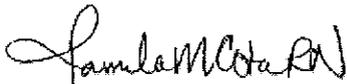
Ms. Jennifer Combs-Wilber, Administrator
Brookside Health And Rehabilitation
1200 Christian Street
White River Junction, VT 05001-9267

Dear Ms. Combs-Wilber:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 13, 2016**. 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

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

PRINTED: 07/26/2016
FORM APPROVED
OMB NO 0938-0391

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 07/13/2016
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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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F 000 INITIAL COMMENTS

An unannounced onsite re-certification survey and investigation of two complaints were completed by the Division of Licensing and Protection from 7/11/16 through 7/13/16. One of The complaints resulted in no identified regulatory findings. The re-certification survey and one complaint investigation identified regulatory violations as follows.

F 000,

The preparation and execution of this Plan of Correction does not constitute an admission or agreement by the Provider as to the truth or accuracy of the facts alleged or the conclusions set forth in the Statement of Deficiencies. This plan of Correction is prepared and executed because it is required by Federal and State law.

F 205 483.12(b)(1)&(2) NOTICE OF BED-HOLD SS=B POLICY BEFORE/UPON TRANSFER

F 205

Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.

It is the policy of Brookside Nursing and Rehab to provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan.

All residents who transfer out of the facility have the potential to be affected by the alleged deficient practice.

A bed-hold notification will be given to any resident transferring out of the facility for a hospitalization or therapeutic leave at the time of transfer. Transfer letters will be given by nursing or social service staff upon leaving. If a signature is unattainable due to an emergency situation a documented verbal agreement may be made and a signed bed hold letter to be completed as soon as physically possible by resident or responsible representative.

At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review the facility failed to provide 2 of 20 sampled residents with a written notice that specifies the duration of

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jennifer Wilber</i>	TITLE NHA	(X6) DATE 8/5/16
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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 205 Continued From page 1

The bed hold policy at the time of transfer to the hospital for Resident #63 and #77. The findings include the following:

1. Per medical record review, Resident # 63 was transferred to the hospital on 3/7/16 and returned to the facility on 3/15/16. There is no evidence that identifies that the resident and/or the family were provided with a bed-hold notice at the time of transfer.

Per interview with both Social Service employees, a bed hold policy is reviewed at the time of admission only and no written notice is provided at the time of discharge/transfer.

2. Per medical record review, Resident #77 was transferred to the hospital on 7/22/15 and returned to the facility on 7/29/15. On 12/8/15 Resident #77, was again transferred to the hospital and returned to the facility on 12/10/15. There is no evidence that identifies that the resident and/or the family was provided with a bed-hold policy at the time of transfer.

F 279 483.20(d), 483.20(k)(1) DEVELOP SS=G COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment

To ensure the alleged deficient practice does not occur, and procedure stays consistent we are taking the following measures: An ongoing quality improvement evaluation has been implemented under the supervision of the Social Worker, quality improvement team, and or designee. Documentation of all transfers and log if bed hold notification requirements have been met.

Completion Date: 8/10/2016 *gcu*

F205 POC accepted 8/5/16 JHsmr/RN/pmm

F 279

It is the policy of Brookside Nursing and Rehab to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment

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F 279 Continued From page 2

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment Under §483.10(b) (4).

This REQUIREMENT is not met as evidenced by:

Based on observation, medical record review and staff interview, the facility failed to develop a comprehensive care plan for 1 of 20 applicable residents in the Stage 2 sample (Resident #52). The findings include the following:

Per interview on 7/11/16 with the Licensed Practical Nurse (LPN), confirmation was made that Resident #52 had a red area (Stage I pressure ulcer) on his/her buttocks. Per observation of Resident #52 on 7/12/16, during incontinent care, in the presence of the Physician, Director of Nurses (DNS) and a Licensed Nurse Aide, Resident #52 was found to have developed a Stage II avoidable pressure ulcer.

Per review of the Interdisciplinary Care Plan, there is no evidence of the development of a plan of care related to skin integrity or any preventable measures to avoid the development of a pressure ulcer. Per interview with the DNS, confirmation was made that the care plan does not include any identification of a pressure ulcer, nor is there any notation identifying interventions for the prevention of skin breakdown.

F 279

Resident #52 has a care plan developed for the alleged Stage 2 pressure ulcer. Interventions have been put in place to promote healing and avoid further skin integrity issues.

To ensure the alleged deficient practice does not occur, and procedure stays consistent we are taking the following measures:

Staff will be reeducated to ensure that care plans identify residents at risks for skin integrity and pressure ulcers and to document all interventions and any preventable measures to avoid the development of a pressure ulcer.

Skin audits will be completed and documented weekly by an RN to identify skin integrity and to identify that resident care plans reflect resident's needs. LNA's will be reeducated on the signs of skin integrity issues and monitor during resident care. LNAs will notify Unit Nurse Manager of any skin integrity concerns immediately.

A quality improvement evaluation has been implemented under the supervision of the Director of Nursing. Documented audits will be completed to identify any inconsistencies with following the policies of prevention and treatment of skin integrity, audits will be reported to the quality improvement committee on a monthly basis for 3 months and quarterly thereafter.

Completion Date: 8/10/2016 *[Signature]*

F279 POC accepted 8/5/16 JHsmereal/pnw

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**F 285 483.20(m), 483.20(e) PASRR REQUIREMENTS
SS=E FOR MI & MR**

A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to The maximum extent practicable to avoid duplicative testing and effort.

A nursing facility must not admit, on or after January 1, 1989, any new residents with:

(i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission;

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.

(ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission--

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.

For purposes of this section:

(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b) (1).

F 285

It is the policy of Brookside Nursing and Rehab to ensure that Pre-Admission screening for existing Mental Illness, Mental Retardation or Related Conditions (PASRR), are completed

Residents #8, #23 and #63 had no ill effects from this alleged deficient practice. Audits have been completed to ensure that all residents have a PASSAR on file.

All residents who require a PASSAR can be affected as a result of this alleged deficient practice.

To ensure the alleged deficient practice does not occur, and procedure stays consistent we are taking the following measures: PASSARs will be completed and reviewed for accuracy on all admissions.

A quality improvement evaluation has been implemented under the supervision of the Admissions coordinator. Documented audits will be completed for accuracy and completion and reported to the quality improvement committee on a monthly basis for 3 months then quarterly thereafter.

Completion date 8/10/16 *[Signature]*

F285 PDC accepted 8/15/16 JHamer RN / PDC

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F 285 Continued From page 4

(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and medical record review, the facility failed to ensure that Pre-Admission screening for existing Mental Illness, Mental Retardation or Related Conditions (PASRR), was completed for 3 of 20 applicable residents reviewed. For Residents # 8, #23 and #63, the findings include the following:

1. Per medical record review for Resident #8, s/he was admitted to the facility on 8/16/11. Evidence identifies the resident to be a Mentally Disabled Adult, as per guardianship petition filed on 4/15/08. There is no evidence that Resident #8 has been evaluated to determine if specialized services are required related to his/her mental disability.

"Specialized services" are those services the State is required to provide or arrange that raise the intensity of services to the level needed by the resident. That is, specialized services are an "add-on" to Nursing Facility (NF) services--they are of a higher intensity and frequency than specialized rehabilitation services, which are provided by the NF.

Per interview with both Social Service workers, confirmation is made that they do not complete PASRR screenings on residents prior to or on admission. PASRR screenings are completed by the hospital discharge planners and accompany

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F 285 Continued From page 5

the resident on admission to the nursing home.

2. Per medical record review, Resident #65 was admitted to the facility for a short stay after a surgical intervention on 3/7/16. S/He was discharged back to the hospital and subsequently readmitted on 3/15/16. Diagnoses include Schizoaffective and Post Traumatic Stress Disorder.

Pre-Admission screening for existing Mental Illness, (PASRR), is not required at the time of a nursing home admission if resident is considered A Short-Stay (30 days or less). The resident has resided in the facility for at least 90 days after the latest admission on 3/15/16. To date, Resident #65 has not had a PASRR completed to Determine if further evaluation by the Department, of Mental Health is necessary.

Per Interview with both Social Service workers, confirmation is made that they do not complete PASRR screenings on residents prior to or at the time of admission, they are completed by the hospital discharge planners and accompany the resident on admission to the nursing home. They also confirm that since Resident #65 was admitted for a short stay, no further evaluation was necessary.

3. Per record review and staff interview, the facility failed to re-screen Resident #23 for Pre-Admission Screen For Existing Mental Illness, Mental Retardation, or Related Condition (PASRR) when the long term care stay extended beyond the 30 day exempt period. Record review showed that Resident #23 was admitted on 3/27/16 with a physician signed PASRR exemption, Part A, related to anticipated short stay of up to 30 days. At 9:40 AM on 7/13/16 the Assistant Director of Nursing services confirmed

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F 285 Continued From page 6

that there had been no PASRR re-screen when
The stay extended beyond 30 days.

3. Per record review and staff interview, the facility failed to re-screen Resident #23 for Pre-Admission Screen For Existing Mental Illness, Mental Retardation, or Related Condition (PASRR) when the long term care stay extended beyond the 30 day exempt period. Record review showed that Resident #23 was admitted on 3/27/16 with a physician signed PASRR exemption, Part A, related to anticipated short stay of up to 30 days. At 9:40 AM on 7/13/16 the Assistant Director of Nursing services confirmed that there had been no PASRR re-screen when the stay extended beyond 30 days.

F 285

F 312 483.25 (a)(3) ADL CARE PROVIDED FOR SS=G 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.

This REQUIREMENT is not met as evidenced by:
Based on observation and confirmed by staff interview, the facility failed to provide necessary services for personal care (Incontinent Care), for 2 of 4 applicable residents in the Stage 2 sample, who are dependent on staff to provide the necessary services. For Residents #8 and #52 the findings include the following:

F 312

It is the policy of Brookside Nursing and Rehab to ensure the facility provides the necessary services for personal care (incontinent care)

Resident #8 and #52 were provided incontinent care.

All residents can be affected by this alleged deficient practice.

To ensure the alleged deficient practice does not occur, and procedure stays consistent we are taking the following measures: Staff are being reeducated on incontinent care and toileting programs.
All resident care plans are being audited for appropriate toileting programs according to meet the resident needs.

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1. Per medical record review, Resident #8 was admitted to the facility in 2011 with diagnoses to include Multiple Sclerosis, Depression, Dementia, Acute Kidney Injury, Urinary Retention, Urosepsis and Neurogenic Bladder.

Per observation of wound care on 7/13/16 at approximately 1 PM, in the presence of the Licensed Practical Nurse (LPN) and a Licensed Nurse Aide (LNA), Resident #8 was mechanically lifted from his/her wheelchair to bed. The resident was found to have an adult brief in place saturated with foul smelling urine that had extended to his/her clothing. At the completion of the observation the Registered Nurse (RN) in charge was asked when the resident last received incontinent care. S/He responded that s/he had assisted the LNA at 10:30 AM with the transfer. This was 2.5 hours earlier.

Per Interdisciplinary Care Plan (ICP), Resident #8 has problems identified as a pressure sore on the buttocks, decreased independence with activities of daily living, and impaired physical mobility related to multiple sclerosis. All three problems identify that the resident is to be assisted to change position every two (2) hours that s/he is dependent on staff to provide incontinent care after each episode, toilet every two (2) hours and transfer via mechanical lift.

Confirmation was made by the LPN and the LNA at the time of the observation (1:00 PM on 7/13/16) that the resident was incontinent and was last provided incontinent care at 10:30 AM, as stated by the RN, 2.5 hours earlier.

2. Per medical record review, Resident #52 was admitted to the facility in 2015 with diagnoses to

F 312

A quality improvement evaluation has been implemented under the supervision of the Director of Nursing. Documented audits will be completed to identify that resident's toileting programs are being followed and resident needs are being met. Audits will be reported to the quality improvement committee on a monthly basis for 3 months and quarterly thereafter.

Completion Date: 8/10/16 *[Signature]*

F312 POC accepted 8/15/16 JHsmertai/PMC

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F 312 Continued From page 8

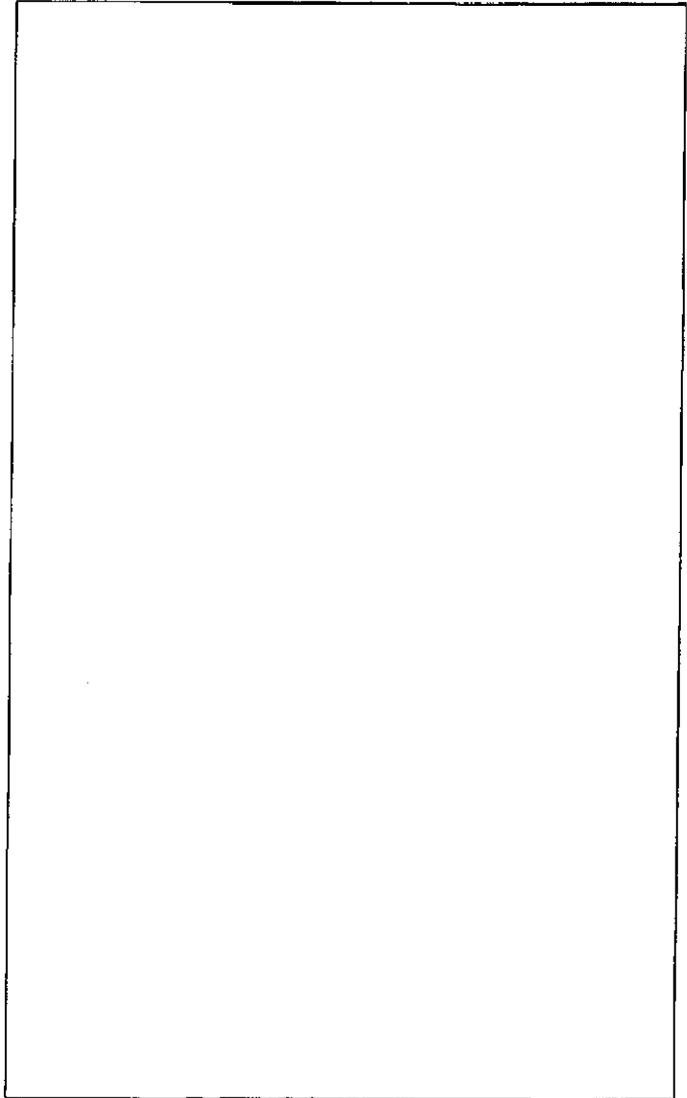
F 312

include Dementia, Behavioral Disturbances, Chronic Kidney Disease, Depression, Anxiety, Chronic Obstructive Pulmonary Disease, Stomach Tumor and general weakness. Resident was placed on Hospice Service on 3/18/15 due to his/her terminal prognosis.

Per observation on 7/12/16 at 7:30 AM, the resident was sitting in his/her glider chair. At 9:45 AM the assigned Licensed Nurse's Aide (LNA), in the presence of the Director of Nurses (DNS), was asked when the resident was to be taken to the toilet. The response was "now". The resident was assisted to the toilet by the LNA and the DNS. The resident was discovered to have been incontinent, adult brief was wet with urine and the Resident also voided on the toilet.

Per Interdisciplinary Care Plan (ICP). Resident #52 has problems identified as decreased independence with activities of daily living, has an unsteady gait, has a history of falls and has urinary incontinence. All problems identify that the resident requires extensive assistance of one (1) LNA, s/he is to be taken to the toilet before and after meals and as needed. Incontinent care to be provided after each incontinent incident.

The State Surveyor observed the resident for 2.25 hours sitting in his/her room unattended. At no time was a staff observed assisting the resident to the toilet or asking the resident if s/he need to go to the bathroom. Per interview with the assigned LNA, confirmation was made that s/he had not provided AM care to the resident (the night shift gets the resident out of bed), nor had s/he taken the resident to the toilet or asked the resident if s/he needed toileting since his/her shift began.



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F 312

Confirmation was made at the time of Observation by both the LNA and the DNS that the resident was incontinent, brief was wet with urine and the resident did void on the toilet at the time of this last transfer.

See also F314.

F 314 483.25(c) TREATMENT/SVCS TO SS=G' PREVENT/HEAL PRESSURE SORES

F 314:

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.

It is the policy of Brookside Nursing and Rehab to provide treatment and services to promote Healing of avoidable pressure ulcers. Incontinence care and treatments were provided to resident #8 and #52. Interventions have been put in place to promote healing and avoid skin integrity issues. All residents have the potential to be affected by this alleged deficient practice. To ensure the alleged deficient practice does not occur, and procedure stays consistent we are taking the following measures: Staff are being reeducated on incontinent care, toileting programs and the documentation process of skin integrity issues. All resident care plans are being audited for appropriate toileting programs and treatments to meet the resident needs. Skin audits are completed and documented weekly by an RN to identify skin integrity and to identify that resident care plans reflect resident's needs. LNA's will be reeducated on the signs of skin integrity issues and monitor during resident care. LNAs will notify Unit Nurse Manager of any skin integrity concerns immediately.

This REQUIREMENT is not met as evidenced by:

Based on observation, record review and confirmed by staff interview the facility failed to provide treatment and services to promote Healing of avoidable pressure ulcers for 2 or 4 applicable residents in the Stage 2 sample (Resident #8 and #52). The finding include the following:

1. Per record review, Resident #8 who was admitted to the facility in 2011 with diagnoses to include Multiple Sclerosis, Depression, Dementia, Acute Kidney Injury, Urinary Retention, Urosepsis and Neurogenic Bladder.

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F 314 Continued From page 10

Per nurse's notes, Resident #8 developed a Stage 1 pressure ulcer to his/her right buttocks on 5/3/16. Per facility protocol, wounds are measured weekly. The first measurement was documented on 5/6/16 as a Stage 1 pressure Ulcer at 0.4 centimeters (cm) x 0.2 cm. The physician was notified and facility wound protocol was initiated. Over the next 9 weeks the Stage 1 pressure ulcer developed into a Stage 2 pressure Ulcer. Per telephone conversation on 7/14/16 with the Director of Nurses confirmation was made that the pressure ulcer currently measures 1.7 cm x 1.7 cm, circular in shape with a moderate amount of drainage. The wound is noted to have 30% slough scattered throughout. The wound bed with 70% granulation tissue. Slough is described as necrotic tissue that is in the process of separating from viable portions of the wound.

Per review of the interdisciplinary Care Plan (ICP) for Resident #8, identifies the resident as having a pressure ulcer, being dependent of staff for activities of daily living, s/he is mechanically lifted for all transfers, s/he is incontinent of urine at all times and is unable to independently reposition herself in bed/chair. Initiatives for treatment include wound care as per physician orders, fortified foods to assist with wound healing, position change every two (2) hours, toilet resident every two (2) hours and incontinent care after each incident.

Per observation of wound care on 7/13/16 at approximately 1 PM, in the presence of the Licensed Practical Nurse (LPN) and the Licensed Nurse Aide (LNA), Resident #8 was mechanically lifted from the wheelchair to his/her bed. The resident was found to have an adult brief in place

F 314

A quality improvement evaluation has been implemented under the supervision of the Director of Nursing. Documented audits will be completed to identify that resident's toileting programs are being followed and resident needs are being met. Audits will be reported to the quality improvement committee on a monthly basis for 3 months and quarterly thereafter

Completion Date: 8/10/16 *[Signature]*

F314 POC accepted 8/5/16 *[Signature]*

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F 314 Continued From page 11

F 314

saturated with foul smelling urine that extended to The resident's clothing. At the completion of the Observation the Registered Nurse (RN) in charge was asked when the resident was last provided incontinent care. S/He responded that s/he she had assisted the LNA at 10:30 AM.

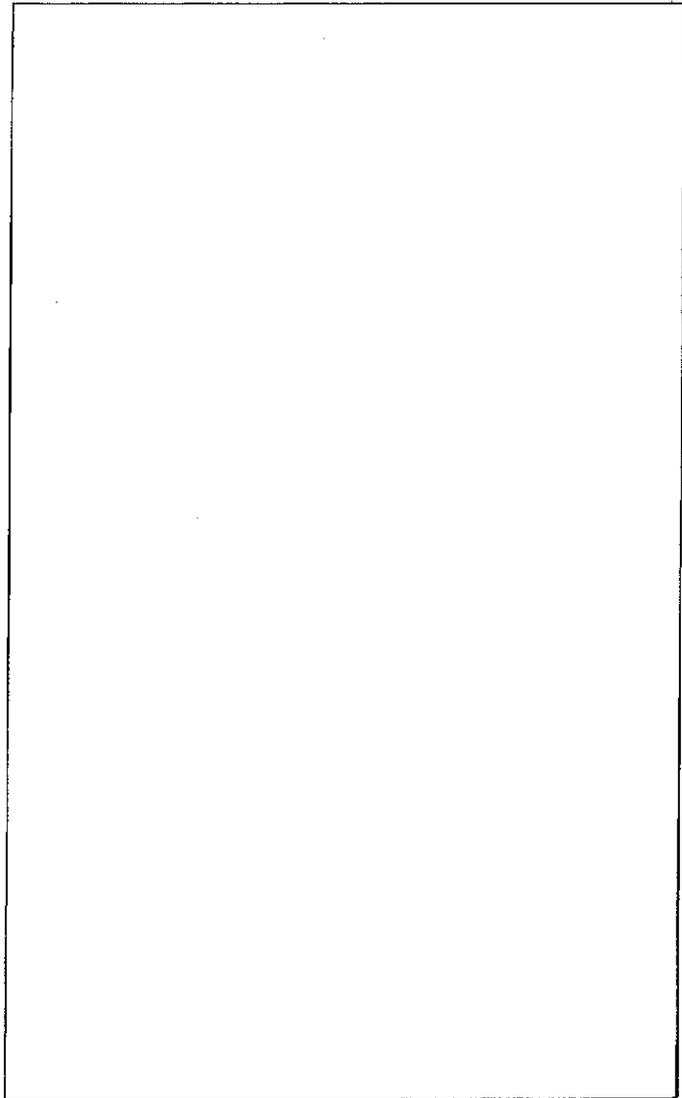
Per interview with the LPN and the LNA at the time of the observation, confirmation was made that the resident was incontinent and had last received incontinent care at 10:30 AM, as stated by the RN. This was 2.5 hours earlier.

Therefore, as per definition of avoidable pressure ulcers, Resident #8 did not receive necessary services to prevent further skin breakdown of the already present pressure ulcer, s/he did not receive incontinent care after an incontinent Episode and the resident, who is unable to reposition him/herself was not transferred from bed to chair for over 2.5 hours.

2. Per medical record review, Resident #52 was admitted to the facility in 2015 with diagnoses to include Dementia, Behavioral Disturbances, Chronic Kidney Disease, Depression, Anxiety, Chronic Obstructive Pulmonary Disease, Stomach Tumor and general weakness. Resident was placed on Hospice Service on 3/18/15 due to his/her terminal prognosis.

Per interview on 7/11/16 with the Licensed Practical Nurse (LPN) confirmation was made that Resident #52 had a red area (Stage I) pressure ulcer on his/her buttocks. There is no documentation in the medical record identifying a Stage 1 pressure ulcer.

Per observation on 7/12/16 at 7:30 AM, the



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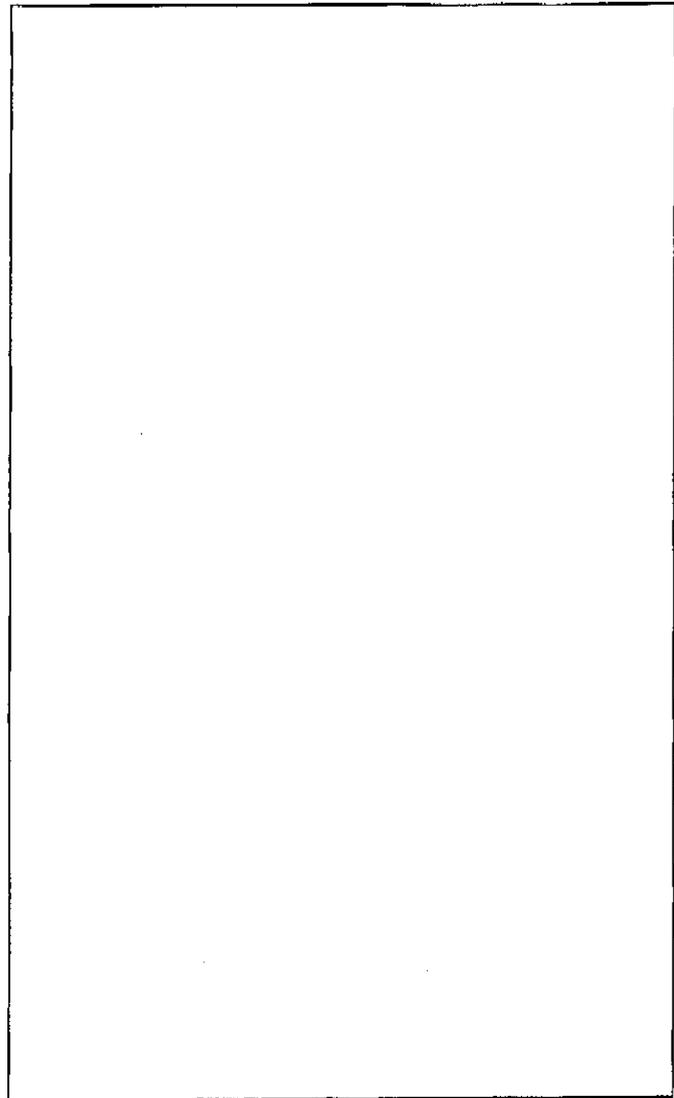
F 314

resident was sitting in his/her glider chair. At 9:45 AM the assigned Licensed Nurse's Aide (LNA), in the presence of the Director of Nurses (DNS), was asked when the resident was to be taken to the toilet. The response was "now". The resident was assisted to the toilet by the LNA and the DNS. The resident was discovered to have been incontinent, adult brief was wet with urine and the resident also voided on the toilet. An avoidable Stage 2 pressure ulcer was discovered at this time.

Observation of incontinent care at approximately 12 noon, in the presence of the Physician, Director of Nurses (DNS) and a Licensed Nurse Aide, Resident #52 who has a Stage 2 pressure ulcer that currently measures 4 centimeters (cm) x 1.5 cm with sloughing skin. Slough is described as necrotic tissue that is in the process of separating from viable portions of the wound.

Per Interdisciplinary Care Plan (ICP), Resident #52 has problems identified as decreased independence with activities of daily living, has an unsteady gait, has a history of falls and has urinary incontinence. All problems identify that the resident requires extensive assistance of one (1) LNA, s/he is to be taken to the toilet before and after meals and as needed. Incontinent care to be provided after each incontinent incident.

The State Surveyor observed the resident for 2.25 hours sitting in his/her room unattended. At no time was a staff observed assisting the resident to the toilet or asking the resident if s/he need to go to the bathroom. Per interview with the assigned LNA, confirmation was made that s/he had not provided AM care to the resident



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F 314 Continued From page 13
(the night shift gets the resident out of bed), nor had s/he taken the resident to the toilet or asked . The resident if s/he needed toileting since his/her shift began.

Confirmation was made at the time of observation by both the LNA and the DNS that the resident was incontinent, brief was wet with urine and the resident did void on the toilet at the time of this last transfer. Therefore as per definition of avoidable pressure ulcers, Resident #52 did not receive necessary services ; To prevent skin breakdown. The resident did not receive incontinent care after an Incontinent episode and was not taken to the toilet before and after meals or as needed.

Refer also to F279 and F312.

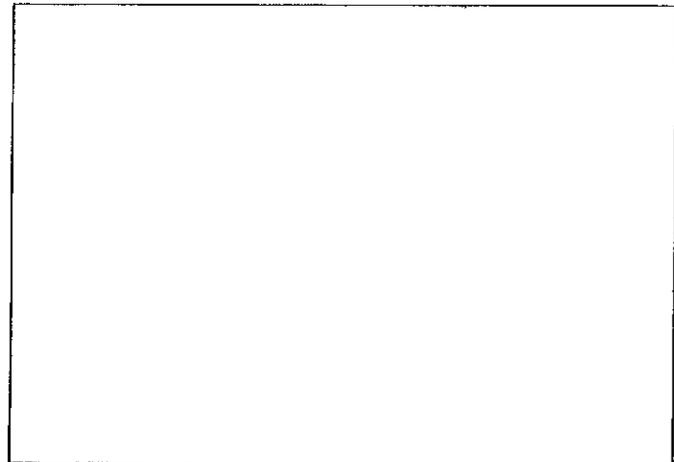
F 322 483.25(g)(2) NG TREATMENT/SERVICES - SS=D, RESTORE EATING SKILLS

Based on the comprehensive assessment of a resident, the facility must ensure that --

(1) A resident who has been able to eat enough alone or with assistance is not fed by naos gastric tube unless the resident ' s clinical condition demonstrates that use of a naos gastric tube was unavoidable; and

(2) A resident who is fed by a naos-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

F 314



F 322

It is the policy of Brookside Nursing and Rehab to ensure a resident with a feeding tube receives appropriate treatment.

All nurses have been reeducated on the process of checking placement prior to administering anything through the G Tube.

All orders for resident # 34 have been verified for NPO status.

All residents who have a G Tube and or are NPO have the potential to be affected by this alleged deficient practice.

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F 322 Continued From page 14

F 322

This REQUIREMENT is not met as evidenced by:

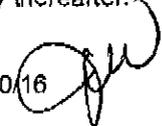
Based on observation, record review, and staff interview, the facility failed to ensure that a resident with a feeding tube received appropriate treatment for 1 applicable resident reviewed (Resident #34). Findings include:

1. Per record review, Resident #34 is not able to eat by mouth due to a very high aspiration risk. The medical record states this clearly that they are NPO (nothing by mouth) for food, Medications, and liquids. The only exception to this order was that the Speech Therapist only could supervise Resident #34 for eating a dessert for pleasure, and a onetime Lorazepam order to dissolve in the mouth after the resident had pulled out their own G-tube and was a n x i o u s .

On 7/12/16 at 9:15 AM, during observation of the administration of medications through the feeding tube for Resident #34, the nurse did not auscultate the stomach with air and listen through a stethoscope to determine that the feeding tube was in the proper placement, nor pull back on the syringe to check for stomach content to determine correct placement. The nurse proceeded to administer water and crushed medications to the resident through the feeding Tube. Per interview directly after this observation, I asked about the check for placement, and the nurse replied that they did not know that this was required prior to administration of fluids or medications through a feeding tube. Per interview

To ensure the alleged deficient practice does not occur, and procedure stays consistent we are taking the following measures: Staff are reeducated on the on the process of checking placement prior to administering anything through the G Tube. Staff, pharmacy and physicians are being reeducated on proper order transcription for those residents with NPO orders.

A quality improvement evaluation has been implemented under the supervision of the Director of Nursing. Documented audits will be completed to identify staff are checking for tube placement prior to administering anything through the G tube and that physician orders reflect proper plan of care for each individual resident. Audits will be reported to the quality improvement committee on a monthly basis for 3 months and quarterly thereafter.

Completion Date: 8/10/16 

F322 POC accepted 8/15/16 JHorne RN/pme

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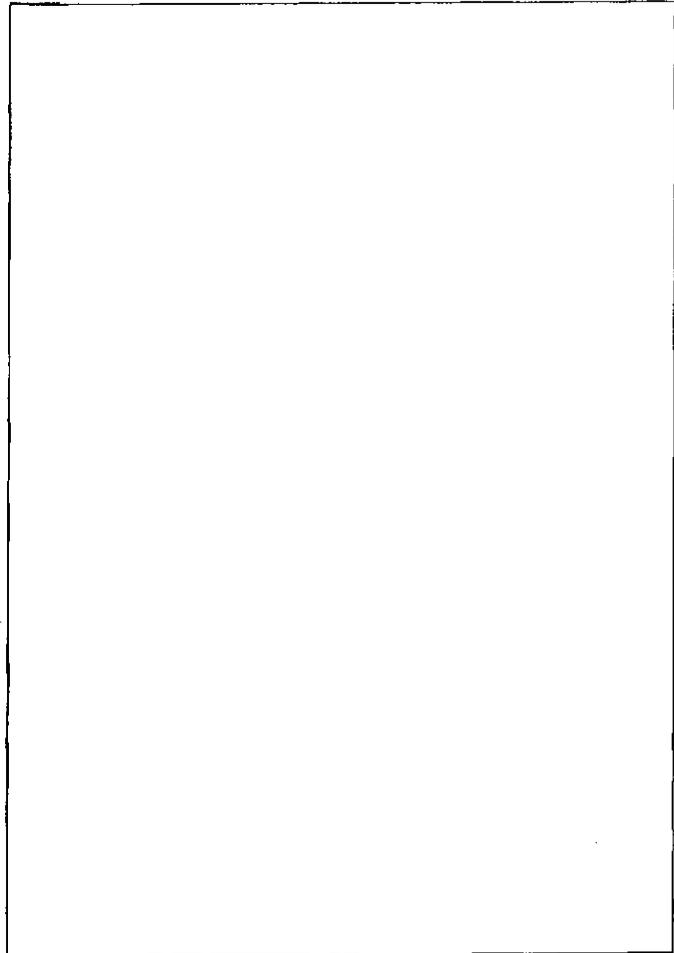
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F 322 Continued From page 15

on 7/12/16 at 10:05 AM, the Director of Nursing confirmed that the facility policy and procedure clearly states that placement of the feeding tube is to be checked by listening for air in the stomach through a stethoscope before administering anything through the feeding tube, and that the nurse had not followed this protocol.

2. Per record review, Resident #34 is not able to eat by mouth due to a very high aspiration risk. The medical record states this clearly that they are NPO (nothing by mouth) for food, medications, and liquids. Per review of the signed physicians order for July 2016, there was an entry on the Medication Administration Record that were orders to give by mouth. The order for liquid "Docusate Sod. 150 mg. /15 ml. 20 ml. (200 mg.) by mouth twice daily". Per review of the previous month's orders, there was a pattern of the pharmacy sending the medication order sheets with "by mouth" orders in them, and this was not how the MD wrote them. Most of these errors were caught by nursing staff when they reviewed the monthly orders, however even after two checks by nursing and the MD review of the July orders, the Docusate Sod. By mouth was not noticed. Per interview on 7/12/16, the resident's physician confirmed that this resident is not to take any medications by mouth, and the errors that originated at the pharmacy should have been detected by the nurses who checked the orders, and by the MD before signing off on the orders.

F 322



Refer also to F428.

F 323 483.25(h) FREE OF ACCIDENT
SS=D HAZARDS/SUPERVISION/DEVICES

F 323

The facility must ensure that the resident

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F 323 | Continued From page 16

F 323

environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:

Based on observation, record review, and staff interview, the facility failed to ensure that the environment remained free of accident hazards as possible for 1 of 20 residents sampled (Resident #60). Findings include:

Per observation on/11/16 during the initial tour of the facility, a resident bed in Rm. 26 was noted to have a bracket protruding from the frame that is meant to hold the bedrails in place. The rails were not attached to the bed, so the metal bracket protruded by the head of the bed sticking out about 3 inches. Resident #60 was the subject of a deficiency during last year's survey, as this hazard was identified at that time, and all brackets that did not hold side rails were removed from the beds throughout the facility, including the one observed this year.

Resident #60 has a history of rolling out of bed in the past. They are care planned to have a low bed and a fall mat beside it when in bed to prevent injuries if they rolled out or tried to climb out of the bed. The bracket was aligned around the shoulder area of a resident lying in the bed, and posed a potential risk of receiving an injury if they contacted the metal while rolling out of bed. Also there was a potential risk of bruises or skin tears to the lower legs of residents in a

It is the policy of Brookside Nursing and Rehab to ensure residents' environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

The bracket has been removed from the bed of resident #60

All residents who have bedrails in place have the potential to affect by this alleged deficient practice.

To ensure the alleged deficient practice does not occur, and procedure stays consistent we are taking the following measures:

An audit of all beds has been completed to identify if there are any brackets on the bed without the side rails. Staff are reeducated to identify brackets that need to be removed for notification to maintenance.

Maintenance is notified of a discharge and the need to remove bracket/side rails.

All side rails and brackets will be removed from beds when resident is discharged and no return expected.

A quality improvement evaluation has been implemented under the supervision the Maintenance director and the quality improvement committee. Audits will be completed on a weekly basis to ensure that no beds have brackets without side rails and reported to the quality improvement team monthly. Audits of discharged beds will be done on going through a room readiness check list to make sure brackets and side rails are removed.

Completion Date: 8/10/16 *[Signature]*

F323 ROC accepted 8/5/16 JHsmurRd/PMLC

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wheelchair who may bump into the bracket Per interview on 7/11/16 at 9:55 AM, the nurse working on that unit confirmed the bracket was attached to the bed of Resident #60, and that the metal protruding was a potential risk for injury to residents if they contacted it Per interview on 7/13/16, the Head of Maintenance stated that the bracket may have been attached to the wall side of the bed and it had been turned around to expose the bracket

F 323

* This is a repeat deficiency.

F 353 483.30(a) SUFFICIENT 24-HR NURSING STAFF SS=G PER CARE PLANS

The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.

Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

F 353

It is the policy of Brookside Nursing and Rehab to assure there is sufficient nursing staff to provide nursing and related services to attain or maintain the highest emotional physical and psychosocial well-being of residents, as determined by the resident assessments and plans of care.

Brookside will continue to have sufficient staff to provide nursing and related services to attain maintain the highest emotional physical and psychosocial well-being of residents, as determined by the resident assessments and plans of care.

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F 353 Continued From page 18

This REQUIREMENT is not met as evidenced by:

Based on surveyor observation, record review and staff interview, the facility failed to provide sufficient staffing services on one of 3 units (unit CID) in order to provide timely incontinence care and repositioning sufficient to prevent skin breakdown for 2 of 20 residents in the stage 2 sample (Residents #8 and 52). Findings include:

During the staffing services interview with the Director of Nursing Services (DNS) on 7/12/16, s/he noted that since 6/15/16 the historical staffing levels for the CID unit have lessened. There were previously 3 LNA staff to serve the CID unit (26 beds, usually 19- 21 residents), and now there are 2 LNAs scheduled per shift. Additionally, some staff were previously hired with an agreement that they would have a 4 day, longer shift work week, so they come in early to provide overlap of shifts at busy times early morning and late afternoon. This overlap hiring practice has been suspended except for those grandfathered, so through attrition and schedule rotations, there are about 3 days per week, plus any call-out incidents, when the overlap staffing does not occur. These staffing practice changes have contributed to time constraints for caregivers which can be identified in the following outcomes: Resident #8 and #52, untimely incontinent care/repositioning and acquired/worsening pressure ulcer. See citations at F312 and F314.

F 428 483.60(c) DRUG REGIMEN REVIEW, REPORT SS=D IRREGULAR, ACT ON

The drug regimen of each resident must be reviewed at least once a month by a licensed

F 353

All residents have the potential to be affected by the alleged deficient practice.

Staffing levels and hours of coverage have not lessened for the C/D unit. The overlap had been shifted to the end of the shift for full shift coverage with no deletion of hours.

Staff are being reeducated on incontinent care and toileting programs.

To assure that this alleged deficient practice does not occur there will continue to be sufficient staff to provide nursing and related services to attain maintain the highest emotional physical and psychosocial well-being of residents, as determined by the resident assessments and plans of care.

A quality improvement evaluation has been implemented under the supervision of the DON and quality improvement team for three consecutive months then quarterly thereafter this evaluation will include audits of schedule, daily staffing sheets and acuity

Completion Date: 8/10/16 *[Signature]*
F353 PDC accepted 8/15/16 *[Signature]*

F 428

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pharmacist.

The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.

This REQUIREMENT is not met as evidenced by:

Based on observation, record review, and staff interview, the Pharmacist failed to ensure that the drug regimen was correct as ordered, and report irregularities to the physician for 2 of 20 residents reviewed (Resident #34, #52) Findings include:

1. Per record review, Resident #34 is not able to eat by mouth due to a very high aspiration risk. The medical record states this clearly that they are NPO (nothing by mouth) for food, medications, and liquids. The only exception to this order was that the Speech Therapist only could supervise Resident #34 for eating a dessert for pleasure, and a onetime Lorazepam order to Dissolve in the mouth after the resident had pulled out their own G-tube and was anxious. Per review of the signed physicians order for July 2016, there was an entry on the Medication Administration Record that were orders to give by mouth. The order for liquid "Docusate Sod. 150 mg. /15 ml. 20 ml. (200 mg.) by mouth twice daily". Per review of the previous month's orders, there was a pattern of the pharmacy sending the medication order sheets with "by mouth " orders in them, and this was not how the MD wrote them. Most of these errors were caught by nursing staff when they reviewed the monthly orders, however even after

F 428

It is the expectation of and policy of the facility to ensure that the pharmacist ensures that the correct drug regimen is correct as ordered and to report irregularities to the physician and the nursing staff.

All nurses have been reeducated on the process of checking placement prior to administering anything through the G Tube.

All orders for resident # 34 have been verified for NPO status. Resident # 52 was not affected by this alleged deficient practices due to resident #52 does not have a Tube.

All residents who have a G Tube and or are NPO have the potential to be affected by this alleged deficient practice.

To ensure the alleged deficient practice does not occur, and procedure stays consistent we are taking the following measures:

Staff, pharmacy and physicians are being reeducated on proper order transcription for those residents with NPO orders.

A quality improvement evaluation has been implemented under the supervision of the Director of Nursing and Pharmacy. Documented audits will be completed to identify that physician orders reflect proper plan of care for each individual resident. Audits will be reported to the quality improvement committee on a monthly basis for 3 months and quarterly thereafter.

Completion Date: 8/10/16 *[Signature]*

F428 POC accepted 01/11/16 JHSmeru/PML

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

PRINTED: 07/28/2016
FORM APPROVED
OMB NO 0938-0391

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 07/13/2016
NAME OF PROVIDER OR SUPPLIER BROOKSIDE HEALTH AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 CHRISTIAN STREET WHITE RIVER JUNCTION, VT 05001	
(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)
			(X6) COMPLETION DATE

F 428 Continued From page 20

two checks by nursing and the MD review of the July orders, the Docusate Sod. by mouth was not noticed. Per interview on 7/12/16, the resident's physician confirmed that this resident is not to take any medications by mouth, and the errors that originated at the pharmacy should have been detected by the nurses who checked the orders, and by the MD before signing off on the orders.

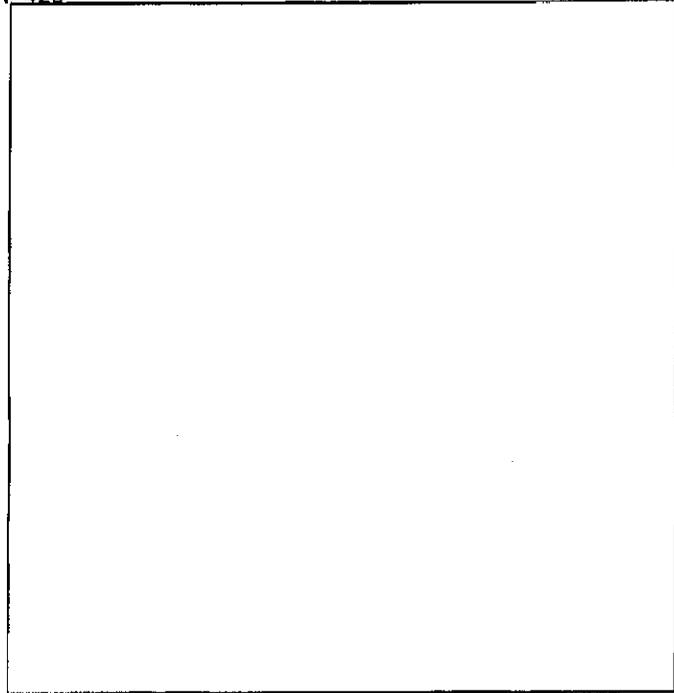
Per review of the Pharmacist's consultations for May and June 2016, the Pharmacist wrote that the resident was taking "Zoloft 50 mg. PO QD" for depression, and "Trazadone 50 mg. PO q PM PRN for insomnia". Per interview with the resident's physician on 7/12/16, it was confirmed that the pharmacy had been sending medication orders for months with the error of the "PO" (by mouth) route on them, and that even the documentation by the pharmacist in May and June had the incorrect route of administration as "by mouth" instead of by feeding tube. The nursing staff had caught some of these errors in past months, however there was still an order for Docusate Sod. Liquid on the current signed orders that had not been noticed by the Pharmacist.

F 441 483.65 INFECTION CONTROL, PREVENT SS=D SPREAD, LINENS

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

F 428



F 441

It is the policy of Brookside Nursing and Rehab to ensure that meals are delivered to residents in a safe and sanitary manner to prevent the transmission of disease and infection.

Staff have been educated on the proper dining room infection control procedures.

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

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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 07/13/2016
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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		(X5) COMPLETION DATE	

F 441 Continued From page 21

F 441

; 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.

This REQUIREMENT is not met as evidenced by:

Based on observation and confirmed by staff interview the facility failed to ensure that meals are delivered to residents in a safe and sanitary manner to prevent the transmission of disease and infection. The findings include the following: Per observation during the noon meal on 7/11/16, in the main dining room, a Licensed Nurse's Aide (LNA) was observed cutting multiple residents' hamburgers with his/her bare hands, distributing

All residents have the potential to be affected by this alleged practice.

To ensure the alleged deficient practice does not occur, and procedure stays consistent we are taking the following measures:

Staff are being reeducated on standard precautions.

A quality improvement evaluation has been implemented under the supervision of the Director of Nursing and or designee, and quality improvement committee to implement and document infection control audits. Audits will be done randomly on a weekly basis for at least 4 weeks, monthly for 3 months and then quarterly thereafter.

Completion Date: 8/10/16

F441 POC accepted 8/15/16 JHesmer RN/PMC

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

PRINTED: 07/26/2016
FORM APPROVED
OMB NO 0938-0381
(X3) DATE SURVEY COMPLETED
C
07/13/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	
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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 441 , Continued From page 22

to residents large bottles of ketchup/mustard which had not been cleansed prior to delivery (also utilizing his/her bare hands) and handling resident equipment (walkers) without washing or sanitizing his/her hands in-between tasks.

Per interview with the LNA s/he confirms that s/he forgot to wash/sanitize her/his hands.

Per Interview with the Director of Nurses, confirmation is made that the LNA has not attended any of the seven (7) educational offerings related to hand-washing or infection control to date for the 2016 year.

F 441

F 465 483.70(h)

SS=E SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

This REQUIREMENT is not met as evidenced by:

Based on observation and confirmed by staff interview, the facility failed to ensure that the dietary department is maintained in a safe and sanitary manner. The findings include the following:

Per tour of the dietary department on 7/11/16 in the presence of the Food Service Supervisor (FSS) the following unsanitary conditions were identified:

-Copper piping connected to the hood, located directly above the stove/grill was found to have

F 465

It is the policy of Brookside Nursing and Rehab to ensure that the dietary department is maintained in a safe and sanitary manner.

Staff have been reeducated on the proper cleaning procedures, schedules and documentation of the dietary department.

All residents have the potential to be affected by this alleged deficient practice.

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

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FORM APPROVED
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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 07/13/2016
NAME OF PROVIDER OR SUPPLIER BROOKSIDE HEALTH AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 CHRISTIAN STREET WHITE RIVER JUNCTION, VT 05001	
(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 465 Continued From page 23

Visible accumulated dust/grime that could easily dislodge and fall onto the stove or any contents on the stove.

- Light fixtures above the food preparation area and the dirty dish room in the kitchen was noted to have many dried spills/splatters, dust/grime and dead bugs under the plastic covers.
- Fan on the clean side of the dish room was noted to have an accumulation of dust/grime.
- The floor in the dietary department was noted to have ceramic tiles that had numerous cracks and missing pieces as well as accumulation of dust, grime and food spills.
- The ceiling tiles throughout the dietary department were noted to have dried food and Splatters.
- The sheetrock behind the coffee maker was noted to have peeling sheetrock and sloughing of paint.

Confirmation was made by the FSS, that all of the above conditions were identified during the tour. And that. The cleaning schedules have not been followed.

F 465

The following alleged deficient concerns have been reviewed and addressed as needed.

- Copper piping connected to the hood, located directly above the stove/grill was cleaned.
- Light fixtures above the food preparation area and the dirty dish room in the kitchen has been cleaned.
- Fan on the clean side of the dish room was cleaned.
- The tiles in the dietary department are being re grouted.
- The ceiling tiles throughout the dietary department have been cleaned.
- The sheetrock is being repaired as needed.

A quality improvement evaluation has been implemented under the supervision of the Dietary Supervisor, Maintenance Supervisor, and the quality improvement team to complete documented audits for unsanitary conditions in the dietary department on a routine basis as well to ensure that the cleaning schedules are being followed.

Completion Date: 8/10/16



F465 POC accepted 8/15/16 J.HosmerRui/PME

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 # 475010	MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____	DATE SURVEY COMPLETE 7/13/2016
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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
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 278	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>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.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to reflect the resident's status on the most recent Minimum Data Set (MOS) for 1 of 20 residents in the sample (Resident # 10). Findings include:</p> <p>Per medical record review and staff interview, Resident # 10 had a 60-day assessment on 6/15/2016. The assessment does not reflect the presence of a Urinary Tract Infection (UTI), identified on 5/21/2016, which resulted in the addition of an antibiotic (Cipro) to the medication regime of Resident # 10. This UTI diagnosis and medication change was confirmed during interview with the MOS Coordinator at 1:50 PM on 7/13/16. The Licensed Practical Nurse (LPN) doing the MOS data gathering explained during interview that, if a diagnosis of UTI, a verifying culture report and an order for antibiotics are not all present in the medical record, the diagnosis of UTI is not coded in the MOS. The three necessary pieces of information were present in the medical record during survey and still the UTI was not coded to the MOS.</p>
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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

The above isolated deficiencies pose no actual harm to the residents