

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

October 5, 2016

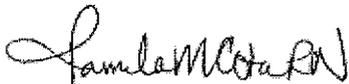
Ms. Lynnette Smith, Administrator
The Manor, Inc
577 Washington Highway
Morrisville, VT 05661-8972

Dear Ms. Smith:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 29, 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: 09/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/29/2016
NAME OF PROVIDER OR SUPPLIER THE MANOR, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 577 WASHINGTON HIGHWAY MORRISVILLE, VT 05661	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	F-226 A report was made for the identified resident in accordance to APS regulation; however report to the DLP was not made in a timely manner.	
F 226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop and operationalize abuse policies regarding the reporting of an allegation of staff to resident abuse to the State Agency within the required timeline for 1 applicable resident. (Resident #1) Findings include: The facility failed to report an allegation of staff to resident abuse to the State Agency (SA) immediately or within 24 hours per regulations. Per review of the facility internal investigation, on 7/2/16 there was an allegation of staff to resident abuse involving Resident #1. Per interview with staff reporter #1 on 8/29/16 at 2:45 PM, s/he stated that s/he reported the allegation of staff to resident abuse to a staff nurse on duty on the day of the incident. Following the staff interview, the DNS (Director of Nursing) reported that the staff nurse on duty on 7/2/16 was no longer working at the facility and that there was no</p>	F 226	<p>The policies titled Abuse Prevention Policy and Procedure and Reporting Requirements have been combined as one policy titled ABUSE PREVENTION POLICY & PROCEDURE AND REPORTING REQUIRMENTS. The revision to this policy reflect the most current regulations from the LICENSING AND OPERATING RULES FOR NURSING HOMES (December 15, 2001) and Regulations: 42 CFR Part 483, Subpart B—Requirements for Long Term Care Facilities (AHCA July 2014). [The reporting of alleged or suspected abuse will be made immediately or within 24 hours to the State Agency.]</p> <p>The revised abuse policy will be disseminated to all Manor staff by 9/26/16, including a test.</p> <p>Staff Educator will monitor test results and provide further education as needed for test scores less than 80%. To be completed by 10/14/16.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

John Smith

Executive Director/Adm

9.21.16 + 10.3.16

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.

DPI changes

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F 226	Continued From page 1 evidence that the nurse reported the incident to facility supervisory staff. On 8/29/16 at 3:00 PM, the MDS/Nurse Manager (NM) stated that staff member #1 reported the allegation of abuse to him/her on 7/4/16. The DNS reported the incident to the State Agency (SA) on 7/6/16 (4 days after the incident). Per review, the facility Abuse Prevention Policy and Procedure (reviewed 6/12) did not include a procedure to report allegations of abuse to the SA immediately or within 24 hours per regulations. A second policy, titled Reporting Requirements (reviewed 7/12) stated to report "Allegation or suspicion of abuse, neglect or exploitation of a vulnerable adult" to the Division of Licensing and Protection (SA) in 48 hours. On 8/29/16 at 10:50 AM, the facility DNS confirmed that there was confusion re the APS (Adult Protective Services) and SA reporting requirements for allegations of abuse and that there was a need for revisions in the facility Abuse Policy to clarifying the reporting requirements.	F 226	All Residents are identified to be at risk for abuse; however, there are contributing factors that increase the risk of abuse. These include the following factors (retrieved from http://www.ncbi.nlm.nih.gov/books/NBK98786/ on September 18, 2016): <ul style="list-style-type: none"> Stressful working situations, particularly staffing shortages; Staff burnout, often a product of staffing shortages and mandatory overtime; Combination of resident aggression and poor staff training on how to handle such challenging behaviors. 		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide services in accordance with the plan of care for 1 of 3 residents (Resident #3) related to catheter care.	F 282	The MDS Coordinator or designee will identify residents with reported aggressive/combatative behaviors placing them at greatest risk for abuse. The Interdisciplinary Team will review Care Plans and a Physical Therapy (PT) referral will be made for observation and evaluation of ADL care for the resident identified at greater risk for abuse. Care Plans will be updated with the PT recommendations. Staff Educator will include LNA and nurse education on care for the aggressive/combatative resident in the ongoing monthly mandatory meetings.		

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F 282	Continued From page 2 Findings include: The plan of care for altered urine pattern and indwelling urinary catheter care was not provided "per facility protocol" as stated in the care plan. Per review, the facility policy Catheter Care, Urinary states under General Guidelines, step 4. "The urinary drainage bag must be held or positioned lower than the bladder at all time to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder." On 8/29/16 at 1:30 PM, during an observation of care by LNA #1 (Licensed Nursing Assistant), Resident #3 was observed in bed with his/her indwelling urinary catheter attached to a leg bag. The leg bag was positioned level with the bladder without gravity drainage; urine was observed in the tubing up to the catheter and was not draining into the leg bag. The LNA reported that s/he thought that Resident #3 was using a leg bag to discourage pulling on the tubing. During the observation, the LNA did not adjust the tubing to gravity to empty the urine into the drainage bag prior to leaving the room. On 8/29/16 at 3:30 PM, LNA #2 reported that Resident #3 keeps his/her leg bag on even when in bed ...stating that s/he "thinks it's in [his/her] care plan." LNA #2 confirmed that the leg bag does not drain well when the resident is in bed. On 8/29/16 at approximately 4:30 PM, the facility DNS (Director of Nursing) confirmed that Resident #3's care plan was not followed related to ensuring that the urinary catheter was draining to gravity per facility protocol. (Refer 315)	F 282	To prevent a reoccurrence of this event the ABUSE PREVENTION POLICY & PROCEDURE AND REPORTING REQUIRMENTS policy will be reviewed annually by the Director of Nursing (DON) and the Resident Care and Services Director. All notices received from the Department of Licensing and Protection regarding reporting requirements to APS and S&C will be immediately included in the policy. Staff will be sent notification of changes through internal electronic email and/or through staff meetings. Signed documentation that the revised policy has been reviewed by staff will be collected by the Staff Educator. Ongoing Reviews: Each reportable incident will be assessed for conformance with the ABUSE PREVENTION POLICY & PROCEDURE AND REPORTING REQUIRMENTS by the Clinical Coordinators, Resident Care and Services Director and the DON. Clinical Coordinators, MDS Coordinator and/or the DON will identify residents with new behaviors that will place them at risk for abuse through the daily review of the 24 Hour Report.		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive	F 315			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 472611

Facility ID: 47E008

If continuation sheet Page 3 of 6

F282 POC accepted 10/5/16 SDennisRA/PM

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F 315	<p>Continued From page 3</p> <p>assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that 1 resident in the sample received appropriate treatment and services to prevent the risk for urinary tract infections related to catheter care (Resident #3). Findings include:</p> <p>Per record review, the physician note from an 8/22/16 visit reported that Resident #3 had a history of multiple Staphylococcus UTI's (urinary tract infections) and was catheterized for urinary retention.</p> <p>On 8/29/16 at 1:30 PM, during an observation of care by LNA #1 (Licensed Nursing Assistant), Resident #3 was observed in bed with his/her indwelling urinary catheter attached to a leg bag. The leg bag was positioned level with the bladder without gravity drainage; urine was observed in the tubing up to the catheter and was not draining into the leg bag. The LNA reported that s/he thought that Resident #3 was using a leg bag to discourage pulling on the tubing. During the observation, the LNA did not adjust the tubing to gravity to empty the urine into the</p>	F 315	<p>A Registered Nurse will perform three random observations of ADL care for residents identified with aggressive/combatative behaviors and physical therapy referrals will be made as needed by 11/1/16. These random audits will be conducted quarterly.</p> <p>Audited findings will be reported at the next quarterly QAPI meeting.</p> <p>F 282 The identified resident had his leg bag removed immediately and an overnight drainage bag was applied. The staff was educated this drainage system needed to be continued and placed below level of bladder for optimal drainage every time resident is in bed.</p> <p>Staff Educator will re-educate LNA staff to ensure catheter care is performed per facility policy and care plans by 10/14/16.</p> <p>DON, Clinical Coordinators, Staff Educator or designee will observe LNA urinary catheter care at least once for each resident with the indwelling urinary catheter by 10/19/16.</p>		

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F 315	<p>Continued From page 4 drainage bag prior to leaving the room.</p> <p>On 8/29/16 at 3:30 PM, LNA #2 reported that Resident #3 keeps his/her leg bag on even when in bed ...stating that s/he "thinks it's in [his/her] care plan." LNA #2 confirmed that the leg bag does not drain well when the resident is in bed.</p> <p>On 8/29/16 at approximately 3:35 PM, the unit Clinical Coordinator (CC) reported that Resident #3's family wanted the resident to keep the leg bag on and not use an overnight bag (the overnight drainage bag has longer tubing and is used to ensure gravity drainage of urine from the catheter). The CC reported, "it was their choice ...we followed what they wanted." The CC was not able to find documentation of the family's request or evidence that the family and resident were provided education related to the increased risks of urinary infections when using a leg bag in bed due to the catheter not being able to consistently drain to gravity.</p> <p>On 8/29/16 at 4:15 PM, the resident's physician, reported that the Foley [catheter] should drain to gravity and that his/her impression was that the family wanted to follow standards of care for Resident #3.</p> <p>Per record review, the resident's plan of care for altered urine pattern and indwelling urinary catheter states "Foley catheter care per facility protocol." Per review, the facility policy Catheter Care, Urinary states under General Guidelines, step 4. "The urinary drainage bag must be held or positioned lower than the bladder at all time to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder." Per</p>	F 315	<p>Results will be presented at the next quarterly QAPI meeting.</p> <p>All residents with indwelling urinary catheters are at risk.</p> <p>Care Plans will be reviewed for all residents with indwelling urinary catheters by the Clinical Coordinators, MDS coordinators and/or DON by 9/30/16. Any discrepancies in resident care, policy, and/or care plan will be immediately corrected.</p> <p>The Care Plans will be immediately updated to reflect new physician orders for indwelling urinary catheters by the Clinical Coordinators.</p> <p>Results will be presented at next quarterly QAPI meeting.</p> <p>Infection Preventionist will continue ongoing monitoring of urinary culture results and assess catheter care for those residents with an UTI that have indwelling catheters.</p>		

Faba, POC accepted 10/5/16 S Dennis RN/PMC

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F 315	Continued From page 5 care plan review, there was no revision to the plan related to the family's request for the use of a leg bag only or evidence of education given to the resident/family related to increased infection risk due to the difficulty of ensuring gravity drainage from the catheter with the use of a leg bag in bed. On 8/29/16 at approximately 4:30 PM, the facility DNS (Director of Nursing) confirmed that Resident #3's care plan was not followed related to ensuring that the urinary catheter was draining to gravity per facility protocol. Additionally, there was no evidence provided that the resident and family were provided education related to the increased risks of urinary infections related to using a leg bag while in bed due to the catheter not being able to consistently drain to gravity. (Refer 282)	F 315	Urinary Catheter Care will be included in the annual mandatory training and with new employee training. F 315 The identified resident had his leg bag removed immediately and an overnight drainage bag was applied. The staff was educated this drainage system needed to be continued and placed below level of bladder for optimal drainage every time resident is in bed. Staff Educator will re-educate LNA staff to ensure catheter care is performed per facility policy and care plans by 10/14/16. DON, Clinical Coordinators, Staff Educator or designee will observe LNA urinary catheter care at least once for each resident with the indwelling urinary catheter by 10/19/16. Results will be presented at the next quarterly QAPI meeting. All residents with indwelling urinary catheters are at risk.		

F315 (continued).

Care Plans will be reviewed for all residents with indwelling urinary catheters by the Clinical Coordinators,

MDS coordinators and/or DON by 9/30/16. Any discrepancies in resident care, policy, and/or care plan will be immediately corrected.

The Care Plans will be immediately updated to reflect new physician orders for indwelling urinary catheters by the Clinical Coordinators.

Results will be presented at next quarterly QAPI meeting.

Infection Preventionist will continue ongoing monitoring of urinary culture results and assess catheter care for those residents with an UTI that have indwelling catheters.

Urinary Catheter Care will be included in the annual mandatory training and with new employee training.

F315 POC accepted 10/5/16 CDUNIBRN/PMC