

Division of Licensing and Protection  
103 South Main Street  
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

July 6, 2015

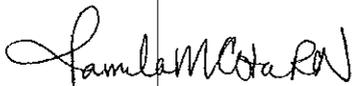
Ms. Lynnette Smith, Administrator  
The Manor, Inc  
577 Washington Highway  
Morrisville, VT 05661-8972

Dear Ms. Smith:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 20, 2015**. 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





STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475057</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/20/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE MANOR, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>577 WASHINGTON HIGHWAY MORRISVILLE, VT 05661</b>	
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F 314	Continued From page 1 am. There is no evidence in the medical record to support that services were put in place at the time of readmission on 03/02/15 to prevent the reddened tender area from re-developing or worsening.  Braden skin assessments for Resident # 97 from Feb 2015 to 3/16/15 are consistently between 15-18 and indicate mild risk for skin breakdown. On 3/16/15 the assessment changed to 13-14 (moderate risk) and on 03/30 it drops to 12 (high risk for skin breakdown).  On 3/16/15 the staff identified an area on his/her coccyx that is 0.5 cm x 0.5 cm x 0.33 with partial skin layers that present as abrasion or blister. Orders are dated 3/16/15 for wound care and dressing changes to be done every other day and as necessary until the area heals. Skin care and preventative measures for pressure ulcer formation are dated on the care plan 03/16/2015, after the previously identified compromised area had broken down. The staff nurse confirmed this during interview on 05/20/2015 at 11:00 am.	F 314	<del>issues will be treated as per</del> physicians' orders. LNA Pressure ulcer prevention training has been provided to further promote staff awareness.  Completed 6/20/15  In order to prevent the recurrence of deficient practice related to the development of comprehensive care plans the director of nursing or her designee will continue to review the comprehensive assessment and care planning process for new admissions assuring that initial care plans are completed within 24 hours and that comprehensive care plans are reflective of the comprehensive assessment/CAA review process. The incidence of residents with wounds will be tracked by DNS or designee and reviewed in the quarterly QAPI Meeting.  Completed 6/20/15 <i>F314 POC accepted 7/16/15 Pmcoturn</i>	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F371 All Residents are at risk related to the deficiencies outlined in F371. To correct the practice the following has been implemented:	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview the facility failed to store, prepare and distribute food under sanitary conditions. The findings include the following:</p> <ol style="list-style-type: none"> <li>Per tour of both pantries/kitchenette's, located on the Spruce and Elmore Units, accompanied by the Food Service Supervisor (FSS), on 5/19/15 at approximately 8:58 AM, both ice machines were found to have built up slimy grime with visible orange/white color material on the water collection trough. FSS confirmed at this time that both troughs need cleaning.</li> <li>Per tour of both pantries/kitchenette's, located on the Spruce and Elmore Units, accompanied by the Food Service Supervisor (FSS), on 5/19/15 at approximately 8:58 AM, both refrigerators that are specifically identified for residents, were found with multiple open quart containers that were dated by facility staff. The handwritten dates identified, were beyond the 3 day discard policy. The "Kitchenette Policy" directs dietary staff to place items in the refrigerator, items must be dated with the received date and the opened date. All items that are 3 days past the opened date marked on the item, must be discarded.</li> </ol> <p>The items in the kitchenettes evidenced the following dates: Elmore Unit: Partially open grape juice dated 12/10, thickened reduced fat milk dated 4/29, pineapple juice dated 3/18, thickened water dated 3/18, thickened apple juice dated 5/16 and thickened cranberry juice dated 4/22. Spruce Unit: Partially open grape juice dated 4/1, pineapple juice dated 3/18, prune juice dated</p>	F 371	<ol style="list-style-type: none"> <li>1) A daily cleaning log for the ice machines in the kitchenette/pantries will be written and reviewed with Dietary staff to ensure the ice machines are cleaned and sanitized on a daily basis. The Food Services Supervisor (FSS) will monitor the cleaning log and inspect the cleanliness of the ice machines weekly for 1 month and then quarterly. Audit reports will be reviewed during Quarterly QAPI meetings.</li> <li>2) A facility policy has been written to ensure all foods have an identifiable discard date that meets current standards set by the USDA. Policy will be reviewed with all Dietary staff. A QAPI audit will be done on a weekly basis for 3 months, and then quarterly by the FSS and findings reported to the Hospitality Director. Audit reports will be reviewed during Quarterly QAPI meetings.</li> <li>3) A daily cleaning log for the refrigerators in the kitchenettes/pantries will be written and reviewed with all staff to ensure the refrigerators are cleaned and</li> </ol>

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F 371	Continued From page 3 4/22 and half and half creamer with no date.  The FSS at that time confirmed that the above listed liquids have been marked by dietary staff with the received date, but there is no evidence of an open date on any of the open quart containers listed.  3. Per tour of both pantries/kitchenette's, located on the Spruce and Elmore Units, accompanied by the Food Service Supervisor (FSS), on 5/19/15 at approximately 8:58 AM, the refrigerators that are specifically identified for residents, were found with caked, dried and sticky substances on the shelves storing juices, milk and thickened liquids. The FSS confirmed at that time that the refrigerators need attention and are to be cleaned daily. Per facility policy labeled "Kitchenette Policy" identifies that the Dietary Department stocks and cleans the refrigerators daily.	F 371	sanitized daily. The FSS will monitor the cleaning logs and inspect the refrigerators on a daily basis for 3 months. Findings will be reported to the Hospitality Director weekly. Audit reports will be reviewed during Quarterly QAPI meetings.  To be completed by 6/20/15 <i>F371 POC accepted 7/6/15 PMA</i>	
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS  The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the physician failed to review the resident	F 386	F 386 In order to correct deficient practice related to Resident #79's Physician's progress notes a statement of correction was sent to the resident's physician to be signed and placed in the residents chart on 6/4/15. This statement will be returned and placed in the medical record by 6/15/15.  All residents are at risk for deficient practice related to F386. In order to identify residents who might be affected an audit of electronically generated Physicians progress notes was conducted on 6/5/15. As a result of this audit and in consultation with the medical director a letter	

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F 386	Continued From page 4 's total program of care, including medications and treatments at each visit for 1 of 17 residents (resident #79) in the stage 2 sample; and failed to update the progress note(s) to reflect current medication orders. Findings include:  Per record review, the physician failed to update the progress note(s) to reflect current medication orders. The medication order dated 5/15/15 for resident #79 was for Seroquel 50 mg tablet, one half tablet by mouth every four hours as needed for breakthrough agitation. Physician progress notes dated 3/13/15, 2/18/15, 1/23/15 under plan for dementia state "continue donepezil tablet, 5 mg, 1 tab(s), orally, once a day(at bedtime); Continue Seroquel tablet, 25 mg, ½ in the am, ½ at 2 PM, 1 in the QHS, orally". Per interview with the Clinical Coordinator and Staff Development nurse on 5/19/15 at 3:12 PM the Seroquel order was discontinued on 10/3/14. Per interview with the clinical coordinator on 5/20/15 at 09:52 AM, he/she confirmed that the physician progress notes on 3/13/15, 2/18/15, 1/23/15 did not accurately reflect current physician orders.	F 386	educating physicians to issues related to this deficiency and a statement for all physicians utilizing outside EMRs will be sent out for signature and return. This statement will then be placed in each residents medical record by 6/20/15.  Audits of electronically generated physicians' progress notes provided from physicians' practices will be performed going forward by DNS or her designee for accuracy of narrative of medical plan by 6/15/15. <i>F386 POC accepted 7/6/15 Amcatarn</i> F441 In order to correct the deficient practice out lined F441 for resident #97, individualized education for the staff nurse involved was conducted on 6/2/15 by infection preventionist/staff educator.		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT 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 in the facility;	F 441	Complete 6/2/15.  All residents are at risk concerning the deficient practice in order to mediate this risk the facility provided global education concerning the need to sanitize hands between glove changes via their Internal messaging system and a 1.5 CEU self-study module was also provided to all		

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F 441	<p>Continued From page 5</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on direct observation and staff interviews, the facility failed to implement proper hand sanitizing during a dressing change for 1 resident (# 97) in the applicable sample. The specifics are as follows:</p> <p>Per direct observation on 05/20/2015 at 10:35 am, a staff nurse was observed changing a pressure ulcer dressing on Resident # 97. Per the facility infection control policy, the proper technique for dressing changes requires that</p>	F 441	<p>licensed nurses. In addition, established annual infection prevention education, which includes glove use, will continue to be provided and documented for all clinical employees by the infection preventionist/Staff educator.</p> <p>Completed 6/8/15. <i>F441 POC accepted 7/6/15 AMCO/ARN</i></p> <p>F514 1) In order to correct deficient practice related to Resident #79's Physician's progress notes, a statement of correction was sent to the resident's physician to be signed and placed in the residents chart on 6/4/15. This statement will be returned and placed in the medical record by 6/15/15.</p> <p>All residents are at risk for deficient practice related to F386. In order to identify residents who might be affected, an audit of electronically generated Physicians progress notes was conducted on 6/5/15. As a result of this audit and in consultation with the medical director, a letter educating physicians to issues related to this deficiency and a statement for all physicians utilizing outside EMRs will be sent out for signature and return. This statement will then be</p>



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F 514	<p>Continued From page 7</p> <p>tablet, 5 mg, 1 tab(s), orally, once a day (at bedtime); Continue Seroquel tablet, 25 mg, ½ in the am, ½ at 2 PM, 1 in the QHS, orally. Per interview with the Clinical Coordinator and Staff Development nurse on 5/19/15 at 3:12 PM the Seroquel order (referred to in the physician progress notes) was discontinued on 10/3/14. Per interview with the Clinical Coordinator on 5/20/15 at 09:52 AM he/she confirmed that the physician progress notes on 3/13/15, 2/18/15, 1/23/15 did not accurately reflect current physician orders for Seroquel.</p> <p>2. Per record review on 5/19/15 at 2:10 PM, the care plan for resident (#79) states; Potential for increased anxiety and expression of suicidal ideations related to nursing home placement, loss of independence, cognitive loss, loss of rational thinking. Goal; will participate in activities, will display fewer symptoms of mood problems, behavior issues will decrease, safety will be maintained. Plan; Encourage involvement in daily decision making , reinforce strengths, assess risk for self harm, q 15 minute safety checks. Safety checks were not documented for the day shift on 5/5/15, 5/6/15, 5/7/15, 5/8/15, 5/9/15, 5/10/15, 5/11/15, 5/12/15, 5/13/15, 5/14/15, and 5/15/15. Per interview with Clinical Coordinator on 5/20/15 at 09:52 AM, he/she stated that he/she was unsure if the 15 minute checks were being done and where the checks were being charted. Per interview with a Licensed Nursing Assistant (LNA) on 5/20/15 at 10:03 AM he/she confirmed that 15 minutes checks were not being done daily, the checks should be done daily, and that staff do not always document when the checks are done.</p> <p>3. Per 5/19/15 medical record review, Resident #45 has a diagnosis of quadriplegia following a cervical neck fracture. Per 5/19/15 observation</p>	F 514	<p>The DNS or her designee will review fifteen minute checks documentation on any resident requiring them for completeness going forward on a weekly basis and report findings of compliance in the QAPI meeting.</p> <p>Complete 6/8/15.</p> <p>3) To correct deficient practice regarding Resident #45 per the MD the resident's diagnosis list was updated to reflect a historical diagnosis of autonomic dysreflexia. In addition, his neurological care plan problem was updated.</p> <p>Complete 5/20/15.</p> <p>All residents are potentially at risk for this deficient practice. To mediate this risk the facility will continue to review and maintain all residents' diagnosis lists through review at admission/readmission, and during the MDS assessment process by the DNS or designee.</p> <p>Complete 5/20/15.</p> <p><i>F514 POC accepted 7/6/15 PMA:ARN</i></p>	

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F 514	Continued From page 8 and interview with the resident, there was a paper treatment plan in his/her room (which the resident stated had been provided by a former facility rehab staff member) for "Autonomic Dysreflexia" that states it "is a medical emergency! It can develop suddenly and if it is not treated promptly it can lead to seizures, stroke and even death." Per Medscape, "Autonomic dysreflexia is a potentially dangerous clinical syndrome that develops in individuals with spinal cord injury, resulting in acute, uncontrolled hypertension. All caregivers, practitioners, and therapists who interact with individuals with spinal cord injuries must be aware of this syndrome, recognize the symptoms, and understand the causes and treatment algorithm."  Per electronic and paper record review; there was no documentation in the resident's medical record of a diagnosis of Autonomic Dysreflexia on the problem list or care plan; there were no other postings of a treatment plan for autonomic dysreflexia visible other than in the resident's room. The above information was confirmed by the nurse clinical coordinator during interviews on 5/19-5/20/15. During the survey, the clinical coordinator contacted the resident's physician and on 5/20/15 the physician confirmed the resident's diagnosis of "autonomic dysreflexia (due to spinal cord injury) [and risks] for difficulty [with] body temp control (sweating, fever), and BP [blood pressure] control."  <a href="http://emedicine.medscape.com/article/322809-overview">http://emedicine.medscape.com/article/322809-overview</a>	F 514	Blank page		