



VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

February 22, 2012

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

Dear Ms. Smith:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 25, 2012**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

A handwritten signature in black ink that reads "Pamela M. Cota RN".

Pamela M. Cota, RN, MS
Licensing Chief

PC:jl



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

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 01/25/2012
NAME OF PROVIDER OR SUPPLIER THE MANOR, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 577 WASHINGTON STREET 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 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop comprehensive care plans for 2 of 19 residents (Resident #6 and Resident #34). Findings include:</p>	F 279	<p>F-279 Resident #6 and #34 care plans were updated to reflect the necessary changes on 1/25/12 and 1/26/12 respectively.</p> <p>All residents are at risk. In order to mitigate this risk the DNS and/or designee(s) will review physicians order changes and the 24-hour report daily to assess for resident treatment and condition changes that warrant an addition of new problems to the Plan of Care. In addition Care plan review and revision will continue to occur with the MDS cycle and during the biweekly quality meetings wounds/weights and falls/pain for these target areas.</p> <p>All resident care plans will be reviewed by DNS or designee within 24 hours of admission</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Executive Director / Administrator* (X6) DATE *2-9-12*

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.

Pme

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 01/30/2012
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 01/26/2012
NAME OF PROVIDER OR SUPPLIER THE MANOR, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 577 WASHINGTON STREET MORRISVILLE, VT 05661		
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F 279	<p>Continued From page 1</p> <p>1. Per medical record review on 01/25/2012 at 11:49 AM, Resident #6 has no nutrition care plan. Since readmission to the facility on 12/09/2011, Resident #6 has been ordered to have full liquids as a diet, supplemented with 3-5 cans of ensure per day, no longer able to eat solids. Staff confirms during interview on 01/25/2011 at 1:55 PM that there is no nutrition care plan for Resident #6 to reflect this change in dietary needs. The Unit manager further confirms that s/he has provided inservices with staff to educate them about the full liquid diet because Resident #6 "tries to get staff to provide solids", not understanding that solids are currently contraindicated.</p> <p>2. Per record review on 1/25/12, Resident #34 was exhibiting combative behaviors associated with dementia. The physician prescribed Zyprexa 2.5 mg (milligrams) at bedtime daily on 1/16/12. Per review of the written plan of care, there was no plan of care developed to address the new antipsychotic medication therapy. Per interview on 1/25/12 at 11:35 AM, the Director of Nursing confirmed that a plan of care was not developed for the new use of psychoactive medication.</p> <p>1. Per medical record review on 01/25/2012 at 11:49 am, Resident # 6 has no nutrition care plan. Since readmission to the facility on 12/09/2011 Resident # 6 has been ordered to have full liquids as a diet, supplemented with 3-5 cans of ensure per day, being no longer able to eat solids. Staff confirms during interview on 01/25/2011 at 1:55 PM that there is no nutrition</p>	F 279	<p>and by day 7 of admission to assure plan of care is meeting resident needs. As an ongoing quality measure 5 Plans of Care will be audited monthly for compliance for 6 months. Additional care plan review will occur with established quarterly QIS sampling utilizing the ABAQIS software package.</p> <p>Corrective action Implementation will be completed by 2/24/12.</p> <p><i>F279. POC accepted 2/15/12 K Campos RN / Pincot RN</i></p>		

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F 279	Continued From page 2 care plan for Resident # 6 to reflect this change in dietary needs. The Unit manager further confirms that s/he has had one-one inservices with staff to educate them about full liquid diets and produced the print-outs that are on the wall for staff to use as a guide because Resident # 6 "tries to get staff to provide solids", not understanding that solids are currently contraindicated. 2. Per record review on 1/25/12, Resident #34 was exhibiting combative behaviors associated with dementia. The physician prescribed Zyprexa 2.5 mg. at bedtime daily on 1/16/12. Per review of the plan of care, there was no area developed to address the new antipsychotic medication therapy. Per interview on 1/25/12 at 11:35 AM, the Director of Nursing confirmed that a plan of care was not developed for the new use of psychoactive medication.	F 279			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	F 280	F-280 Resident # 90 was affected and to correct the deficient practice related to lack of Plan of care revision Resident's weight loss issues were brought to the attention of the RD on 1/30/12 and her case was reviewed in weight wellness meeting on 2/6/12. At this time resident was found to		

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NAME OF PROVIDER OR SUPPLIER THE MANOR, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 677 WASHINGTON STREET MORRISVILLE, VT 05861		
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F 280	<p>Continued From page 3</p> <p>and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon observation, interview and record review, the facility failed to revise the plan of care for 2 of 4 residents in the applicable Stage 2 sample related to the development of a blister-like in appearance skin condition (Resident #50) and weight loss (Resident #90). Findings include:</p> <p>1. Per record review of the 12/4/11 Nursing Notes, plan of care and confirmed with the Director of Nursing Services (DNS) at 3:12 PM on 1/23/12, Resident #50 had one blister-like skin condition on the right lower buttock measuring 1 centimeter (cm) by 1.6 cm and 3 blister-like skin conditions on the left lower buttock measuring from the top to bottom: 1 cm by 1 cm, 1 cm by 1 cm, and 1 cm by 1.4 cm. The Potential for Impairment of Skin Integrity care plan was not updated to include the 1 blister-like skin condition located on right lower buttock and the 3 blister-like skin conditions located on the left lower buttock.</p> <p>2. Per clinical record review on 1/25/12, Resident #90 was admitted 09/16/11 and had diagnoses of seizure disorder and cerebrovascular accident</p>	F 280	<p>have an improved appetite consuming 100% at most meals and had gained 2 lbs. Care plan was revised on 2/8/12 to reflect current resident nutritional status with interventions to promote stable weight in this resident including continued weekly weight monitoring and documentation of resident food preferences.</p> <p>RD will follow up weekly until resident weight is stable and care plan updated as needed to reflect her recommendations.</p> <p>Affected Resident #50's skin condition had been resolved by time of annual survey. Her Plan of care was reviewed for accuracy related to continued risk of alterations in skin integrity on 1/25/12.</p> <p>All residents are at risk. In order to mitigate this risk the DNS and/or designee(s) will review physicians order changes and the 24 hour report</p>		

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F 280	<p>Continued From page 4</p> <p>with weakness and dysphagia. The Minimum Data Set (MDS) assessment completed 12/20/11 indicated that Resident #90 weighed 118 pounds and reflected a significant weight loss. Resident #90 was alert and oriented. The physician orders indicated a dysphagia level II diet which includes ground meats and soft, moist foods. Review of the dietary progress record dated 10/03/11, revealed that Resident #90 had significant weight loss prior to admission. Review of the facility weight record indicated a weight of 123 pounds on 09/16/11, 121 pounds on 9/27/11, 118.2 pounds on 12/14/11, 118.2 pounds on 12/21/11, 115.4 pounds on 01/04/12 and 117.6 pounds on 01/13/12. Review of the plan of care for potential alteration in nutrition that was initiated on 09/28/11, revealed the potential for weight loss related to difficulty swallowing related to stroke, poor dental condition, and variable intake. Interventions included to monitor weights and food intake, to assist with eating as needed, provide replacement foods, be positive and encourage the resident to try a variety of different foods. Entries on the plan of care for evaluation dated 9/28/11, 11/11/11, and 12/29/11 indicated to continue with the plan of care. The plan of care did not indicate Resident #90 experienced a significant weight loss prior to admission or continued gradual weight loss in the facility. No changes to the initial interventions were noted.</p> <p>During interview with the Resident on 1/24/12 at 3:40 P.M., Resident #90 indicated s/he was aware of some weight loss. Resident #90 indicated that she had been instructed by her physician not to eat meat because of her high cholesterol. The Resident also indicated that mashed potatoes were not a favorite food</p>	F 280	<p>daily to assess for resident treatment and condition changes that warrant revisions to the Plan of Care.</p> <p>In addition, Care plan review and revision will continue to occur with the MDS cycle and during the biweekly quality meetings wounds/weights and falls/pain for these target areas. All resident care plans will be reviewed by DNS or designee within 24 hours of admission and by day 7 of admission to assure plan of care is meeting resident needs. As an ongoing quality measure 5 Plans of Care will be audited monthly for compliance for 6 months. Additional care plan review will occur with established quarterly QIS sampling utilizing the ABAQIS software package.</p> <p>Corrective action implementation will be completed by 2/24/12.</p> <p><i>F280 POC accepted 2/15/12 K Campos RN / P Mentzer RN</i></p>		

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F 280	Continued From page 5. because she ate them dally growing up and the facility served a lot of mashed potatoes. These revelations were not noted to be included in the plan of care for nutrition. Interview of the Kitchen Manager on 1/25/12 at 1:10 P.M., revealed that she attended care conferences and was aware of the weight loss. The kitchen manager indicated that the Dietician was in the building one day per week and no changes were made to Resident #90's plan of care related to the weight loss. Interview with the Director of Nursing Services (DNS) on 1/25/12 at 1:25 P.M., revealed that continued weight loss had been recognized by staff and had not been addressed in a timely manner. The DNS indicated that, ideally the plan of care would be revised within a week of the MDS assessment or other indication of weight loss.	F 280	This page left blank.		