

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

May 6, 2014

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

**[Sent via fax 802-888-8788]**

Dear Ms. Smith:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 2, 2014**. 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

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  04/02/2014
--	--	--	--

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	This page left blank	
F 156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the</p>	F 156	<p>POC accepted K Campos / F Key RN SIS / KJ</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Executive Director/Adm	(X6) DATE 4.24.14
---	---------------------------------	----------------------

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.

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  04/02/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE MANOR, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 577 WASHINGTON HIGHWAY MORRISVILLE, VT 05861
--	--

(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 156	<p>Continued From page 1</p> <p>facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p>	F 156	This page left blank	
-------	---	-------	----------------------	--

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  476057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/02/2014
--	--	--	--

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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 156	<p>Continued From page 2</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admision oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and administrative and staff interview, the facility failed to provide the correct contact number for the State Licensing and Protection Agency on posted resident rights notices and in resident admission packets as required by federal regulations. Findings include:</p> <p>Per observation on 4/1/14 at 10:25 AM, the facility resident rights posters on the Spruce and Elmore units had an incorrect contact number for the State Licensing and Protection Agency (SA) posted (the SA number was changed in 2011); the observation was confirmed by the facility's Director of Nursing (DON) at the same time. Additionally, per review on 4/1/14 at 12:48 PM, the facility's resident admission packet contained the same incorrect contact number for the SA, which was confirmed by the resident care services director; s/he stated that the information was corrected one week ago and s/he reported that s/he had not made the change in all of the completed admission packets, but stated s/he was changing each individual packet to include the new information prior to handing them out to new residents.</p>	F 156	<p>F-156 Upon receiving verbal notice that 1 of 3 telephone numbers was out dated, Immediate action was taken to correct the facility resident right posters. In additlon, immediate action was taken to correct all of the pre-fabricated admission packets that had not yet been corrected, to eliminate the potential for accidental deliverance of the incorrect number for the state agency to residents and families.</p> <p>All admision packets going forward have the correct contact number for the state agency.</p> <p>Information will be reviewed annually by the Resident Care and Services Director to assure that needed changes, if any, have been made.</p> <p>Corrective action completed 4/3/14.</p>	
F 325	483.25(l) MAINTAIN NUTRITION STATUS	F 325		

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

PRINTED: 04/15/2014  
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  04/02/2014
---	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE MANOR, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 677 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 325 SS=D	<p>Continued From page 3 UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, the facility failed to ensure that 1 of 19 residents in the stage 2 sample, identified with nutritional needs and a significant weight loss, received a therapeutic diet supplement when a nutritional problem was identified (Resident #23). Findings include:</p> <p>Per record review, Resident #23 was admitted to the facility on 9/18/12. S/he had diagnoses that included: depression, Alzheimer's disease, esophageal reflux, Vitamin B 12 and Vitamin D deficiencies, osteoarthritis, and a history of a stage 2 pressure ulcer on his/her left heel that was reported as healed on 3/6/14. Per his/her nutrition care plan, dated 2/14/14, s/he was identified as at risk for unintended weight loss due to variable intake, cognitive impairment, weak mastication (chewing) requiring diet texture alteration, functional impairment, and confusion.</p> <p>Per review of the facility's dietary progress note,</p>	F 325	This page left blank	
---------------	---	-------	----------------------	--

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

PRINTED: 04/15/2014  
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  04/02/2014
--	--	--	--

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 325	<p>Continued From page 4</p> <p>on 3/24/14 the Registered Dietician (RD) identified that Resident #23 had experienced a significant decline in weight status with a 7 pound weight decline in the past month or 5.45% [weight loss]. Weight on 3/1/14 was 128.4 pounds and was down to 121.4 pounds on 3/22/14. The RD noted that there was a decline in the percentage of meal consumption with some refusals. The RD recommended to offer the resident Ensure, a nutritional supplement with meal refusals and medication pass.</p> <p>On 4/1/14 at 2:30 PM, a staff nurse confirmed the RD's 3/24/14 recommendations and confirmed that there was no documentation that the physician or family was contacted about the findings, there was no nutrition supplement listed on the physician orders, and there was no documentation on the MAR or TAR (Medication Administration Record/Treatment Administration Record) that the supplement was given during medication passes.</p> <p>On 4/1/14 at 3:25 PM, the nurse clinical coordinator stated that the usual facility procedure for handling nutritionist recommendations, is to notify the family of the recommendation and if approved, to contact the physician for an order for a supplement. S/he confirmed that the family and physician had not been contacted as of the date of the survey and the resident did not obtain the supplement as recommended.</p> <p>On 4/9/14 the facility faxed additional information that Resident #23 was reweighed on 4/1/14 at 16:32:31 (4:32 PM) and his/her weight was 128.8 pounds; his/her meal consumption for 3/31, 4/1 and 4/2/14 was between 75-100% for these 3</p>	F 325	<p>F325 The deficient practice identified for resident #23 was addressed and rectified between 4/1/14 and 4/3/14 by notifying Family/physician, obtaining order for supplementation, and amending the Nutritional care plan.</p> <p>All Residents are potentially affected; thus, RD Recommendations discussed in the current biweekly Weight and Wound meeting will be immediately transcribed onto MD orders for MD Review.</p> <p>To monitor for compliance RD notes will be audited weekly by DNS or designee to assure recommendations are followed through in a timely fashion and the results of the audits will reviewed by the QAPI team.</p> <p>Corrective action to be implemented by 4/22/14.</p>	
-------	---	-------	---	--

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

PRINTED: 04/15/2014  
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  04/02/2014
--	--	--	--

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 325	Continued From page 5 days. On 4/1/14, the physician was faxed [the RD's recommendations] and a revision was made to the resident's care plan on 4/3/14 to include the recent recommendations.  Per review of the documentation at the time of the survey and the additional documentation submitted by the facility, the resident did not suffer harm based on the delay in offering nutritional supplementation; however, the facility failed to identify and respond timely to the recommendations of the RD, for a resident who was identified as at risk for harm based on his/her significant risk factors related to nutrition, until this was brought to their attention at the time of the survey.	F 325	This page left blank	
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; (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	F 441		

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

PRINTED: 04/15/2014  
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  04/02/2014
--	--	--	--

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 441	<p>Continued From page 6</p> <p>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 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: Based on observation, record and policy review and interview, the facility failed to implement proper infection control measures during a dressing change for 1 of 19 residents (Resident #90) in the stage 2 sample. Findings include:</p> <p>Per observation of a wound dressing change on 4/2/14 at 7:45 AM, a staff nurse assisted by an LNA (licensed nursing assistant) failed to follow infection control measures for Resident # 90 who has a draining leg wound requiring daily dressing changes. Per observation, a blood stained ace wrap was placed directly on the resident's bedding without a protective barrier. After a clean ace bandage was wrapped on the leg, the LNA took the blood soiled wrap and washed it in the resident's bathroom sink without using protective eye wear (other than his/her personal glasses) or a gown/apron to protect his/her clothing. Three</p>	F 441	<p>F441 The deficient practice for resident #90 was addressed and rectified at time of incident when the spread on his bed was changed and the Ace wraps were removed from the grab rail and discarded. The Certified Wound Nurse then changed the resident's treatment to Coban, a disposable product.</p> <p>All Residents are potentially affected. All staff providing dressing changes are instructed that Ace wraps soiled with blood and or body fluids should be discarded and disposable products will be utilized when contamination is likely.</p> <p>To monitor for compliance the Infection control nurse shall conduct at least four dressing change observations per month and results of audits will be reviewed by QAPI Team.</p> <p>Corrective action completed 4/4/14.</p>	
-------	---	-------	---	--

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

PRINTED: 04/15/2014  
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  04/02/2014
--	--	--	--

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 441	<p>Continued From page 7</p> <p>washed ace wraps were observed hanging on the bathroom's toilet grab bar directly adjacent to the toilet bowl. The staff nurse confirmed that the resident uses the toilet and there was a risk for contamination of the hanging ace wraps; s/he and the LNA confirmed the above observations and confirmed they were breaks in infection control practices.</p> <p>Per 4/2/14 review, the facility's "Infection Control, Standard Precautions" policy, provided by the Infection control nurse (on 4/1/14), states "handle resident care equipment soiled with blood, body fluids, secretions, and excretions in a manner that prevents ...contamination of clothing and transfer of other microorganisms to other residents and environments." Additionally, the policy states to wear "eye protection or a face shield to protect mucous membranes of the eyes, nose, and mouth during procedures...that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions" and to "wear a gown (clean, nonsterile) to protect skin and prevent soiling of clothing during procedures...that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions."</p>	F 441	This page left blank	
-------	---	-------	----------------------	--