

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

March 26, 2014

Mr. David Silver, Administrator  
Newport Health Care Center  
148 Prouty Drive  
Newport, VT 05855-9821

Dear Mr. Silver:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 26, 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

RECEIVED  
Division of

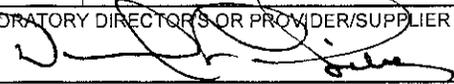
PRINTED: 03/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	<b>MAR 26 14</b> Licensing and Protection	(X3) DATE SURVEY COMPLETED  <b>02/26/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>NEWPORT HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>148 PROUTY DRIVE NEWPORT, VT 05855</b>
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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 000	INITIAL COMMENTS  An unannounced onsite recertification survey was conducted by the Division of Licensing and Protection from 2/24/14 through 2/26/14. Based on information gathered, regulatory violations were cited as follows.	F 000	See attached Plan of Corrections.	
F 159 SS=B	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS  Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.  The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)  The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.  The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.  The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.	F 159		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>ADMINISTRATOR</b>	(X6) DATE <b>3/21/14</b>
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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.

*pm*

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F 159	<p>Continued From page 1</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility failed to ensure that 2 of 22 residents in the stage two sample have ready and reasonable access to their personal funds including on weekends (Resident #41 and Resident #56). Findings include:</p> <p>Per interview on 2/24/14 at 11:24 AM, Resident # 56 reported that the business "office is closed on Saturday and Sunday, so [I] can't get money on the weekend. I make sure that I get money when they are open so I will have it when I need it". On 2/25/14 at 8:51 AM, Resident # 41 reported that s/he could not access personal funds on the weekend and has to "get money on Friday if [s/he] thinks [s/he will] need it for the weekend".</p> <p>Per interview on 2/25/14 at 12:53 PM, the staff member in charge of personal funds reported that resident funds are available when s/he is working from 8-4 PM Monday-Friday; on weekends, an</p>	F 159		
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F 159	Continued From page 2 envelope with approximately \$30 is available at the nurses' station.  Per 2/25/14 interview at 1:00 PM, the facility nursing supervisor stated s/he was not sure how to access resident funds on the weekend. Per 2/25/14 interview at 1:01 PM, a west wing staff nurse, reported that since the first of the year, [resident] funds have not been brought to the unit for weekends. On 2/25/14 at 1:05 PM, an east wing nurse reported that there used to be an envelope with \$30 kept in the medication cart, but it's been "at least a year" since s/he had funds available on the cart. Per 2/25/14 interview at 2:44 PM, the Director of Nursing (DNS) stated that s/he did not know that there was an envelope with money on the medication cart [for resident funds] or that it was no longer being put on the cart and stated s/he would call the person in charge of the funds for access on weekends. On 2/26/14 at 12:48 PM, the facility nursing supervisor confirmed that s/he was not aware of how residents could access personal funds on the weekends and confirmed that the funds need to be available to residents 7 days per week.	F 159			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or	F 225			

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F 225	<p>Continued From page 3 other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on the review of the facility internal investigation and resident, staff and administrative interviews, the facility staff failed to promptly notify the administration of an incident involving alleged staff to resident abuse for 2 of 22 residents in the stage 2 sample (Residents # 40 and #45 ). The findings are as follows: 1. Per interview on 2/24/14 at 11:57 AM, Resident #24 reported an alleged incident of verbal abuse involving a staff Licensed Nurse Assistant (LNA)</p>	F 225		

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F 225	<p>Continued From page 4</p> <p>and Resident #45 that had occurred about 3 days prior. Resident #24 stated that s/he reported the abuse to a staff LNA on the day of the incident. Per interview on 2/26/14 at 8:44 AM, a staff LNA confirmed that Resident #24 reported the allegation of abuse to him/her on 2/21/14. The LNA stated that s/he reported the incident to the facility Director of Nursing (DNS) on 2/24/14. Per 2/26/14 review of the internal investigation conducted by the facility DNS, the staff LNA told a nursing supervisor about the alleged incident on 2/22/14 and also mentioned it "in passing" to another nurse (no date given); on 2/24/14 at 8 AM, the LNA reported the alleged incident to the DNS.</p> <p>During an interview with the DNS on 2/25/14 at 2:17 PM, s/he confirmed that direct care staff did not report this incident as directed in the facility abuse prohibition policy, but that the facility did notify the State Licensing Office when they became aware of it, on 2/24/14 (3 days after the incident).</p> <p>2. Per record review of the Resident Council Minutes on 2/25/14, the minutes from September 5, 2013 stated that an LNA was "very rude and forceful" when feeding Resident #40. There were also complaints from the residents that some of the LNAs were disrespectful, teasing residents about food on their faces, and going on their cell phones while feeding residents. Per interview on 2/25/14 at 3:00 PM, the Activity Director stated that they had brought these concerns to the Director of Nursing, and an inservice was held for staff on November 14, 2013 to go over resident rights in the facility. Before this meeting, the Activity Director stated that the LNAs were told not to have their cell phones at meal times, and addressed some of the concerns of them talking to each other instead of the residents, and having</p>	F 225		

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F 225	Continued From page 5 a respectful attitude. Despite addressing these concerns, there was no report made or internal investigation conducted into the allegation of abuse by the LNA who was reported as being "rude and forceful" while feeding Resident #40. Per interview on 2/26/14 at 10:15 AM, the Director of Nursing confirmed that the allegation had not been reported to the state or internally investigated by the facility as an allegation of abuse.	F 225			
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on the review of the facility internal investigation and resident, staff and administrative interviews, the facility failed to implement written policies and procedures for reporting resident abuse for 2 of 22 residents in the stage 2 sample (Residents #40 and #45). The findings are as follows: 1. Per interview on 2/24/14 at 11:57 AM, Resident #24 reported an alleged incident of verbal abuse involving a staff Licensed Nurse Assistant (LNA) and Resident #45 that had occurred about 3 days prior. Resident #24 stated that s/he reported the abuse to a staff LNA on the day of the incident. Per interview on 2/26/14 at 8:44 AM, a staff LNA confirmed that Resident #24 reported the allegation of abuse to him/her on 2/21/14. The	F 226			

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F 226	<p>Continued From page 6</p> <p>LNA stated that s/he reported the incident to the facility Director of Nursing (DON) on 2/24/14. Per 2/26/14 review of the internal investigation conducted by the facility DNS, the staff LNA told a nursing supervisor about the alleged incident on 2/22/14 and also mentioned it "in passing" to another nurse (no date given); on 2/24/14 at 8 AM, the LNA reported the alleged incident to the DNS.</p> <p>The facility policy titled, "Policy and Procedures on Abuse, Neglect, or Mistreatment" states, "Any person witnessing or having knowledge of potential or actual abuse must immediately report the incident to the charge nurse and submit a written report. The charge nurse shall inform the administrator/DON/ADON (ADON= assistant Director of Nursing) or their designees within 24 hours." ... "The Administrator or designee shall notify the resident's representative and the Vermont Agency of Licensing and Protective services within twenty-four (24) hours".</p> <p>During an interview with the Director of Nursing on 2/25/14 at 2:17 PM, s/he confirmed that direct care staff did not report an abuse allegation in the time frame as directed in the facility abuse prohibition policy, but that the facility did notify the State Licensing Office when they became aware of it, on 2/24/14 (3 days after the incident).</p> <p>2.. Per record review of the Resident Council Minutes on 2/25/14, the minutes from September 5, 2013 stated that an LNA was " very rude and forceful" when feeding Resident #40. There were also complaints from the residents that some of the LNAs were disrespectful, teasing residents about food on their faces, and going on their cell phones while feeding residents. Per interview on 2/25/14 at 3:00 PM, the Activity Director stated that they had brought these concerns to the Director of Nursing. There was no report made or</p>	F 226		

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F 226 Continued From page 7  
internal investigation conducted into the allegation of abuse by the LNA who was reported as being "rude and forceful" while feeding Resident #40. Per interview on 2/26/14 at 10:15 AM, the Director of Nursing confirmed that the allegation had not been reported to the state or internally investigated by the facility as an allegation of abuse.

F 226

F 242 483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES  
SS=E

F 242

The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.

This REQUIREMENT is not met as evidenced by:

Based on resident, staff and administrative interview, the facility failed to ensure that each resident is given the right to make choices that are significant about his or her life in the facility for 2 of 22 residents in the stage 2 sample (Resident #6 and Resident #41). The findings include:

1. On 2/25/14 at 8:43 AM, when asked the question, "Do you choose when you get up in the morning," Resident # 41 stated, "No, someone comes in and wakes me up. Unless you are sick, you get up. [It] would be nice to stay in bed longer, but we can't".

Per Licensed Nurse Assistant (LNA) interviews on 2/26/14 at 12:51 PM, LNA #1 stated that s/he has seen LNAs say we need to get care done and

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F 242	<p>Continued From page 8</p> <p>even if the resident doesn't want to get up, "they make them". S/he further added that there are nurses who "insist" that residents get up early and that s/he has gone to the Director of Nursing Services (DON) for support to allow residents to remain in bed. On 2/26/14 at 12:59 PM, LNA #2 reported that if a resident wants to stay in bed, s/he would check with the nurse to see if it was OK first. On 2/26/14 at 1:10 PM, LNA #3 reported that, "different aides and nurses have their own ideas about what is right; have seen mostly nurses telling aides that [a resident] has to get up". Then the aide goes in and tries to get the resident up. The LNA further stated that if the resident doesn't want to get up, s/he has gone to the DON who supports the resident's request to sleep late. On 2/26/14 at 1:14 PM, LNA #4 stated that the nurses want to make sure that everyone is up in the morning. On the west wing, there are approximately 18 residents and there are 2 LNAs scheduled to come in at 5 AM to get residents washed and changed. This week, LNA #4 observed that about 8-10 residents on the west wing were up and dressed when s/he arrived at the facility at 7 AM. S/he also reported that Resident #41 has requested to stay in bed late but "it depends on who is working whether [s/he] can stay in bed".</p> <p>2. Per interview on 2/25/14 at 9:50 AM, Resident #6 stated that s/he was told s/he needed to get up early whether or not s/he wanted to stay in bed longer, and that sometimes it was earlier than they would like to get up. Resident #6 felt that s/he did not have a choice as to what time s/he got out of bed in the morning. On 2/26/14 at 1:24 PM, the facility DON confirmed that LNAs have come to him/her to request permission for residents to remain in bed later [in the morning] when a staff nurse has said the resident must get</p>	F 242		

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F 242	Continued From page 9 up early. S/he confirmed that last week an LNA requested that Resident #41 be allowed to stay in bed when the nurse told the aide s/he must get up. The DON stated s/he will need to reeducate staff [about resident rights].	F 242		
F 243 SS=B	<p>483.15(c)(1)-(5) RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP</p> <p>A resident has the right to organize and participate in resident groups in the facility; a resident's family has the right to meet in the facility with the families of other residents in the facility; the facility must provide a resident or family group, if one exists, with private space; staff or visitors may attend meetings at the group's invitation; and the facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to provide opportunity for at least 1 of 22 residents in the applicable sample (Resident #48) to meet in a council group on a regular basis. Findings include:</p> <p>Per Interview on 2/24/14, Resident #48 was identified by the Activity Director as an active participant in the resident council group. S/he stated that there was no official president of the council. Resident #48 was interviewed on 2/25/14, and the responses triggered a further investigation into the meetings and follow-up to residents' concerns. The last council meeting was held on 10/9/13, with 20 residents attending, per</p>	F 243		

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F 243	Continued From page 10 council minutes. Per interview with Resident #48, the meetings had not been held for "months", and the resident stated that s/he was not sure of the reason. Per interview with the Activity Director, every month since October 2013, when the calendar of activities was being formulated, s/he had asked about a date for the Resident Council meeting, and was told by the Human Resources (HR) Director that they wanted to revamp the meetings and were hoping to find a volunteer to run the meetings in the future. Per interview on 2/25/14 at 1:15 PM, the HR Director stated that they did not realize that the Resident Council could be facilitated by a staff member, and that they did not realize it had been that long (4 months) since the last council meeting was held.	F 243		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP 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.  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	F 279		

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F 279	Continued From page 11 under §483.10(b)(4).  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a plan of care related to a major medical condition for 1 of 22 residents sampled (Resident #18). Findings include:  Per record review on 2/25/14, Resident #18 was admitted on 1/31/13 and had an existing diagnosis of Diabetes Mellitus. The resident was on oral medications to control blood glucose levels, and a fingerstick to check these levels was ordered to be completed daily. Per review of the plan of care, there was no nursing care plan related to the diagnosis of diabetes to include goals and interventions such as daily monitoring of glucose by fingerstick, or monitoring for side effects of medications or symptoms of hypo/hyperglycemia. Per interview on 2/25/14 at 3:40 PM, the Director of Nursing confirmed that a plan of care related to the diagnosis of Diabetes had not been developed for Resident #18.	F 279		
F 280 SS=E	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	F 280		

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F 280	<p>Continued From page 12</p> <p>physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, 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 on record review and on staff interview, the facility failed to revise the care plan for 4 of 22 residents in the stage 2 sample (Residents # 25, 14, 34, 5). Findings include:</p> <p>1. Resident # 5 was admitted to the facility on 01/29/2014. The resident was prescribed several psychotropic medications. The care plan devised for the resident notes that the nurse is to monitor and document behavior every shift, and to observe for possible side effects every shift. Per record review, no behavior monitoring was documented related to the use of an antipsychotic medication per care plan instruction. No reference is made in the care plan that the antipsychotic medication Seroquel is being utilized for behavioral acting out. The medication is not listed in the care plan, nor are the targeted behaviors for its use. On 02/26/2014 @ 10:20 AM the charge nurse confirmed that the documentation was not in the care plan.</p> <p>2. Resident # 34 was admitted to the facility on 08/09/2010. The resident was prescribed several psychotropic medications. The care plan devised</p>	F 280		
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F 280	<p>Continued From page 13</p> <p>for the resident notes that the nurse is to document behaviors weekly and as needed, and to monitor the resident daily for side effects. Per record review no behavioral monitoring was documented related to the use of an antipsychotic medication, nor were revisions made to the care plan indicating that the resident's condition had been regulated through the use of the psychotropic medication. There was also no documentation of possible side effects related to the use of psychotropics. On 02/26/2014 @ 10:25 AM the charge nurse confirmed the documentation was not in the resident's record.</p> <p>3. Per 2/26/14 medical record review, Resident #14 was admitted to the facility on 3/5/10. S/he had diagnoses that included an anxiety disorder, depression, confusion and hallucinations which were treated with psychotropic medications. Per review of the nursing progress notes, on 12/31/13 the resident was reported to be extremely upset and was found with a glass picture frame against his/her throat expressing that s/he wanted to die. Per review, the resident's care plan was not revised to include the resident's risk for suicide or to specify monitoring related to his/her safety. On 1/2/14, the facility referred the resident for psychological services; however suicidality was not listed on the referral form as a reason for the referral. On 2/26/14 at 3:25 PM, the nursing supervisor confirmed the above findings.</p> <p>4. Per 2/26/14 medical record review, Resident #25 was admitted to the facility on 10/14/13 following a fall at home resulting in a fracture to his/her right knee. The resident also had diagnoses that included severe orthopedic and spine pain, osteoarthritis, childhood polio, severe kyphosis, depression and other chronic medical</p>	F 280		

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F 280	<p>Continued From page 14</p> <p>conditions. Per observation on multiple occasions during the three days of the survey (2/24-2/26/14), the resident was observed to have slid down in the bed so that his/her head was flexed forward and his/her upper body shifted to the right side. On 2/24/14 at 12:36 PM, s/he was observed eating in bed in this position (this position was also observed on 2/25/14 at 9:15 AM and 2/26/14 at 9:18 AM). Per 2/26/14 interview at 10:05 AM, a Licensed Nursing Assistant (LNA) stated that Resident #25 is always asking to be boosted up and that s/he is pulled up before his/her meals, but starts scooting down in bed almost immediately. The LNA stated that s/he did not know if anything was ever tried to keep the resident from scooting down. S/he further stated that s/he pulls the resident up in bed at least 15 times during a 3-9 PM shift. At 2/26/14 at 10:02 AM, another LNA stated that Resident #25 is always sliding down in bed and is difficult to position due to his/her hunched back. S/he stated that during meals, the resident's neck almost looks "contracted." The LNA reported that s/he has to pull the resident up in bed about every 30-60 minutes and that there were no wedges to help with positioning.</p> <p>On 2/26/14 at 9:18 AM, the resident reported that if s/he gets scrunched down in bed, "I'm like in a ball and then can't breathe." Per 2/26/14 interview at 9:26 AM, the facility's nursing supervisor stated that the resident's kyphosis makes positioning difficult and that the resident refuses to get out of bed. On 2/26/14 at approximately 10:30 AM, the Director of Nursing (DON) confirmed that there were no revisions made to the resident's care plan related to the resident's decreased mobility and unique positioning needs.</p>	F 280		
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F 282 SS=E	<p><b>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b></p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and administrative and staff interview, the facility failed to implement the care plan for monitoring and documenting behavioral symptoms for 5 of 22 residents in the survey sample who were receiving psychotropic medications (Residents #3, 5, 14, 34, 43). Findings include: 1. Per record review, Resident #3 was admitted to the facility on 11/15/13. Psychoactive medications were prescribed by the physician to address symptoms of anxiety and depression (Risperdal 1 mg by mouth at hour of sleep, Lorazepam 1 mg by mouth every 6 hours as needed for anxiety). The written plan of care for Resident #3 directed staff to observe for possible side effects every shift. Per review of the nurse notes, there was not a specific reference per shift to monitoring symptoms of anxiety and depression, nor related behavioral manifestations. In an interview on 2/26/14 at 8:10 AM, the Director of Nursing Services (DNS) stated that the expectation is that the per shift nurse note would reflect monitoring for symptoms and side effects, and at this time the facility is not using behavioral monitoring sheets. 2. Resident # 5 was admitted to the facility on 01/29/2014. The resident was prescribed several psychotropic medications. The care plan devised for the resident notes that the nurse is to monitor</p>	F 282		

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F 282	<p>Continued From page 16</p> <p>and document behavior every shift, and to observe for possible side effects every shift. Per record review no behavior monitoring was documented related to the use of an antipsychotic medication per care plan instruction, and there was no documentation of possible side effects documented each shift. On 02/26/2014 @ 10:20 AM the charge nurse confirmed that the documentation was not in the medical record.</p> <p>3. Resident # 34 was admitted to the facility on 08/09/2010. The resident was prescribed several psychotropic medications. The care plan devised for the resident notes that the nurse is to document behaviors weekly and as needed, and to monitor the resident daily for side effects. Per record review no behavioral monitoring was documented related to the use of an antipsychotic medication per care plan instruction, nor was there documentation of possible side effects documented. On 02/26/2014 @ 10:25 AM the charge nurse confirmed the documentation was not in the resident's record.</p> <p>4. Per 2/26/14 record review, Resident #14 was admitted to the facility on 3/5/10. S/he had diagnoses that included an anxiety disorder, depression, confusion and hallucinations which were treated with psychotropic medications. The resident's 2/11/14 care plan for psychotropic medication stated that nursing will monitor and document behaviors each shift. On 2/26/14 at 3:25 PM, the nursing supervisor confirmed that there is no documentation in the resident's record for behavior monitoring and that the care plan was not followed.</p> <p>5. Per 2/25/14 record review, Resident # 43 was admitted to the facility on 1/27/10 with diagnoses</p>	F 282		

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F 282	Continued From page 17 that included depression and dementia with agitation and behavioral symptoms for which the resident was prescribed psychotropic medications. The resident's care plan for psychotropic medications (last updated on 3/14/13) states that nursing will monitor the resident daily for side effects from Seroquel and will "chart behavior weekly and PRN" (PRN=as needed). On 2/26/14 at 9:48 AM, the facility MDS nurse (Minimum Data Set nurse) confirmed that behaviors were not documented in the resident's medical record.	F 282		
F 309 SS=D	<b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: The facility failed to assure that 1 of 22 residents (Resident #25) in the stage two survey sample received care and services to maintain his/her highest level of function. Findings include:  Per 2/26/14 medical record review, Resident #25 was admitted to the facility on 10/14/13 following a fall at home that resulted in a fracture to his/her right knee. The resident also had diagnoses that included severe orthopedic and spine pain, osteoarthritis, childhood polio, severe kyphosis, depression and other chronic medical conditions.	F 309		

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F 309	<p>Continued From page 18</p> <p>Per review of the 12/10/13 Physical Therapy discharge summary, the resident's status at the time of discharge, included that the resident transferred out of bed with moderate assistance of one person, from bed to recliner and ambulated a few steps with a wheeled walker from bed to recliner with the moderate assistance of one.</p> <p>Per multiple observations during the three days of the survey (2/24-2/26/14), the resident was not observed out of bed; on multiple occasions, s/he was observed to have slid down in the bed so that his/her head was flexed forward and his/her upper body was shifted to the right side. On 2/24/14 at 12:36 PM, s/he was observed eating in bed in this position (this position was also observed on 2/25/14 at 9:15 AM and 2/26/14 at 9:18 AM). On 2/26/14 at 9:18 AM, the resident reported that if s/he gets scrunched down in bed, "I'm like in a ball and then can't breath." The resident further reported that s/he had not been out of bed for the week week.</p> <p>On 2/26/14 at 10:05 AM, a Licensed Nursing Assistant (LNA) stated that Resident #25 is always asking to be boosted up and that s/he is pulled up before his/her meals, but starts scooting down in bed almost immediately. The LNA stated that s/he did not know if anything was ever tried to keep the resident from scooting down. S/he further stated that s/he pulls the resident up in bed at least 15 times during a 3-9 PM shift. At 2/26/14 at 10:02 AM, another LNA stated that Resident #25 is always sliding down in bed and is difficult to position due to his/her hunched back. S/he stated that during meals, the resident's neck almost looks "contracted." The</p>	F 309		

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F 309	Continued From page 19 LNA reported that s/he has to pull the resident up in bed about every 30 -60 minutes and that there were no wedges to help with positioning.  Per 2/26/14 interview at 9:26 AM, the facility's nursing supervisor stated that the resident's kyphosis makes positioning difficult and that the resident refuses to get out of bed. At On 2/26/14 at approximately 10:30 AM, the Director of Nursing (DON) confirmed that there were no revisions made to the resident's care plan related to the resident's decreased mobility and unique positioning needs; s/he confirmed that the resident has had a decrease in function since Physical Therapy services ended in December 2013.	F 309			
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 329			

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F 329	<p>Continued From page 20 contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and on staff interview, the facility failed to ensure that the drug regimen for 3 of 22 residents was free of unnecessary medications (Residents #5, 34, 58). Findings include: 1. Resident # 5 was admitted to the facility on 01/29/2014. His/her admitting diagnoses include Bilateral Pulmonary Embolus, Mild Intellectual Disability, Diabetes, Neuropathy, Congestive Heart Failure, Hypertrophic Cardiomyopathy, Angina, Fredreich's Ataxia, Hypertension, Scoliosis, Morbid Obesity, Dysphagia, Asthma, and a history of assaultive behaviors and aggression. Per review of the Minimum Data Set (MDS) 14 day assessment, the resident was not coded for having behavioral problems or difficulties. On February 26, 2014 @ 10:00 AM the MDS Registered Nurse confirmed that the coding was correct. Per review of the resident record, no nursing documentation supported the resident having behavioral problems. Per review of the resident's care plan, it was discovered that there was no behavioral disturbance or problem noted specifically corresponding to the use of the antipsychotic medication the patient is receiving, and there is no diagnosis listed for the use of the antipsychotic medication. The care plan addressed manipulative behaviors and depression only. On February 26, 2014 @ 10:30 AM the charge nurse confirmed that there were</p>	F 329		

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F 329	Continued From page 21 no problematic behaviors or a specific diagnosis targeted for the use of the antipsychotic medication other than "manipulative behaviors." S/he further confirmed that the resident did have problematic behaviors in a previous admission and that perhaps somehow the history was carried forward from that admission. 2. Resident # 34 was admitted to the facility on 09/10/2011. His/her admitting diagnoses, per record review, included Atrial-ventricular Heart Block, Uncomplicated Senile Dementia, Mitral Valve Stenosis, Diabetes Mellitus, Metabolism Disorder, Hyperlipidemia, Essential Hypertension, Depressive Disorder, and Restless Leg Syndrome. The resident was prescribed the antipsychotic medication Seroquel 12.5 mg by mouth daily in 2011 and has continued to receive it to date. There were no physician progress notes addressing problematic behaviors requiring the use of an antipsychotic medication in the current medical record, nor was there any supportive nursing documentation regarding problematic behaviors. The most recent MDS available dated 01/08/2014 does not support problematic behaviors, and does not endorse an active psychotic condition or diagnosis being treated specific to the use of an antipsychotic agent. A pharmacist consultation note dated 3/14/13 recommended a Seroquel dose reduction and the physician declined. The pharmacist recommended trial dose reduction of Seroquel again September 16, 2013 and again the MD declined. The resident has remained on the Seroquel dose of 12.5 mg daily. The consulting pharmacist on 2/16/2014 recommended that the Seroquel be evaluated for continued need. The physician discontinued the Seroquel on 02/26/2014.	F 329			

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/26/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>NEWPORT HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>148 PROUTY DRIVE NEWPORT, VT 05855</b>		
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F 329	Continued From page 22  3. Based on record review, Resident #58 has among the listed diagnoses: altered mental status, subdural hematoma, depression, and insomnia. There is no evidence in the medical record that medications which specifically address sleep disturbance (insomnia) have been prescribed. There is evidence in the nurse notes that staff have been addressing issues of exit seeking and agitation. The written plan of care directs staff to observe Resident #58 every shift and document for side effects of psychotropic medication use (Seroquel). On eight occasions in February, 2014, a 25 mg oral dose of Seroquel was administered [as ordered] at hour of sleep. Corresponding nurse documentation indicates that the Seroquel was used to address behaviors which could not be redirected using non-pharmacological interventions. On the medication orders, the physician's indication for use of Seroquel is "as needed for sleep" without mention of specific targeted behaviors. During a pharmacy review on 1/16/14, the pharmacist questioned the diagnosis of sleep as an indication for use of Seroquel, an antipsychotic medication. The facility faxed the pharmacy review of 1/16/14 to the physician. Again on 2/10/14, the pharmacist addressed the indication for use of Seroquel during the monthly medication regimen review. During an interview on 2/25/14 at 4:00 PM, the Director of Nursing Services (DNS) confirmed that from 1/16/14 to the present, there had been no physician response to the two requests by the Pharmacist to provide an indication for use of the antipsychotic medication Seroquel other than sleep.	F 329			

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  <b>475026</b>	MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	DATE SURVEY COMPLETE:  <b>2/26/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>NEWPORT HEALTH CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>148 PROUTY DRIVE NEWPORT, VT</b>	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
<b>F 514</b>	<p><b>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</b></p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: The facility failed to accurately document in the resident's medical record behavioral symptoms for 1 of 22 residents (Resident #43). Findings include:</p> <p>Per 2/25/14 record review, Resident # 43 was admitted to the facility on 1/27/10 with diagnoses that included depression and dementia with agitation and behavioral symptoms for which the resident was prescribed psychotropic medications. The resident's care plan for psychotropic medications (last updated on 3/14/13) states that nursing will monitor the resident daily for side effects from Seroquel and will "chart behavior weekly and prn" (prn, as needed). Per record review, there is no documentation of daily behavioral symptom monitoring.</p> <p>Per 2/26/14 record review, Resident #43's 12/22/13 MDS quarterly review states that the resident exhibits physical and verbal behaviors directed at others daily and rejects care 4-6 days per week. On 2/26/14 at 9:48 AM, the MDS nurse was asked where s/he gets the information to complete data entry responses for the minimum data set reviews (minimum data set entries are required per federal regulation). On 2/26/14 at 9:48 AM, the facility MDS nurse (Minimum Data Set nurse) reported that s/he obtained MDS data through resident observation and staff report; s/he confirmed that behaviors were not documented in the resident's medical record and stated that this is a documentation issue. (Refer F282)</p>		

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

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Provider # 475026

- F 159 The resident funds are available Monday through Friday from 8 am to 4 pm. During all other times there will be an envelope of money kept at the nurse's station in the medication cart. Nursing staff notified. Completed 2/27/14.
- F 225 The abuse policy will be reviewed with all staff as well as the procedure for reporting an alleged abuse. Investigations and reports to the state will follow policy and procedure. Anything that is reported to another department other than nursing including resident council will also be reported to the Director of Nursing immediately and an investigation will be initiated. Meetings with nursing staff have been held on 3/7 and 3/18/14. The policy has been reviewed and copies have been posted at the nurse's station. All other departments have been given copies of the policy and have been reviewed with their department heads. This policy will also be reviewed on hire, on a yearly basis and as needed. A grievance policy and procedure has also been instituted. Completed 3/21/14
- F 226 The abuse policy was reviewed and revised as needed. This has been reviewed with all staff at the meetings listed in F 225. Completed 3/21/14.
- F242 All residents will be offered choices and given the right to make choices that are significant about his or her life. This will be reviewed during care plan meetings and written on the care plan for each resident. All staff has been reminded of the resident's right to choose at the meetings listed in F 225. Also a copy of resident rights has been posted at the nurses station for periodic review by staff. Yearly inservice will be held on resident rights and as needed. Completed 3/21/14
- F 243 Resident council will be held on a regular basis lead by the Activities Director. All concerns will be addressed with the appropriate departments immediately following the meetings. Meeting held on 3/6/14. Minutes will be given to the administrator and Director of Nurses following the meeting for review and follow through. Completed 3/6/14
- F 279 All comprehensive care plans will be reviewed and all major medical conditions will be addressed in the care plan. All care plans will be reviewed immediately and during care plan meetings. All nursing staff will be responsible to update The care plan as needed when condition changes. Audits will be done on admission and monthly to make sure this is being accomplished. Completed 3/21/14
- F 280 All care plans will include any behavioral issues including suicidal ideas psychoactive medications and will be revised as needed following all care plan meetings. Also care plans will be revised whenever any medical condition warrants a review or adjustment of treatment to maintain functionality or comfort. Care plans will be reviewed and revised as needed by all nurse's as well as during care plan meetings. Monthly audits will be done. Completed 3/21/14.

- F 282 Behavioral symptoms will be monitored and documented using behavioral Checklists. Any behaviors that occur will also be documented in the nurse's notes as well as on the checklist. Behavior checklists were started on 3/12/14. All interventions will also be documented. The care plan will also address what monitoring and documentation is needed. Charts will be audited on a monthly basis. Completed 3/21/14.
- F 309 Each resident will be evaluated by nursing. Any medical condition that needs to be addressed will be brought to the attention of the Director of Nursing and the physician. All residents will maintain their highest level of function. All potential therapies as well as supplies will be reviewed and instituted as needed. This will be followed up with documentation and the plan of care. Staff has been reminded that if special items such as wedges are needed then they need to request them if not available. Completed 3/13/14.
- F 329 All drugs will be reviewed during the physician visit. Each drug will have the corresponding diagnosis. Residents will be evaluated regarding the continued need of medications such as psychoactives and discontinued if no longer needed. Care plans will include any behaviors that are ongoing and the need for the use of these meds. The drug reviews by the pharmacist will be faxed immediately to the physician and monitored for a timely response. Drug reviews will be faxed the physician when completed by the pharmacist. Follow through for responses will be done by the Director of Nursing. If no response, the physician will be notified by phone and if no response then the Medical Director will be contacted. A procedure for this was completed on 3/21/14.
- F 514 The clinical record will contain documentation of all behaviors on the behavior checklists as well as in the nurse's notes. It will also be included in the care plan. This will also facilitate the MDS coordinator when obtaining information for the MDS. Behavior checklists started on 3/12/14.

F159, F225, F226, F242, F243, F279, F280, F282, F309, F329 + F514  
Plans of correction accepted 3/24/14 JHoxmer RN / PMC