

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

September 3, 2014

Mr. Dane Rank, Administrator  
Thompson House Nursing Home  
80 Maple Street  
Brattleboro, VT 05302-6551

Dear Mr. Rank:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 24, 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

PRINTED: 08/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

RECEIVED

Division of

AUG 27 14

Licensing and  
Protection

(X3) DATE SURVEY  
COMPLETED

07/24/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____
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NAME OF PROVIDER OR SUPPLIER  THOMPSON HOUSE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 80 MAPLE STREET BRATTLEBORO, VT 05302
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F 000	INITIAL COMMENTS	F 000	F 157	
F 157 SS=D	<p>An unannounced on-site re-certification survey was conducted by the Division of Licensing and Protection from July 21 to July 24, 2014. There were regulatory findings as a result of the survey.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 157	<p>Resident # 13 expired. 8/6/14</p> <p>DNS or designee will audit resident records to ensure notifications have been made for current orders and conditions. 8/20/14</p> <p>Policies regarding Notification of changes reviewed and updated as necessary. 8/15/14</p> <p>DNS or designee will educate nursing staff regarding Notification of changes. 8/20/14</p> <p>DNS or designee will perform audits of 5 resident records per quarter to ensure that Notification of changes is done. Ongoing</p> <p>Results will be reported at QA meetings. DNS to monitor for compliance. Ongoing</p> <p>F157 POC accepted BBontekRN/PMC 8/21/14</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 8/26/14
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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.

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F 157	Continued From page 1  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member upon the commencement of a new form of treatment for 1 of 3 residents, Resident #13. Findings include:  1. The facility failed to immediately inform the physician of Resident #13 of a change in the resident's physical status or a need to alter treatment significantly. Per medical record review on 07/22/14, Resident #13 was admitted to the facility with a pressure sore. Per the Nursing assessment upon admission dated, 05/27/14, notes 2 open areas. Per two nursing notes dated 06/04/14 and 06/06/14, they state the wounds "are largely healed". Per review of the TAR (Treatment Administration Record) no treatments were provided after 06/08/14 for skin issues. Per observation on 07/23/14 at 3:50 PM in the presence of the nurse, MDS coordinator and LNA (Licensed Nursing Assistant) two dressings were present on the resident's buttocks. When these dressings were removed, dried blood was noted on the dressings as well as red open areas on the skin. The nurse stated "I thought the wounds were healed" and confirmed that the family nor doctor were notified of the two pressure ulcers.	F 157	F 241  Resident #8 Care plan updated to reflect use of slippers.  DNS or designee will audit care plans to ensure interventions reflect resident choice.  Policies regarding Care Plans reviewed and updated as necessary.  DNS or designee will educate nursing staff regarding care plans.  DNS or designee will perform audits of 5 resident records per quarter to ensure that care plan interventions reflect choice.  Results will be reported at QA meetings. DNS to monitor for compliance.	7/22/14  8/20/14  8/15/14  8/20/14  Ongoing  Ongoing
F 241 SS=D	Also see F-314 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241	<i>F241 POC accepted 8/21/14 BBW/CLP/PMC</i>	

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F 241	<p>Continued From page 2</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews the facility failed to promote care, for 1 applicable resident, in a manner that recognized his or her individuality or choice. (Resident #8) Findings include:</p> <p>1. Per observation on 07/21/14 and 07/22/14 at all times of day, Resident #8 who has dementia, was wearing socks only. Review of the care plan notes, social service notes, physician's visit notes and care plan meeting notes, does not mention that the resident's personal preference would be to wear socks versus shoes nor any pain that prohibits shoes.</p> <p>Per interview on 07/22/14 at 3:05 PM the LNA stated [resident] has a reoccurring sore on the top of [her/his] foot and when [s/he] wears shoes [s/he] says 'ouch' so we now keep the slipper socks on". Per review of the MAR [medication administration record] no pain or pain medication was noted during the months of April, May, June or July. Nursing notes do not indicated sores or pain. Per interview at 07/22/14 at 3:56 PM The MDS coordinator stated "I was not aware that [the resident] is not wearing [her/his] shoes but let us look". Per observation at 4:09 PM two pairs of right foot only [1 black, 1 brown] shoes were stored in the bedside table. After examination some edema was noted but no sores. The resident smiled and did not express any pain. The MDS coordinator stated that if socks were to</p>	F 241		

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F 241	Continued From page 3 be worn that would be indicated and revised on the care plan and that either slippers with firm soles or shoes are indicated for this resident. S/he confirmed the services were not provided in accordance the resident's choice or individuality.	F 241	F 244	8/15/14
F 244 SS=C	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION  When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.  This REQUIREMENT is not met as evidenced by: Based on interview with residents and staff, and documentation review, there is no evidence of the facility's response to expressed grievances and recommendations concerning proposed policy and operational decisions affecting resident care and life in the facility. Findings include:  1. Per interview on 07/21/14 at 4:30 PM, the acting Vice President of Resident Council, as identified by the facility stated, "I haven't heard of the results [of the issues or concerns] but I think they should let us know, I haven't heard but it is usually about food". Upon review of the Resident Council Minutes for the several past months, residents were raising the concern regarding food issues however, there is no documentation that the concerns were addressed either to an individual nor reported back to the group. Per interview with the MSW (medical social worker) on 07/22/14 at 11:15 AM stated "yes food is	F 244	Activity Director will add the item: "Old Business" to the Resident Council Meeting agenda. Minutes of the meetings will be taken, and distributed to Residents and Staff. Concerns voiced by residents during the meeting will be annotated on a Concern Form (currently located next to the telephones on resident floors). Concern forms will be given to the staff responsible for the area of concern.  Staff receiving a Concern Form will note a response to the concern. Action may be taken, or an explanation may be noted. This form will be returned to the Activity Director prior to the next meeting.  Activity Director will cover concerns voiced at the last meeting under the agenda item: "Old Business."	Ongoing  Ongoing

*F244 ROC accepted 8/29/14 BBA/AR/RJ/PMC*

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F 244	Continued From page 4 always an issue and that the big concern was [name brand] ice cream, more salads and sugar free desserts. I know we have talked to them in the past but I can see that we don't explain it or go over the concern, certainly we are not documenting that this old business was discussed to their understanding." The MSW further stated "it does look that we are not addressing their concerns because they do seem to bring it up time and again and we are not writing what would be the plan if we could or couldn't provide lets say the [name brand] ice cream." Per interview on 07/22/14, the Activity Director said that when there are concerns expressed by residents in the Resident Council Meetings, those issues are brought to the specific Department and "...they take it from there." S/he confirmed there is no evidence of the response by the facility to the Resident Council's concerns.	F 244	F 246 Resident #12 Call bell was place within reach.  DNS or designee checked each resident room to ensure call bell was in reach.  DNS or designee will educate nursing staff regarding call bells.  DNS or designee will perform audits of 5 resident rooms per quarter to ensure that call bells are in reach.  Results will be reported at QA meetings. DNS to monitor for compliance.	7/21/14  7/22/14  8/20/14  Ongoing  Ongoing
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES  A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.  This REQUIREMENT is not met as evidenced by: The facility failed to ensure that call lights were in reach for 1 of 30 residents, Resident #12. Findings include:  Based on observation and resident interview on	F 246	<i>F246 POC accepted 8/29/14 Bortell RN/PMC</i>	

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F 246	Continued From page 5 7/21/14 at 4:26PM, Resident #12 was sitting in wheelchair in room and this surveyor asked him/her how they would get assistance from the staff if they needed anything and h/she stated that they would use the call light if they had it. Asked where it was and resident looked around and pointed to floor behind the bed. Observed call light cord to be on the floor behind the bed and out of resident reach. When Licensed Nursing Assistant (LNA), who entered the room during conversation between this surveyor and the resident, h/she was asked how the resident would call for assistance, h/she stated that the resident uses the call bell and at this time the resident stated "Not if I don't have it." It was confirmed by the LNA that bell was not in reach at 4:23PM.	F 246	F 253  Administrator, Maintenance Director, or their designee, on a monthly basis, will do an environmental evaluation of all resident rooms and common areas. The evaluation shall note issues requiring attention or repair including, but not limited to: Walls, flooring, plumbing, leaks, outlets, cords, and ceilings. All noted items will be kept on record and a report of these will be made quarterly in the QA Committee. Repair of rooms noted in the 2567 for the 7/24/14 survey commenced on August 1 <sup>st</sup> , and will be substantially completed by 8/20/14.	8/20/14
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based upon observation, interview, and record review, the facility failed to ensure that all areas of residents' rooms are maintained in good repair for 6 residents [#4, 5, 14, 24, 34, 35] of 17 residents in the sample group, and failed to store resident care equipment in a manner to maintain an orderly living environment. Findings include:  1. Per observations on 7/21/14 & 7/22/14, multiple areas in residents' rooms were identified as in need of repair or maintenance.	F 253	Lifts will be stored in equipment storage areas on each unit, or in the tub room.  <i>F253 POC accepted 8/29/14 [signature]</i>	Ongoing

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F 253	Continued From page 6 Repairs/maintenance issues identified and confirmed by the facility's Maintenance Director included ripped wall paper, chipped paint, frayed wood on a door, cracked or punctured sheet rock, and a cracked electrical cover plate.  Per interview with the Maintenance Director on 7/22/14 at 3:30 P.M. the facility does not do regular rounds or checks on resident rooms regarding maintenance or repairs. The Director stated that the maintenance department is reliant upon Nursing/LNA staff to report repair needs of resident rooms or equipment, and if the repair needs are not reported by staff they are not done. Per record review of the maintenance request logs for the residents' units, there was no documentation that the confirmed issues had been identified by staff and scheduled for repair or replacement.  2. Additionally, during the 4 days of the recertification survey, multiple pieces of resident equipment including hoist lifts, wheel chairs, and a resident bed were observed stored in the main hallways. Per interview with the Maintenance Director on 7/22/14 at 3:30 P.M., the director confirmed the resident equipment is stored out in the hallways on a regular basis.	F 253	F 272  Resident #3 Screened by SLP, found to have no difficulty chewing or swallowing.  Resident #11 Dental problems reviewed with MDS Coordinator, will be addressed on next MDS due on 8/7/14.  DNS or designee will audit resident records to ensure dental problems are addressed.  DNS or designee will perform audits of 5 resident records per quarter to ensure that dental problems are addressed.  Results will be reported at QA meetings. DNS to monitor for compliance.	7/30/14  8/7/14  8/20/14  Ongoing  Ongoing
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the	F 272		

*F272 PO accepted 8/29/14 BB/ACL/PML*

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F 272	<p>Continued From page 7.</p> <p>resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:</p> <ul style="list-style-type: none"> <li>identification and demographic information;</li> <li>Customary routine;</li> <li>Cognitive patterns;</li> <li>Communication;</li> <li>Vision;</li> <li>Mood and behavior patterns;</li> <li>Psychosocial well-being;</li> <li>Physical functioning and structural problems;</li> <li>Continence;</li> <li>Disease diagnosis and health conditions;</li> <li>Dental and nutritional status;</li> <li>Skin conditions;</li> <li>Activity pursuit;</li> <li>Medications;</li> <li>Special treatments and procedures;</li> <li>Discharge potential;</li> <li>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and</li> <li>Documentation of participation in assessment.</li> </ul> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, medical record review and staff interviews the facility failed to conduct a comprehensive, accurate, standardized reproducible assessment of residents' functional capacity. Using the Resident Assessment Instrument (RAI) for of 2 of 17 sampled resident,</p>	F 272		
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F 272	<p>Continued From page 8</p> <p>(Resident #3 and #11), the facility must identify the resident's needs. The findings include the following:</p> <p>1. Per observation of Resident #3's oral cavity, h/she presents with missing back teeth and per family interview on 7/22/14, the resident has trouble chewing. Per record review, there is no evidence of dental assessment being completed for Resident #3. Interview with the Registered Nurse, Minimum Data Set (MDS) coordinator, the admission assessment is incomplete and verified that dentition is not addressed.</p> <p>2. Per medical record review on 3/1/14 Resident #11 was seen by the dentist for various concerns such as: evaluation for dentures, extractions of carious teeth and follow up appointments on 11/19/13, 1/28/14, 2/04/14, 2/20/14, 3/18/14, 3/24/14, 4/17/14, 4/24/14, 5/14/14, 5/08/14, 5/13/14, 5/22/14, 6/26/14 and 7/15/14. Minimum Data Set (MDS) assessments conducted on 2/13/14 and 5/22/14 do not address dental issues. Per interview on 7/22/14 at 3:25 PM with Registered Nurse (RN) MDS Coordinator, confirms that MDS assessments do not include dental problems and that the assessments are coded incorrectly.</p>	F 272		
F 279 SS=E	<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</p>	F 279		

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F 279	<p>Continued From page 9</p> <p>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 observation, staff interview and medical record review the facility failed to develop a comprehensive care plan for 3 of 17 sampled residents in the Stage II survey. For residents # 13, #41, and #29 each resident's care plan did not include measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The findings include the following:</p> <p>1. Resident #13 was identified in the comprehensive assessment as having a stage 2 pressure ulcer as well as another wound upon admission on 05/27/14, however, there was no comprehensive care plan that include measurable objectives and goals for the wounds. The care plan dated 06/05/14 - potential for skin breakdown- related to needs assist with ADLs and mobility, has as the interventions as, monitor</p>	F 279	<p>F 279</p> <p>Resident #13 expired. 8/6/13</p> <p>Resident # 41 Compression stockings were discontinued. 7/24/14</p> <p>Resident #29 Care Plan updated to include compression fracture, bruising. 7/23/14</p> <p>All resident care plans were reviewed to ensure that all identified needs are addressed. 8/20/14</p> <p>Policies regarding care planning were reviewed and updated as necessary. 8/15/14</p> <p>DNS/SDC provided education to staff involved in care planning. 8/20/14</p> <p>DNS or designee will perform audits of 5 resident care plans per quarter to ensure that all identified needs are addressed Ongoing</p> <p>Results will be reported at QA meetings. DNS to monitor for compliance. Ongoing</p> <p><i>F279 POC accepted 8/29/14 B. B. KERN / PML</i></p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475050</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/24/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>THOMPSON HOUSE NURSING HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>80 MAPLE STREET BRATTLEBORO, VT 05302</b>		
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F 279	<p>Continued From page 10</p> <p>skin daily, report changes to charge nurse immediately, assist with repositioning as needed and throughout the day, encourage turning, treatments as ordered. The care plan did not identify the intermediate steps nor the objectives to monitor resident progress for the pressure ulcers. Per interview on 07/23/14 at 2:45 P.M. the MDS [minimum data set] coordinator stated "when a person comes in with multiple [skin] areas there would be a care plan with the wound number and the specific treatment ordered, when healed, would be yellowed out [resolved], the wound would be on a wound sheet and monitor at least weekly by nursing". The MDS coordinator confirmed at that time there was no comprehensive care plan for the pressure ulcer and wound.</p> <p>Also see F-314</p> <p>2. During observation on 7/22/14 at 2:38PM, of Resident #41, there was no evidence that the resident was wearing compression stockings. Confirmation made at this time by the Registered Nurse (RN), Minimum Data Set (MDS) coordinator, the resident was not wearing compression stockings. I asked him/her where the Licensed Nursing Assistant (LNA) would get information regarding the plan of care for this resident. H/she stated that the LNA gets information regarding the care of the resident from the care plans. At this time, I reviewed the medical record with the RN, MDS coordinator and asked him/her to show me evidence regarding a care plan for compression stockings. H/she stated that there was no care plan developed. H/she further stated that the compression stockings ordered by the physician were not noted on the treatment record either. The RN</p>	F 279		

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F 279	<p>Continued From page 11</p> <p>went into the room of Resident #41 to check on whereabouts of compression stockings and upon return stated that the LNA would not know that the resident was care planned for compression stockings, because h/she did not have any and it appears as if they had not been ordered for him/her.</p> <p>3. Per medical record review on 7/23/14 at approximately 11:30 AM, Resident # 29 who was admitted on 12/20/13 with diagnoses to include Fluid and Electrolyte Imbalance, Pneumonia, Chronic Airway Obstruction, Heart Failure, Muscle Weakness, Shortness of Breath, Abdominal Aneurysm, Hypotension, Lumbar Pain, Diabetes, Neuropathy, Epilepsy and Osteoporosis. Per Physician progress notes dated 5/8/14, documents that Resident #29 has extreme fragility of her skin and edema leading to blistering and shearing forces. Physician also identifies that resident has been on Prednisone 5 milligrams (MG) daily for a long period of time for her Chronic Lung Disease and has been weaned down to 1 mg daily at present. Nursing progress notes dated 7/11/14 and 7/12/14 identifies resident is having difficulty ambulating, increased back and abdominal pain with elevated laboratory studies. Physician progress note dated 7/17/14 documents Osteoporotic Compression Fracture of the Spine, treatment for suspected Pneumonia, Congestive Heart Failure with Fluid Overload and Hypokalemia. Per interview with the Director of Nurses (DNS) and Registered Nurse (RN) on 7/23/14 at 2:20 PM confirmation is made that Resident #29's Care Plan has not been developed for compression fractures and bruising of upper and lower extremities related to fragile skin and long standing use of Prednisone.</p>	F 279			

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F 280 F 280 SS=D	Continued From page 12 483.20(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, 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.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review for 1 of 17 sampled residents, the facility failed to review and revise the Care Plan for Resident #29, identifying his/her current health status. The findings include the following:  Per medical record review on 7/23/14 at approximately 11:30 AM, Resident # 29 who was admitted on 12/20/13 with diagnoses to include Fluid and Electrolyte Imbalance, Pneumonia, Chronic Airway Obstruction, Heart Failure, Muscle	F 280 F 280	F 280  Resident #29 Care Plan updated to include compression fracture and edema.  All resident care plans were reviewed to ensure resident specific issues are included.  Policies regarding care planning were reviewed and updated as necessary.  DNS/SDC provided education to staff involved in care planning.  DNS or designee will perform audits of 5 resident care plans per quarter to ensure that all identified needs are addressed  Results will be reported at QA meetings. DNS to monitor for compliance.  <i>FABO POC accepted 8/29/14 BBORCH RN/PMC</i>	   7/23/14  8/20/14  8/15/14  8/20/14  Ongoing  Ongoing

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F 280	Continued From page 13 Weakness, Shortness of Breath, Abdominal Aneurysm, Hypotension, Lumbar Pain, Diabetes, Neuropathy, Epilepsy and Osteoporosis. Nursing progress notes dated 7/11/14 and 7/12/14 identify resident having difficulty ambulating, increase back and abdominal pain and abnormal laboratory studies. Physician progress note dated 7/17/14 identifies Osteoporotic Compression Fracture of the Spine, treatment for suspected Pneumonia, Congestive Heart Failure with Fluid Overload and Hypokalemia. Per interview with Director of Nurses (DNS) and Registered Nurse (RN) on 7/23/14 at 2:20 PM, confirmation was made that Resident # 29 has not had his/her care plan updated for the following problems: 1) Problem #0602 identifying needs for the assistance with Activities of Daily Living and ambulation secondary to newly developed compression fractures and 2) Problem #0603 Fluid Volume Deficit that has resulted in changes to monitoring of leg edema, use of as needed (PRN) diuretics and newly diagnosed pneumonia.	F 280		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, medical review and staff interview, the facility failed to provide services to meet professional standards of quality for 5 residents in the Stage 2 sample. Resident #29, #33, #41, #42 and #43. Findings include:	F 281		

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F 281	Continued From page 14 1. During observation on 7/22/14 at 2:38PM, of Resident #41, there was no evidence that the resident was wearing compression stockings. Confirmation made at this time by the Registered Nurse (RN), Minimum Data Set (MDS) coordinator, the resident was not wearing compression stockings. I asked him/her where the Licensed Nursing Assistant (LNA) would get information regarding the plan of care for this resident. H/she stated that the LNA gets information regarding the care of the resident from the care plans. At this time, I reviewed the medical record with the RN, MDS coordinator and asked him/her to show me evidence regarding a care plan for compression stockings. H/she stated that there was no care plan developed. H/she further stated that the compression stockings ordered by the physician were not noted on the treatment record either. The RN went into the room of Resident #41 to check on whereabouts of compression stockings and upon return stated that the LNA would not know that the resident was care planned for compression stockings, because h/she did not have any and it appears as if they had not been ordered for him/her. The MDS RN confirmed at this time that the physician orders were not followed.  *Reference: Based on Standards of Professional Nursing Practice, Lippincott Manual of Nursing Practice 19th edition, Wolters Kluwer Health/Lippincott Williams, Page 17, Standards of practice was deviated with the failure to follow physician orders.  2.) Medical-review of Resident #33 on 7/23/14 at 1:55PM presents that resident sustained an unwitnessed fall in his/her room on 7/19/14 at 11:30AM and had told staff that h/she tried to get	F 281	F 281  Resident #41 Compression stockings were discontinued.  Resident #33 was discharged.  Resident #42 Order for Prilosec was verified with physician.  Resident #29 Lasix was discontinued.  Resident #43 Resident expired.  All resident records were reviewed to ensure MD orders are accurate.  Policies regarding order transcription were reviewed and updated as necessary.  Policies regarding incidents and monitoring were reviewed and updated as necessary.  DNS/SDC provided education to staff involved in order transcription and incident monitoring.  DNS or designee will perform	7/24/14  8/11/14  7/23/14  8/11/14  8/4/14  8/20/14  8/15/14  8/15/14  8/20/14  Ongoing

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F 281	Continued From page 15 up quickly and answer the phone. Was lying on right side and had bruise and swelling of temple area. Refused ice pack. No follow up note written on condition again until 7/20/14. 2:17PM interview with the Director of Nursing (DON), the expectations are that staff will monitor and document every shift for at least 24 hours, the condition of the resident. Per interview with the Registered Nurse (RN) and the Licensed Practical Nurse (LPN) at 2:19PM if someone falls and they have hit their head or if it is an unwitnessed fall, neuro checks are done per facility policy. Neither the RN or LPN could confirm what the policy was in regards to how often. Neuro vital signs and checks are recorded on a separate neuro check sheet and then the sheet is given to the DON. It is expected that every shift would document on the condition of the resident. Verified that no documentation was done after the initial note. 7/23/2014 at 2:55:13 PM per verification from the DON, there is no evidence of neuro vital signs being done by the staff and no documentation of follow up by the nursing staff to indicate the condition of the resident.  *Reference: Based on Standards of Professional Nursing Practice, Lippincott Manual of Nursing Practice 19th edition, Wolters Kluwer Health/Lippincott Williams, Page 17, Standards of practice was deviated with the failure to monitor a patient's clinical status adequately.  3. Per medical review on 7/23/14 at 10:14AM, it was confirmed by the Licensed Practical Nurse (LPN), that Resident #42 had an order that was written for Prilosec 40 mg, two capsules, by mouth daily. LPN produced a card of house	F 281	audits of 5 resident records per quarter to ensure that orders are properly transcribed, and monitoring following an incident is complete.  Results will be reported at QA meetings. DNS to monitor for compliance.  <i>F281 POC accepted 8/29/14 SBC/ACH/RN/PML</i>	Ongoing

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F 281	<p>Continued From page 16</p> <p>stock Prilosec 20 mg and said that the resident only gets one per day. I asked how h/she would know based on how the order is written and h/she stated that they wouldn't unless the order is verified, but that giving Prilosec 20mg is the usual dose. H/she confirmed that the order was not verified by the physician.</p> <p>*Reference: Based on Standards of Professional Nursing Practice, Lippincott Manual of Nursing Practice 19th edition, Wolters Kluwer Health/Lippincott Williams, Page 17, Standards of practice was deviated with the failure to get verification of physician orders.</p> <p>4. Per medical record review on 7/23/14 at approximately 11:30 AM, Resident # 29 who was admitted on 12/20/13 with diagnoses to include Fluid and Electrolyte Imbalance, Pneumonia, Chronic Airway Obstruction, Heart Failure, Muscle Weakness, Shortness of Breath, Abdominal Aneurysm, Hypotension, Lumbar Pain, Diabetes, Neuropathy, Epilepsy and Osteoporosis. Per Physician orders dated 7/21/14, directs staff to discontinue directions for Lasix as needed (PRN) use, but instructs staff to administer Lasix 20 mg PO daily PRN, monitor edema. Per interview on 7/23/14 at 1:23 PM, with Licensed Practical Nurse (LPN) and Registered Nurse (RN), confirmation was made, for Resident #29, there is no documented leg measurements, daily weights or other initiatives in place to monitor for increased edema. Therefore, professional nurses are unable to accurately identify the need for PRN Lasix administration. Both nurses also confirm that PRN Lasix is highlighted with a yellow marker, identifying that the PRN Lasix has been discontinued. PRN Lasix is still a current Physician order as dated on 7/21/14.</p>	F 281		
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F 281	<p>Continued From page 17</p> <p>*Reference: Based on Standards of Professional Nursing Practice, Lippincott Manual of Nursing Practice 19th edition, Wolters Kluwer Health/Lippincott Williams, Page 17, Standards of practice was deviated with the failure to get verification of physician orders.</p> <p>5. Per medical record review on 7/23/14 at 9:00 AM for Resident #43, admitted on 7/11/14 with diagnoses to include Lung Cancer Stage IV, Diabetes, Chronic Obstructive Lung Disease, Colon Cancer, Chronic Kidney Disease, History of Bladder Cancer and Chronic Back Pain. Physician Orders dated 7/11/14, identifies Decadron 2 milligrams (mg) by mouth (PO) as needed (PRN). Nurses Notes dated 7/12/14 identifies that the physician feels that Decadron should be daily rather than PRN and states ["that there was a discussion prior to discharge and medication should be daily"]. Per interview with Registered Nurse on 7/23/14 at 10:12 AM, he/she confirms that there is no physician order to discontinue PRN use of Decadron and there are no physician orders to identify the reason the medication should be administered on a PRN basis.</p> <p>*Reference: Based on Standards of Professional Nursing Practice, Lippincott Manual of Nursing Practice 19th edition, Wolters Kluwer Health/Lippincott Williams, Page 17, Standards of practice was deviated with the failure to get verification of physician orders.</p> <p>6. Centers of Disease Control (CDC) identifies that Universal Precautions are designed to prevent transmission of bloodborne pathogens when providing first aide or health care. For</p>	F 281		

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F 281	Continued From page 18 Resident #43, Physician Orders dated July 11 through July 31, 2014, request capillary blood glucose testing at 7:30 AM, 11:30 AM, 4:30 PM and hour of sleep. Sliding Scale Insulin orders identify dose of medication to be administered as per glucose testing results. Per observation on 7/22/14 at 4:21 PM Registered Nurse (RN) was observed obtaining capillary blood from Resident #43's finger without wearing gloves, and returned the glucometer (testing kit) to the medication cart. S/he then requested the Licensed Practical Nurse (LPN) to obtain other needed glucose readings for residents located in the Residential Care Home section of the facility. At no time were the RN or the LPN observed cleaning the equipment after use as identified in the manufacturers Quality Assurance/Quality Control Manual or the facilities policy for Glucometer reading. Per interview with RN at 4:35 PM, confirmation was made that s/he did not wear gloves during the glucose testing nor did s/he clean the equipment after use. Per interview with the LPN at 4:35 PM confirmation was made that s/he did not clean glucose testing equipment after use.  *Reference: Based on Standards of Professional Nursing Practice, Lippincott Manual of Nursing Practice 19th edition, Wolters Kluwer Health/Lippincott Williams, Page 17, Standards of practice was deviated with the failure to get verification of physician orders.	F 281		
F 282 SS=E	(see F 282 and F 441) 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in	F 282		

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F 282	Continued From page 19 accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and medical record review for 2 of 17 sampled residents, (Residents #6, and #29), the facility failed to provide services by qualified persons in accordance with each resident's written plan of care. The findings include the following:  1. Per medical record review on 7/23/14 at approximately 11:30 AM, Resident # 29 was admitted on 12/20/13 with diagnosis to include Fluid and Electrolyte Imbalance, Pneumonia, Chronic Airway Obstruction, Heart Failure, Muscle Weakness, Shortness of Breath, Abdominal Aneurysm, Hypotension, Lumbar Pain, Diabetes, Neuropathy, Epilepsy and Osteoporosis. Per Physician orders dated 7/21/14 directs staff to discontinue directions for Lasix as needed (PRN) use, but identifies to administer Lasix 20 mg PO daily PRN, monitor edema. Per interview on 7/23/14 at 1:23 PM, with Licensed Practical Nurse (LPN) and Registered Nurse (RN), confirmation was made that for Resident #29 there are no documented leg measurements, daily weights or other initiatives in place to monitor for increase edema. Therefore, professional nurses are unable to accurately identify the need for PRN Lasix administration. Both nurses also confirm that PRN Lasix is highlighted with a yellow marker, identifying that the PRN Lasix has been discontinued. PRN Lasix is still a current Physician order as dated on 7/21/14. (see 281)	F 282	F 282  Resident #29 Lasix was discontinued.  Resident #6 Behavior Monitoring sheet was implemented.  All resident care plans were reviewed to ensure interventions are in place.  All residents on antipsychotic medication were reviewed to ensure Behavior Monitoring sheets are in place.  Policies regarding care plans, and behavior monitoring were reviewed and updated as necessary.  DNS/SDC provided education to staff involved in care planning, and Behavior Monitoring.  DNS or designee will perform audits of 5 resident records per quarter to ensure that care plan interventions and Behavior Monitoring sheets are in place.  Results will be reported at QA meetings. DNS to monitor for compliance.	8/11/14 8/15/14 8/20/14 8/20/14 8/15/14 8/20/14 Ongoing Ongoing

F282 PO accepted 8/19/14 Bowen RN/PMC

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F 282	Continued From page 20  2. Per record review, Resident #6, who is prescribed an antipsychotic medication, has a Care Plan which includes "potential for adverse side effects related to antipsychotic drug use". Interventions in the Care Plan include "complete the Behavior Monitoring Sheet every shift, and note side effects." Per record review and confirmed during an interview with Resident #6's nurse on 7/23/14 at 11:11 A.M. Resident #6 is on an antipsychotic medication and there is no documentation of behavior monitoring regarding potential side effects of the resident's medication. The nurse stated Resident #6 was "not on behavior monitoring" and no behavior monitoring sheets were being completed on every shift per the resident's plan of care.	F 282	F 314  Resident #13 expired.  Policies regarding Pressure Ulcer Risk Assessment and documentation were reviewed and updated as necessary.  DNS/SDC will provide education to all nursing staff regarding Pressure Ulcer Risk Assessment and documentation.  DNS or designee will audit 5 resident records each quarter to ensure that assessments are complete.  Results will be reported at QA meetings. DNS to monitor for compliance.	8/6/14  8/15/14  8/20/14  Ongoing  Ongoing
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical review, the facility failed to ensure that 1 of 3 residents in the Stage 2 sample, Resident #13, was free from developing pressure sores and received the necessary treatment and	F 314	F314 POC accepted 8/29/14 B. Bortell R/pme	

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F 314	<p>Continued From page 21</p> <p>services to promote healing, prevent infection and prevent new sores from developing. Findings include:</p> <p>1. Per medical record review on 07/22/14, Resident #13 was admitted to the facility with a wound and Stage 2 pressure sore however, during survey an additional pressure ulcer was noted. Per the Nursing assessment upon admission dated 05/27/14, notes 2 open areas (#1- a skin slit 1 centimeter (cm) at mid sacrum-bony region above spine, thin-skinned; and area #2 -stage 2 pressure ulcer on the right buttocks superficial depth redness/bruise surrounding 1.2 cm x 1.2 cm.) The resident was identified in the comprehensive assessment as having a stage 2 pressure ulcer as well as another wound upon admission on 05/27/14, however, there was no comprehensive care plan that includes measurable objectives and goals for the pressure ulcer and wound. The care plan dated 06/05/14 - potential for skin breakdown-related to needs assist with ADLs and mobility, has as the interventions as, monitor skin daily, report changes to charge nurse immediately, assist with repositioning as needed and throughout the day, encourage turning, treatments as ordered. The care plan did not identify the intermediate steps nor the objectives to monitor and evaluate the resident's progress for the pressure ulcer or to revise treatments as appropriate.</p> <p>The physician's admission order dated 05/27/14 states "mepilex border dressing to right buttock open area; skin prep to periwound, wash with normal saline change every three days and as needed [PRN]". Per review of the TAR [treatment administration record] no treatments were</p>	F 314		
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F 314	<p>Continued From page 22</p> <p>provided after 06/08/14 for skin issues. There were no wound monitoring sheets found. In addition, the June TAR as written, does not clearly show two separate wound dressing areas but only a dressing change to be done every three days. Per nursing notes dated June 1, 2, 3, 5, 7, 8, 9, 10, 11 does not mention wounds. The nursing note on 06/04/14 states "sacral wounds are largely healed, the dressing is protective only to newly healed tissue". On 06/06/14 the nursing notes states "two caregiver assist with dressing [as] resident uncooperative, noted small &lt;1 cm red area right buttocks".</p> <p>Per interview on 07/23/14 at 11:58 A.M., the LNA stated "when I dressed [resident] today there was two brown-colored dressings [and pointed to buttocks area].... not sure what the skin underneath looks like. If it needed to be changed then the nurse will do that on bath day". Per interview on 07/23/14 at 2:45 P.M. the MDS [minimum data set] coordinator stated 'when a person comes in with multiple [skin] areas there would be a care plan with the wound number and the specific treatment ordered, when healed, the TAR would be yellowed out [resolved]." The MDS coordinator further stated the wound would be on a wound sheet and monitor at least weekly by nursing. The resident's bath day was on July 20th however, there is no skin assessment that notes any skin issues. The MDS coordinator then stated "I don't think the resident has a pressure ulcer".</p> <p>Per observation on 07/23/14 at 3:50 PM in the presence of the nurse [who stated 'I thought the wounds were healed'], MDS coordinator and LNA, two dressings, one on each buttock, were noted. When the dressings were removed, dried</p>	F 314		
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F 314	Continued From page 23 blood was noted on the dressings as well as red open areas. The MDS coordinator confirmed that there was not consistent monitoring, assessments, consistent treatments, or revisions of the interventions as appropriate to treat the pressure ulcers.	F 314		
F 323 SS=D	(also see F-157 & F-279) 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based upon observation, interview, and record review, the facility failed to ensure that the resident environment remains as free of accident hazards as is possible for 1 resident [Resident #24] and that adequate supervision of residents is provided to ensure a safe environment for 1 resident (Resident #99) of 17 residents in the sample group. Findings include:  1. Per record review, Resident #99, whose diagnoses include dementia, was admitted to the facility on 4/17/14. Per record review of Resident #99's Minimum Data Sheet [MDS], the resident has long term and short term memory problems, and h/her cognitive skills for daily decision making are 'severely impaired'. Under 'mood', the	F 323	F 323  Resident #99 was discharged.  Resident #24 Repair of electrical outlet for resident #24 was repaired by August 1 <sup>st</sup> .  All resident rooms were checked for safety concerns.  Policies regarding supervision of residents were reviewed and updated as necessary.  Administrator, Maintenance Director, or their designee, on a monthly basis, will do an environmental evaluation of all resident rooms and common areas.  The evaluation shall note issues of safety and health and other hazards. All noted items will be kept on record and a report of these will be made quarterly in the QA Committee.  <i>F323 POC accepted 8/29/14 Bostelira/PMC</i>	4/24/14  8/1/14  8/20/14  8/15/14  Ongoing  Ongoing

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F 323	<p>Continued From page 24</p> <p>MDS assessment lists Resident #99 as 'being short tempered, easily annoyed', and under 'behavior', the resident is recorded as having 'physical behavioral symptoms directed toward others [e.g. hitting, kicking, pushing, scratching, grabbing]', and 'Verbal behavioral symptoms directed toward others [threatening others, screaming at others, cursing at others]'.</p> <p>Per record review, the resident's Care Plan includes "potential for agitation, secondary to dementia", with interventions listed as "keep in common areas as able, gently remove from area if she has increased agitation, allow to ambulate/wander with supervision. Redirect, re-approach as needed". Per review of the resident's Physician Admission Notes dated 4/17/14- "patient is now in a controlled and supervised environment". Per record review of the resident's Behavior Intervention Flow Record, the resident's behaviors include- 'danger to self, danger to others', and 'striking out/hitting'. During Resident #99's 8 days at the facility, the behavior record lists the resident demonstrating a danger to self or others 12 times, and striking out/hitting 11 times.</p> <p>Nursing Notes during the resident's 8 days in the facility record "raising h/her fist at people", "hit staff a few times, becoming verbally and physically abusive when attempted to redirect", "grabbed this nurse's wrist while trying to redirect", "slaps LNA, slaps nurse". On 4/18/14 the resident is documented as having "entered room 112 with an emergency situation and started yelling at EMT's and writer. Escorted out by LNA, cursing at everyone." On 4/22/14 the resident is "grabbing onto people, swearing, yelling, wandering into rooms, going into other</p>	F 323		

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F 323	<p>Continued From page 25</p> <p>resident's belongings.. Found sitting on [Res. #98]'s bed, taking [Res. #98]'s oxygen off. Had shut off tank". Nursing Notes from 4/21/14 record the resident "enters other rooms despite 'STOP' Velcro signs: either tears them down or ducks under them." Per review of Resident #99's Medication Administration Record, the resident was given an antipsychotic medication 9 times during h/her stay in an attempt to reduce agitation, with a third of the times reported having "little or no effect".</p> <p>Per record review of Nursing Notes and the facility's Incident Accident Report dated 4/24/14 Resident #3 "was sitting in a wheelchair by the nurses' station. [Resident #99 ] walked up to h/her, started swearing at [Res. #3] and hit h/her on the collarbone." Resident #3 then stated "Don't hit me". After Resident #3 was struck by Resident #99, Physician Progress Notes on 4/24/14 report "contacted by the Administrator of violent and aggressive behavior by patient. Patient has been challenging as regards behaviors since admission [swearing, agitated, raising a fist ...] Patient was witnessed striking an employee with h/her fist in the shoulder. Discharge and transport to BMH ER as an emergency measure necessary for the health and safety of the resident and other residents".</p> <p>Per interview with the Director of Nursing [DON] on 7/23/14, the DON confirmed the facility could not ensure a safe environment regarding Resident #99's behaviors while the resident was in the facility.</p> <p>2. During the initial tour on 7/21/14 a cracked wall plate covering an electric outlet was observed in the room of Resident #24. Per</p>	F 323		
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F 323	Continued From page 26. interview with the facility's Maintenance Director on 7/22/14 at 3:30 P.M. the facility does not do regular rounds or checks on resident rooms regarding maintenance or repairs. The Director stated that the maintenance department is reliant upon Nursing/LNA staff to report repair needs of resident rooms or equipment, and if the repair needs are not reported by staff they are not done. Per record review of the maintenance request log for Resident #24's unit, there was no documentation that a safety hazard had been identified and that a repair was scheduled. The Maintenance Director confirmed that Resident #24 had access to the electric outlet and that the cracked electrical wall plate was a potential safety hazard for the resident.	F 323			
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION  The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.  The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to	F 356			

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F 356	<p>Continued From page 27 residents and visitors.</p> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to insure that posting of daily nursing staff was in an accurate and readable format as required by regulation. This potentially affects all Residents in the facility. Findings include:</p> <p>1. During four days of survey, 07/21- 07/24/14, the daily nurse staffing posting did not contain the resident census and correct and/or actual hours worked by nursing on a daily basis at the beginning of each shift. Per observation during the day and evening shifts during survey, the nurse assigned to the nursing home residents who live on the second floor will also pass medications to residents who are not part of the nursing home (the separately-licensed residential care home side). This is not reflected in the number of hours that the nurse actually works in the nursing home versus the residential care home. The format is not clear in regards to the number of staff to the number of hours worked. For example on 07/19/14 there were 5 evening LNAs with numbers of hours as '8/6' and 2 LPNs as working '8/4'. This was also noted for July 20 - 23. In addition, one error on 07/19/14 shows 5</p>	F 356	<p>F 356</p> <p>Posting of Daily Nurse Staffing forms updated.</p> <p>Policies regarding Posting of Daily Nurse Staffing reviewed and updated as necessary, and reviewed with Scheduler for future posting.</p> <p>DNS or designee to provide education to all staff responsible for completing and updating the form.</p> <p>DNS or designee to review forms weekly to ensure compliance.</p> <p>Results will be reported at QA meetings. DNS to monitor for compliance.</p> <p><i>F356 POC accepted 8/27/14 BB:ACH RN/PMC</i></p>	<p>7/25/14</p> <p>8/15/14</p> <p>8/20/14</p> <p>Ongoing</p> <p>Ongoing</p>
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F.356	Continued From page 28 LNA when in fact per the actual staffing should only be 4.  Per interview on 07/23/14 at 2:38 PM the DNS stated that the scheduler will post the staffing in the morning of the day but no one is responsible for any updates that would happen during the evening and night shifts, and the staff posting is made in advance for the weekend on Friday only. The DNS stated that the format could be confusing and perhaps family/residents would not understand that the hours noted as '8/6' or '8/4' means that some staff work less hours. The DNS stated at 2:03 PM. that the "upstairs nurse's hours are not accurately reflected on the Staff Posting" and confirmed the posting was not accurate, in a readable format and did not contain all the elements as required by regulation.	F 356		
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  This REQUIREMENT is not met as evidenced by: Based upon observation and interview, the facility failed to store, prepare, distribute and serve food under sanitary conditions. Findings include:	F 371	F 371  All Dietary Department staff inserviced on sanitation issues to include the covering of any items when leaving the kitchen.  The Administrator, Food Service Director, or their designee will perform random audits at least weekly to ensure compliance. A report of these audits will be reported quarterly in the QA meeting.  <i>F371 POC accepted 8/29/14 BB/ACURM/PML</i>	8/15/14  Ongoing

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F 371	<p>Continued From page 29</p> <p>Per interview with the Food Services Director [FSD] on 7/22/14, meal trays and food items are to be covered and delivered to the residents' units via dedicated food carts which are cleaned by staff daily.</p> <p>Per observation on 7/21/14, facility staff delivered trays with uncovered food items on visibly dirty food carts to 2 resident floors. Per interview with a Licensed Nursing Assistant [LNA] on 7/21/14 at 1:14 P.M., the LNA confirmed the food delivery cart s/he had used had visible dried spills and caked on food and should not have been used for food delivery.</p> <p>Per observation on 7/22/14 Lunch desserts were delivered to the first and second floor resident units on uncovered trays on visibly dirty food carts. Per interview with the FSD on 7/22/14 at 12:30 P.M., the FSD confirmed the carts used to deliver the food on 7/21/14 &amp; 7/22/14 were visibly dirty and should not have been used to transport food, and the dessert items transported on the dirty carts should have been covered and were not.</p>	F 371	<p>F 387</p> <p>Resident #9 Seen by Physician on 7/9/14 Dictated note received form office and placed in record.</p> <p>Resident #12 Seen by physician on 6/11/14. This date was verified on 7/25/14 and documentation placed in chart.</p> <p>All resident records were reviewed to ensure evidence of physician visit.</p> <p>DNS or designee will perform audits of 5 resident records per quarter to ensure evidence of physician visit.</p> <p>Results will be reported at QA meetings. DNS to monitor for compliance.</p>	<p>7/24/14</p> <p>7/25/14</p> <p>8/20/14</p> <p>Ongoing</p> <p>Ongoing</p>
F 387 SS=E	<p>483.40(c)(1)-(2) FREQUENCY &amp; TIMELINESS OF PHYSICIAN VISIT</p> <p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p>	F 387	<p><i>F387 POC accepted 8/27/14 [Signature]</i></p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475050</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/24/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>THOMPSON HOUSE NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>80 MAPLE STREET BRATTLEBORO, VT 05302</b>	
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F 387	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on medical review and staff interview, the facility failed to ensure that 2 of 17 residents in the Stage 2 sample, Resident #9 and #12, were seen by a physician in a timely manner. Findings include:  1.) On 7/21/14 at 2:21PM during medical review for Resident #9, there was not evidence in the medical record of a signed physician progress note, nor signed physician orders per requirements. The medical record contained unsigned physician orders for April through July 2014 and per confirmation with the Licensed Practical Nurse (LPN), the last signed and dated physician progress note was for 9/27/13 and the last signed orders were dated 6/17/2013, over a year prior to the survey.  2.) On 7/22/14 at 10:19 AM per medical review, Resident #12, had signed physician orders in the medical record that were dated 11/20/13 and the last signed physician progress note to indicate the resident had been seen, was dated 6/20/2013. Per interview with the Director of Nursing at 10:27AM, h/she stated that the medical director keeps track of scheduled visits and informs the Director of Nurses if they are due. H/she then verified that the orders had not been signed, nor were there progress notes to indicate a visit.	F 387	<del>F 387 Resident #9 Seen by Physician on 7/9/14 Dictated note received form office and placed in record.  Resident #12 Seen by physician on 6/11/14. This date was verified on 7/25/14, <i>and documentation placed in chart</i> All resident records were reviewed to ensure evidence of physician visit.  DNS or designee will perform audits of 5 resident records per quarter to ensure evidence of physician visit.  Results will be reported at QA meetings. DNS to monitor for compliance.</del>	7/24/14  7/25/14  8/20/14  Ongoing  Ongoing
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428		

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F 428	<p>Continued From page 31</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview and interview with the facility's consulting pharmacist, the pharmacist did not report irregularities to the attending physician and the director of nursing for 1 of 17 residents, Resident # 42. Findings include:</p> <p>Per medical review on 7/23/14 at 10:14AM, it was confirmed by the Licensed Practical Nurse (LPN), that Resident # 42 had an order that was written Prilosec 40mg, two capsules, by mouth daily. LPN produced a card of house stock Prilosec 20mg and said that the resident only gets one per day. I asked how h/she would know based on how the order is written and h/she stated that they wouldn't unless the order is verified, but that giving Prilosec 20mg is the usual dose. H/she confirmed that the order was not verified by the physician. A monthly pharmacy consult was conducted by the facility consulting pharmacist on 7/22/14. Per interview with the Pharmacist consultant on 7/23/14 at 11:30AM. h/she verified that it is expected for staff to get clarification of an order prior to administration. H/she stated that the pharmaceutical review was completed and it was missed, but it was done at 9PM and there are "forty" records to review at one time.</p>	F 428	<p>F 428</p> <p>Resident #42 Order for Prilosec was verified with physician. 7/23/14</p> <p>Pharmacist is aware of order clarification is needed. 7/23/14</p> <p>All resident records were reviewed to ensure MD orders are accurate. 8/20/14</p> <p>Policies regarding order transcription were reviewed and updated as necessary. 8/15/14</p> <p>DNS/SDC provided education to staff involved in order transcription. 8/20/14</p> <p>DNS or designee will perform audits of 5 resident records per quarter to ensure that orders are properly transcribed. Ongoing</p> <p>Results will be reported at QA meetings. DNS to monitor for compliance. Ongoing</p> <p><i>F428 POC accepted 8/29/14 BB/AR/pml</i></p>	

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F 441 F 441 SS=E	<p>Continued From page 32</p> <p><b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b></p> <p>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.</p> <p>(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.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (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>	F 441 F 441	<p>F 441</p> <p>Policies regarding indwelling foley catheters, changing oxygen tubing, glucometer testing and cleaning, and infection control were reviewed and updated as necessary.</p> <p>DNS or designee will perform observations and audits weekly to ensure compliance with indwelling foley catheters, changing oxygen tubing, glucometer testing and cleaning, and infection control.</p> <p>Results will be reported at QA meetings. DNS to monitor for compliance.</p> <p><i>F441 POC accepted 8/29/14 SS=E RN/ML</i></p>	8/15/14  Ongoing  Ongoing

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F 441	<p>Continued From page 33</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to insure safe and infectious free protocols for the facility and 3 of 17 residents in Stage 2 sample, Resident #2, #27 and #43. Findings include:</p> <p>1. Per observation of urinary catheter care for Resident #2, staff failed to follow established protocols to prevent the development or transmission of possible infection. On 07/22/14 at 9:15 AM the LNA [licensed nursing assistant], after emptying Resident #2's overnight drainage Foley bag, placed the overnight drainage Foley bag directly on the floor. In addition, the LNA failed to wash hands and change gloves between dirty and clean procedures. The LNA disconnected the overnight drainage Foley bag from the catheter, handed the catheter end to the resident to hold and opened a new leg drainage bag. The LNA cleaned the new leg drainage bag tip, but not the catheter's end, and connected the two tubes. The LNA then said "I'll just throw it [overnight drainage Foley bag] into the trash....I usually change it when it smells". There were no markings or dates as to when the overnight drainage Foley bag should be changed. The LNA was unable to state the facility's protocols changing the overnight drainage Foley bag nor the leg drainage bag, as the previous day's drainage bag was noted hanging on the pipe behind the toilet. The LNA stated "I just get a new one each time".</p> <p>Per interview on 07/22/14 at 9:45 AM, DNS stated that the facility's protocol is that hands</p>	F 441		
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F 441	<p>Continued From page 34</p> <p>should be washed/sanitized and gloves changed between dirty/clean techniques. Both tips[catheter and drainage bags] should be cleaned/sanitized when connected and disconnected. The DNS further stated that the overnight drainage Foley bag should be labeled and then discarded weekly. S/he confirmed at that time staff did not follow established infection control practices.</p> <p>2. On 7/23/14 at 10:15AM, per observation on Unit 2, an Licensed Nursing Assistant (LNA) brought a dirty breakfast cart from a resident's room and placed it on top of a "hydration cart", used for storing clean water and pitchers for residents, and went into another resident room. The sign on the cart clearly stated in bold print, not to place dirty meal trays on top of the cart. Per LNA confirmation at 10:30AM, h/she was busy and left it there to go assist care for a resident.</p> <p>3. Per record review, Resident #27's Physician's orders and Treatment Record include "oxygen at 2 liters/per min via nasal cannula at hour of sleep". Per observation on 7/21/14, the oxygen tubing and nasal cannula for Resident #27's use was labeled with the date '5/17/14'. Per interview with Resident #27's nurse on 7/21/14, the facility's policy is to change oxygen tubing for residents every week. The nurse confirmed the date on the tubing as 5/17/14 and confirmed the date indicated the oxygen tubing for Resident #27 had not been changed for greater than 2 months.</p> <p>4. Per observation on 7/22/14 at 4:21 PM on the</p>	F 441		

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F 441	<p>Continued From page 35</p> <p>upper level of the nursing home, the Registered Nurse (RN) was observed obtaining capillary blood from Resident #43's finger, completing the test without wearing gloves and returned the glucometer (testing kit) to the medication cart. RN then requested the Licensed Practical Nurse (LPN) obtain other needed blood glucose readings for residents located in the Residential Care Home section of the facility. At no time were the RN or the LPN observed cleaning the equipment after use, between residents, as identified in the manufacturers Quality Assurance/Quality Control Manual or the facilities policy for Glucometer reading. Per interview with RN at 4:35 PM confirmation was made that s/he did not wear gloves during the glucose testing nor did s/he clean the equipment after use. Per interview with the LPN at 4:35 PM confirmation was made that s/he did not clean glucose testing equipment after use.</p> <p>Per observation on 7/22/14 at 5 PM on the First Floor, the LPN cleansed a glucometer meter with an alcohol wipe and continued to obtain and test a resident's capillary blood glucose. LPN confirmed at 5:07 PM that she was unaware that the wipe did not meet the manufacturers recommendations for disinfecting the equipment after use for more than on resident.</p> <p>Per review of information available from the Centers for Disease Control and Prevention [CDC] via <a href="http://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html">http://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html</a></p> <p>"Regarding Infection Prevention during Blood Glucose Monitoring and Insulin Administration: Unsafe practices during assisted monitoring of blood glucose and insulin administration that have put persons at risk for infection include: Using a blood glucose meter for more than one</p>	F 441	

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F 441	<p>Continued From page 36</p> <p>person without cleaning and disinfecting it in between uses. Examples of settings where 'assisted monitoring of blood glucose and insulin administration' may occur include: Long term care settings such as nursing homes and assisted living facilities Whenever possible, blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions."</p> <p>Per review of information available for the Truebalance Owner's Booklet identifies that instructions for use of the System for more than one person may be found in the Quality Assurance/Quality Control Manual on the following website: <a href="http://www.niprodiagnostics.com">www.niprodiagnostics.com</a> &lt;<a href="http://www.niprodiagnostics.com">http://www.niprodiagnostics.com</a>&gt;</p> <p>Manufacturer recommends one meter per resident. Per Chapter 7 Care, Cleaning/Disinfection and Storage of System (pages 37-40), manufacturer suggests cleaning and disinfecting the Meter between resident when the Meter is used on multiple residents. To clean and disinfect Meter use PDI Super Sani-cloth Germicidal Disposable wipes. (active ingredients 55% Isopropyl alcohol/Isopropanol, 5,000 Parts Per Million (PPM) quarternary ammonium chlorides or disinfectants with identical active ingredients.)</p> <p>Per interview on 7/23/14 at 8:30 AM with the Administrator (NHA) and the Director of Nurses (DNS), that approximately six (6) months ago the facility decided to utilize one meter per medication cart. No consultation was made with the Infection Control Practitioner or the Quality Assurance Committee. When asked if there is a copy of the Quality Assurance/Quality Control Manual in the facility for review the DNS responded ["No"]</p> <p>Per Centers of Disease Control (CDC) identifies</p>	F 441	<p>F 460</p> <p>Maintenance Director completed full facility rounds on August 1st, 2014, ensuring that all privacy curtains in bathrooms extended far enough to the floor to provide privacy for residents while in the bathroom.</p> <p>2 curtains were replaced for Resident #15 and #16.</p> <p>This item will be added to the environmental evaluation completed monthly by the Administrator, Maintenance Director, or their designee, and reported on quarterly in the QA Committee Meeting.</p> <p><i>F460 POC accepted 8/29/14 Beckell RN/MLK</i></p>	<p>8/1/14</p> <p>8/1/14</p> <p>8/1/14</p>
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F 441	Continued From page 37 that Universal Precautions are designed to prevent transmission of bloodborne pathogens when providing first aide or health care.	F 441		
F 460 SS=D	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY  Bedrooms must be designed or equipped to assure full visual privacy for each resident.  In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.  This REQUIREMENT is not met as evidenced by: Based upon observation and interview the facility failed to assure residents had full visual privacy regarding short curtains in the residents' bathroom entrance for 2 Residents [Residents #15 & #6] of 17 residents in the sample group. Findings include:  Per observation on 7/21/14 the curtains used for privacy when Resident #15 and #6 are in their bathrooms measured approximately 22 inches and 14 inches, respectively, off the floor. The bathrooms are located immediately inside the residents' doorways and are visible from the public hallway. Per interview with the facility's Maintenance Director on 7/22/14 at 3:30 P.M., the Director stated the privacy curtains "looked like window curtains" and confirmed the curtains did not provide adequate privacy for the residents, and with the residents' doors open and the curtains pulled, anyone could see the	F 460	<del>F 460 Maintenance Director completed full facility rounds on August 1st, 2014, ensuring that all privacy curtains in bathrooms extended far enough to the floor to provide privacy for residents while in the bathroom.  2 curtains were replaced for residents 15 &amp; 16 This item will be added to the environmental evaluation completed monthly by the Administrator, Maintenance Director, or their designee, and reported on quarterly in the QA Committee Meeting.</del>	<del>8/1/14  8/1/14 8/1/14</del>

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F 460	Continued From page 38 residents sitting on or standing in front of the commode/toilet.	F 460		
F 514 SS=B	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  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.  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.  This REQUIREMENT is not met as evidenced by: Based on family and staff interviews and medical review, the facility failed to maintain a complete and accurately documented clinical record for 3 of 17 residents, Resident #3, #43 & #29 in the Stage 2 sample. Findings include:  1. On 7/24/14 at 8:48 AM, per interview with the Registered Nurse (RN), that as a part of the admission process, an inventory list is to be completed and then placed and left in the chart. The RN stated that there is no evidence of an admission inventory for Resident #3. Interview with the Director of Nurses (DON) confirmed that an inventory is to be kept in the medical record and h/she was not able to provide evidence of inventory. Asked how the facility would address a	F 514	<del>F 514 Resident #3 Missing item (quilt) was found in laundry, labeled and returned to resident. Inventory List completed and placed in record.  Resident #43 Decadron  Resident #29 Oxygen order clarified.  Policies regarding clinical records were reviewed and updated as necessary.  DNS/SDC provided education to staff involved in maintaining clinical records.  DNS or designee will perform audits of 5 resident records per quarter to ensure that clinical records are complete.  Results will be reported at QA meetings. DNS to monitor for compliance.</del>	<del>8/15/14  8/15/14  7/23/14  8/15/14  8/20/14  Ongoing  Ongoing</del>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475050</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/24/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THOMPSON HOUSE NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>80 MAPLE STREET BRATTLEBORO, VT 05302</b>
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F 514	Continued From page 39 report of a missing item, the DON stated that it would be addressed in social service notes. Per medical review, the DON and RN were unable to produce evidence of missing item being addressed for Resident #3.  2. Per medical record review on 7/23/14 at 9:00 AM for Resident #43, admitted on 7/11/14 with diagnosis to include Lung Cancer Stage IV, Diabetes, Chronic Obstructive Lung Disease, Colon Cancer, Chronic Kidney Disease, History of Bladder Cancer and Chronic Back Pain. Physician Orders dated 7/11/14, directs staff to administer Decadron 2 milligrams (mg) by mouth (PO) as needed (PRN). Nurses Noted dated 7/12/14 identifies that the physician feels that Decadron should be daily rather than PRN and states ["that there was a discussion prior to discharge and medication should be daily"]. Per interview with Registered Nurse on 7/23/14 at 10:12 AM, he/she confirms that there are no physician orders to discontinue PRN use of Decadron and there are no orders to identify the reason the medication should be administered on a PRN basis.  3. Per medical record review on 7/23/14 at approximately 11:30 AM, Resident # 29 who was admitted on 12/20/13 with diagnoses to include Fluid and Electrolyte Imbalance, Pneumonia, Chronic Airway Obstruction, Heart Failure, Muscle Weakness, Shortness of Breath, Abdominal Aneurysm, Hypotension, Lumbar Pain, Diabetes, Neuropathy, Epilepsy and Osteoporosis. Physician orders dated 7/1/14 through 7/31/14 identify O2 @ _____ Liter/minute as needed (PRN) at rest hypoxia/dyspnea/less than 89% saturation. Per interview with Registered Nurse and Licensed Practical Nurse at 1 PM confirmation is made that	F 514	F 514  Resident #3 Missing item (quilt) was found in laundry, labeled and returned to resident. Inventory List completed and placed in record.  Resident #43 Resident expired.  Resident #29 Oxygen order clarified.  Policies regarding clinical records were reviewed and updated as necessary.  DNS/SDC provided education to staff involved in maintaining clinical records.  DNS or designee will perform audits of 5 resident records per quarter to ensure that clinical records are complete.  Results will be reported at QA meetings. DNS to monitor for compliance.  <i>F514 POC accepted 8/29/14 BBK/RLN/PML</i>	8/15/14 8/15/14 8/4/14 7/23/14 8/15/14 8/20/14 Ongoing Ongoing
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  <b>THOMPSON HOUSE NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>80 MAPLE STREET BRATTLEBORO, VT 05302</b>
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F 514	Continued From page 40 there are no physician orders for the oxygen liter flow. Order was clarified by the physician on 7/23/14 identifying Oxygen 1-2 liters via nasal cannula for hypoxia or dyspnea to maintain saturation levels greater than 89% to 94%. May leave off for minor transfers.	F 514	F 516 The 3 unsecured medical discharge records were moved to a secure location.	7/23/14
F 516 SS=B	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS  A facility may not release information that is resident-identifiable to the public.  The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.  The facility must safeguard clinical record information against loss, destruction, or unauthorized use.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to safeguard clinical record information against loss, destruction, or unauthorized use. Findings include:  At 6:30PM on July, 23, 2014, the Administrator was informed of 3 unsecured medical discharge records that were in the sitting room on the second floor. The administrator stated that h/she would take care of the medical record that needed to be returned to the unit and would put the other records in the office of the Director of	F 516	Policies regarding Clinical Records were reviewed and updated as necessary.  ADM or designee will perform audits of Clinical Record storage areas to ensure that all Records are secure.  Noncompliance with policy will be reported at QA meetings.  <i>F516 POC accepted 8/29/14 BBA/HEH/pme</i>	8/15/14  Ongoing  Ongoing

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F 516	Continued From page 41 Nursing. Upon arrival to the facility on July 24, 2014 at 7:15AM, the door to the sitting room on second floor was unlocked. This surveyor asked the nurse on the second floor if h/she had unlocked the door and the nurse stated they had not. H/she further stated that the dietician had been in the room and announced that there were records on the table in the room. On 6/24/14 at 12:30PM per interview with administrator, the administrator stated that h/she did not leave the facility until 7:30PM and thought they had locked the door, but must have forgotten to do so.	F 516	F 520  Systems developed for each department in the QAA process to include identifying quality issues, developing action plans, implementing action plans and revising plans if found to be ineffective.	8/20/14
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.  A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.  Good faith attempts by the committee to identify and correct quality deficiencies will not be used as	F 520	Audits will be performed routinely and presented for active action plans and reported to the DNS, Administrator, or designee for follow up.  DNS and Administrator will review audits and action plans monthly to determine if revisions or modifications are necessary.  Results will be reported quarterly at QA meetings. Administrator to monitor for compliance.	Ongoing  Ongoing  Ongoing

*F520 POC accepted 8/29/14 BB/MLR/PM*

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F 520	<p>Continued From page 42 a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: The facility failed to have a quality assessment and assurance committee that develops and implements appropriate plans of action to correct identified quality deficiencies. Findings include:</p> <p>Based on interview with the Administrator and the facility Quality Assurance (QA) coordinator on 7/22/14 at 4:16PM, the facility failed to develop and implement appropriate plans of action to correct identified quality deficiencies in order to monitor and assess success or failure of actions put into place by the committee. Per the QA coordinator, the facility will conduct random audits for example: care plan compliancy, as this has been an ongoing cited deficient practice. They are looking for timeliness that a care plan is developed, the contents and look to insure completion. Once the plan of correction time frame is complete, there is no process for assessing if the deficient practice is recurring. At 4:30PM the administrator stated that "obviously a more thorough system is needed to insure that repeat deficiencies do not continue to occur."</p>	F 520		
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