

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

October 30, 2013

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

Dear Mr. Rank:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 25, 2013**. 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: 10/09/2013  
FORM APPROVED  
OMB NO. 0938-0391

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>09/25/2013</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 000	INITIAL COMMENTS	F 000	F 279	
	An unannounced on-site Recertification survey was conducted from 9/23/13 to 9/25/13, by the Division of Licensing and Protection. There were regulatory deficiencies identified. The findings include:		Resident #53 was discharged.	6/6/13
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279	All resident care plans were reviewed to ensure that all identified needs are addressed.	10/24/13
	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.		Policies regarding care planning were reviewed and updated as necessary.	10/24/13
	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.		DNS/SDC provided education to staff involved in care planning.	10/24/13
	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).		DNS or designee will perform audits of 5 resident care plans per quarter to ensure that all identified needs are addressed	Ongoing
	This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a plan of care that addressed all the identified needs for 1 of 18 residents in the sample (Resident #53). Findings include:		Results will be reported at QA meetings. DNS to monitor for compliance.	Ongoing
			<i>F279 POC accepted 10/29/13 Pmodarw</i>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrator</b>	(X6) DATE <b>10/22/13</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.

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F 279	Continued From page 1  Per record review on 9/25/13, Resident #53 was admitted on 4/26/13 for a rehabilitation stay after a fall with a pelvic fracture. The resident had considerable pain issues, and a poor appetite when admitted. There was no plan of care available in the closed record, and when the DNS was asked, she produced a temporary initial care plan that did not include a plan for nutritional concerns. The Registered Dietician conducted the initial nutrition assessment on 5/2/13, identified that pain was affecting the resident's appetite, was aware of the weight loss based on weight recorded by the hospital before admission to the nursing home, and recommended supplements which were administered to the resident. The Dietician also identified low Calcium and Albumin levels based on lab reports. There was no plan of care developed that addressed the nutritional needs of the resident including an actual weight loss of seven pounds from 4/26-5/22/13, and an additional four pounds by 6/3/13. Per interview on 9/25/13 at 8:28 AM, the Director of Nursing confirmed that no care plan after the initial admission one was developed, and that the plan of care available in the medical record did not address the actual nutritional concerns including weight loss for Resident #53.	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	F 280		

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F 280	Continued From page 2 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 record review and staff interview, the facility failed to update the plan of care for 2 of 18 residents in the sample (Residents #15, #25). Findings include:  1. Per record review on 9/25/13, Resident #25 had a diagnosis of Depression that was treated with Fluoxetine 20 milligrams daily. The Pharmacist consultant recommended an attempted Gradual Dose Reduction of the medication in the monthly medication review in April 2013. The Physician responded by discontinuing the antidepressant medication on 4/18/13. Per review of the plan of care for Resident #25, the plan of care for this area was reviewed twice on 6/4/13 and again on 9/3/13, still with the medication listed as an active therapy, with no mention of the antidepressant being discontinued, and no side effects to monitor for due to the discontinuation of the antidepressant. Per interview on 9/25/13 at 4:10 PM, the Staff Development Coordinator confirmed that the care	F 280	F 280  Resident #25's care plan was updated to include discontinuation of antidepressant.  Resident 15's skin integrity care plan was updated to include current status.  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>F280 POC accepted 10/29/13 pmeetaRN</i>	9/27/13  9/30/13  10/24/13  10/24/13  10/24/13  Ongoing  Ongoing
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F 280

Continued From page 3  
plan had not been updated to include the discontinuation of the antidepressant and additional side effects to be aware of.

2. Per medical record review, Resident #15 was readmitted on 8/2/13 with diagnoses that include Pulmonary Edema and Hyponatremia, Hypertensive Heart Disease, Cerebral Infarction, Worsening Dementia and Pulmonary Fibrosis. The resident has a history of pressure ulcers. Per medical record review on 9/25/13 of the Comprehensive Assessment Minimum Data Set (MDS) completed on 8/10/13 by the RN Director of Nurses (DNS) identifies Resident #15 with one stage 1 and one stage 2 pressure ulcers that were present on admission.

The Treatment Administration Record (TAR) documents physician orders to cleanse open area on buttocks, apply skin prep & Mepilex AG, and cover with border dressing, which was dated 8/14/13 and discontinued on 8/20/13. Per a nursing note on 8/21/13, there was then a change in dressing orders. On 8/27/13, notes were made about the wound changes (indicating a total area of 10 centimeters with a 3 cm by 8 cm opening) and the TAR noted new orders for wound treatment that began on 8/27/13. Per nurses notes dated 9/14/13, the resident had a new slit (opening of the skin) noted on his/her buttock area.

Per medical record review on 9/25/13 of the Comprehensive Care Plan identifies a Potential for skin breakdown related to: the resident needs assistance with Activities of Daily Living and mobility. This problem was initiated on 8/3/11. The Comprehensive Care plan was last updated

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F 280	Continued From page 4 on 7/22/13. Per medical record review and interview with DNS on 9/25/13 at 2:30 PM she/he confirms that there is no evidence that care plan updates have occurred to reflect the ongoing changes in skin integrity since 7/22/13, prior to the resident being readmitted to the facility.	F 280	F 281 Resident #38's MD order was clarified and properly transcribed.	9/25/13	
F 281 SS=E	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, record review and staff interview, the facility failed to assure that professional standards were met regarding following physician's orders for 2 of 18 residents in the stage 2 sample (Residents #38 and #46). Findings include:  1. Per review of Resident #38's medical record, there is an order for Chlorhexidine oral rinse for 30 seconds, twice a day for seven days each month. This order was obtained on June 3, 2013. Per review of the MAR (Medication Administration Record), the resident has received the oral rinse daily for the months of June, July, August and September. Per confirmation by the DON at 1:46 PM, the order was not followed and the documentation indicates that it has been administered daily.  2. Per record review on 9/25/13, Resident #46 had physician's orders that included "Weight 3 x [times] weekly" starting on 4/3/13 to monitor weight loss and edema concerns. Per review of	F 281	Resident #46 was discharged.  All resident records were reviewed to ensure MD orders are accurate.  Policies regarding order transcription were reviewed and updated as necessary.  DNS/SDC provided education to staff involved in order transcription.  DNS or designee will perform audits of 5 resident records per quarter to ensure that orders are properly transcribed.  Results will be reported at QA meetings. DNS to monitor for compliance.  <i>F281 POC accepted 10/29/13 [unclear]</i>	8/9/13 10/24/13 10/24/13 10/24/13 Ongoing Ongoing	

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F 281	Continued From page 5 the medical record of Resident #46, the weights were not recorded as being monitored 3 times a week. The weights available in the chart were taken on 4/4/13 (180.8 lbs), then not again until 4/18/13 (171.4 lbs.). Other recorded weights were documented on 4/30/13 (168 lbs.), 5/1, 5/2, and again on 5/9/13 (160.9 lbs.). Weights were also recorded on 5/5/13, 5/16, 5/17, 5/18, 5/23, 5/31, and 6/3/13 (169.8 lbs. fully dressed). The next recorded weight was documented as done on 6/27/13 (181.5 lbs.). The next available weight recording was documented on 7/4/13 (185 lbs.) The following weight recorded was over a month later on 8/8/13 (173 lbs.). Per interview on 9/25/13 at 4:15 PM, the Director of Nursing confirmed that the weights were not consistently monitored 3 times per week as ordered by the physician.	F 281		
F 314 SS=E	*Reference: Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins. 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:	F 314		

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F 314	<p>Continued From page 6</p> <p>Based on the Comprehensive Assessment, Clinical Record review and interviews for 1 (Resident #15) of 3 sampled residents, the facility failed to 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. The findings include:</p> <p>Per medical Record review, Resident #15 was readmitted on 8/2/13, with diagnoses that include Pulmonary Edema and Hyponatremia, Hypertensive Heart Disease, Cerebral Infarction, Worsening Dementia and Pulmonary Fibrosis. The resident has a history of pressure ulcers. The Comprehensive Assessment Minimum Data Set (MDS) completed on 8/10/13 by the RN Director of Nurses (DNS) identifies Resident #15 with one stage 1 and one stage 2 pressure ulcers that were present on admission. DNS confirms on 9/25/13 at 2:30 PM that there is no evidence in the nurses notes identify that pressure ulcers were present on admission.</p> <p>The Treatment Administration Record (TAR) documents physician orders to cleanse open area on buttocks, apply skin prep &amp; Mepilex AG, and cover with border dressing, which was dated 8/14/13 and discontinued on 8/20/13. Per a nursing note on 8/21/13, there was then a change in dressing orders. On 8/27/13, notes were made about the wound changes (indicating a total area of 10 centimeters with a 3 cm by 8 cm opening) and the TAR noted new orders for wound treatment that began on 8/27/13. Per nurses notes dated 9/14/13, the resident had a new slit</p>	F 314	<p>F 314</p> <p>Resident #15's pressure sore was assessed and documented.</p> <p>Policies regarding Pressure Ulcer Risk Assessment and documentation were reviewed and updated as necessary.</p> <p>DNS/SDC will provide education to all nursing staff regarding Pressure Ulcer Risk Assessment and documentation.</p> <p>DNS or designee will audit 5 resident records each quarter to ensure that assessments are complete.</p> <p>Results will be reported at QA meetings. DNS to monitor for compliance.</p> <p><i>F314 POC accepted 10/29/13 [signature]</i></p>	<p>9/30/13</p> <p>10/24/13</p> <p>10/24/13</p> <p>Ongoing</p> <p>Ongoing</p>

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F 314	<p>Continued From page 7 (opening of the skin) noted on his/her buttock area.</p> <p>Per medical record review during interview with the RN on 9/25/13 at 1 PM she/he confirms that Resident #15 currently has an unstagable wound. Medical record reviewed with RN, who confirms that measurements have been not been obtained routinely and evaluation at the time of dressing changes are not documented anywhere in the medical record. Also, the resident's plan of care was not revised to reflect the changes in the wounds and treatments.</p> <p>Per Thompson House Policy and Procedure provided by the DNS on 9/25/13 identifies that all wounds will be evaluated weekly and documented on weekly pressure ulcer record to include location and stage of ulcer, size of the ulcer and presence of any sinus tract. Per medical record review and interview with DNS on 9/25/13 at 2:30 PM she/he confirms that there is no evidence that weekly measurements, assessment, evaluation and documentation have occurred.</p> <p>Per facility policy, residents with pressure ulcers are to be assessed weekly to determine if treatment is/is not effective and over a 2-week period consultation with a member of the Wound Committee Team or the Physician is to occur. There is no evidence in the medical record and confirmed by interview with the DNS on 9/25/13 at 2:30 PM that a review took place to evaluate treatment and services to promote healing, prevent infection and prevent new pressure sores from developing.</p>	F 314		
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431		

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F 431 SS=E	<p>Continued From page 8</p> <p><b>LABEL/STORE DRUGS &amp; BIOLOGICALS</b></p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the</p>	F 431	<p>F 431</p> <p>All medications needing to be destroyed were destroyed.</p> <p>All medications were checked to ensure none are outdated.</p> <p>The door to the DNS office was modified to be self closing and self locking.</p> <p>Policies regarding medication storage and destruction were reviewed and updated.</p> <p>DNS/SDC provided education to staff involved in medication storage and destruction.</p> <p>DNS or designee will perform audits of medication storage monthly to ensure that all medications are secured and destroyed per policy.</p> <p>Results will be reported at QA meetings. DNS to monitor for compliance.</p> <p><i>F431 PDC accepted 10/29/13 pmcota:RW</i></p>	<p>9/26/13</p> <p>9/26/13</p> <p>9/27/13</p> <p>10/24/13</p> <p>9/26/13 10/24/13</p> <p>Ongoing</p> <p>Ongoing</p>

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F 431	<p>Continued From page 9</p> <p>facility and pharmacist failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation. The facility and the pharmacist also failed to assure that all drugs are stored in locked compartments and failed to assure only authorized personnel have access to drugs. The facility also failed to dispose of/return out-dated medications. The findings include:</p> <p>1. Per observation and interviews, on 9/25/13 at 8:40 AM the Director of Nurses' (DNS) office door, located off the main resident dining room, was found wide open, unlocked with no staff present. The unlocked office contained, approximately, but not limited to 500 bubble cards of outdated and discontinued prescription and over the counter medications dating back to 2010. These cards were located on the floor, in plastic bags, boxes and wash basins. Some examples of medications accessible were injectable Haldol, Insulin, Trazadone, Lisinopril, Simvastin, Warfarin Sodium, Potassium, Lasix, Hydroxyzine, Cardeziem, Depakote, Doxyciline, Effexor, Keflex, Coumadin, Prednisone, ASA, Heparin, Elavil and numerous over the counter tablets and liquids in bottles that contained multiple doses.</p> <p>Interview with a Registered Nurse (RN) 9/25/13 at 10:06 AM confirms that the office was unattended, unlocked, the DNS was not in the building and the office contained both prescription and non-prescription medications that needed to be destroyed and posed a risk to resident safety. Interview with the Administrator on 9/25/13 at 11:30 AM confirms that he/she was aware of the need to destroy the medications that were improperly stored in the DNS' office.</p>	F 431		
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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>475050</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/25/2013</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>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	<p>Continued From page 10</p> <p>Per interview with the Registered Pharmacist (RP) on 9/25/13 at 12:30 PM confirms that she/he has been addressing the ongoing issue over the course of the year with both the DNS and the Administrator of medication disposition at Thompson House. RP confirms that on 4/16/13 during a Quality Assurance (QA) meeting, he/she reported the stockpiling of medications in the DNS office as a compliance issue to the management team, including the Medical Director.</p> <p>Per interview with the Administrator on 9/25/13 at 3:30 PM, he/she confirms that during a QA meeting in April 2013 the team was made aware of the need to destroy medications that are being stored in the DNS office. He/she confirmed that the process that has been in place is not working.</p> <p>Per facility policy Disposal of Medications, Section 5.1 dated 10/07 states: Medications awaiting disposal are stored in a locked secure area designated for that purpose until destroyed or picked up by pharmacy staff. Policy 5.3 Disposal and returning Medications to the Pharmacy dated 9/10 states: the consultant pharmacist and/or designated technical staff should assist the nursing center in assuring that all returned goods are processed in a timely manner. Findings demonstrate that the facility chose to manage the destruction independent of the RP. Per interview with the RP on 9/25/13 at 12:30 PM confirms that the facility has failed to act on his/her recommendations.</p> <p>2. Per observation and interview on 9/23/13, medication refrigerator located on the first floor contained a multiple dose canister of glycerin</p>	F 431		

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F 431	Continued From page 11 suppositories with an expiration date of July 2012. This was available for use as confirmed by the nurse in attendance.	F 431	F 516 The door to the DNS office was modified to be self closing and self locking.	9/27/13	
F 516 SS=E	3. Per observation and interview on 9/24/13 at 11 AM, in a locked medication cabinet on the first floor, an unopened bottle of Loperamide Hydrochloride with an expiration date of November 2012 was available for use and confirmed by the DNS who was in attendance. 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 assure that clinical records were stored in a secure location. Findings include:  Per observation on 9/24/13 at 8:28 AM, the office door of the Director of Nursing's office was left wide open. Per observation at that time, there were various medical records scattered around	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 10/29/13 PmcotakRN</i>	10/24/13  Ongoing  Ongoing	

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F 516	Continued From page 12 the office that were unsecured and sitting out in the open. Observed at this time also, numerous bubble packed and other medications with resident names on them were also observed out in the open in the unlocked office. Per interview on 9/24/13 at 8:32 AM, the MDS coordinator confirmed that the office door was left opened with numerous medications and clinical records unlocked and scattered around the office, and that being located directly off the resident dining room, was easily accessible to unauthorized entry by a resident or visitor.	F 516			