VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

July 1, 2011

Ms. Patricia Russell, Administrator
Union House Nursing Home
3086 Glover Street
Glover, VT 05839

Dear Ms. Russell:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 18, 2011.** Please post this document in a prominent place in your facility.

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

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:jl

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

RECEIVED
Division of
JUN 30 11
Licensing and Protection

PRINTED: 06/01/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475036	A. BUILDING B. WING	05/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNION HOUSE NURSING HOME	3086 GLOVER STREET GLOVER, VT 05839

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F 000	INITIAL COMMENTS An unannounced onsite annual recertification survey was conducted by the Division of Licensing and Protection from 5/16/11 to 5/18/11.	F 000	**F 272 Comprehensive Assessment Immediate Correction** Immediate correction was achieved following meeting with Administrator, Food Service Supervisor and the Director of Nursing. Existing policy has been revised and expanded to reflect appropriate dietary interventions in meeting the needs of the terminally ill or residents at end of life.	
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 resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	The Food Service Supervisor met with his staff and dietician between May 23 and 27, 2011 to familiarize all employees with the revised policy, to ensure all requirements referenced in F 272 are met. Copy of Dietary/Nutrition Assessment and Progress Notes Policy and Consulting Dietician Policy, enclosed. **Measures Put in Place to Ensure Deficient Practice Does Not Recur** For QA purposes, initial dietary assessment will be reviewed and cosigned by the DNS within one week of admission, form enclosed. Current protocol requires that all admission charts be audited within 7 days to ensure completeness. F272 POC Accepted 6/30/11 M.Higgins RN/	May 27, '11 June 9, '11

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE [signature] (X8) DATE 6/9/11

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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F 272	Continued From page 1	F 272		
	This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to comprehensively assess 1 of 30 sampled residents (Resident # 30). Findings include; 1. Per record review on 05/18/11 at 8:25 AM, Resident # 30 was not assessed by a Registered Dietician (RD) as is required by facility policy. Resident # 30 has diagnoses including chronic kidney disease, gastritis, Anemia, Hyperlipidemia, Gastroesophageal Reflux Disease and an unstageable pressure ulcer. Review of nursing documentation regarding the unstageable sacral ulcer indicated that the ulcer increased in size between 01/26/11 - 02/16/11. A dietary assessment was done by staff identified by the Director of Nurses (DON) as a Dietary Aide on 01/31/11. The assessment did not acknowledge the presence of a pressure ulcer and did not address the likes/dislikes of the resident or nutritional needs. Per review of the facility Dietary/Nutrition Assessments and Progress Notes policy, the Registered Dietician is responsible for completing a nutrition assessment for each resident admitted to the facility prior to completion of the MDS (Minimum Data Set) process and comprehensive care plan. At 10:12 AM on 05/18/11, the DON confirmed that the RD did not assess resident # 30 per facility policy.			

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F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to develop care plans for two residents (Residents #38 & 10) for the use of a psychoactive medication. Findings include: 1. Per record review on 05/18/11 at 10:25 AM and staff interviews, there is no care plan for psychoactive medications for Resident #10 who is on medications that include Ativan 0.5 mg (milligrams) twice a day and Ativan 1 mg at bedtime as needed. This was confirmed with the Director of Nursing Services on 05/18/11 at 10:50	F 279	**F 279 Develop Comprehensive Care Plans** **Immediate Correction** A thorough review of current care planning process was conducted by the MDS coordinator and DNS on June 6, 2011. . The existing care plan pertaining to use of psychotropic drugs has been expanded to include more specific guidelines in the use of psychotropic drugs. This will serve as the basis for developing an individualized care plan for each resident. All patient charts will be audited on or before June 15, 2011, with the expanded care plan incorporated as needed MDS coordinator will provide DON with a report quarterly, for QA inclusion, on the ongoing use of the expanded care plan. Copy of Interdisciplinary Plan of Care Psychotropic Drug Use, enclosed. **Measures Put in Place to Ensure Deficient Practice Does Not Recur** The initial care plan is initiated at time of admission and is done so as an interdisciplinary activity which	June 6, '11 June 15 '11 June 6, '11 ongoing

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F 279	Continued From page 3 AM. 2. Per record review on 05/17/11 at 1:45 PM and staff interview, Resident #38 was prescribed Ativan 0.5 mg three times a day on 4/22/11 for increased anxiety and restlessness. There is no care plan for psychoactive medications present in the record. This was confirmed with the Director of Nursing Services on 05/17/11 at 2:35 PM.	F 279	includes the resident and their family. The MDS coordinator will complete and formalize the initial care plan once all assessments have been done and measures put in place to ensure resident needs are being addressed. F279 POC Accepted 6/30/11 M. Higgins RN / [illegible] RN	June 6, '11 ongoing
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assure adequate monitoring of medications or adequate indications for use of medications for 2 of 10 sampled residents (Resident #50 and #25). Findings include: 1. Per record review on 05/17/11 at 4:30 PM, there was no Abnormal Involuntary Movement Scale (AIMS) assessment done for Resident #50. Per physician order, Resident # 50 has been on Seroquel, an antipsychotic medication, since 04/05/11. On 05/17/11 at 4:32 PM, the Director of Nurses (DON) stated that an AIMS is to be done as soon as antipsychotic medication is started and confirmed that Resident #50 has been on Seroquel since 04/05/11 and that an AIMS had not been done. 2. Per record review in the afternoon of 05/17/2011, there are 3 different analgesics ordered for pain for Resident #25 without adequate indications for use. Per physician orders, Ibuprofen, Tylenol and Ultram are all ordered to be given as necessary for pain. There are no parameters for the staff to determine which medication should be used based on resident complaints or assessments. This is confirmed during interview with the staff nurse on 05/18/11 at 11:39 AM. S/he further confirms that guidelines for the use of analgesics should be included in the orders when more than one analgesic is ordered. The Medication Administration Record (MAR) indicates that Ultram has been given to Resident #25 at least daily during the month of May 2011. Staff further confirms during an 05/18/11 interview that Ultram	F 329	**F329 Drug Regimen is Free from Unnecessary Drugs** **Immediate Correction** The Medication Policy has been reviewed and guidelines pertaining to requirement of F 329 have been further developed to provide concise direction to the nurse. By June 20, 2011, each medication nurse will be provided with a copy of the expanded Medication Policy, further educated and tested to clarify the requirements when using any medications, with a focus on analgesics and psychotropics. Copy of Medication Administration Policy enclosed. **Measures Put in Place to Ensure Deficient Practice Does Not Recur** Daily audits of any new medication orders and new admission orders will be conducted by the DNS or her designee from June 13 to July 11, 2011. Nurses found to implement any order without adhering to the medication policy will be required to complete additional training and be subject to disciplinary action. Incidents requiring disciplinary	June 20, 11 July 11, '11

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F 329	Continued From page 5 has been determined to provide the best pain relief for Resident #25 and that it is always the medication of choice when an analgesic is required.	F 329	action will be tracked and included in the QA quarterly report. F329 POC Accepted 6/30/11 M.Higgins RN/ PMcotaRN	
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a safe and functional environment by not ensuring that bathroom wall tiles are replaced when broken and by not stabilizing a sink in 1 resident bathroom. Findings include: During the initial tour of the facility on 05/16/2011 between 10:30 and 11:00 AM, tiles are broken and separating from the walls in the bathrooms between rooms 06 and 09 on the 2nd floor and between rooms 114 and 116 on the first floor. Also, the sink in the bathroom between rooms 01 and 02 on the first floor is loose, despite being supported by a wooden brace underneath it. It is used as a support by residents getting up off the toilet and has separated from the wall by 2-3 inches when weight is applied to it. These observations are confirmed by the Director of Maintenance during the environmental tour on 05/17/2011 at 3:00 PM.	F 465	**F 465** **Safe/Functional/Sanitary/Comfortable Environment** **Immediate Correction** The sink in the bathroom between rooms 01 and 02 was shimmed and tightened the day surveyors identified the problem, 5/17/11. Floor tiles were replaced in the bathroom between first floor rooms 114 and 116 on the day surveyors identified the problem. Tiles and cove base trim were ordered, with expected delivery of June 9 and installation between June 9 and 13, 2011, for replacement in second floor bathroom between rooms 06 and 09 **Measures Put in Place to Ensure Deficient Practice Does Not Recur** Director of Maintenance has added checking floor tiles and bathroom fixtures to his weekly building and grounds checklist (see enclosed). By checking each bathroom weekly, we will be able to identify needed repairs and arrange for timely repair.	May 17, '11 June 20, '11 June 9, '11
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS	F 468		

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F 468	Continued From page 6 The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure that the corridors have firmly secured handrails on each side. Findings include: Per observation during the initial tour on 05/16/11 between 10:30 and 11:00 AM the hand rail on the left side of a first floor corridor is loose and easily pulls away from the wall. During the environmental tour with the Director of Maintenance on 05/17/11 at 3:03 PM, s/he confirms that the hand rail over a heating vent in the corridor on the first floor is not secured to the wall.	F 468	all shifts to report matters needing attention. (Capital construction projects are handled by outside contractors, generally in the winter months.) Maintenance checklists are given to the Director of Nursing and included in the quarterly Quality Assurance Reports. F465 POC Accepted 6/30/11 M Higgins RN/PMcotaRN **F 468** **Corridors Have Firmly Secured Handrails** **Immediate Correction** Upon identification by surveyors, Director of Maintenance secured the end of railing with a three inch sheet rock screw, and covered the head with wood putty. The railing does not move. **Measures Put in Place to Ensure Deficient Practice Does Not Recur** Director of Maintenance has added checking railings to his weekly building and grounds checklist (see enclosed). By checking each railing weekly, we will be able to identify needed repairs and arrange for timely repair. Maintenance checklists are given to the Director of Nursing and in included in the quarterly Quality Assurance Reports. **THIS DEFICIENCY IS BEING QUESTIONED THROUGH THE INFORMAL DISPUTE RESOLUTION PROCESS. SEE ENCLOSED REQUEST.** F468 POC Accepted 6/30/11 M Higgins RN/PMcotaRN	May 17 '11 June 9 '11