



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

November 4, 2010

Mr. Thomas Rice, Administrator  
Brookside Nursing Home Inc  
1200 Christian Street  
White River Junction, VT 05001

Provider #: 475010

Dear Mr. Rice:

Enclosed is a copy of your acceptable plans of correction for the on-site recertification survey conducted on **October 6, 2010**. Please post this document in a prominent place in your facility.

We will 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

Enclosure



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

RECEIVED  
Division of

PRINTED: 10/18/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475010</b>	(X2) MULTIPLE CONSTRUCTION OCT 29 10 A. BUILDING _____ Licensing and B. WING _____ Protection	(X3) DATE SURVEY COMPLETED  <b>10/06/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BROOKSIDE NURSING HOME INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1200 CHRISTIAN STREET WHITE RIVER JUNCTION, VT 05001</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  An unannounced, on-site recertification survey was conducted by the Division of Licensing and Protection from 10/04/2010 to 10/06/2010. The findings are as follows:	F 000	<b>Disclaimer</b> The filling of this plan of correction is filed as the facilities does not constitute the fact deficiencies did in fact exist. This limits this plan of correction is filed as evidence of the facility's desire to comply with the requirements and provide high quality care.	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE  A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.  The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.  This REQUIREMENT is not met as evidenced by: Based on observation, the Facility failed to post the most recent survey in a place readily accessible to residents. Findings include:	F 167	<b>Corrective Action:</b> All survey results were immediately reinstalled in the survey binder that was not available at the front door.  <b>Protection of Other Residents:</b> All survey results will be installed in the survey binder at the front door.  <b>Systemic Changes:</b> When survey results come to the facility, they will be installed in the survey binder by the administrative Assistant in a timely manner.	Completion Date: 10/7/10
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  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.	F 241	<i>Re auptd 11-4-10</i> <i>G. Colman / SR</i> <b>Corrective Action:</b>  The individual LNA was counseled as to the appropriate way to remove plates and food from the table when the resident has completed meal.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Thomas E. Rice</i>	TITLE <i>Administrator</i>	(X6) DATE <i>10/27/10</i>
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A deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the 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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NAME OF PROVIDER OR SUPPLIER  BROOKSIDE NURSING HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 CHRISTIAN STREET WHITE RIVER JUNCTION, VT 05001
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F 241	Continued From page 1  This REQUIREMENT is not met as evidenced by: Based on observation and interview, facility staff failed to provide an environment that maintains or enhances each resident's dignity for 2 applicable residents during a meal observation (Residents #16, #35). Findings include:  1. During observation of the noon meal on 10/04/10 in the main dining area, a staff member was observed scraping off the unfinished meal of Resident #16 from the plate onto the paper place mat and rolling up the place mat in front of that resident and while the table mate Resident #35 was eating. This same activity was observed at another table during the same meal. Per interview on 10/06/10 at 2:30 PM, the Food Service Supervisor stated that the expectation is that the plate/food is to be taken away from the table and scraped off near the sink, and not onto the paper place mat in front of the residents.	F 241	<b>Protection of Other Residents:</b> All residents are at risk.  <b>Systemic Changes:</b> The social services Director and the Director of Nursing Services to provide in-service to all staff that includes dinning room procedures that promote/enhance the respect and dignity of individual dinning experience.  <b>Monitoring:</b> The charge nurses to monitor dinning room each meal and to report any deviations to the unit manager dfoe4 immediate correction. Dinning room committee to review/monitor reporting dining room procedures and update as necessary through quality Assurance meetings.	Completion Date 11/15/10
F 272 SS=D	483.20, 483.20(b) 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 RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision;	F 272	<i>DC unmet 11-4-10</i> <i>G. Colman / 8/10</i>  <b>Corrective Action:</b> Resident provided with additional dental supplies. The individual's nurse was counseled to the importance and accuracy of documentation to support comprehensive assessments.  <b>Protection of Other Residents:</b> All residents are at risk.	

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F 272	<p>Continued From page 2</p> <p>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 through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to conduct an accurate comprehensive assessment for 1 of 12 residents in the sample. (Resident #2) Findings include:</p> <p>Per interview on 10/04/10 at 2:30 PM, Resident #2 stated that staff do not assist with oral hygiene and s/he did not have a toothbrush. Per observation of the resident (confirmed to have teeth) and of his/her toiletry, there was no toothpaste, mouth wash, toothbrush and/or sponge toothettes. Per record review of the initial nursing assessment (admission on 08/26/10) it was erroneously documented that the resident was edentulous. Per review of the admission Minimum Data Set (MDS) dated 9/12/10 the resident was coded as having lost some/all natural teeth and was also coded as needing daily cleaning or mouth care. Per interview on 10/06/10 at 12:00 PM, the Unit Charge nurse</p>	F 272	<p><b>Systemic Changes:</b> All Licensed staff will be in-service on how to perform an accurate and comprehensive assessment of a patient. Unit Coordinators/Managers to perform audits on all new admissions to ensure accuracy and completeness of the comprehensive assessments. The MDS Coordinator to report any inaccuracies identified for immediate correction.</p> <p><b>Monitoring:</b> Director of Nursing services to monitor compliance utilizing audits during monthly Quality Assurance meetings</p> <p><i>PC umpt 11-4-10</i> <i>G. Calman / S</i></p>	<p>Completion Date: 11/15/10</p>
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F 272  F 281 SS=E	<p>Continued From page 3</p> <p>confirmed the failure to accurately assess the Resident's dental/oral condition.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide services in accordance with professional standards regarding the administration of medication for 4 residents in the sample of 10 residents (Residents #44, #13, #84, and #73). Findings include:</p> <p>1. Per record review and staff interview, the facility failed to follow a physician's order for Resident #44. Per observation of a medication administration at 12 noon on 10/04/10, the resident received Miralax (a laxative). Per review of the medical chart, a signed physician's order dated September 2010 was for the laxative to be given at 8 AM. Per interview on 10/06/10 at 1:30 PM the Unit Charge nurse stated the the time was changed per nursing judgement in the beginning of October 2010, however, further confirmed that the change was without a physician's order.</p> <p>2. During a medication administration observation on 10/6/10 at 10:20 AM, Resident #13 had the following medications listed, the order last signed by the physician on 9/2/10: Norvasc 10 mg (milligrams) one tab QD at 8AM, Aspirin 81 mg one tab at 8AM, Isosorbide EC 30 mg one tab at 8AM, Metoprolol 25 mg one tab twice daily at 8AM and 8PM, Seroquel 25 mg one tab twice</p>	F 272  F 281	<p><b>Corrective Action:</b> The individual nurse will be assessed for medication administration and time compliance.</p> <p><b>Protection of Other Residents:</b> All residents are at risk.</p> <p><b>Systemic Changes:</b> All licensed staff to be in-serviced on crushable medications, BP HR monitoring R/T medication administration and obtaining a written order to change the times of any medication. In-service also to include the five rights of medication administration.</p> <p><b>Monitoring:</b> Unit Coordinators, Unit Managers to monitor MARS daily for completeness and compliance.</p> <p><i>PC Gupta 11-4-10</i> <i>G. Colman / S</i></p>	<p>Completion Date 11/15/10</p>

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F 281	<p>Continued From page 4</p> <p>daily at 8AM and 8PM, Depakote 250 mg one tab twice daily at 8AM and 8PM, Depakote 500 mg one tab at 2PM, and Acetaminophen 650 mg four times daily at 8AM, 2PM, 6PM, 10 PM. Per interview on 10/6/10 at 11:05 AM, the medication nurse confirmed that these medications were ordered to be given at 8 AM, and that they were being given over 2 hours later or earlier than ordered.</p> <p>3. During a medication administration observation at 9:44 AM on 10/05/2010, it was observed that Resident #84 did not have their pulse and blood pressure assessed, prior to being given Amlodipine and Atenolol, as ordered by the physician. Documentation on the Medication Administration Record (MAR) further reveals that the resident's B/P was not taken during am med pass of 10/05/2010 and once in Sept. 2010. It was confirmed during interview with the Unit Manager on 10/06/2010 at 1:58 PM that vital signs for this resident are routinely taken on a weekly basis but should also be checked by the nurse prior to giving these medications. It was further confirmed that documentation indicates that the resident's pulse was not counted during that morning med pass and 3 other times during September 2010.</p> <p>4. During a medication administration observation on the morning of 10/05/2010, it was noted that Resident #73 received Enteric Coated Aspirin that was ordered to be given to this resident on a daily basis. The medication was crushed by the nurse administering the medication and given with other crushed medications and put in applesauce. This was confirmed during interview with the Unit Manager on 10/06/2010, who further indicated that enteric coated aspirin is not to be crushed.</p>	F 281		

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F 281	Continued From page 5	F 281		
F 332 SS=E	<p>Reference: Nettina, S.M., (2006), Lippincott Manual of Nursing Practice, 8th Edition, p 18, Lippincott, Williams &amp; Wilkins, Philadelphia</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to maintain medication error rate less than 5 % during the recertification survey, involving 4 of 10 residents in the medication pass sample (Residents #44, #13, #84, and #73). The findings include:</p> <p>1. Per observation of 52 medication opportunities involving 10 different residents during the 3 days of survey, 10/04-06/2010. Eleven medication errors were observed, including 8 medications given 2 hours late or early, one medication administered without the resident vital signs being assessed as directed by MD orders, one enteric coated medication crushed prior to administration and one medication given without a proper MD order. This makes the medication error rate 21%. Findings were verified by facility staff on each of the 3 nursing units involved. Refer to specific examples below.</p> <p>2. Per record review and staff interview, the facility failed to follow a physician's order for Resident #44. Per observation of a medication administration at 12 noon on 10/04/10, the</p>	F 332	<p><b>Corrective Action:</b> The individual nurse will be assessed for medication administration and time compliance.</p> <p><b>Protection of Other Residents:</b> All residents are at risk.</p> <p><b>Systemic Changes:</b> All licensed staff to be in-serviced on crushable medications, BP HR monitoring R/T medication administration and obtaining a written order to change the times of any medication. In-service also to include the five rights of medication administration.</p> <p><b>Monitoring:</b> Unit Coordinators, Unit Managers to monitor MARS daily for completeness and compliance.</p> <p><i>POC complete 11-4-10</i> <i>G. Colman 18</i></p>	Completion Date: 11/15/10

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F 332	<p>Continued From page 6</p> <p>resident received Miralax (a laxative). Per review of the medical chart, a signed physician's order dated September 2010 was for the laxative to be given at 8 AM. Per interview on 10/06/10 at 1:30 PM the Unit Charge nurse stated the the time was changed per nursing judgement in the beginning of October 2010, however, further confirmed that the change was without a physician's order.</p> <p>3. During a medication administration observation on 10/6/10 at 10:20 AM, Resident #13 had the following medications listed, the order last signed by the physician on 9/2/10: Norvasc 10 mg (milligrams) one tab QD at 8AM, Aspirin 81 mg one tab at 8AM, Isosorbide EC 30 mg one tab at 8AM, Metoprolol 25 mg one tab twice daily at 8AM and 8PM, Seroquel 25 mg one tab twice daily at 8AM and 8PM, Depakote 250 mg one tab twice daily at 8AM and 8PM, Depakote 500 mg one tab at 2PM, and Acetaminophen 650 mg four times daily at 8AM, 2PM, 6PM, 10 PM. Per interview on 10/6/10 at 11:05 AM, the medication nurse confirmed that these medications were ordered to be given at 8 AM, and that they were being given over 2 hours later or earlier than ordered.</p> <p>4. During a medication administration observation at 9:44 AM on 10/05/2010, it was observed that Resident #84 did not have their pulse and blood pressure assessed, prior to being given Amlodipine and Atenolol, as ordered by the physician. Documentation on the Medication Administration Record (MAR) further reveals that the resident's B/P was not taken during am med pass of 10/05/2010 and once in Sept. 2010. It was confirmed during interview with the Unit Manager on 10/06/2010 at 1:58 PM that vital signs for this resident are routinely taken on a</p>	F 332		

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F 332	Continued From page 7 weekly basis but should also be checked by the nurse prior to giving these medications. It was further confirmed that documentation indicates that the resident's pulse was not counted during that morning med pass and 3 other times during September 2010.	F 332		
F 465 SS=C	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 observations and interview, the facility failed to provide a sanitary environment in the kitchen area. Findings include:  During the initial kitchen tour which occurred on 10/04/10 at 7:30 am, the following observations were made with the Food Service Supervisor (FSS):  1) a large floor fan in the kitchen area had a build	F 465	<b>Corrective Action:</b> The dust and debris has been cleaned (10/6/10)10:am  <b>Protection of Other Residents:</b> All residents are at risk.	

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F 465	<p>Continued From page 8 up of dust and debris 2) the floor, especially in the corners and around the baseboards, had a build up of grime 3) food particles [lettuce and onion peels] from the previous evening meal were observed under the food prep table.</p> <p>On the subsequent tour on 10/06/10 at 9:00 AM, the fan remained dirty and the FSS confirmed these observations.</p>	F 465	<p><b>Systemic Changes:</b> An n new schedule for cleaning and management shall develop and implement plan.</p> <p><b>Monitoring:</b> Daily the Head Cook, Food Service Supervisor, shall inspect and cause action for the cleanliness and sanitation of the kitchen. Daily the safety officer shall inspect5 the kitchen as well as all of the areas within the facility of operations for sanitation, presentation and patient safety. Results will be shared with the safety committee monthly. Safety committee meets with the Quality Assurance committee Quarterly and shall report the finding to the Q.A. Committee.</p> <p><i>G. Colman / POC accepted 11-4-10</i></p>	<p>Completion date 10/6/10</p>



STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # <b>475010</b>	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: <b>10/6/2010</b>
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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**F 156**

Continued From Page 1

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:  
Based on record review and interview, the facility failed to inform 1 applicable resident before, or at the time of admission, regarding charges not covered under Medicare services.(Resident #10) Findings include:

During record review of the facility's demand bill process, there was no indication that Resident #10 received advanced notification of a request for Medicare Intermediary Review. Resident #10 was admitted on 6/30/10 with 'ulcers requiring dressing changes and therapies to eval and treat.' The Determination on Admission form listed services as 'nonskilled care - full denial'.  
A request for medicare intermediary review was signed and dated on 7/8/10 by a family member. Per interview on 10/06/10 at 11:45 AM the Social Worker confirmed there was no evidence that information was given at admission or before non-coverage services.

**Corrective Action:**

The facility has informed the individual in writing if which the resident sponsors had signed and forgotten to date the Denial Notice Form.

**Protection of Other Residents:**

All residents are at risk by this oversight.

**Systemic Changes:**

A management procedure shall be developed and implemented.

Completion date
11/15/10

**Monitoring:**

The Business office manager shall educate staff for completeness and accuracy, reviewing each of the demand billing notices for accuracy for a period of three months.

The Business office Manager shall report to the Q.A Committee

*see page - 11-4-10*  
*G. Clark 152*