

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

May 8, 2014

Mr. Thomas Rice, Administrator
Brookside Health And Rehabilitation
1200 Christian Street
White River Junction, VT 05001-9267

Dear Mr. Rice:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 16, 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,



Frances L. Keeler, RN, MSN, DBA
Assistant Division Director
State Survey Agency Director

FK:jl

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

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MAY 6 14
PRINTED: 04/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIDN	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ Licensing and Protection		(X3) DATE SURVEY COMPLETED 04/16/2014
NAME OF PROVIDER OR SUPPLIER BROOKSIDE HEALTH AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 CHRISTIAN STREET WHITE RIVER JUNCTION, VT 05001		
(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 F 282 SS=E	<p>INITIAL COMMENTS</p> <p>An unannounced on site recertification survey was conducted by the Division of Licensing and Protection on 4/14/14 - 4/16/14. The following regulatory violations were identified:</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to implement the plan of care for 4 of 18 applicable residents (Residents #9 , #32, #75, #26). Findings include:</p> <p>1. Per record review on 4/16/14 at 8:07 AM, staff failed to implement the care plan for Resident #9 by not administering medications as ordered. Resident # 9 was administered a medication that had been discontinued by the physician. A physician's order dated 3/19/14 stated to discontinue Dilaudid (pain medication) when Fentanyl patch (also pain medication) is available. A progress note by the same physician on 3/19/14 also stated to discontinue the Dilaudid. Review of the March 2014 Medication Administration Record (MAR) showed that Resident # 9 received a Fentanyl patch on 3/19/14 at 2:00 PM. The MAR showed that Resident # 9 was administered Dilaudid at 6:00 PM on 3/19/14. There was no indication on the</p>	F 000 F 282	<p>POC accepted T Daugherty / F Keeler RN MGN DBA</p>	5/6/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Thomas E. Rice

TITLE
Administrator

(X6) DATE
5/2/14

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 282 Continued From page 1

MAR that the Dilaudid was discontinued. The care plan to address pain/discomfort was dated 3/13/14. Approach # 00007 stated to medicate as ordered. On 4/16/14 at 8:36 AM, the Unit Manager confirmed that Resident # 9 was not medicated as ordered as stated on the care plan

2. Per medical record review, Resident #32 was admitted on 01/04/13 with a diagnosis to include Cerebral Vascular Accident (CVA) with left sided Hemiparesis. Per medical record review on 04/15/14, the Interdisciplinary Care Plan (ICP) dated 01/14/14 identifies that Resident #32 has a problem of contractures of her/his left arm and leg secondary to left sided hemiplegia. Nursing is to provide Range of Motion (ROM) exercises every morning (AM) and evening (PM) while providing Activities of Daily Living (ADL'S). Per interview with the primary evening Licensed Nurse Aide (LNA) on 04/15/14 at 1:20 PM, s/he confirms that ROM exercises are conducted during Resident #32's bath night, which is every Tuesday, once a week. S/he confirms the ROM exercises are not conducted as per ICP identifies, therefore the care plan is not implemented.

3. Per record review the Minimum Data Sheet [MDS] for Resident #75, dated 12/19/13 assesses "how the resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture" as 'total dependence' and lists the treatment Resident #75 receives for skin and ulcer conditions as a "turning/repositioning program". The resident's Care Plan identifies a 'risk for development of pressure ulcers' with the intervention "...assist resident to change positions every two hours". Additional risks identified include incontinence and pain, with preventive actions which include

F 282 F282

Disclaimer

The filling of this plan of correction is filed as the facility's does not constitute the fact that deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply the requirements and provide High quality care

1. Resident #32,75,26 has been assessed, no negative outcome as a result of this alleged deficient practice. Resident #9 was a closed record and has expired of unrelated chronic conditions. Completed by 4/28/14
2. All residents on medication, All residents having a repositioning program, and all residents on a ROM program may be affected by this alleged deficient practice.
3. All residents receiving medications had their medication reconciled with the care plan, md orders and the MAR to ensure all are being given. All residents on a repositioning program have been evaluated to ensure appropriateness of plan. Plans have been communicated to staff for implementation All residents on a ROM program have been evaluated to ensure appropriateness of their program. Programs have been communicated to staff for implementation. 5/09/14

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F 282 Continued From page 2

"assist with repositioning every 2 hours" and "reposition every 2 hours while in bed or cardiac chair", along with comfort measures that include repositioning.

Per record review, Resident #26's MDS also lists the resident's functional status as 'total dependence' and the treatment Resident #26 receives for skin and ulcer conditions as a "turning/repositioning program". The resident's Care Plan states that Resident #26 experiences chronic pain, with interventions which include "provide comfort measures...repositioning".

Per record review on 4/15/14 the "Standards of Care" for the resident's unit records both residents as requiring repositioning every 2 hours. Per observation on 4/14/14, both residents were in their room positioned in chairs at 11:15 A.M. The residents were observed in the same position while being fed in the facility's dining room an hour later, and again in the same position in their chairs while back in their room at 2:11 P.M. and again at 3:32 P.M.

Per record review of the unit's Licensed Nursing Assistant [LNA] "Turn/Reposition Record" for 4/14/14, there are no entries for Resident #75 from 7:00 A.M. to 3:00 P.M. At 3:00 P.M. the resident is recorded as being in a chair, with no repositioning noted until 8:00 P.M. when the resident was moved to h/her bed. Per record review of the LNA "Turn/Reposition Record" for 4/14/14 the record for Resident #26 is almost identical, with no entries from 7:00 A.M. to 3:00 P.M., and at 3:00 P.M. the resident is recorded as being in a chair, with no repositioning noted until 10:00 P.M. that night.

F 282

4. Nursing staff re-educated for process for care plan implementation of medication, ROM and repositioning by 5/09/14
5. Random weekly audits x4 to ensure continued compliance. Results to be reported to QAA x3 for determination of compliance. Start 5/09/14
6. Plan completed by 5/09/14. Director of Nursing or designee responsible for implementation

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F 282	Continued From page 3 Per interview with the Unit Coordinator for Residents #75 & #26 on 4/15/14 at 12:03 P.M., it is h/her expectation that every resident is turned and repositioned "at least" every 2 hours, and confirmed the LNA Turn/Reposition Record for 4/14/14 demonstrates both residents remained in a chair and were not repositioned as per expectation, the residents' care plans, and the unit's "Standards of Care".	F 282			
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 staff interview and record review, the facility failed to ensure 1 of 10 applicable residents was free from unnecessary medications (Resident # 9).
Findings include:

Per record review on 4/16/14 at 8:07 AM, Resident # 9 was administered a medication that had been discontinued by the physician. A physician's order dated 3/19/14 stated to discontinue Dilaudid when Fentanyl patch is available. A progress note by the same physician on 3/19/14 also stated to discontinue the Dilaudid. Review the March 2014 Medication Administration Record (MAR) showed that Resident # 9 received a Fentanyl patch on 3/19/14 at 2:00 PM. The MAR showed that Resident # 9 was also administered Dilaudid at 6:00 PM on 3/19/14. There was no indication on the MAR that the Dilaudid was discontinued. During interview on 4/16/14 at 8:36 AM, the C/D wing Unit Manager (UM) confirmed that the Dilaudid should have been discontinued after the Fentanyl patch was available and it had not been discontinued on the MAR. The UM also confirmed that the Fentanyl patch was placed by his/herself at 2:00 PM on 3/19/14 and that the Dilaudid had been administered at 6:00 PM on 3/19/14.

F 371 483.35(i) FOOD PROCURE,
SS=D STORE/PREPARE/SERVE - SANITARY

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and

F329
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1. Resident #9 was a closed record and expired of unrelated chronic conditions.
2. All residents who receive medication have the potential to be effected by this alleged deficient practice.
3. All MARs have been reconciled with physicians orders for appropriateness and accuracy 5/2/14
4. Re-educate nursing staff for process for obtaining, and implementing MD orders 5/09/14
5. MD re-educated for the process to discontinue orders already written. 5/09/14
6. Random weekly audits x4 to ensure continued compliance. Begin 5/09/14
7. Results to be reported to QAA for determination of continued surveillance.
8. Plan completed by 5/09/14. Director of Nursing or designee responsible for implementation

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F 371 Continued From page 5
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based on observation and on staff interview the facility failed to store, prepare, distribute and serve food under sanitary conditions.
Findings include:

Per surveyor kitchen inspection conducted on April 14, 2014 it was discovered that kitchen staff were air drying recently cleansed eating utensils directly underneath two ceiling lights that had thick, caked black dust accumulating between them on the ceiling. It was also further noted that adjacent to the lights on the ceiling the fire sprinkler was also caked in thick, black dust. The Kitchen Manager confirmed that the areas were dirty on April 14, 2014 at 0934 AM.

F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

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.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;

F371
F 371 **Disclaimer**
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1. All utensils cleaned. Sprinkler head and light fixtures were also cleaned on 4/14/14.
2. All sprinkler heads and light fixtures are at risk to be dirty as a result of this alleged deficient practice.
3. All sprinkler heads and light fixtures in building and cleaned by 5/7/14
4. Staff re-educated as to the process for cleaning fixtures and sprinkler heads by 5/9/14
5. Random weekly audits x4 to ensure continued compliance. Results to be reported to QAA x3 for determination of compliance. Start 5/09/14
6. Plan completed by 5/09/14. Director of Housekeeping or designee responsible for implementation

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F 441 Continued From page 6
(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.

- (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.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and medical record review, the facility failed to 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 for 1 resident [Resident #22] of 18 residents in the sample group.
Findings include:

Per initial tour on 04/14/14 at approximately 10:30

F 441

Disclaimer

The filing of this plan of correction is filed as the facility's does not constitute the fact that deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply the requirements and provide High quality care

F441

1. Resident #22 has been assessed, no negative outcome as result of this alleged deficient practice
2. Residents on isolation precautions are at risk to be affected by this alleged deficient practice.
3. No other residents on precautions. Contact precaution sign hung on door by 4/ 23/14.
4. Nursing staff re-educated for process for implementation of isolation precautions by 5/9/14
5. Random weekly audits x4 to ensure continued compliance. Start 5/9/14
6. Results to be reported to QAA x3 for determination of compliance and further surveillance.
7. Plan completed by 5/9/14. Director of Nursing or designee responsible for implementation

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F 441	<p>Continued From page 7</p> <p>AM the Unit Manager (UM) was asked by the surveyor if there were any residents currently on contact precautions. UM denied knowledge of any residents on precautions, that s/he needed to check with the Assistant Director of Nurses (ADNS) to provide accurate information.</p> <p>Per medical record review on 04/16/14, Resident #22 was admitted on 10/23/13 with a diagnosis of Clostridium Difficile (C-Diff.). Per facility policy and Centers for Disease Control (CDC) guidelines, residents with diarrhea associated C-Diff. will be placed on Contact Precautions. Healthcare workers and visitors will wear gloves and gowns when entering the room of a resident with a C-Diff. infection. Per medical record review on 04/16/14, Resident #22 has had two (2) positive stool tests indicating the presence of C-Diff. dated 11/08/13 and 02/25/14. Per medical record review on 04/16/14 the Interdisciplinary Care Plan (ICP) dated 01/15/14 identifies that Resident #22 has a C-Diff. infection and has been placed on contact precautions until results are available. If results are positive continue with contact precautions.</p> <p>During the initial tour on 04/14/14 at approximately 10:30 AM, four (4) State Surveyors observed the hall outside of Resident #22's room, noting the storage of personal protective equipment (PPE). Surveyors also observed at that time, that there was no sign on Resident #22's door alerting visitors and staff to see nurse before entering and the need to utilize PPE for visitors and staff before entering the room.</p>	F 441			

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475010	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	DATE SURVEY COMPLETE: 4/16/2014
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 280	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to revise the care plan for 1 of 18 applicable residents (Resident # 24). Findings include:</p> <p>Per record review on 4/15/14 at 11:05 AM, Resident # 24 was being weighed monthly as of January 2014. Resident # 24 has end stage disease and is receiving comfort care. Both the Nutrition and Activities of daily living (ADL) care plans indicate that the resident is to be weighed weekly. There is no indication on the Licensed Nursing Assistant (LNA) daily plan of care when the resident is to be weighed. On 4/15/14 at 11:48 AM, the Unit Nurse confirmed that weights are scheduled weekly on both care plans and neither the nutrition or ADL care plans had been revised to reflect the change in weight status.</p> <p>*This is an "A" level citation, which requires the facility to address and correct the identified issue, but does not require a written plan of correction.</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents