

Division of Licensing and Protection
103 South Main Street
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

December 31, 2014

Ms. Patricia Russell, Administrator
Union House Nursing Home
3086 Glover Street
Glover, VT 05839-9701

Dear Ms. Russell:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 6, 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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475036 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 11/06/2014 |
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| NAME OF PROVIDER OR SUPPLIER UNION HOUSE NURSING HOME | STREET ADDRESS, CITY, STATE, ZIP CODE 3086 GLOVER STREET GLOVER, VT 05039 |
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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 |
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| F 000 | INITIAL COMMENTS An unannounced onsite investigation of a complaint concerning resident care and services was conducted by the Division of Licensing & Protection on 11/6/14. The following regulatory findings were identified. | F 000 | Union House Nursing provides this plan of correction without admitting or denying the validity or existence of the alleged deficiency. The plan of correction is prepared and executed solely because it is required by federal and state law. | |
| F 281 SS=D | 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 interview and record review, the facility failed to ensure services provided met professional standards of quality for 1 of 3 residents in the sample regarding: 1. Monitoring for pain and pain relief after the administration of analgesic medications and 2. Failure to alert the nutritionist of a corrected weight measurement for a resident with a diagnosis of malnutrition and 3. Failure to ensure that a resident who develops incontinence receives the care and services needed to restore bladder function. (Resident #1). Findings include: 1. Per 11/6/14 medical record review, Resident #1 was admitted to the facility on 9/24/14 for rehab following hospitalization for a fall that resulted in fractures of the right humerus (upper arm) and right femur (thigh bone). The resident also had diagnoses that included pain, malnutrition, and sacral tissue injury (pressure ulcers), a history of dehydration, an acute UTI (Urinary tract infection), diabetes and other chronic medical conditions. Per 11/6/14 record review, the facility nursing staff | F 281 | F281 #1 Facility has implemented a policy and procedure plan for pain management. Revisions were made to the "pain flowsheet" for clearer directions and ease of use to maintain consistency and accuracy in documentation of pain medication. Audits for accurate and consistent use will be done weekly X 4, then monthly X 3, then random audits to be done quarterly with results reviewed at the Quality Assurance Meetings. Person responsible: DValiquette RN DNS A mandatory inservice on Union House Pain Management Policy, pain med administration and use of the "pain flowsheet" will be held on December 9 and December 10, 2014 for all licensed nursing staff. Person responsible: DValiquette RN DNS | 12/5/14 <i>[Signature]</i> 12/30/14 11/11/14 11/10/14 |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i> | TITLE <i>[Signature]</i> | (X8) DATE 12/2/14 |
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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 281 | Continued From page 1 used a Pain Management Flow Sheet, to document the treatment of Resident #1's pain. The tool had spaces to document the location of pain, its intensity (pain scale of 1-10 with 10/10 being the worst pain), non-medical and medical interventions, follow up monitoring at 30 minute and 2 hour intervals, arousal state and initials. From 9/25/14- 9/27/14 nursing staff documented the resident reported 10/10 pain at his/her fracture sites; the nurses documented checking the resident at 30 minutes post administration of oxycodone (a narcotic analgesic) and documented a positive effect from the treatment. From 10/3-10/10/14, nursing staff documented that Resident #1 reported 10/10 fracture pain and the administration of oxycodone, but performed follow up monitoring for pain relief in 2 hours post medication administration. On 2 times on 10/11/14 and 2 times on 10/12/14 nursing staff documented the resident as having 10/10 pain that was "all over" and documented checking for pain relief in 2 hours (in 2 instances there was no positive effect from oxycodone, on 1 instance a fair effect and on 1 instance a positive effect). On 10/13/14 in 3 instances of resident reported 10/10 pain, the resident was again reassessed for effectiveness of the oxycodone in a 2 hour interval; on 1 instance, the intervention was documented as not effective, one time the resident was not reassessed for effect, and on the 3rd intervention, the nurse reported "fair" response to oxycodone. Per review, not all pain medication administrations were documented on the Pain management Flow Sheet; nursing staff also made entries on the MAR (Medication Administration Record) for the administration of oxycodone to Resident #1. Per review of the MAR, nurses were also inconsistent in reporting the | F 281 | | | |

P. Hill

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| F 281 | <p>Continued From page 2</p> <p>effectiveness from the administration of pm pain medication, sometimes making no entry or writing "pending" and not documenting the results of when or if pain relief was obtained.</p> <p>On 11/6/14 at 2:57 PM, the Director of Nursing (DON) reported that the facility does not have a pain policy/procedure. S/he reported that staff nurses are oriented about pain assessments on hire and are expected to do a pain scale assessment each time a narcotic is given and follow up to see that the resident obtained relief from interventions; however, s/he reported there is no specific policy regarding documentation for medication administration or checking pain relief.</p> <p>On 11/6/14 at 4:24 PM, the DON confirmed that the staff were inconsistent in checking Resident #1's response to pain medications and that a 2 hours interval was too long to wait before checking for pain relief after the administration of a pain medication.</p> <p>2. Per 11/6/14 interview with the DON (Director of Nursing), Resident #1 was difficult to weigh due to his/her fractures at the time of admission to the facility and was initially identified as weighing 94.8 pounds on 9/24/14 (height 5' 6"). The DON reported that the resident was reweighed on 9/24/14 and his/her corrected weight was determined to be 84 pounds which was consistent with his/her weight at the time of his/her hospital discharge. On 10/2/14 when the facility nutritionist completed his/her assessment of Resident #1, s/he used the non-corrected admission weight to calculate the resident's BMI as 15.17 (Body Mass Index) and to determine the resident's nutrition plan. (If the corrected weight had been used, the calculated BMI would have been 13.6). On the 10/8/14 (14) day nutrition review, the nutritionist continued to report the resident's weight as 94.8 pounds. On 11/6/14 at</p> | F 281 | <p>F281</p> <p>#2. All current residents weights have been reviewed with dietician. All current weights are accurate with appropriate dietary interventions. Daily wts/rewts will now be obtained every day for 3 days upon admission/readmission to the facility to assure accuracy. Dietician will receive a copy of all resident weights on a weekly basis and review with RN Supervisor, DNS or designee.</p> <p>A mandatory inservice on resident weights/reweights will be held on December 9 and December 10, 2014 for all licensed nursing staff.</p> <p>Person responsible: B Grant RD DValiquette RN DNS</p> | <p><i>Review completed 11/28/14 [Signature]</i></p> <p><i>Complete date 12/11/14 [Signature]</i></p> <p><i>10.30.14 [Signature]</i></p> |
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| F 281 | <p>Continued From page 3</p> <p>3:22 PM, the DON confirmed that there was no evidence that the nutritionist was notified of the corrected admission weight to determine if there were further dietary recommendations based on the resident's significantly lower BMI, pressure ulcers and other medical conditions. (A BMI is a method of screening for weight categories that may lead to health problems. A BMI between 18.5-24.9 is considered normal while a BMI below 18.5 is considered underweight). <http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html?s_cid=tw_0b064></p> <p>3. Per 11/6/14 medical record review, on admission, Resident #1 was receiving treatment for an acute UTI (Urinary Tract Infection) and was completing a course of antibiotics (Vantin 100 mg one tablet twice per day). Per review of the 9/30/14 (5) day MDS (Minimum Data Set), Resident #1 was identified as having "occasional" urinary incontinence. Per review of the LNA (Licensed Nursing Assistant) activities of daily living flow sheets, Resident #1 was documented as having 2 episodes of urinary incontinence from 9/24/14-9/30/14; incontinence was monitored for all 3 shifts for the 7 days (20 of 22 entries document urinary continence for the period; 2 of 22 entries document an incontinent episode). Per review of the MAR (Medication Administration Record); on 10/1/14 Resident #1 finished his/her antibiotic course of Vantin (for treatment of his/her UTI). Per review of LNA flow sheets, starting on 10/1/14, Resident #1 had daily urinary incontinent episodes: 10/1 incontinent on one shift; 10/2 incontinent on 2 shifts; 10/3, incontinent on 1 shift, 10/4, incontinent on 3 shifts; 10/5 incontinent on 2 shifts, and from 10/6-10/12/14, the LNAs documented daily</p> | F 281 | <p>F281 #3 See plan for F 315</p> <p>F281 #3 All current resident charts have been reviewed for signs & symptoms. SBAR form for possible UTI communication to MD created by the Northeast MDRO Committee will be initiated. Audits for accurate and consistent use will be done weekly X 4, then monthly X 3, then random audits to be done quarterly with results reviewed at the Quality Assurance Meetings.</p> <p>A mandatory in-service regarding UTI communication to the MD. will be held on December 9 and December 10, 2014 for all licensed nursing staff. Person Responsible: D Valiquette RN DNS</p> | <p>Complete Date: 12/18/14 peh</p> <p>Complete Date: 12/11/14 peh</p> <p>12/18/14</p> | |

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| F 281 | <p>Continued From page 4</p> <p>urinary incontinence on all three shifts. On 10/6/14, the facility completed an "In-House Urinalysis" which was positive for blood, leukocytes and nitrate (lab indicators of a possible UTI). A note on the urinalysis form by the nursing supervisor stated that the resident continues with severe complaints of frequency/urgency every 15 minutes or less; color of urine "pea soup", increased confusion, increased agitation, and increased anxiety. The physician was consulted and advised to push fluids pending results from a CBC (complete blood count), repeat urinalysis and urine culture. The 10/6/14 urine culture did not confirm an infection; the repeat urinalysis confirmed 2+ blood and leukocytes; the white blood count was elevated (an indicator of infection). Per 11/6/14 interview with the DON (Director of Nursing), s/he reported that the resident was not treated for a UTI as the culture did not determine an infection; s/he reported that the physician was consulted and plans were put in place to monitor the resident's blood count for infection and staff were to push fluids.</p> <p>Per review of the 10/7/14 physician note, the resident was identified as having escalating behaviors: "...since [his/her] admission, behaviors have been escalating. [S/he] is constantly yelling for various reasons ...will need to 'pee', they will bring [him/her] to the bathroom and, once back in bed, [s/he] will yell again that [s/he] needs to go to the bathroom ..."</p> <p>Per review of the nursing progress notes, on 10/10/14 the resident had two elevated temperatures: 101.5 at 12:30 AM; Tylenol 650 mg was administered and the temperature was reported decreased to 100.7. Later that day (time was not entered); the temperature was recorded as 99.4. Per review of the pain management flow</p> | F 281 | | |

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| F 281 | Continued From page 5 sheet, on 2 times on 10/11/14 and 2 times on 10/12/14 nursing staff documented the resident as having 10/10 pain that was "all over" and documented in 2 instances there was no positive effect from oxycodone, on 1 time a fair effect and on 1 time a positive effect. On 10/13/14, the resident was treated for complaints of pain in his/her back 3 times (along with arm and buttock pain) and staff reported no relief from oxycodone for 1 time, did not reassess pain relief for the second dose of oxycodone and reported fair relief for the 3rd dose of oxycodone. On 10/13/14 Resident #1 was taken from the facility and brought to a hospital by family where s/he was admitted for a UTI with sepsis. On 11/6/14 at approximately 5:11 PM, when asked why the facility had not rechecked the resident for a UTI following worsening of his/her Incontinence symptoms from the time of admission, history of UTI's, intermittent fever, poor response to pain medications, and escalating behavioral symptoms, the DON stated that the resident was being monitored for infection with blood work. (Refer 315) | F 281 | | |
| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is Incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. | F 315 | F315 #3 See written request for Informal Dispute Resolution F315 All current resident charts have been reviewed for signs & symptoms. SBAR form for possible UTI communication to MD created by the Northeast MDRO Committee will be initiated. Audits for accurate and consistent use will be done weekly X 4, then monthly X 3, then random audits to be done quarterly with results reviewed at the Quality Assurance Meetings. A mandatory in-service regarding UTI communication to the MD will be held on December 9 and December 10, 2014 for all licensed nursing staff. Person Responsible: DValiquette RN DNS | Copley 12/8/14 per Copley date 12/10/14 per Copley 12/10/14 per |

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| F 315 | Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that a resident who developed incontinence received appropriate treatment and services to prevent and treat urinary tract infections and to restore as much bladder function as possible for 1 applicable resident (Resident #1). Findings Include: Per 11/6/14 medical record review, Resident #1 was admitted to the facility on 9/24/14 for rehab following hospitalization for a fall that resulted in fractures of the right humerus (upper arm) and right femur (thigh bone). On admission, the resident was also under treatment for an acute UTI (Urinary Tract Infection) and was completing a course of antibiotics (Vantin 100 mg one tablet twice per day). Per review of the 9/30/14 (5) day MDS (Minimum Data Set), Resident #1 was identified as having "occasional" urinary incontinence. Per review of the LNA (Licensed Nursing Assistant) activities of daily living flow sheets, Resident #1 was documented as having 2 episodes of urinary incontinence from 9/24/14-9/30/14; incontinence was monitored for all 3 shifts for the 7 days (20 of 22 entries document urinary continence for the period; 2 of 22 entries document an incontinent episode). Per review of the MAR (Medication Administration Record), on 10/1/14 Resident #1 finished his/her antibiotic course of Vantin (for treatment of his/her UTI). Per review of LNA flow sheets, starting on 10/1/14, Resident #1 had daily urinary incontinent episodes: 10/1 incontinent on one shift; 10/2 incontinent on 2 shifts; 10/3, incontinent on 1 shift, 10/4, incontinent on 3 shifts; 10/5 incontinent on 2 shifts, and from 10/6-10/12/14, the LNAs documented daily | F 315 | | | |

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| F 315 | <p>Continued From page 7</p> <p>urinary incontinence on all three shifts. On 10/6/14, the facility completed an "In-House Urinalysis" which was positive for blood, leukocytes and nitrate (indicators of a possible UTI). A note on the form by the nursing supervisor stated that the resident continues with severe complaints of frequency/urgency every 15 minutes or less; color of urine "pea soup", increased confusion, increased agitation, and increased anxiety. The physician was consulted and advised to push fluids pending results from a CBC (complete blood count), repeat urinalysis and urine culture. The 10/6/14 urine culture did not confirm an infection; the repeat urinalysis confirmed 2+ blood and leukocytes; the white blood count was elevated (an indicator of infection). Per 11/6/14 interview with the DON (Director of Nursing), s/he reported that the resident was not treated for a UTI as the culture did not determine an infection; s/he reported that the physician was consulted and plans were put in place to monitor the resident's blood count for infection and staff were to push fluids. Per review of the 10/7/14 physician note, the resident was identified as having escalating behaviors: "...since [his/her] admission, behaviors have been escalating. [S/he] is constantly yelling for various reasonswill need to 'pee', they will bring [him/her] to the bathroom and, once back in bed, [s/he] will yell again that [s/he] needs to go to the bathroom ..."</p> <p>Per review of the nursing progress notes, on 10/10/14 the resident had two elevated temperatures: 101.5 at 12:30 AM; Tylenol 650 mg was administered and the temperature was reported decreased to 100.7. Later that day (time was not entered); the temperature was recorded as 99.4. Per review of the pain management flow sheet, on 2 times on 10/11/14 and 2 times on</p> | F 315 | | |

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| F 315 | Continued From page 8 10/12/14 nursing staff documented the resident as having 10/10 pain that was "all over" and documented in 2 instances there was no positive effect from oxycodone, on 1 time a fair effect and on 1 time a positive effect. On 10/13/14, the resident was treated for complaints of pain in his/her back 3 times (along with arm and buttock pain) and staff reported no relief from oxycodone for 1 time, did not reassess pain relief for the second dose of oxycodone and reported fair relief for the 3rd dose of oxycodone. On 10/13/14 Resident #1 was taken from the facility and brought to the hospital by family where s/he was admitted for a UTI with sepsis. On 11/6/14 at approximately 5:11 PM, when asked why the facility had not rechecked the resident for a UTI following worsening of his/her incontinence symptoms from the time of admission, history of UTI's, intermittent fever, poor response to pain medications, and escalating behavioral symptoms, the DON stated that the resident was being monitored for infection with blood work. (Refer to 281) | F 315 | | | |
| F 514 SS=D | 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; | F 514 | | over → | |

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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 514 | Continued From page 9 and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assure that the clinical record for 1 of 3 residents in the survey sample was complete and accurate (Resident #1). Findings include: Per 11/6/14 medical record review, Resident #1 was admitted to the facility on 9/24/14 for rehab following hospitalization for a fall that resulted in fractures of the right humerus (upper arm) and right femur (thigh bone). The resident also had diagnosis that included malnutrition, and sacral tissue injury (pressure ulcers), a history of dehydration, an acute UTI (Urinary tract infection), diabetes, pain and other chronic medical conditions. Per 11/6/14 interview with the DON (Director of Nursing), Resident #1 was difficult to weigh due to his/her fractures at the time of admission to the facility and was initially identified as weighing 94.8 pounds on 9/24/14 (height 5' 6"). The DON reported that the resident was reweighed on 9/24/14 and his/her corrected weight was determined to be 84 pounds which was consistent with his/her weight at the time of his/her hospital discharge. On 10/2/14 when the facility nutritionist completed his/her assessment of Resident #1, s/he used the non-corrected admission weight to calculate the resident's BMI as 15.17 (Body Mass Index) and to determine the resident's nutrition plan. (If the corrected weight had been used, the calculated BMI would have been 13.6). On the 10/8/14 (14) day nutrition review, the nutritionist continued to report the resident's weight as 94.8 pounds. On 11/6/14 at 3:22 PM, the DON confirmed that there was no | F 514 | F514 All current residents weights have been reviewed with dietician. All current weights are accurate with appropriate dietary interventions. Daily wts/rewts will now be obtained every day for 3 days upon admission/readmission to the facility to assure accuracy. Dietician will receive a copy of all resident weights on a weekly basis and review with RN Supervisor, DNS or designee. A mandatory inservice on resident weights/reweights will be held on December 9 and December 10, 2014 for all licensed nursing staff. Person responsible: B Grant RD DValiquette RN DNS | <i>Completed</i> <i>11/23/14</i> <i>pa</i> <i>Completed</i> <i>12/11/14</i> <i>pa</i> <i>12-30-14</i> <i>5/15</i> | |

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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475036 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 11/06/2014 |
|--|--|--|---|

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| NAME OF PROVIDER OR SUPPLIER UNION HOUSE NURSING HOME | STREET ADDRESS, CITY, STATE, ZIP CODE 3086 GLOVER STREET GLOVER, VT 05839 |
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|--------------------|--|---------------|---|----------------------|
| F 514 | Continued From page 10 evidence that the nutritionist was notified of the corrected admission weight to determine if there would be additional dietary recommendations based on the resident's significantly lower BMI, pressure ulcers and other medical conditions. (A BMI is a method of screening for weight categories that may lead to health problems. A BMI between 18.5- 24.9 is considered normal while a BMI below 18.5 is considered underweight). < http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html?s_cid=tw_ob064 > | F 514 | | |