VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

March 20, 2020

Ms. Lynnette Smith, Administrator
The Manor, Inc
577 Washington Highway
Morrisville, VT 05661-8972

Dear Ms. Smith:

Enclosed is a copy of your acceptable plans of correction for the federal investigation survey conducted on **February 19, 2020**. 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

Pamela M. Cota, RN
Licensing Chief

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475057	A. BUILDING _____ B. WING _____	C 02/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MANOR, INC	577 WASHINGTON HIGHWAY MORRISVILLE, VT 05661

(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 onsite investigation of four complaints was conducted by the Division of Licensing and Protection on 2/18 to 2/19/2020. The following regulatory violation was identified.	F 000		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that residents were free from significant medication errors for one resident sampled (Resident #1). Findings include: Per record review, Resident #1 was admitted to the facility on 11/8/19, was sent back to the hospital with respiratory distress on 11/10/19, where they were treated for aspiration pneumonia, acute respiratory failure, an illeus, and sepsis. The hospital cleared the resident to be sent back to the nursing home on 11/15/19, when comfort care was discussed with the family. On 11/16/19 the resident was given 2 doses of an anti-anxiety medication that was ten times what was intended to be ordered by the physician. On 11/16/19, Resident #1 was declining rapidly and displaying alot of discomfort. The physician was kept updated regarding the condition, and gave the LPN on duty during the day shift a telephone order for Ativan at 19:15. The LPN confirmed in interview that they took the order, and wrote that it was for 2.5 ml/ 5 mg. every 4 hours, as written on the telephone order slip. The	F 760	The RN and LPN who were involved in the identified medication error received re-education on The Manor's policies and procedures regarding receiving Transcription of Orders, which includes reading the Physician's Order back to the Physician and having a second nurse sign the order in the chart and co-sign in the EMAR. All residents have the potential to be affected by the same deficient practice therefore all RNs and LPNs will be re-educated on The Manor's policies and procedures regarding receipt of Physician Orders as above through Mandatory Inservice Education sessions. To ensure that the same deficient practice does not recur periodic random audits will be performed weekly by the Nursing Director and/or designee. Any areas of concern that require further education and/or supervision will be addressed immediately to ensure full compliance from all RNs and LPNs.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

John Smith — ED/Adm — 3.16.20

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 760	Continued From page 1	F 760		

LPN gave a 2.5 ml/ 5 mg. dose at 19:23 to the resident. For the next shift, an RN came in to take over at approximately 20:00 hours.

The physician was called at 20:30, and the physician spoke by telephone with the family who were at the facility. It was agreed that Resident #1 should not be sent to the hospital, but put on comfort care and made comfortable with Ativan and Morphine. The RN took a telephone order from the physician at 20:50 which read " Give 10 mg. Morphine now. Give Ativan PRN as ordered now. Assess vitals now and in 20-30 minutes after med administration". The RN gave the incorrectly transcribed dosage of 2.5 ml/5 mg. as written on the telephone order by the other nurse.

Per interview with the RN on 2/19/2020 at 2:40 PM, s/he confirmed that the PRN order was written as the 2.5 ml/5 mg. dose which is what the RN gave the resident at 20:50. When the RN called the physician back a half hour later to report on the effect, it was discovered at that time that the LPN had taken the order incorrectly, and the physician confirmed that it was supposed to read "Ativan .25 ml/0.5 mg q 1 hour as needed for dyspnea/anxiety." One tenth of the dose that was given twice this day.

Per interview on 2/19/2020 at 10:55 AM, the LPN acknowledged that s/he took the telephone order from the physician at 19:15. The LPN stated that they did not recall reading the order back to the MD at that time. The LPN also stated that they did not follow facility protocol by having a second nurse review the order before it was transcribed to the EMar, but instead entered the order into the electronic system themselves without the second check by another nurse. The LPN also

The completion of nursing audits will be reviewed regularly scheduled QAPI meetings to ensure that all staff are following protocol.

To be completed by 3/19/20

Addendum: Per TC with Administrator on 3/17/20, the Administrator and Director of Nursing will be responsible for monitoring of ongoing compliance.

F760 POC accepted 3/17/20 KCampoRN/PMA

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F 760	Continued From page 2	F 760		

acknowledged that the telephone order states to give the Ativan PRN every 4 hours, however it was transcribed to the EMar as to give every hour as needed.

The pharmacy noted this error on the following day and alerted the facility. An investigation was conducted by the former Director of Nursing at the time of this incident, and completed on 11/18/19, that indicated the facts as listed above. The investigation identified errors by the LPN and RN to include:
1. The LPN wrote a telephone order for the wrong dosage of Ativan, and did not read the information back to the doctor when taking the order.
2. The LPN co-signed their own order.
3. The LPN administered the wrong dosage of Ativan at 19:23.
4. The RN administered the incorrect dosage of Ativan at 20:50 hours.

The former Director of Nursing noted that the Pharmacist had contacted the facility the following day to alert them to the error. Per the physician progress notes, the incorrect dosage of Ativan would not have caused the death of the already dying resident. Per interview on 2/19/2020 at 2:45 PM, the current interim Director of Nursing confirmed that these medication errors had occurred, and that both the RN and LPN had not followed protocol for taking telephone orders from the physician.

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Sincerely,

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	47E008	A. BUILDING: _____ B. WING _____	C 02/19/2020

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S 000	Initial comments During an unannounced onsite complaint investigation, completed by the Division of Licensing and Protection on 2/19/20, the following violation of the State of Vermont Licensing and Operating Rules for Nursing Homes was identified.	S 000		
S320 SS=F	7.13 (d)(1) QUALITY OF CARE - STAFFING LEVELS 7.13 (d)(1) The facility shall maintain staffing levels adequate to meet resident needs. 1. At a minimum, nursing homes must provide: i. no fewer than three (3) hours of direct care per resident per day, on a weekly average, including nursing care, personal care and restorative nursing care, but not including administration or supervision of staff; and ii. of the three hours of direct care, no fewer than two (2) hours per resident per day must be assigned to provide standard LNA care (such as personal care, assistance with ambulation, feeding, etc.) performed by LNAs or equivalent staff and not including meal preparation, physical therapy or the activities program. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that minimum staffing levels were maintained regarding Licensed Nursing Assistants (LNA) providing two hours of care per day per resident. Findings include: Per review of the nursing hours for the months of	S320	All residents have the potential to be affected by this deficient practice. The Manor is maintaining a 90% census until LNA staffing is increased. Active recruitment and retention efforts continue for nursing staff, including: a. Increased wages b. Agency staff added c. Increased Per Diem staff d. New scheduling models Our electronic scheduling software provides projected PPD as well as actual PPD. Actual and projected PPD are reviewed daily. If the projected PPD for the following day will be below 2.0, administrative staff with LNA licenses will be asked to assist with care. Nurses, and nurse managers, may be requested to assist with care as well. To be completed by 3/19/20 Addendum: Per Tc with Administrator on 3/17/20, The Administrator and Director of Nursing will be responsible for monitoring of ongoing compliance. S320 POC accepted 3/17/20 KCampos RN/BSN	

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S320	Continued From page 1 January and February 2020, the LNA hours per day per resident fell below the minimum 2 hours per day per resident. The first week in January, which include the 3 last days of December 2019 in my calculation, averaged 1.95 hours daily. The LNA hours per resident for the week of 1/5 to 1/11 averaged 1.97 hours. The week of 1/12- 1/18, the hours averaged 1.86. The week of 1/19- 1/25 averaged 1.89 hours. The week of 1/26- 2/1 averaged 1.97 hours. The week of 2/2- 2/2/8 averaged 1.91 hours. The week of 2/9-2/15 averaged 1.88 hours. Per interview on 2/19/2020 at 3:00 PM, the Administrator confirmed that the hours as listed did not meet the minimum requirements, and that they are in need of more LNAs. The Administrator also acknowledged that the assistance given for direct care by the licensed nurses and the activity staff who are also LNAs is not always captured on the daily hours per resident.	S320	**This page left blank**	