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

February 27, 2024

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 recertification survey conducted on **February 7, 2024.** 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

Enclosure

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 _____	02/07/2024

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

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E 000	Initial Comments The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey, concluded on 2/7/24. There were no regulatory violations identifed related to emergency preparedness.	E 000		
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey from 2/4/24 through 2/7/24 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey.	F 000	As of 1/12/24 Resident #35 has a skin treatment ordered. All staff will be re-educated on the admission process, which includes a skin assessment, obtaining skin/wound photos if necessary, initiating the wound care protocol and obtaining an MD order. Entering the wound order in the TAR. To monitor that the deficient practice does not recur periodic chart audits will be completed by the DNS or her designee. Completed audits will be reviewed during bi-weekly weight and wound committee and at quarterly QAPI meeting. To be completed by 3/7/24.	
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure that residents received care in accordance with professional standards of practice related to the worsening of an arterial ulcer that resulted in a Staphylococcus (Staph) infection (an infection caused by a bacteria commonly found on the skin) for 1 of 23 residents sampled (Resident #35). Findings include:	F 684	F 684 All residents have the potential to be affected by the same deficient practice. **Tag F 684 POC accepted on 2/27/24 by N. Baker/P. Cota**	

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

Executive Director 2.26.24

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 684	Continued From page 1 Per record review Resident #35 was admitted to the facility on 12/13/23 with diagnoses that include venous insufficiency (leg veins become damaged causing blood to pool in your legs. This increased pressure in your leg veins causes symptoms like swelling and ulcers), and chronic venous ulcers of bilateral lower extremities (leg ulcers caused by problems with blood flow in your leg veins. They may heal and then open back up chronically). An admission nursing progress note dated 12/13/23 reveals that on admission to the facility the resident had venous wounds to medial (inner) right ankle and right lower shin. Per documented Wound Evaluation with photo taken on 12/13/23, the right front lateral lower leg (right lower shin) wound measured at 1.31 cm (length) x 0.88 cm (width), there were no measurements documented for the right ankle at that time. Further description of the wound indicates there is no exudate (drainage) present and the peri wound edges have epithelialization (tissue that forms during wound healing). These wounds were cleaned with Normal Saline, and a non-adhesive dressing was placed with foam. Coban (a wrap dressing that applies compression to the area it is applied to) and Kerlix (gauze-type dressing wrap used to secure and cover other dressings) were also applied. There is no evidence that the physician was notified of the wounds or that a physician's order for the wound treatment was obtained. Review of Resident #35's admission orders and the Medication Administration Record (MAR) and Treatment Administration Records (TAR) for December 2023 and January 2024 confirm that an order for treatment to the right lower leg was not obtained	F 684	This page intentionally left blank	

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F 684	Continued From page 2 until January 12th, 2024, thirty days after the wound was identified. A Nurse progress note dated 1/2/24 reveals that a dressing was removed from the wound on the resident's right lower leg and was left open to the air for part of the shift. Due to increased drainage, another dressing was applied until the wound nurse could evaluate and put a "proper" treatment plan in place. A Wound Evaluation completed on 1/2/24 identified a venous ulcer measuring 8.3 cm length, and 3.6 cm width, this identifies a significant increase in wound size. A photo of the wound taken at the time of the Wound Evaluation revealed a large area of scaly, macerated skin with visible open areas. The Wound Evaluation was incomplete and did not provide a description or identify the location of the wounds. No further progress notes were documented addressing the right lower leg wounds until 1/11/24, 9 days later. There were no further assessments completed until 1/31/24, 29 days later. A documented telephone encounter on 1/12/24 reveals that a nurse had called the Physician's office with concerns about the right lower leg and reported that a dressing on the right lower leg had not been changed for at least 9 days. The encounter documentation further revealed that when the dressing was removed it had a foul odor, and purulent drainage, (thick drainage can vary in color from grayish, to yellow, green to brown, it usually indicates an infection), and the site was red and painful. The encounter indicated that a new treatment was started on 1/11/24 and the nurse asked how the Physician would like to proceed. The physician responded to the message with the following directions "Continue with the above wound care and obtain a wound	F 684	This page intentionally left blank	

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F 684	Continued From page 3 culture." The wound culture was ordered to be obtained on 1/13/24 however, a review of the January TAR indicated that the resident was sleeping, and the culture was not obtained on this date. There is no documented evidence that the Physician was notified that the culture was not obtained. Further review of the TAR reveals the wound culture was not obtained until 1/23/24, ten days after the order was received. A nurse progress note dated 1/29/24 reveals that the facility was notified by the physician's office that Resident #35's right leg wound culture was positive for Staph infection. The facility Wound & Skin Care Protocol states that "For any new alteration to skin integrity, notify MD and Wound Care Nurse. Assess and measure all new areas (prior to applying dressing) and document in the correct location of chart. Utilize skin care protocol unless other orders are in place or otherwise advised by MD or Wound Nurse." Under "Non-Pressure Related Ulcers: Cleanse area with soap and water, pat dry. Apply sureprep skin protectant wipe to surrounding intact skin. Allow time to dry. Cover with foam border dressing. Change dressing BID and PRN [as needed] until area is resolved." During an interview on 2/6/24 at 11:56 a.m. a staff Registered Nurse (RN) confirmed that the dressings to the right leg wound had not been changed from 1/2/24 to 1/11/24. During an interview on 2/6/24 at 3:13 p.m. the Director of Nurses confirmed that there was not a Physician's order for the care of the wound or changing of the dressing until 1/11/24, and the expectation is that there would be an order in	F 684	This page intentionally left blank	

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F 684	Continued From page 4 place.	F 684	F755	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based upon observation, interview, and record	F 755	All residents have the potential to be affected by the same deficient practice. All MARS and TARS must be signed. All Staff will be re-educated on documenting in the MARS and TARS-they cannot leave blanks. Staff will be re-educated on what to do if a resident is sleeping, refusing medication, or if the medication is unavailable. To monitor that the deficient practice does not recur periodic chart audits will be completed by the DNS or her designee. Completed audits will be reviewed in bi-weekly strategic nursing meetings and at quarterly QAPI meeting. To be completed by 3/7/24. **Tag F 755 POC accepted on 2/27/24 by N. Baker/P. Cota**	

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F 755	Continued From page 5 review, the facility failed to implement procedures that assure the accurate acquiring, dispensing and administering drugs to meet the needs of one resident [Res.#45] of 23 sampled residents. Finding include: Review of Res.#45's medical record reveals the resident has diagnoses that include Hypertension [high blood pressure], Hypokalemia [low potassium levels in the blood], Dementia with Behavioral Disturbance, restlessness and agitation, osteoarthritis of the right knee, and an Overactive bladder, Review of Physician Orders for Res.#45 include: Amlodipine tab - related to Essential Hypertension. Potassium Chloride tab- related to Hypokalemia Quetiapine tab- related to Restlessness and Agitation Diclofenac Topical Gel- for Right Knee pain Acetaminophen- for pain Myrbetriq Oral Tablet- for overactive bladder Review of the facility's 'Administering Medications' policy [Version 2.0 Revised Dec. 2021] includes "Medications must be administered in accordance with the orders, including any required time frames". Additionally, the policy states "The individual administering the medication must sign on the resident's electronic Medication Administration Record [MAR] on the appropriate space after giving the medication", "the individual administering the medication will record in the resident's medical record the date and time the medication was administered", and "if a drug is withheld, refused, or given at time other than the scheduled time, the individual administering the medication shall indicate such	F 755	This page intentionally left blank	

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F 755	Continued From page 6 on the electronic MAR". Per interview on 2/6/24 at 4:34 PM with a Staff Nurse regarding unavailable medications; if a medication is unavailable, the resident's Nurse should check the backup medications stored in the medication room to see if the missing medication is available. If not, then call the Pharmacy to expedite delivery of the medication. The Nurse should also notify the resident's Physician if it is an 'important' medication such as to treat high blood pressure. The nurse then documents in the resident's medical record if and when the medication was given, if not why not, and contact made with the physician and if any orders were given. Review of Res.#45's Medication Administration Record [MAR] for October 2023 reveals blank spaces on the resident's MAR on 10/4/23 for the medications; Amlodipine for hypertension, Potassium Chloride for hypokalemia, Quetiapine for Restlessness and Agitation, Diclofenac Topical Gel for Right Knee pain, and Acetaminophen for pain. Review of Res.#45's medical record reveals no documentation as to why the medications were not given as ordered, if the medications were unavailable, and if the physician was notified that multiple medications were not administered as ordered to meet the needs of the resident. Review of Res.#45's MAR for November 2023 reveals blank spaces on the resident's MAR on 3 dates [11/2, 11/7, & 11/18] for Amlodipine, Potassium Chloride, Quetiapine, Diclofenac Topical Gel, and Acetaminophen. An additional medication, Myrbetriq for overactive bladder, is also blank on the MAR on 11/18. Again, Review	F 755	This page intentionally left blank	

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F 755	Continued From page 7 of Res.#45's medical record reveals no documentation as to why the medications were not given as ordered, if the medications were unavailable, and if the physician was notified that multiple medications were not administered as ordered to meet the needs of the resident. Review of Res.#45's MAR for December 2023 reveals blank spaces on the resident's MAR on 12/19 for the same 6 medications: Amlodipine, Potassium Chloride, Quetiapine, Diclofenac Topical Gel, Acetaminophen, and Myrbetriq. Again, Review of Res.#45's medical record reveals no documentation as to why the medications were not given as ordered, if the medications were unavailable, and if the physician was notified that multiple medications were not administered as ordered. An interview was conducted with a second Staff Nurse on 2/7/24 at 12:56 PM. The Staff Nurse reported that the facility keeps a supply of Stock medications available in medication room. Review of the list of medications available includes 3 of Res. #45's medications not given as ordered: Amlodipine, Potassium Chloride, and Quetiapine. An interview was conducted with the facility's Quality Assurance Director on 2/7/24 at 10:00 AM. The Quality Assurance Director [QAD] confirmed that Res.#45's Medication Administration Record [MAR] contained multiple dates where multiple medications were not documented as given as ordered. The QAD also confirmed Res.#45's medical record contained no documentation as to why the medications were not given as ordered, if the medications were unavailable, and if the	F 755	This page intentionally left blank	

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F 755	Continued From page 8 physician was notified that multiple medications were not administered as ordered. The QAD also confirmed that 3 of the medications not administered were available in the facility's stock medication supply. The QAD stated they would investigate why the medications were not dispensed and administered to meet the needs of Res. #45 and would report back to the surveyor. The QAD did not return with any results of an investigation.	F 755	F758 All residents have the potential to be affected by the same deficient practice. Residents #51- medication was discontinued due to not using the PRN medication and having a 14 day end date. Resident#10 – the physician(s) have been faxed requesting documented rationale for continuing the psychotropic medications, if they wish to continue them. The response was that the resident is on hospice. All nurses will be re-educated when a physician orders a PRN psychotropic medication that there must be a 14 day limit, or documented rationale for psychotropic medication to be continued.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		

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F 758	Continued From page 9 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure the physician documented a duration of use or rational for extending the use for an as needed (prn) psychotropic medication for 2 of 5 sampled residents (Residents #51 and #10). Findings include: 1. Per record review Resident #51 has a Physicians order for Mirtazapine (antidepressant) 7.5mg every 24 hours as needed (PRN) related to dementia with psychotic disturbance. The order exceeds the required limit of 14 days with no specified duration or documented rational to exceed 14 days. During interview on 2/7/2024 at 2:30 PM the	F 758	Physicians will be re-educated on needing a better rationale than "hospice". Psychotropic medications will be reviewed bi-weekly to ensure that 14-day limit is maintained. To ensure that this deficient practice does not reoccur, all GDR pharmacy consultation reports that are faxed to physicians will be tracked for return response. If no response from the MDs then Pharmacy consults will be hand delivered to the offices, if still no response, the medical director will be notified. Status of outstanding pharmacy consultation reports will be reviewed in bi-weekly strategic nursing meetings and at quarterly QAPI meeting. To be completed by 3/7/24. **Tag F 758 POC accepted on 2/27/24 by N. Baker/P. Cota**	

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F 758	Continued From page 10 Director of Nursing (DON) confirmed that there was no documented duration or rational for exceeding the 14 day limitation for the PRN Mirtazapine. 2. Per record review Resident #10 had an order for Lorazepam oral tablet 0.5 mg (an anti-anxiety medication) to be given every 8 hours as needed (PRN) for anxiety without a specified duration of days. This order was noted to have become active on 7/21/23. Per interview with the consultant Pharmacist on 2/6/24 at 11:30 AM requests for duration for PRN use of Lorazepam were made on November 23, 2023 and repeated on Jan 5, 2024 without physician response.	F 758	F 880 All residents have the potential to be affected by the same deficient practice. All education to family and visitors must be documented. All staff will be educated to document when a family member or visitor receives education when entering an isolation room. In addition to current practice for having signage posted, a new sign will be posted on isolation rooms stating, "See Nurse Before Entering." Staff will be educated to document if a family member or visitor refuses to follow isolation precautions. On going audits to ensure compliance will be performed with residents in isolation rooms and during quarterly QA meetings. To be completed by 3/7/24.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		

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F 880	Continued From page 11 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident, including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880	**Tag F 880 POC accepted on 2/27/24 by N. Baker/P. Cota** This page intentionally left blank	

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 _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 12 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement and maintain contact precautions for 1 resident [Res.# 108] of 23 sampled residents. Findings include: Per record review, Physician Orders for Res.#108 dated 1/26/24 call for "Maintain contact precautions due to C-Diff unless otherwise instructed. Every shift." [Clostridioides difficile (C-Diff) is a bacterium that causes an infection of the colon. Symptoms can range from diarrhea to life-threatening damage to the colon. Because C. difficile can live outside the body, the bacteria spread easily. Not washing hands or cleaning well make it easy to spread the bacteria.] (https://www.mayoclinic.org/diseases-conditions/c-difficile/symptoms-causes/syc-20351691) Per observation, posted on the outside of Res.#108's room is a Centers for Disease Control and Prevention [CDC] sign reading "STOP. CONTACT PRECAUTIONS. EVERYONE MUST: Clean their hands, including before entering and when leaving the room." Per observation on 2/5/24 at 9:41 AM, the resident's spouse was sitting in a chair next to the resident in bed. The spouse was holding the resident's left hand. After a few minutes' observation, the spouse exited the room with a water pitcher without washing hands, walked to	F 880	This page intentionally left blank	

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F 880	Continued From page 13 the nurse's station to have the pitcher filled and returned with the water pitcher to the room. No hand hygiene was observed by the spouse prior to exiting or entering the resident's room. An interview was conducted on 2/6/24 at 9:53 AM with the spouse and the resident in the resident's room. The spouse was holding hands with the resident throughout the interview. Regarding Res.#108's contact precautions the spouse stated, "I don't know what it is" and "I have no idea. Some kind of precautions. It might have something to do with [h/her] feet or wounds". The spouse was then observed exiting the room with no hand hygiene and walking through the Spruce and Elmore resident units to the Care and Services Director's office. An interview was conducted with a Staff Nurse on 2/5/24 at 9:45 AM. The Staff Nurse confirmed that Res.#108 was on contact precautions and stated that "anyone" entering and exiting the room was required to wash their hands. An interview was conducted with a second Nurse on 2/6/24 at 9:49 AM. The nurse confirmed Res.#108's spouse was sitting with the resident in the resident's room, holding the resident's hand. The nurse confirmed the spouse had failed to wash their hands before entering the room and again after exiting the room. The nurse stated that Contact Precautions were not being properly implemented and reported they "will mention it to the Charge Nurse". Per observation, there was no education provided to the spouse or the resident regarding hand washing and contact precautions during the two days of observation.	F 880	This page intentionally left blank	