

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

April 18, 2013

Ms.. Lisa Bohlman, Administrator
Derby Green Nursing Home
Po Box 24
Derby, VT 05829

Dear Ms.. Bohlman:

Enclosed is a copy of your acceptable plans of correction for the re-certification survey conducted on **March 20, 2013**. 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

PC:jl



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

PRINTED: 04/01/2013
FORM APPROVED
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 476048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER DERBY GREEN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 24 DERBY, VT 05829	
(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)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	Derby Green provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The Plan of correction is prepared and executed solely because it is required by federal and state law.	
F 225 SS=D	483.13(c)(1)(II)-(III), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	F 225	F225 The Administrator and DNS review and investigate all resident-to-resident incidents including questioning staff involved with re-enactments, when indicated. Per CMS "abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Although the internal investigations of the incidents listed did not indicate the actions of the residents involved were "willful." Effective 3/20/13 all resident-to-resident incidents will be reported immediately (within 24 hours) to all agencies in accordance with state and federal law. The internal investigation results will be filed with all agencies in accordance with state and federal law within 5 working days of the incident. The Administrator and DNS will monitor that required reports are filed with state officials in accordance with state law (including the state survey and certification agency.) All resident-to-resident incidents will be reviewed in the quarterly QA meeting. <i>F225 POC accepted 4/15/13 JHosmer RN/PMC</i>	3/20/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *4/11/13*

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.

PMC

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F 225	<p>Continued From page 1</p> <p>representative and to other officials in accordance with State law (Including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based upon interview and record review, the facility failed assure a series of witnessed resident to resident incidents involving potential abuse by 1 of 17 residents in the Stage 2 sample was reported to the State Survey Agency (DLP). (Resident #19) Findings include:</p> <p>1. Per 3/20/13 record review of a nursing incident report dated 10/13/12, Resident #19 was identified as the perpetrator in a resident to resident incident. In interview with the facility's Administrator and Director of Nursing Services (DNS), their investigation revealed that Resident #19 hit another resident on the chest and made contact, but there was no evidence of injury to the alleged victim.</p> <p>2. Per 3/20/13 review of a nursing incident report dated 12/16/12, Resident #19 was identified as the perpetrator in a resident to resident incident. Resident #19 was walking by another resident and reportedly grabbed the other resident's arm and started yelling at the other resident. There was no evidence of injury to the alleged victim. The other resident then slapped Resident #19 in the face. The incident was witnessed by staff and investigated internally.</p> <p>3. Per 3/20/13 review of a nursing incident report</p>	F 225			

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F 225	<p>Continued From page 2</p> <p>dated 1/18/13, Resident #19 was identified as the perpetrator in a resident to resident incident. The second resident was heard to deny that she did anything when a staff member observed the two residents slapping at each other.</p> <p>4. Per 3/20/13 review of a nursing incident report dated 1/19/13, Resident #19 was identified as the perpetrator in a resident to resident incident which was witnessed by a family member of the alleged victim. Administrative investigation with the family member determined that Resident #19 was pulling at the material on the alleged victim's chair. When the family member asked Resident #19 to stop, he/she appeared angry and struck out, hitting the other resident in the face.</p> <p>During an interview on 3/20/13 at 1:58 P.M., the facility's Administrator and DNS confirmed that they did not report to the State Survey Agency the 4 resident to resident incidents of abuse.</p>	F 225		