

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

February 13, 2014

Ms.. Lisa Bohlman, Administrator
Derby Green Nursing Home
Po Box 24
Derby, VT 05829-0024

Dear Ms.. Bohlman:

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



Pamela M. Cota, RN
Licensing Chief

PC:jl

FEB 10 2014

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

PRINTED: 01/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/16/2014
--	--	--	---

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000 INITIAL COMMENTS

An unannounced on-site complaint investigation was initiated on 1/6/14 by the Division of Licensing and Protection, and concluded on 1/16/14 after further offsite interviews. The following regulatory violations were identified:

F 155 483.10(b)(4) RIGHT TO REFUSE: FORMULATE ADVANCE DIRECTIVES

The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview the facility failed to ensure the right to refuse treatment for 1 of 3 residents in the survey sample (Resident #2). Findings include:
Per review of the clinical record on 1/6/14

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 155

F155 The administrator or her designee requests advance directives and/or guardianship papers from the resident or his/her representative upon admission. Upon admission the resident and or representative is informed and given a written copy of residents rights. Resident's wishes/choice is incorporated into the plan of care per their advance directives or their appointed guardian. It is documented in the resident's chart, when the resident does not have decision making capacity. Example: Guardianship paperwork. Advance directives and residents rights are reviewed with the resident and or their representative, if one is appointed, at their annual total care plan meeting beginning 1/27/14. Any changes will be addressed and noted in ECS. A button in ECS (electronic charting system) will be the tracking source for compliance and will be monitored quarterly by the administrator and/or DNS. There will be staff education conducted by the Administrator and DNS regarding the residents rights and the right to refuse on 2/14/14. A sample of records will be reviewed by the DNS or her designee over the next quarter for compliance. This will be reported to the QA committee in which the committee will determine the length of time this process of monitoring will need to be done. (Revised per request of S. Dennis, NP 2/6/14)

F155 POC accepted 2/13/14 S.Dennis APRN /PMC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Handwritten Signature] Administrator 2/16/14

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.

PMC

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

PRINTED: 01/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/16/2014
--	---	--	---

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 155 Continued From page 1

Resident #2 was admitted to the facility on 1/2/13 with diagnoses that included depression, aggressive behaviors, adjustment disorder, mental challenges, Parkinson's disease, and other chronic medical conditions. Per review of the annual MDS dated 11/18/13, s/he can sometimes make him/herself understood and usually understands others. On a brief test of cognitive function, s/he scored in the intact range; s/he requires limited assistance for transfers and uses a wheelchair.

Per 1/6/14 review of physician orders, Resident #2 was prescribed Abilify (Aripiprazole) 5 mg at 8 AM; if does not take PO, gets 9.75 mg IM (PO= by mouth; IM= by intramuscular injection). Per review of the nursing progress notes dated 12/17/13 at 10:52, Abilify 9.75 mg/1.3 ML Solution was given "for refusal of PO medication per MD order." "Reason: Refused Aripiprazole 5 mg tablet." Per 1/6/14 interview at 3:45 PM with the nurse administering the abilify injection on 12/17/13, s/he reported at the time of the injection, the facility had "6 staff" members present in the room; "it was the first time we had ever given the shot, so we wanted to be sure no one would get hurt." Resident #2 told me, "No" but if [s/he] really didn't want the shot, [s/he] could have prevented me from giving it. "The order is written to give abilify IM if refuses the PO form." Per review of nursing progress notes dated 12/21/13, the nurse documented, resident "refused Aripiprazole 5 mg tablet... Abilify 9.75 mg/1.3 ML Solution given for refusal of po." Per review of nursing progress notes dated 12/28/13, "... When told at 10:00 that [s/he] needed to take [his/her] pills or it was going to be too late stated 'no' when asked if [s/he] would take them. Explained that because of [his/her] behavior history my orders were that if [s/he]

F 155

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

PRINTED: 01/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/16/2014
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)	(X5) COMPLETION DATE
F 223	<p>Continued From page 3</p> <p>residents. The findings include: Per review of the clinical record on 1/6/14, Resident #1 was admitted to the facility on 12/3/12 with diagnoses that included, Alzheimer's dementia, depressive disorder, osteoarthritis and other chronic medical conditions. Per review of the quarterly MDS (Minimum Data Set) dated 11/22/13, Resident #1 has no speech, sometimes understands others, but is rarely understood. S/he requires extensive assistance for bed mobility, dressing, eating and toileting and is totally dependent for transfers, requiring a mechanical lift. Per review of the clinical record on 1/6/14, Resident #2 was admitted to the facility on 1/2/13 with diagnoses that included depression, aggressive behaviors, adjustment disorder, mental challenges, Parkinson's disease, and other chronic medical conditions. Per review of the annual MDS dated 11/18/13, s/he can sometimes make him/herself understood and usually understands others. On a brief test of cognitive function, s/he scored in the intact range; s/he requires limited assistance for transfers and uses a wheelchair for mobility. Per 1/6/14 review of the nursing progress notes and facility investigation, on 9/20/13, Resident #1 and #2 were sitting in the activity room. LNA #1 noticed that the buttons for Resident #1's top were undone and refastened them. After leaving the room, LNA #1 and LNA #2 observed Resident #1 and Resident #2 through a mirror and saw Resident #2 "grabbing" Resident #1's breast. Per review of the nursing progress notes and facility investigation, on 11/24/13, LNA #2 observed Resident #2 "wheel himself over" to [Resident #1] and "lifted up [Resident#1's] shirt, exposing [his/her] stomach." When Resident #2 was asked what s/he was doing, s/he replied,</p>	F 223		

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

PRINTED: 01/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/16/2014
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)	(X5) COMPLETION DATE
F 223	<p>Continued From page 4</p> <p>"nothing." Per LNA statement. Resident #2 "did stop when s/he noticed I was in the room "</p> <p>Per review of the nursing progress notes and the facility investigation, on 12/2/13 a housekeeper observed Resident #2 touching Resident #1's breast. Per the facility investigation dated 12/2/13, Resident #2 had his/her hand under Resident #1's shirt.</p> <p>Per LNA interview on 1/6/14 at 10:22 AM, when Resident #1 is in "sleepy mode," s/he cannot defend herself and this is when s/he has seen things happening [incidents between Resident #2 and Resident #1]. When asked how Resident #2 was able to access Resident #1 while s/he was on 1:1 supervision, the LNA reported that, "it depends who is working ... if [someone] forgets about [the] monitoring, it may not happen ...or some people may not have read updates, might not have been aware of monitoring that was needed."</p> <p>Per interview with the Director of Nursing Services (DNS) on 1/6/14 at 4:52 PM, s/he reported that although Resident #2 was to have 1:1 staff supervision when in common areas with female residents, on 11/24/13 and 12/2/13 Resident #2 "got ahead of the staff" to approach Resident #1.</p> <p>Per facility policy provided by the DNS on 1/6/13 at 2:10 PM, titled, "Reporting Abuse to Facility Management," sexual abuse is defined as, but is not limited to sexual harassment, sexual coercion, or sexual assault. Per review of the facility investigations, the sheriff's department was notified after each incident.</p> <p>(Refer to F 280)</p>	F 223		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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

PRINTED: 01/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/16/2014
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)	(X5) COMPLETION DATE
F 280	<p>Continued From page 5</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 upon medical record review and interview, the facility failed to revise the care plan of 1 of 3 residents (Resident # 1) to reflect his/her needs for monitoring and safety following 3 instances of resident to resident sexual abuse. Findings include: Per review of the clinical record on 1/6/14, Resident #1 was admitted to the facility on 12/3/12 with diagnoses that included, Alzheimer's dementia, depressive disorder, osteoarthritis and other chronic medical conditions. Per review of the quarterly MDS (Minimum Data Set) dated 11/22/13, Resident #1 has no speech, sometimes understands others, but is rarely understood S/he requires extensive assistance for bed</p>	F 280	<p>F280 The administrator and DNS will continue to review and report to the appropriate authorities all resident to resident incidents. The involved residents care plans will continue to be reviewed and revised with updates as warranted. The DNS will monitor the effectiveness of the care plan weekly x 2 weeks, then monthly and then be reviewed at the next QA meeting. Resident #1 care plan was updated 1/28/14 to protect him/her from any abuse. (Revised per request of S. Dennis, NP 2/6/14)</p> <p><i>F280 POC accepted 2/12/14 SDennis APPN/ PWC</i></p>	

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

PRINTED: 01/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/16/2014
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)	(X5) COMPLETION DATE
F 280	<p>Continued From page 6</p> <p>mobility, dressing, eating and toileting and is totally dependent for transfers, requiring a mechanical lift.</p> <p>Per 1/6/14 clinical record review and review of facility investigations, Resident #1 was the witnessed victim of 3 incidents of resident to resident sexual abuse, occurring on 9/20/13, 11/24/13 and 12/2/13.</p> <p>Per 1/6/14 interview at 11:42 AM, a facility nursing supervisor confirmed there were no updates to Resident #1's care plan related to his/her 3 incidents as a victim of sexual abuse and no care plan revisions related to his/her personal safety or need for monitoring; s/he confirmed that there were also no updates to the LNA (licensed nursing assistant) care plan related to the sexual abuse incidents or for safety/monitoring of Resident #1.</p> <p>Per interview on 1/6/14 at 5:40 PM, the Director of Nursing Services (DNS) confirmed that Resident #1's care plan had not been updated to reflect her personal safety needs as "all female residents [in the facility] were at risk." When asked, the DNS stated that, "no other female residents were known" to have been victims of sexual abuse from the same resident perpetrator.</p> <p>(Refer to F 223)</p>	F 280		