

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

July 3, 2013

Mr. Bradford Ellis, Administrator
Vernon Green Nursing Home
61 Greenway Drive
Vernon, VT 05354-9474

Dear Mr. Ellis:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 24, 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

RECEIVED
Division of
PRINTED: 06/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		Licensing and Protection	(X3) DATE SURVEY COMPLETED 04/24/2013
NAME OF PROVIDER OR SUPPLIER VERNON GREEN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 61 GREENWAY DRIVE VERNON, VT 05354			
(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	F 000	Allegation of Substantial Compliance			
F 223 SS=E	<p>An unannounced on-site recertification survey was completed by the Division of Licensing and Protection from 4/22/13 to 4/24/13. There were regulatory issues identified:</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that 5 residents identified (Resident # 58, #15, 50, 68 and, #43) were free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The findings include.</p> <p>1. Per review of the medical record of Resident #70 on 4/24/13, the record indicated that Resident #70 had been involved in several resident to resident physical altercations. Per review of the medical record of Resident #15 on 11/29/12, Resident #70 was sitting in a chair next to Resident #15 whom was moaning and yelling. Resident #70 became agitated and hit Resident #15 three times on the shin with his/her cane.</p> <p>2. Per review of the medical record of Resident #70, on 4/24/13, the record indicated that</p>	F 223	<p>Vernon Green Nursing Home has and continues to be in substantial compliance with 42 CFR Part 483 subpart B. Vernon Green Nursing Home has or will have substantially corrected the alleged deficiencies and achieved substantial compliance by the date specified herein.</p> <p>This Plan of Correction constitutes Vernon Green Nursing Home's allegation of substantial compliance. such that the alleged deficiencies cited have been or will be substantially corrected on or before May 16, 2013.</p> <p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To continue to remain in substantial compliance with state and federal regulations, Vernon Green Nursing Home has taken or will take the actions set forth in this plan of correction.</p> <p><u>F223</u></p> <p>The Facility continues to assure that residents are free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>1., 2., 3., 4., 5., and 6.: Staff education on behavior interventions for residents #70, #15, #58, and #43 have been reviewed with staff. Social Service will meet with residents #70, #15, #58, and #43, #21 to assure that the</p>	5/16/13	05/15/13	

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

TITLE

(X6) DATE

M. Donald Ellis

Executive Director

June 26, 2013

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 223	Continued From page 2 Resident #21 slapped resident #68 saying-that's mine. Resident #21 was moved away from resident #68. Shortly after being moved resident #50 moved next to resident #21. Resident #21 slapped resident #50 after s/he hit the balloon stating again that's mine. According to the investigative file the decision was made that this incident did not require a report to the state agency Per interview with the facility Administrator on 4/24/13, the Administrator reviewed the dates of each of the incidences of resident to resident altercations and confirmed that he/she was aware that on 11/29/12, 2/15/13, 3/8/13, 3/12/13, 3/30/13, and 4/19/13 there were resident to resident physical altercations.	F 223	<u>F223 continued</u> Provide education to staff regarding the facility's abuse policy and the process for reporting observed/reported episodes of abuse to management staff in a timely fashion. Director of Nursing or designated RNs will conduct monthly Quality Assurance audit of residents with "Behaviors that affect others/self" to determine that these residents are free from abuse. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.	05/16/13 05/10/13	
F 224 SS=E	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATE The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to implement written policies and procedures that prohibit mistreatment, neglect and abuse of the residents and misappropriation of resident property for 7 residents identified (Resident # 15, #21, #58,# 43,#50, # 68 and #	F 224	The Behaviors Affecting Others audit will be conducted on a monthly basis and the results will be reviewed at the monthly QA meeting to ensure ongoing compliance until the QA committee has determined that 100% compliance has been achieved. The Director of Nurses shall report to the Quality Assurance Committee all episodes of resident to resident altercations that have been reported to the licensing agency. The Quality Assurance Committee shall determine if further monitoring is needed. <i>F223 rec. a copy 7/1/13 [unclear]</i> <u>F224</u> The Facility has developed and continues to implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents.	05/14/13 5/16/13 05/14/13	

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F 224	Continued From page 4 attempted to assist Resident #58 to his/her feet and Resident #70 was saying to Resident #58 to " get up, hurry up, get up " and hitting Resident #58 on the arm. 6. Per review of the medical record of Resident #70 on 4/24/13, the record indicated that on 3/30/13, Resident #70 slapped the hand of Resident #15 and was yelling at Resident #15 to " get out of here. " 7. Per record review. Resident # 21 was at an activity on 4/19 2013 and during the activity (a balloon toss) resident#68 caught the balloon. Resident #21 slapped resident #68 saying-that's mine. Resident #21 was moved away from resident #68. Shortly after being moved resident #50 moved next to resident #21. Resident #21 slapped resident #50 after s/he hit the balloon stating again that's mine. According to the investigative file the decision was made that this incident did not require a report to the state agency. Per interview with the facility Administrator on 4/24/13, the Administrator reviewed the dates of each of the incidences of resident to resident altercations and confirmed that he/she was aware that on 11/29/12, 2/15/13, 3/8/13, 3/12/13, 3/30/13 and 4/19/13 there were resident to resident physical altercations. Per interview with the facility Administrator on 4/24/13, the Administrator confirmed that per facility policy, any suspected abuse should be thoroughly investigated and that the appropriate State Agencies are to be notified. The Administrator confirmed that the resident to	F 224	<u>F224 continued</u> How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. An audit of resident to resident altercations will be conducted on a weekly basis and the results will be reviewed at the monthly QA meeting to ensure ongoing compliance is complete and timely until the QA committee has determined that 100% compliance has been achieved. <i>F224 has accepted this incident</i>	05/14/13	

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F 224	Continued From page 5 resident altercations on 11/29/12, 2/15/13, 3/13/13 and 4/19/13 were not called into the appropriate state agencies and the Administrator was unable to provide complete and through investigations conducted for each the resident to resident altercations occurring on 11/29,2/15,3/8 and 3/13.	F 224		
F 225 SS=E	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	F 225	<u>F225</u> The Facility has and continues to ensure that all alleged violations involving mistreatment, neglect, or abuse are reported immediately to the administrator of the facility and/or to other officials in accordance with State law through established procedures. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; 1., 2., 3., 4., 5., and 6.: Resident to resident altercations involving residents #70, #15, #43, and #58 have been investigated and reported to Adult Protective Services (APS). 7.: Resident to resident altercations involving residents #21, #50 and #68 have been investigated and reported to APS. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by this alleged deficient practice.	5/16/13 05/13/13 05/13/13

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F 225	Continued From page 6 to the administrator or his designated 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that all reports of alleged abuse for 6 Resident ' s identified (Resident # 15, 21 43, 58 , 68 and, 70) were thoroughly investigated and reported to the appropriate officials in accordance with State law through established procedures. The findings include: 1. Per review of the medical record of r Resident #70 on 4/24/13, the record indicated that Resident #70 had been involved in several resident to resident physical altercations. Per review of the medical record on 11/29/12, Resident #70 was sitting in a chair next to another resident whom was moaning and yelling. Resident #70 became agitated and hit Resident #15 three times on the shin with his/her cane. 2. Per review of the medical record of Resident #70, on 4/24/13, the record indicated that Resident #70 reported to staff that at approximately 3:15 PM, Resident #70 punched Resident #15 after Resident #15 entered the room of Resident #70 because Resident #70 felt Resident #15 " was after him/her " .	F 225	<u>F225 continued</u> An audit of residents involved in resident to resident altercations in the last 60 days has been conducted to ensure that a complete and thorough investigation has been completed. A report was made to APS of any outstanding incidents of alleged abuse. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; Provide education to staff regarding the facility's abuse policy and the process for reporting observed/reported episodes of abuse to management staff in a timely fashion. Reported incidents of resident to resident altercations will be reviewed at a weekly risk meeting to ensure that all incidents have been reported timely until the interdisciplinary team determines that 100% compliance is achieved and the risk meeting reviews are no longer necessary. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The risk meeting's weekly review of resident to resident altercations will be reviewed at the monthly QA meeting to ensure ongoing compliance is complete and timely until the QA committee has determined that 100% compliance has been achieved. <i>For all accepted this procedure</i>	05/13/13 05/16/13 05/15/13 05/14/13	

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F 225	<p>Continued From page 7</p> <p>3. Per review of the medical record of Resident #70 on 4/24/13, the record indicated that on 2/15/13 at the supper meal, Resident #70 slapped Resident #58 on the hand twice after Resident #58 attempted to hold hands with Resident #70.</p> <p>4. Per review of the medical record of Resident #70 on 4/24/13, the record indicated that on 3/08/13, Resident #70 was in activities and another resident, Resident #43 was singing. Resident #70 told Resident #43 to " shut up " and hit Resident #43 on the arm.</p> <p>5. Per review of the medical record of Resident #70 on 4/24/13, the record indicated that on 3/12/13 after the music program, Resident #70 hit Resident #58 on the arm when the aide attempted to assist Resident #58 to his/her feet and Resident #70 was saying to Resident #58 to " get up, hurry up, get up " and hitting Resident #58 on the arm.</p> <p>6. Per review of the medical record of Resident #70 on 4/24/13, the record indicated that on 3/30/13, Resident #70 slapped the hand of Resident #15 and was yelling at Resident #15 to " get out of here. "</p> <p>7. Per record review on 4/23&24/2013 resident # 21 was at an activity on 4/19 2013 and during the activity (a balloon toss) resident#68 caught the balloon. Resident #21 slapped Resident #68 saying-that's mine. Resident #21 was moved away from resident #68. Shortly after being resident #50 after s/he hit the balloon stating again that's mine.</p>	F 225		

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F 225	<p>Continued From page 8</p> <p>Per interview with the facility Administrator on 4/24/13, the Administrator reviewed the dates of each of the incidences of resident to resident altercations and confirmed that he/she was aware that on 11/29/12, 2/15/13, 3/8/13, 3/12/13 and 3/30/13 there were resident to resident physical altercations.</p> <p>Per interview with the facility Administrator on 4/24/13, the Administrator confirmed that any suspected abuse should be thoroughly investigated and that the appropriate State Agencies are to be notified. The Administrator confirmed that the resident to resident altercations on 11/29/12, 2/15/13 and 3/13/13 were not called into the appropriate state agencies and the Administrator was unable to provide complete and thorough investigations conducted for each the resident to resident altercations occurring on 11/29,2/15,3/8 and 3/13.</p> <p>Per interview on 4/24/2013 the Administrator and the Director of Nursing Services (DON) both stated that a decision was made, by the Investigative Committee that there was no need to report the 4/19/13 incident and that no report had been made to the State Agency</p>	F 225		
F 226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 226	<p><u>F226</u></p> <p>The Facility has and continues to ensure that a policy regarding mistreatment, neglect, or abuse is implemented in accordance with State law through established procedures.</p>	5/16/13

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F 226	Continued From page 11 required that all suspected abuse be reported within 24 hours	F 226		
F 250 SS=E	Per interview with the facility Administrator on 4/24/13, the Administrator confirmed that any suspected abuse should be thoroughly investigated and that the appropriate State Agencies are to be notified. The Administrator confirmed that the resident to resident altercations on 11/29/12, 2/15/13, 3/8/13, 3/13/13 and 4/24/13 were not called into the appropriate state agencies and the Administrator was unable to provide complete and through investigations conducted for each the resident to resident altercations occurring on 11/29,2/15,3/8 and 3/13. 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident for 4 residents identified (Resident # 15, 43, 58 and 70). The findings include: 1. Per review of the medical record of Resident #70 on 4/24/13, the record indicated that Resident #70 had been involved in several	F 250	<u>F250</u> The Facility has and continues to ensure that residents are provided medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.	5/15/13

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F 250	Continued From page 12 resident to resident physical altercations. Per review of the medical record on 11/29/12, Resident #70 was sitting in a chair next to another resident whom was moaning and yelling. Resident #70 became agitated and hit Resident #15 three times on the shin with his/her cane. Per review of the medical records for Resident #70 and Resident #15, there was no evidence that social services assessed the resident 's specific needs after the altercation to ensure that the resident 's mental and psychosocial needs had not changed after being involved in a resident to resident altercation. Per review of the comprehensive care plan, there was no plan of care that addressed that Resident #15 was a victim of abuse from a resident to resident altercation occurring on 11/29/12 and resident specific interventions that would prevent abuse from reoccurring. Per interview with the Social Service Director (SSD) on 4/24/13, he/she reviewed the 11/29/12 incident and confirmed that the SSD was aware of the incident but had not assessed either Resident #70 or Resident #15 and the SSD confirmed that there was no care plan that indicated that Resident #15 was the victim of abuse and there were no resident specific interventions to help ensure that Resident #15 did not become a victim of abuse again. 2. Per review of the medical record of Resident #70, on 4/24/13, the record indicated that on 2/15/13, Resident #70 reported to staff that at approximately 3:15 PM, Resident #70 punched	F 250	<u>F250 continued</u> What corrective action will be accomplished for those residents found to have been affected by the deficient practice; 1., 2., 3., 4., 5., 6., and 7.: Social services will meet with residents #70, #15, #58, and #43 to ensure that they do not exhibit any emotional signs and/or symptoms of distress from the incidents. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by this alleged deficient practice. An audit of residents involved in resident to resident altercations in the last 60 days has been conducted to ensure that a complete and thorough investigation has been completed. Social services will meet with any residents identified in the audit to ensure that the identified residents are not exhibiting any emotional signs and symptoms of distress from the altercation. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; Administrator will follow up with social services to ensure that social services has assessed the involved residents for emotional distress.	05/15/16	05/13/13	05/15/13

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F 250	<p>Continued From page 13</p> <p>Resident #15 after Resident #15 entered the room of Resident #70 because Resident #70 felt Resident #15 " was after him/her " .</p> <p>Per review of the medical records for Resident #70 and Resident #15, there was no evidence that social services assessed the resident ' s specific needs after the altercation to ensure that the resident ' s mental and psychosocial needs had not changed after being involved in a resident to resident altercation.</p> <p>Per review of the comprehensive care plan, there was no plan of care that addressed that Resident #15 was a victim of abuse from a resident to resident altercation occurring on 2/15/13 and resident specific interventions that would prevent abuse from reoccurring.</p> <p>Per interview with the Social Service Director (SSD) on 4/24/13, he/she reviewed the 2/15/13 incident and confirmed that the SSD was aware of the incident but had not assessed either Resident #70 or Resident #15 and the SSD confirmed that there was no care plan that indicated that Resident #15 was the victim of abuse and there were no resident specific interventions to help ensure that Resident #15 did not become a victim of abuse again.</p> <p>3. Per review of the medical record of Resident #70 on 4/24/13, the record indicated that on 2/15/13 at the supper meal, Resident #70 slapped Resident #58 on the hand twice after Resident #58 attempted to hold hands with Resident #70.</p>	F 250	<p><u>F250 continued</u></p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>The risk meeting's weekly review of resident to resident altercations will be reviewed at the monthly QA meeting to ensure ongoing compliance is complete and timely until the QA committee has determined that 100% compliance has been achieved.</p> <p><i>F250 not accepted this morning</i></p>	05/14/13

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F 250	<p>Continued From page 14</p> <p>Per review of the medical records for Resident #70 and Resident #58, there was no evidence that social services assessed the resident ' s specific needs after the altercation to ensure that the resident ' s mental and psychosocial needs had not changed after being involved in a resident to resident altercation.</p> <p>Per review of the comprehensive care plan, there was no plan of care that addressed that Resident #58 was a victim of abuse from a resident to resident altercation occurring on 2/15/13 and resident specific interventions that would prevent abuse from reoccurring.</p> <p>Per interview with the Social Service Director (SSD) on 4/24/13, he/she reviewed the 2/15/13 incident and confirmed that the SSD was aware of the incident but had not assessed either Resident #70 or Resident #58 and the SSD confirmed that there was no care plan that indicated that Resident #58 was the victim of abuse and there were no resident specific interventions to help ensure that Resident #58 did not become a victim of abuse again</p> <p>4. Per review of the medical record of Resident #70 on 4/24/13, the record indicated that on 3/08/13, Resident #70 was in activities and another resident, Resident #43 was singing. Resident #70 told Resident #43 to " shut up " and hit Resident #43 on the arm.</p> <p>Per review of the medical records for Resident #70 and Resident #43, there was no evidence that social services assessed the resident ' s specific needs after the altercation to ensure that the resident ' s mental and psychosocial needs</p>	F 250		

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F 250	<p>Continued From page 15</p> <p>had not changed after being involved in a resident to resident altercation.</p> <p>Per review of the comprehensive care plan, there was no plan of care that addressed that Resident #43 was a victim of abuse from a resident to resident altercation occurring on 2/15/13 and resident specific interventions that would prevent abuse from reoccurring.</p> <p>5. Per review of the medical record of Resident #70 on 4/24/13, the record indicated that on 3/12/13 after the music program, Resident #70 hit Resident #58 on the arm when the aide attempted to assist Resident #58 to his/her feet and Resident #70 was saying to Resident #58 to " get up, hurry up, get up " and hitting Resident #58 on the arm.</p> <p>Per review of the medical records for Resident #70 and Resident #58, there was no evidence that social services assessed the resident ' s specific needs after the altercation to ensure that the resident ' s mental and psychosocial needs had not changed after being involved in a resident to resident altercation.</p> <p>Per review of the comprehensive care plan, there was no plan of care that addressed that Resident #58 was a victim of abuse from a resident to resident altercation occurring on 3/12/13 and resident specific interventions that would prevent abuse from reoccurring.</p> <p>Per interview with the Social Service Director (SSD) on 4/24/13, he/she reviewed the 3/12/13</p>	F 250		

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F 250	<p>Continued From page 16</p> <p>incident and confirmed that the SSD was aware of the incident but had not assessed either Resident #70 or Resident #58 and the SSD confirmed that there was no care plan that indicated that Resident #58 was the victim of abuse and there were no resident specific interventions to help ensure that Resident #58 did not become a victim of abuse again</p> <p>6. Per review of the medical record of Resident #70 on 4/24/13, the record indicated that on 3/30/13, Resident #70 slapped the hand of Resident #15 and was yelling at Resident #15 to " get out of here. "</p> <p>Per review of the medical records for Resident #70 and Resident #15, there was no evidence that social services assessed the resident ' s specific needs after the altercation to ensure that the resident ' s mental and psychosocial needs had not changed after being involved in a resident to resident altercation.</p> <p>Per review of the comprehensive care plan, there was no plan of care that addressed that Resident #15 was a victim of abuse from a resident to resident altercation occurring on 3/30/13 and resident specific interventions that would prevent abuse from reoccurring.</p> <p>Per interview with the Social Service Director (SSD) on 4/24/13, he/she reviewed the 3/30/13 incident and confirmed that the SSD was aware of the incident but had not assessed either Resident #70 or Resident #15 and the SSD confirmed that there was no care plan that indicated that Resident #15 was the victim of abuse and there were no resident specific</p>	F 250		

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F 250	Continued From page 17 interventions to help ensure that Resident #15 did not become a victim of abuse again. 7. Per record review of Resident #70, the progress notes indicated that Resident #70 was physically aggressive towards other residents on 11/29, 2/15, 3/8, 3/12 and 3/30/13. There was no evidence in the medical record that indicated that the SSD assessed Resident #70 after any of the physical altercations to determine resident specific needs that may need to be addressed for a resident with aggressive behaviors. Per interview with the SSD on 4/24/13, he/she confirmed that he/she was aware of the incidences on 11/29, 2/15, 3/8, 3/12 and 3/30/13. The SSD confirmed that he/she had not assessed Resident #70 after any of the resident to resident physical altercations where Resident #70 was the aggressor. The SSD confirmed that no assessment made by Social Services regarding potential needs for an aggressive resident and assessment by social services regarding potential interventions to prevent reoccurrence.	F 250			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279	<u>F279</u> The facility has and continues to ensure that the facility revises and/or reviews care plans as needed.	5/15/13	

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F 279	<p>Continued From page 19</p> <p>behaviors for Resident #70 was not initiated until 2/14/13 which is over 2 months after the first episode of aggression toward other residents documented as being 11/29/12.</p> <p>2. Per review of the medical record of Resident #70 on 4/24/13, the record indicated that Resident #70 had been involved in several resident to resident physical altercations. Per review of the medical record on 11/29/12, Resident #70 was sitting in a chair next to another resident whom was moaning and yelling. Resident #70 became agitated and hit Resident #15 three times on the shin with his/her cane.</p> <p>Per review of the medical record of Resident #70, on 4/24/13, the record indicated that on 2/15/13, Resident #70 reported to staff that at approximately 3:15 PM, Resident #70 punched Resident #15 after Resident #15 entered the room of Resident #70 because Resident #70 felt Resident #15 " was after him/her " .</p> <p>Per review of the medical record of Resident #70 on 4/24/13, the record indicated that on 3/30/13, Resident #70 slapped the hand of Resident #15 and was yelling at Resident #15 to " get out of here. "</p> <p>Per review of the comprehensive care plan, there was no plan of care that addressed that Resident #15 was a victim of abuse from a resident to resident altercation occurring on 11/29/12, 2/15/13 and 3/30/13 and resident specific interventions that would prevent abuse from reoccurring.</p> <p>Per interview with the Quality Assurance Nurse</p>	F 279	<p><u>F279 continued</u></p> <p>resident behaviors and the methods can be added to the residents plan of care as indicated.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>This audit will be conducted on a monthly basis and the results will be reviewed at the monthly QA meeting to ensure ongoing compliance until the QA committee has determined that 100% compliance has been achieved.</p> <p><i>From the accepted 7/11/13</i></p>	05/14/13	

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F 279	<p>Continued From page 20</p> <p>and Charge Nurse on 4/26/13, they reviewed the comprehensive care plan and confirmed that there was no evidence in the care plan that indicated that Resident #15 was a victim of physical aggression by another resident care plan and resident specific interventions that would help prevent reoccurrence.</p> <p>3. Per review of the medical record of Resident #70 on 4/24/13, the record indicated that on 2/15/13 at the supper meal, Resident #70 slapped Resident #58 on the hand twice after Resident #58 attempted to hold hands with Resident #70.</p> <p>Per review of the medical record of Resident #70 on 4/24/13, the record indicated that on 3/12/13 after the music program, Resident #70 hit Resident #58 on the arm when the aide attempted to assist Resident #58 to his/her feet and Resident #70 was saying to Resident #58 to " get up, hurry up, get up " and hitting Resident #58 on the arm.</p> <p>Per review of the comprehensive care plan, there was no plan of care that addressed that Resident #58 was a victim of abuse from a resident to resident altercation occurring on 2/15/13 and 3/12/13 and resident specific interventions that would prevent abuse from reoccurring.</p> <p>Per interview with the Quality Assurance Nurse and Charge Nurse on 4/26/13, they reviewed the comprehensive care plan and confirmed that there was no evidence in the care plan that indicated that Resident #58 was a victim of physical aggression by another resident care plan</p>	F 279		

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F 279	Continued From page 21 and resident specific interventions that would help prevent reoccurrence. 4. Per review of the medical record of Resident #70 on 4/24/13, the record indicated that on 3/08/13, Resident #70 was in activities and another resident, Resident #43 was singing. Resident #70 told Resident #43 to " shut up " and hit Resident #43 on the arm. Per review of the comprehensive care plan, there was no plan of care that addressed that Resident #43 was a victim of abuse from a resident to resident altercation occurring on 3/08/13 and resident specific interventions that would prevent abuse from reoccurring. Per interview with the Quality Assurance Nurse and Charge Nurse on 4/26/13, they reviewed the comprehensive care plan and confirmed that there was no evidence in the care plan that indicated that Resident #43 was a victim of physical aggression by another resident care plan and resident specific interventions that would help prevent reoccurrence	F 279			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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. 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	F 280	<u>F 280</u> The Facility has and continues to ensure that the care plans are developed/revised and/or reviewed as needed and that residents can participate in their plan of care.	5/15/13	

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F 280	Continued From page 23 3. Per review of the medical record of Resident #70 on 4/24/13, the record indicated that on 2/15/13 at the supper meal, Resident #70 slapped Resident #58 on the hand twice after Resident #58 attempted to hold hands with Resident #70. 4. Per review of the medical record of Resident #70 on 4/24/13, the record indicated that on 3/08/13, Resident #70 was in activities and another resident, Resident #43 was singing. Resident #70 told Resident #43 to " shut up " and hit Resident #43 on the arm. 5. Per review of the medical record of Resident #70 on 4/24/13, the record indicated that on 3/12/13 after the music program, Resident #70 hit Resident #58 on the arm when the aide attempted to assist Resident #58 to his/her feet and Resident #70 was saying to Resident #58 to " get up, hurry up, get up " and hitting Resident #58 on the arm. 6. Per review of the medical record of Resident #70 on 4/24/13, the record indicated that on 3/30/13, Resident #70 slapped the hand of Resident #15 and was yelling at Resident #15 to " get out of here. " Per review of the comprehensive care plans for Residents #15, 43, 58 and #70 there was no evidence that the care plans were reviewed and revised to ensure that interventions for Resident # 15, 43, 58, and 70 were placed to meet the specific needs of a resident involved in resident to resident physical altercation and that interventions were developed to prevent	F 280	<u>F280 continued</u> compliance is achieved and the risk meeting reviews are no longer necessary. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The risk meeting's weekly review of resident to resident altercations will be reviewed at the monthly QA meeting to ensure ongoing compliance is complete and timely until the QA committee has determined that 100% compliance has been achieved. <i>Per FCC report 7/11/13</i>	05/14/13	

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F 280	Continued From page 24 reoccurrence of aggressive behaviors.	F 280			
F 281 SS=D	<p>Per interview with the Quality Assurance Nurse and the Charge Nurse, reviewed the behavior care plans for Resident # 15, 43, 58, and 70 and confirmed that there was no evidence that the care plans was reviewed to ensure that interventions were placed to meet the specific needs of a resident with aggressive behaviors and that interventions were developed to prevent reoccurrence of aggressive behaviors.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure that professional standards of quality were met for ?? of ?? residents sampled. (Resident #70). Findings include:</p> <p>1. Per observation on 4/23/13 at 9:00 AM during medication administration review, Resident #70 had an order to receive Alendronate Sodium 70 mg. one time per week on Tuesdays at 7:00 AM. The resident was administered this medication after just eating breakfast at 9:05 AM along with all of the other medications scheduled at 8:00 AM, which included Gabapentin, Paxil, Vitamin B-12, Vitamin D, Acetaminophen, Seroquel, Calcium Antacid chew, and Diphenhydramine. The Physicians order states to give this</p>	F 281	<p><u>F281</u></p> <p>The Facility has and continues to ensure that it meets professional standards of care.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>Physician was notified, staff education, and the utilization of Fosamax was reviewed with the Medical Director.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>All residents have the potential to be affected by this alleged deficient practice.</p>	<p>5/16/13</p> <p>05/16/13</p>	

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F 281	Continued From page 25 medication at 7:00 AM, 1/2 hour before breakfast. This is based on the manufacturer's recommendation that Alendronate must be given on an empty stomach, and the resident must sit in an upright position after administration for 30 minutes. Per telephone conversation with a consulting pharmacist on 4/23/13 at 3:10 PM, the medication would most likely lose its effectiveness when administered with other medications and food, and that it should be given per the manufacturer's recommendation on an empty stomach and remain in an upright position for 30 minutes. Per interview on 4/23/13 at 9:20 AM, the nurse administering the medication confirmed that they had missed the 7:00 AM timing of the Alendronate administration as ordered by the physician, and were giving the medication two hours after the scheduled time, not on an empty stomach, and along with all the other morning medications prescribed to the Resident #70. The manufacturer's information sheet that came from the box of Alendronate gives specific instructions to take this medication on an empty stomach, with no food or other medications, and only with a glass of water. The administration with food or medications may greatly reduce the effectiveness. (Sun Pharmaceuticals Ind.LTD Package insert information,	F 281	<u>F281 continued</u> What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; Two medication pass competencies will be conducted weekly by the Director of Nurses or designee to ensure that nurses are completing med passes in a timely fashion and that nurses are reading the directions for safe and appropriate administration of medication. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The results of the med pass competencies will be reviewed monthly at the QA meeting until such time the QA Committee deems compliance has been met. <i>F281 has no impact on this assessment</i>	05/14/13 05/14/13
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309		5/16/13

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NAME OF PROVIDER OR SUPPLIER VERNON GREEN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 61 GREENWAY DRIVE VERNON, VT 05354
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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 309	<p>Continued From page 26 and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, psychosocial well-being, in accordance with the comprehensive assessment and plan of care for 4 residents identified (Resident #15, 43, 58, and 70.) The findings include:</p> <p>1. Per review of the medical record of Resident #70 on 4/24/13, the record indicated that Resident #70 had been involved in several resident to resident physical altercations. Per review of the medical record of Resident #15 on 11/29/12, Resident #70 was sitting in a chair next to Resident #15 whom was moaning and yelling. Resident #70 became agitated and hit Resident #15 three times on the shin with his/her cane.</p> <p>2. Per review of the medical record of Resident #70, on 4/24/13, the record indicated that Resident #70 reported to staff that at approximately 3:15 PM, Resident #70 punched Resident #15 after Resident #15 entered the room of Resident #70 because Resident #70 felt Resident #15 " was after him/her " .</p> <p>3. Per review of the medical record of Resident #70 on 4/24/13, the record indicated that on 2/15/13 at the supper meal, Resident #70 slapped Resident #58 on the hand twice after Resident #58 attempted to hold hands with</p>	F 309	<p><u>F309</u></p> <p>The Facility has and continues to ensure that each resident receive care and services that attain or maintain highest practicable physical and mental and psychosocial well-being.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>1., 2., 3., 4., 5., and 6.:</p> <p>Residents' #70, #15, #58, and #43 physicians were notified.</p> <p>Resident to resident altercations involving residents #70, #15, #58, and #43 have been investigated and reported to Adult Protective Services (APS).</p> <p>Staff education on behavior interventions for residents #70, #15, #58, and #43 have been review with staff.</p> <p>Social Service will meet with residents #70, #15, #58, and #43 to assure that the residents have sustained the highest practicable psychosocial well-being and determine if a change may have occurred in the residents' assistance in daily living.</p> <p>Resident #40 care plan have been reviewed and updated to address his/her behaviors. Residents #15, #43, and #58 impacted by resident #40's behaviors have had care plans reviewed and updated.</p>	<p>05/13/13</p> <p>05/13/13</p> <p>05/16/13</p> <p>05/15/13</p> <p>05/15/13</p>
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2013
NAME OF PROVIDER OR SUPPLIER VERNON GREEN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 61 GREENWAY DRIVE VERNON, VT 05354		
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F 309	Continued From page 28 Administrator confirmed that the resident to resident altercations on 11/29/12, 2/15/13, 3/8/13 and 3/13/13 were not called into the appropriate state agencies and the Administrator was unable to provide complete and thorough investigations conducted for each the resident to resident altercations occurring on 11/29,2/15,3/8 and 3/13 Per review of the medical records for Resident #15, 43, 58 and #70, there was no evidence that social services assessed the resident 's specific needs after the altercation to ensure that the resident 's mental and psychosocial needs had not changed after being involved in a resident to resident altercation. Per interview with the SSD on 4/24/13, he/she confirmed that he/she was aware of the incidences on 11/29, 2/15, 3/8, 3/12 and 3/30/13. The SSD confirmed that he/she had not assessed Resident #15, # 43, #58 or #70 after any of the resident to resident physical altercations where Resident #70 was the aggressor. The SSD confirmed that no assessment made by Social Services regarding potential needs for an aggressive resident and assessment by social services regarding potential interventions to prevent reoccurrence. Per review of the comprehensive care plans for Residents #15, 43, 58 and #70 there was no evidence that the care plans were reviewed and revised to ensure that the interventions for Resident # 15, 43, 58, and 70 to ensure that interventions were placed to meet the specific needs of a resident involved in resident to resident altercations and that interventions were	F 309	<u>F309 continued</u> Director of Nursing or designated RNs will conduct Quality Assurance audit of residents with "Behaviors that affect others/self" to determine that a care plan is in place to address aggressive behavior/potential aggression from other residents' related to disruptive behavior. In an effort to develop more effective individualized interventions for behavior management "team huddles" will be conducted on the units with direct care nursing staff so that direct care staff who have a familiarity with behavioral residents can share effective methods for managing resident behaviors and the methods can be added to the residents plan of care as indicated. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Audits will be reviewed at the monthly QA meeting to ensure ongoing compliance until the QA Committee determine that compliance has been achieved. <i>F309 not accepted this practice</i>	05/10/13 05/13/13 05/14/13	

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F 309	<p>Continued From page 29</p> <p>developed to prevent reoccurrence of aggressive behaviors.</p> <p>Per interview with the Quality Assurance Nurse and the Charge Nurse, they reviewed the behavior care plans for Resident # 15, 43, 58, and 70 and confirmed that there was no evidence that the care plans was reviewed to ensure that interventions were placed to meet the specific needs of a resident with aggressive behaviors and that interventions were developed to prevent reoccurrence of aggressive behaviors.</p> <p>7. Per observation on 4/23/13 at 9:00 AM during medication administration review, Resident #70 had an order to receive Alendronate Sodium 70 mg. one time per week on Tuesdays at 7:00 AM. The resident was administered this medication after just eating breakfast at 9:05 AM along with all of the other medications scheduled at 8:00 AM, which included Gabapentin, Paxil, Vitamin B-12, Vitamin D, Acetaminophen, Seroquel, Calcium Antacid chew, and Diphenhydramine.</p> <p>Physicians order states to give this medication at " 7:00 AM, 1/2 hour before breakfast". This is based on the manufacturer's recommendation that Alendronate must be given on an empty stomach, and the resident must sit in an upright position after administration for 30 minutes.</p> <p>Per telephone conversation with a consulting pharmacist on 4/23/13 at 3:10 PM, the medication would most likely lose its effectiveness when administered with other medications and food, and that it should be</p>	F 309		

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F 371	Continued From page 31 sandwich with bare hands. He also handled a drinking cup being used by a second resident (R#36) and then returned to feeding the sandwich to the first resident again with bare hands and without washing or sanitizing his hands. When interviewed he acknowledged that he had handled food with bare, unsanitized hands. During lunch on 4/22/2013 at 12:34P a second staff member took over feeding resident #43 and alternated between assisting that resident and a second resident handling utensils and foods without sanitizing or washing hands. In an interview on 4/22/13 at 12:35 s/he acknowledged that hands should be sanitized between assisting residents residents and that s/he had not done so.	F 371	<u>F371 continued</u> What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; Provide education to staff regarding the facility's policy on sanitary conditions when assisting residents with food related activities. Two dining assistance competencies will be conducted weekly by the Director of Nurses or designee. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The results of dining assistance competencies will be reviewed monthly at the QA meeting until such time the QA Committee deems compliance has been met. <i>1/20/13 completed. This document</i>	05/16/13 05/14/13 05/14/13	