

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 22, 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 **June 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 PRINTED: 07/08/2013
Division of 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 _____	JUL 18 13 Licensing and Protection	(X3) DATE SURVEY COMPLETED R 06/24/2013
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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 000}	INITIAL COMMENTS An unannounced revisit was conducted by the Division of Licensing and Protection on 6/24/13. During the course of the revisit regulatory deficiencies were identified. The findings include: {F 223} SS=D 483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that 1 of 7 residents identified (Resident #50) was free from verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. The findings include: 1. Per record review on 6/24/13, Resident #50 was admitted to the facility on 3/31/11 with diagnoses that include, Alzheimer's disease, non-organic psychoses/unspecified psychosis, paranoid delusions and paranoid psychosis. The record indicates a long standing history of wandering behaviors and history of Resident #50 being involved in physical and verbal altercations with other residents. Per review of the facilities internal investigation dated 5/21/13, on 5/16/13 at approximately 0800	{F 000}	Allegation of Substantial Compliance 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. 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 July 19, 2013. 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. <u>F223</u> The Facility continues to assure that residents are free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion.	5/16/13
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 7-16-13
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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 223}	<p>Continued From page 1</p> <p>AM, Resident #50 was sitting in his/her wheelchair next to Resident #21, who was in his/her wheelchair positioned halfway in the dayroom on the A-wing and half way in the corridor. When Resident #50 attempted to move his/her wheelchair away the wheelchair was caught on Resident #21. Resident #21 began to yell and became agitated and with a closed fist hit Resident #50 three times on the left cheek.</p> <p>Per review of the plan of care for Resident #50, the care plan titled : "Wanders in wheelchair; unaware of safety issues and personal boundaries elopement risk, intrusive wandering that may place resident at risk for aggression from other resident's" the care plan indicates that on the revised care plan dated 2/2/13 the following interventions were to be utilized for resident #50's behavior. Redirect resident way from other residents, encourage wandering away from dayroom and monitor residents whereabouts.</p> <p>Per review of the medical record there was no evidence that Resident #50's whereabouts were being monitored by staff and no evidence that Resident #50 had been redirected by staff away from Resident #21 or encouraged to sit away from the dayroom.</p> <p>Per interview with the Unit Manager (UM) on 6/24/13, he/she confirmed that Resident #50 has a longstanding documented history of being involved in physical and verbal altercations with other residents, where Resident #50 is the aggressor and has a history of being a victim also. The UM confirmed that on 5/16/13, Resident #50 was the victim of physically</p>	{F 223}	<p>F223 continued</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Residents' care plan has been reviewed. Resident #50 was placed on fifteen minute checks.</p> <p>The LNA and LPN that were involved and witnessed the incident will receive warnings for not following the care plan interventions.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken;</p> <p>All residents have the potential to be affected by this practice.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;</p> <p>Nursing staff will be educated on resident care plan changes, behaviors and interventions that have been put into place. Continued education will be completed through interdisciplinary staff huddles and by an electronic notification system.</p> <p>Director of Nursing will initiate walk through rounds. The focus of these rounds being the observation of resident interactions on the units and specific observation of residents at risk for aggression from or towards others. Special attention will be given to the adherence of high risk resident care plans and in the</p>	05/28/13	07/19/13
				07/19/13	07/19/13

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{F 223}	<p>Continued From page 2</p> <p>aggressive behavior by Resident #21. Per interview the UM reviewed the progress notes in the medical record of Resident #50 dated 5/16/13 and confirmed that there was no documentation that indicated facility staff was monitoring the whereabouts of Resident #50 as per the care plan. Per interview with the UM, he/she confirmed that there was no formal monitoring process in place to monitor the whereabouts of Resident #50 as per the care plan. The UM also confirmed after review of the progress notes, that Resident #50 should have been redirected away from Resident #21 and out of the day room for his/her safety as per the care plan intervention dated 2/21/13.</p> <p>2. Per review of the facilities internal investigation dated 5/25/13, on 5/22/13 at approximately 08:30 AM, Resident #50 was in his/her wheelchair wandering the hallway. Resident #21 was seated in his/her wheelchair in his/her doorway where Resident #21 was left there by a Licensed Nurses Assistant (LNA) who was asked to assist another resident. The medication nurse was in the hallway with his/her back to Resident #21 when the LNA heard Resident #21 yell "get away from me" and the medication nurse witnessed Resident #50 being kicked by Resident #21.</p> <p>Per review of the plan of care for Resident #50, the care plan titled: "Wanders in wheelchair; unaware of safety issues and personal boundaries elopement risk, intrusive wandering that may place resident at risk for aggression from other resident's" the care plan indicates that on the revised care plan dated 5/16/13, Resident #50 is to be "encouraged/redirected away from other residents when wandering in wheelchair and encourage other residents to be encouraged</p>	{F 223}	<p>F223 continued</p> <p>moment education will be provided if the care plan is not being followed.</p> <p>How the corrective action 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 completed walk through round forms will be reviewed by the Director of Nurses or designee to ensure compliance. A summary of the results of the walk through rounds will be reviewed by the Quality Assurance Committee.</p> <p><i>F223 POC accepted 7/22/13 McLuthan RN/pmc</i></p>	07/19/13
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{F 223}	<p>Continued From page 3</p> <p>to not sit near traffic area of hallway where Resident #50 frequently propels by."</p> <p>Per review of the plan of care for Resident #21, the care plan titled: "May be physically aggressive", updated on 5/16/13 indicates "not to park [Resident #21] near traffic areas, so that he/she doesn't get bumped into."</p> <p>Per interview with the UM on 6/24/13, he/she reviewed the medical record for Resident #50 and confirmed that on 5/22/13, Resident #50 was the victim of physically aggressive behavior by Resident #21. The UM reviewed the careplan titled : "Wanders in wheelchair; unaware of safety issues and personal boundaries eiopement risk, intrusive wandering that may place resident at risk for aggression from other resident's" . and confirmed that the care plan indicates that on the revised care plan dated 5/16/13, Resident #50 is to be "encouraged/redirectioned away from other residents when wandering in wheelchair and encourage other residents to be encouraged to not sit near traffic area of hallway where Resident #50 frequently propels by." The UM confirmed after review of the progress notes dated 5/22/13 at 2:00 PM, that Resident #50 rolled over the toes of Resident #21 with his/her wheelchair and Resident #21 kicked resident #50.</p> <p>The UM confirmed after review of the progress notes dated 5/22/13 at 2:00 PM that a 8:25 AM Resident #21 was sitting in wheelchair in doorway of room and Resident #50 rolled over Resident #21's toe with his/her wheelchair and Resident #21 yelled out and kicked Resident #50. The UM confirmed that the progress note also indicated that the aide took Resident #50 out of the hallway</p>	{F 223}		
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{F 223}	<p>Continued From page 4 to another area. The UM indicated Resident #50 was moved after the incident.</p> <p>Per interview the UM reviewed the care plan for Resident #50 and confirmed that the care plan indicated that Resident #50 is to be "encouraged/redirected away from other residents when wandering in wheelchair and that there was no evidence that this occurred until after the altercation with Resident #21. The UM also confirmed that the careplan indicated that staff is to "encourage other residents to be encouraged to not sit near traffic area of hallway where Resident #50 frequently propels by." The UM confirmed after review of the medical record that there was no evidence that Resident #21 had been encouraged not to sit near a high traffic area of the hallway and the UM confirmed that Resident #21 was sitting in the bedroom doorway which is in the hallway that Resident #50 frequently wanders.</p> <p>The UM confirmed after review of the care plan revised on 5/16/13 for Resident #21 that staff is "not to park Resident #21 near traffic areas, so that he/se doesn't get bumped into." The UM confirmed that on 5/22/13 at approximately 08:30 AM, Resident #50 was in his/her wheelchair wandering the hallway. Resident #21 was seated in his/her wheelchair in his/her doorway where Resident #21 was left there by a Licensed Nurses Aide (LNA) . the UM also confirmed that the care plan for Resident #50 indicates the staff is to monitor Resident #50's whereabouts and redirect resident away form other resident's. The UM confirmed the medication nurse had her back to Resident #21 and #50 at the time of the incident and that Resident #50 had not been redirected</p>	{F 223}		
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{F 223} F 282 SS=D	Continued From page 5 away from other residents. 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that 2 of 7 resident identified (Resident #50 and #21) had services provided or arranged by the facility and provided by qualified persons in accordance with each resident's written plan of care. The findings include: 1. Per record review on 6/24/13, Resident #50 was admitted to the facility on 3/31/11 with diagnoses that include, Alzheimer's disease, nonorganic psychoses/unspecified psychosis, paranoid delusions and paranoid psychosis. The record indicates a long standing history of wandering behaviors and history of Resident #50 being involved in physical and verbal altercations with other residents. Per review of the facilities internal investigation dated 5/21/13, on 5/16/13 at approximately 0800 AM, Resident #50 was sitting in his/her wheelchair next to Resident #21, who was in his/her wheelchair positioned halfway in the dayroom on the A-wing and half way in the corridor. When Resident #50 attempted to move his/her wheelchair away the wheelchair was	{F 223} F 282	<u>F282</u> The Facility has developed and continues to provide resident care by qualified persons in accordance with each resident's written plan of care. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Residents' care plan has been reviewed. Resident #50 was placed on fifteen minute checks. The LNA and LPN that were involved and witnessed the incident will receive warnings for not following the care plan interventions. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken; All residents have the potential to be affected by this practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; Nursing staff will be educated on resident care plan changes, behaviors and interventions that have been put into place. Continued education will be completed through interdisciplinary staff huddles and by an electronic notification system. Director of Nursing will initiate walk through rounds. The focus of these rounds	05/28/13 07/19/13 07/19/13 07/19/13
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F 282	<p>Continued From page 6</p> <p>caught on Resident #21. Resident #21 began to yell and became agitated and with a closed fist hit Resident #50 three times on the left cheek.</p> <p>Per review of the plan of care for Resident #50, the care plan titled: "Wanders in wheelchair; unaware of safety issues and personal boundaries elopement risk, intrusive wandering that may place resident at risk for aggression from other resident's" the care plan indicates that on the revised care plan dated 2/2/13 the following interventions were to be utilized for resident #50's behavior. Redirect resident way from other residents, encourage wandering away from dayroom and monitor residents whereabouts.</p> <p>Per review of the medical record there was no evidence that Resident #50's whereabouts were being monitored by staff and no evidence that Resident #50 had been redirected by staff away from Resident #21 or encouraged to sit away from the dayroom.</p> <p>Per interview with the Unit Manager (UM) on 6/24/13, he/she confirmed that Resident #50 has a longstanding documented history of being involved in physical and verbal altercations with other residents, where Resident #50 is the aggressor and has a history of being a victim also. The UM confirmed that on 5/16/13, Resident #50 was the victim of physically aggressive behavior by Resident #21. Per interview the UM reviewed the progress notes in the medical record of Resident #50 dated 5/16/13 and confirmed that there was no documentation that indicated facility staff was monitoring the whereabouts of Resident #50 as per the care</p>	F 282	<p><u>F282</u> continued</p> <p>being the observation of resident interactions on the units and specific observation of residents at risk for aggression from or towards others. Special attention will be given to the adherence of high risk resident care plans and in the moment education will be provided if the care plan is not being followed.</p> <p>How the corrective action 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 completed walk through round forms will be reviewed by the Director of Nurses or designee to ensure compliance. A summary of the results of the walk through rounds will be reviewed by the Quality Assurance Committee.</p> <p><i>F282 POC accepted 7/22/13 McLuhannan/PMC</i></p>	07/19/13

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F 282	<p>Continued From page 7</p> <p>plan. Per interview with the UM, he/she confirmed that there was no formal monitoring process in place to monitor the whereabouts of Resident #50 as per the care plan. The UM also confirmed after review of the progress notes, that Resident #50 should have been redirected away from Resident #21 and out of the day room for his/her safety as per the care plan intervention dated 2/21/13.</p> <p>2. Per review of the facilities internal investigation dated 5/25/13, on 5/22/13 at approximately 08:30 AM, Resident #50 was in his/her wheelchair wandering the hallway. Resident #21 was seated in his/her wheelchair in his/her doorway where Resident #21 was left there by a Licensed Nurses Aide (LNA) who was asked to assist another resident. The medication nurse was in the hallway with his/her back to Resident #21 when the LNA heard Resident #21 yell "get away from me" and the medication nurse witnessed Resident #50 being kicked by Resident #21.</p> <p>Per review of the plan of care for Resident #50, the care plan titled : "Wanders in wheelchair; unaware of safety issues and personal boundaries elopement risk, intrusive wandering that may place resident at risk for aggression from other resident's" the care plan indicates that on the revised care plan dated 5/16/13, Resident #50 is to be "encouraged/redirected away from other residents when wandering in wheelchair and encourage other residents to be encouraged to not sit near traffic area of hallway where Resident #50 frequently propels by."</p> <p>Per review of the plan of care for Resident #21, the care plan titled: "May be physically aggressive", updated on 5/16/13 indicates "not to</p>	F 282		
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F 282	<p>Continued From page 8 park [Resident #21] near traffic areas, so that he/se doesn't get bumped into."</p> <p>Per interview with the UM on 6/24/13, he/she reviewed the medical record for Resident #50 and confirmed that on 5/22/13, Resident #50 was the victim of physically aggressive behavior by Resident #21. The UM reviewed the careplan titled : "Wanders in wheelchair; unaware of safety issues and personal boundaries elopement risk, intrusive wandering that may place resident at risk for aggression from other resident's" . and confirmed that the care plan indicates that on the revised care plan dated 5/16/13, Resident #50 is to be "encouraged/redirected away from other residents when wandering in wheelchair and encourage other residents to be encouraged to not sit near traffic area of hallway where Resident #50 frequently propels by." The UM confirmed after review of the progress notes dated 5/22/13 at 2:00 PM, that Resident #50 rolled over the toes of Resident #21 with his/her wheelchair and Resident #21 kicked resident #50.</p> <p>The UM confirmed after review of the progress notes dated 5/22/13 at 2:00 PM that a 8:25 AM Resident #21 was sitting in wheelchair in doorway of room and Resident #50 rolled over Resident #21's toe with his/her wheelchair and Resident #21 yelled out and kicked Resident #50. The UM confirmed that the progress note also indicated that the aide took Resident #50 out of the hallway to another area. The UM indicated Resident #50 was moved after the incident.</p> <p>Per interview the UM reviewed the care plan for Resident #50 and confirmed that the care plan indicated that Resident #50 is to be</p>	F 282		

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F 282	Continued From page 9 "encouraged/redirected away from other residents when wandering in wheelchair and that there was no evidence that this occurred until after the altercation with Resident #21. The UM also confirmed that the careplan indicated that staff is to "encourage other residents to be encouraged to not sit near traffic area of hallway where Resident #50 frequently propels by." The UM confirmed after review of the medical record that there was no evidence that Resident #21 had been encouraged not to sit near a high traffic area of the hallway and the UM confirmed that Resident #21 was sitting in the bedroom doorway which is in the hallway that Resident #50 frequently wanders. The UM confirmed after review of the care plan revised on 5/16/13 for Resident #21 that staff is "not to park Resident #21 near traffic areas, so that he/she doesn't get bumped into." The UM confirmed that on 5/22/13 at approximately 08:30 AM, Resident #50 was in his/her wheelchair wandering the hallway. Resident #21 was seated in his/her wheelchair in his/her doorway where Resident #21 was left there by a Licensed Nurses Aide (LNA) . the UM also confirmed that the care plan for Resident #50 indicates the staff is to monitor Resident #50's whereabouts and redirect resident away form other resident's. The UM confirmed the medication nurse had her back to Resident #21 and #50 at the time of the incident and that Resident #50 had not been redirected away from other residents.	F 282			
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and	F 386			

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

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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 R 06/24/2013
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F 386	<p>Continued From page 10</p> <p>treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that the physician for 1 of 7 residents identified (Resident #70) reviewed the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. The findings include;</p> <p>1. Per review of the medical record for Resident #70 on 6/24/13, the records indicate that Resident #70 was admitted on 11/13/12 with diagnoses that include; Alzheimer's, atypical psychosis and recent upper respiratory infection.</p> <p>Per review of the medical record the physician progress notes indicate that Resident #70 was last seen by the attending physician on 3/18/13. Further review of the medical record indicated that the monthly orders for Resident #70 for the months of 4/1/13-4/31, 5/1/13-5/31, and 6/1/13-6/31 were not signed by the physician. Per</p>	F 386	<p><u>F386</u></p> <p>The Facility has and continues to ensure that physicians review each resident's care.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The doctor has been notified and has been in to see her resident and orders have been signed.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken;</p> <p>All residents have the potential to be affected by this practice.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;</p> <p>A new tracking template has been implemented to monitor physician visits. A house wide audit will be conducted and any outstanding physician visits will be reported to the appropriate provider so that the physician visit can be conducted.</p> <p>How the corrective action 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 tracking template for physician visits will be reviewed monthly by the Director of Nurses or designee to ensure compliance with physician visits. The audit results will be reviewed by the Quality Assurance Committee.</p>	<p>06/27/13</p> <p>07/17/13</p> <p>07/19/13</p>
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F386 POC accepted 7/22/13
mculihan RN / PML

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F 386	<p>Continued From page 11</p> <p>review of the medical record nurses progress notes, Resident #70, during the month of May had been being treated for upper respiratory infection.</p> <p>Per review of the facility policy and procedure titled "Physicians Visits" the policy and procedure indicates that "the attending physician must make visits in accordance with applicable state and federal regulations." The policy and procedure also indicates that "the attending physician must visit his/her patients at least once every 30 days for the first 90 days following resident admission, and then at least every 60 days thereafter." The policy and procedure also indicates that "the attending physician must perform relevant tasks at the time of each visit, including review of the resident's total program of care and appropriate documentation". The policy and procedure also indicates that "a physician visit is considered timely if it occurs not later than 20 days after the date the visit was required."</p> <p>Per interview with the Unit Manager on 6/24/13 at 1225 PM, he/she confirmed after review of the medical record that Resident #70 had not been seen by the attending physician since 3/18/13, that the physician's orders had not been signed by the physician for April, May and June. The UM confirmed that the attending physician assigned to Resident #70 had other patients in the facility and that the attending physician had been in to the facility to see his/her other residents in May and did not know why Resident #70 was not seen by the physician or the orders reviewed and signed. The UM confirmed that Resident #70 was being treated during the month of May for an upper respiratory infection.</p>	F 386			

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F 386	Continued From page 12 The UM in interview on 6/24/13 confirmed that the expectation is that the attending physician must see their assigned residents every 60 days. The UM confirmed that the expectation is that the physician sign the residents monthly orders every month and review the residents plan of care.	F 386		
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