

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

August 8, 2012

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

Provider #: 475008

Dear Mr. Ellis:

Enclosed is a copy of your acceptable plans of correction for the extended survey and complaint investigation conducted on **May 17, 2012**. 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, MS
Licensing Chief

PC:ne

Enclosure - **This version replaces the existing Accepted POC (survey date 5/17/12) with cover letter dated June 12, 2012.**



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

PRINTED: 07/23/2012
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 C 05/17/2012
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 157	<p>Continued From page 1</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to immediately consult with the physician of 1 applicable resident (Resident #1) identified to have a change in physical condition and notify Resident #1's interested family member of Resident #1's change in physical condition. The findings include:</p> <p>1. Per review of the medical record on 4/26/12, Resident #1 was admitted to the facility on 3/16/11 with diagnoses that included: dementia, hypertension, history of gastric bleeding, and history of a gastric ulcer. Review of the nurses notes dated 4/11/12 at 12:45 AM, Resident #1 had a temperature of 100.6 F (Fahrenheit) and Tylenol 650 mg (milligrams) suppository was given for an increased temperature. At 2:00 AM, Resident #1 had a "small amount of drool from the corner of the right mouth, clear mucous with brown stripes, Guiac positive (a test done on stool to identify blood), vital signs: temperature: 99.3 [F], pulse: 68 [bpm (beats per minute)], respiratory rate: 18 , blood pressure: 180/100 after care given, SPO2 [oxygen saturation]95%, makes eye contact but non verbal."</p> <p>At 2:15 AM, the nurse's notes indicate, "large amount of brown slimy emesis." Vital signs: Blood pressure: 150/80, temperature: 99.3 F, pulse: 86</p>	F 157	<p><u>Continued from page 1</u></p> <p>F 157; respectfully denies and disputes that any action or inaction on the part of the facility in respect to F 157 caused any harm or potential for any harm to any facility residents; and requests that F 157 be deleted from the public record or at the very least that the scope and severity be reduced.</p> <p>Resident #1 was admitted to the facility on March 16, 2011, with diagnoses that included dementia and hypertension. The resident did suffer a gastric ulcer and gastric bleeding in 2001. Resident #1 also had a history of low-grade fevers and vomiting which frequently resolved without the need for hospitalization.</p> <p>For example, Resident #1 returned to Vernon Green from a five-day hospital stay on March 1, 2012. On the date of discharge her temperature was 98.2 Degrees F; pulse was 70, blood pressure 149/66, respirations at 18 and SpO2 91%. The resident had tested negative for gastric bleeding during the hospital stay. In addition, nearly every day the resident cried out for help, and yet was unable to identify the help that she needed. In these instances, nursing staff provided 1:1 care for the resident, tried to redirect, and soothe the resident in a variety of ways.</p> <p>From January 1, 2012 to April 11, 2012, Resident #1's blood pressure was recorded in a range between 180/100 and 120/60. Resident #1's temperature fell in the following range 97.0-101.1 degrees F. Resident #1's respiration rate was between 18 and 28. On April 10, 2012, Vernon Green notified Resident #1's physician that she had a low-grade fever, and the nursing home received instructions to monitor the resident's condition. Therefore, Resident #1's physician</p>	

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F 157	<p>Continued From page 2</p> <p>bpm, respiratory rate: 28, Spo2 95%. At 5:30 AM, temperature was 100.4 F, pulse: 86 bpm, respiratory rate: 22, Spo2 94%, Tylenol given for increased temperature. Per the nurses notes dated 4/11/12 at change of shift, "respiratory status changed, reassessment of temperature 101.1, respiratory rate 24, labored breathing, breathing very moist and audible, resident moaning, SPO2 87-88% on room air, oxygen applied via facemask at 4 liters, SPO2 increases to 90-91% however labored breathing continues, resident lethargic, diaphoretic, call placed to Grace Cottage Emergency Room after speaking with family received order from physician to transport resident to Brattleboro Memorial Hospital, rescue received [Resident #1] at approximately 7:40 AM". Per nurses notes dated 4/11/12 at 9:45 AM, the facility received a call from the hospital reporting that Resident #1 had expired.</p> <p>Per review of the 4/11/12 emergency room documentation, the notes by the physician indicate that Resident #1 arrived to the hospital in "severe distress, unresponsive and presenting to be experiencing a terminal event on arrival." The emergency room documentation indicates that Resident #1 "expired at 9:37 AM and the physician's clinical impression was "terminal episode? perforated ulcer". Per interview on 4/27/12, the Medical Examiner indicated that Resident #1's cause of death to be Gastric Ulcer/Gastric Bleed.</p> <p>Per review of the nurse's notes and the facilities notification log, there was no evidence that the facility on-call physician was notified from 12:00 AM until 7:05 AM that Resident #1 had a change</p>	F 157	<p><u>Continued from page 2</u></p> <p>was aware of the condition and was monitoring it. As was often her habit, Resident #1 took her medicine mixed with chocolate pudding. Over the course of the early morning of April 11, 2012, Resident #1's vital signs fluctuated as follows:</p> <table border="1"> <thead> <tr> <th>Time</th> <th>temp</th> <th>BP</th> <th>SPO2</th> <th>Res.</th> <th>Pulse</th> </tr> </thead> <tbody> <tr> <td>9:00pm</td> <td>99.3</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>12:45am</td> <td>100.6</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>2:00am</td> <td>99.3</td> <td>180/100</td> <td>95%</td> <td>18</td> <td>68</td> </tr> <tr> <td>2:15am</td> <td>99.3</td> <td>150/80</td> <td>95%</td> <td>28</td> <td>86</td> </tr> <tr> <td>4:00am</td> <td></td> <td></td> <td>94%</td> <td></td> <td></td> </tr> <tr> <td>5:30am</td> <td>100.4</td> <td></td> <td>94%</td> <td>22</td> <td>86</td> </tr> <tr> <td>7:00am</td> <td>101.1</td> <td></td> <td>87-88%</td> <td>24</td> <td></td> </tr> </tbody> </table> <p>In addition the surveyor correctly notes that the resident had drool streaked with a brown substance at 2:00 AM and at 2:15 AM vomited a large amount of brown slimy emesis. However, the resident's temperature, and Spo2 remained unchanged, and the resident's blood pressure had improved. It should also be noted that the nursing notes indicate that the resident was "resting quietly" at 4:00 AM and 5:30 AM, and again at 6:30 AM.</p> <p>When viewed in the context of the resident's history, without the benefit of hindsight, it was not an unreasonable nursing judgment to decide to monitor the resident's respirations and pulse as directed by the physician before concluding that the resident had a significant change in condition.</p> <p>At 7:05 AM, the day nurse identified a significant change in condition. As soon as a significant change in condition, as defined in the interpretive guidelines was identified, the resident's primary care physician was notified as were the resident's family. The resident records demonstrate that Resident #1 had had</p>	Time	temp	BP	SPO2	Res.	Pulse	9:00pm	99.3					12:45am	100.6					2:00am	99.3	180/100	95%	18	68	2:15am	99.3	150/80	95%	28	86	4:00am			94%			5:30am	100.4		94%	22	86	7:00am	101.1		87-88%	24		
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F 157	<p>Continued From page 3</p> <p>in medical status. Per review of the nurse's notes and the facility's notification log, there was no evidence that Resident #1's appointed emergency contact was notified of Resident's #1 change in medical condition.</p> <p>Per review of the facility policy and procedure titled "Change in Resident Condition or Status" dated 9/27/10, the "Charge Nurse/ House Supervisor will notify the resident's Attending Physician or the On-Call Physician when there has been a significant change in the resident's physical/emotional/mental condition". The policy also indicates that the "Charge Nurse /House Supervisor unless otherwise instructed by the resident, the Charge Nurse/House Supervisor will notify the resident's family when there is a significant change in the resident's physical, mental, or psychosocial status".</p> <p>Per review of the 2012 Physician Standing Orders for Resident #1, Tylenol 650 mg can be given per rectum for discomfort or elevated temperature every 4 hours as needed until physician is notified. The nurses notes dated 4/11/12 show that Tylenol 650 mg was given per rectum at 12:45 AM for an elevated temperature and again at 5:30 AM. There was no evidence in the nurse's notes that the primary or on-call physician was notified of the increase in temperature and the need to re-administer Tylenol at 5:30 AM.</p> <p>Per interview with the night Registered Nurse (RN) on duty the early morning of 4/11/12 via phone on 5/16/12 at 7:30 AM, the RN indicated that the LNA's notified him/her that Resident #1 had drool streaked with a brown substance on his/her right shoulder at 2:00 AM on 4/11/12. The</p>	F 157	<p><u>Continued from page 3</u></p> <p>slightly elevated temperatures and bouts of vomiting and that the Nursing Home had notified her physician of these symptoms frequently, including but not limited to the notification on April 10, 2012.</p> <p>The regulation requires a facility to:</p> <ul style="list-style-type: none"> immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is (A) An accident involving the resident which results in injury and has the potential to require physician intervention; (B) A significant change in the resident's physical, mental or psychosocial status (i.e., a deterioration in health mental or psychosocial in either life threatening conditions or clinical complications); (C) A need to alter treatment significantly ... (D) A decision to transfer . . . the resident from the facility. . . <p>42 C.F.R. § 483.10(b)(11).</p> <p>The interpretive guidelines under guidance to surveyors in the SOM states "For purposes of §483.10(b)(11)(i)(B) life-threatening conditions are such things as a heart attack or stroke. Clinical complications are such things as development of a stage II pressure sore, onset or recurrent periods of delirium, recurrent urinary tract infection, or onset of depression." SOM Appendix PP Tag F157.</p> <p>As evidenced by the chart, Resident #1 did not experience a "significant change in . . . physical status," until approximately 7:00 AM. The resident did not show a deterioration in health evidenced by clinical complications, until the day nurse identified a low SpO2 and</p>	

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F 157	<p>Continued From page 4</p> <p>RN stated that that he/she knew that the test he/she used to test the brown substance in the drool was used to test for blood in stool, but that he/she used it to test the drool to identify if the brown substance was blood or stomach content. The RN stated that the test showed positive for blood. The RN stated that he/she did not notify the physician of Resident #1's vomiting of a brown substance that was determined to be blood. The RN stated that he/she knew that Resident #1 had an increased temperature of 100.6 F at 12:45 AM. The RN stated he/she knew that Resident #1 had an elevated blood pressure at 2:00 AM of 180/100 and was non-verbal. The RN stated that he/she knew at 2:15 AM that Resident #1 vomited a large amount of slimy brown emesis and Resident #1 had an elevated respiration rate of 28. The RN stated that he/she knew that at 5:30 AM, Resident #1 had a temperature of 100.4 F and an elevated respiration rate of 22.</p> <p>During the same interview, the RN stated that he/she "did not know that [Resident #1] had a medical history of gastric bleeds and gastric ulcers, and that [he/she] could not possibly know the medical histories of all of the residents that [he/she] was assigned to". The RN stated that the physician on call would probably just tell him/her to monitor Resident #1. The RN also stated per interview that "the on-coming day shift nurse would notify the physician of [Resident #1's] condition and notify the family."</p> <p>Per review of the comprehensive care plan dated 3/8/12 and titled; "Will demonstrate an effective respiratory rate, depth, and pattern", the care plan indicates to monitor for increased temperature,</p>	F 157	<p><u>Continued from page 4</u></p> <p>fast respiration rate. Because the day nurse and the night nurse did not get along, the day nurse may have assumed that the low SpO2 and fast respirations had been present during the night nurse's shift. The medical record does not support this assumption. These symptoms were not present throughout the evening of April 10 or the early morning of April 11, 2012. As late as 6:30 AM on April 11, 2012, the resident was observed to be resting quietly.</p> <p>The resident's physician was already aware of the low-grade fever and vomiting, and therefore, these conditions did not represent a "significant change in status." The interpretive guidelines provide examples that support this interpretation. A single instance of vomiting does not rise to the same level as "recurrent periods of delirium,[or] recurrent urinary tract infection." SOM Appendix PP Tag F157.</p> <p>In this instance, the surveyors' allegations are "unsupported by the facility's contemporaneous treatment records," and therefore, the immediate jeopardy finding lacks support. <i>See Grace Healthcare v. U.S. HHS</i>, 603 F.3d 412, 420-21 (8th Cir. 2009).</p> <p>The facility has shown that it has been and remains in substantial compliance in regards to F157, notification of changes, and therefore respectfully requests that this tag be removed from the 2567 and the public record.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The resident's physician was consulted and responsible party was notified at 7:05 a.m. regarding the change of status of Resident #1.</p>	4/11/12
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F 157	Continued From page 5 monitor for signs and symptoms of aspiration, and report any signs and symptoms to the physician. Per interview with the Director of Nursing Services (DNS) on 4/26/12 at 11:27 AM, he/she reviewed the nurses notes dated 4/11/12 and the facility notification log and confirmed that there was no documentation by the overnight nurse that the primary physician or on-call physician was notified of Resident #1's change in medical condition. Per review of the notification log and the nurses' notes, the on-coming day nurse called the primary physician at 7:05 AM. The DNS also indicated that his/her expectation would be that a call be placed to the primary or on-call physician whenever there is a change in medical condition of a resident and that a call be placed to the DNS also. The DNS indicated that he/she received a phone call regarding Resident #1 at 6:00 AM on 4/11/12 informing him/her that Resident #1 was having a respiratory change and being transferred to the hospital. Resident #1 was transferred to the hospital via ambulance at approximately 7:40 AM per the nurse's late entry note dated 4/11/12 at 10:00 AM. The DNS confirmed that he/she was not made aware of Resident #1's temperature increase, blood pressure changes, or the vomiting of a "brown substance" that was Guiac positive for blood.	F 157	<u>Continued from page 5</u> 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 with a status change have the potential to be affected by this alleged deficient 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 have been re-educated on physician consultation and responsible party notification when a resident has a significant change in physical status. The policy and procedure on <u>Change in Resident Condition or Status</u> will be reviewed with all nursing staff. Director of Nursing and/or designated RNs will conduct charts audits to assure notifications are made in timely manner until 100% compliance has been achieved. Thereafter, audits will be conducted on a monthly schedule for one year and after that on a schedule to be determined by the Quality Assurance Committee. 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. Director of Nurses or designee will conduct Quality Assurance/Quality Improvement audits to ensure continued compliance of staff to assure notifications are made in timely manner until 100% compliance has been achieved. Thereafter, audits will be conducted on a monthly schedule for one year. The Director of Nurses or designee will report the results of the audits to the Quality Assurance Committee which will determine the need for further monitoring.	5/17/12 5/22/12 6/19/12
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations,	F 164		

F157 POC accepted as circled 01/01/12 Pmcoturn

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F 164	<p>Continued From page 6</p> <p>medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure the right to personal privacy and that the contents of two residents medical records were kept confidential for 2 residents identified (Resident #1 and #8), except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. The findings include:</p> <p>1. Per interview with a staff Licensed Nursing Assistant (LNA) on 5/16/12 at 6:05 AM, the LNA stated that another LNA (#1) had taken a picture</p>	F 164	<p><u>F164</u></p> <p>The Facility has and continues to ensure a resident's personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Allegation of Substantial Compliance</p> <p>Vernon Green Nursing Home, herein after sometimes "facility", 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 June 9, 2012.</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>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The residents' photos had been taken off the Facebook page as confirmed by the LNA that initially reported finding the posted resident photos. The LNA that posted the photos on his/her Facebook page was terminated as the surveyor states in his/her findings.</p>	5/8/12	

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F 164	<p>Continued From page 7</p> <p>of Resident #1 and placed the picture from his/her cell phone on the LNA's Facebook account under "favorite residents". Per review of the employee file for LNA #1 on 5/16/12, the file indicated that the LNA was terminated from the facility for posting pictures of Resident #1 on the LNA's personal Facebook account on the computer on 5/7/12 without Resident #1's permission or Resident #1's Durable Power of Attorney (DPOA)'s permission. Per record review Resident #1 was not able to make his/her own decisions and had a DPOA (Durable Power of Attorney) assigned to make all medical decisions regarding care.</p> <p>Per interview with the DNS (Director of Nursing Services) and Administrator on 5/16/12, the DNS and Administrator confirmed that on 5/7/12 a staff LNA was terminated for posting pictures the LNA had taken, of Resident #1's picture from the medical record with his/her cell phone, on the LNA's computer Facebook account. The DNS and Administrator stated that he/she was terminated for violating the rights of Resident #1 and posting his/her picture on a computer Facebook account with out permission from the resident or DPOA. Per interview with the DNS and Administrator on 5/17/12, they confirmed that the posting of a picture of Resident #1 without permission on a computer Facebook account was a violation of the rights of Resident #1.</p> <p>2. Per interview with a staff Licensed Nursing Assistant (LNA) on 5/16/12 at 6:05 AM, the LNA stated that another LNA had taken picture of Resident #8 and placed the picture from his/her cell phone on the LNA's Facebook account under "favorite residents". Per review of the employee</p>	F 164	<p><u>Continued from page 7</u></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; All residents have the potential to be affected by this alleged deficient 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; The facility implemented a written policy on professional misconduct which includes detailed investigation procedures.</p> <p>In a recent staff meeting, the Administrator reviewed the facilities policy on resident confidentiality, staff responsibility of resident confidentiality and the disciplinary measures if the policy is not adhered to.</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 Director of Human Service shall report to the Quality Assurance Committee all episodes of professional misconduct for one year. The Quality Assurance Committee shall determine further monitoring if needed.</p>	5/31/12 5/22/12 5/31/12 6/19/12	
<p><i>F164 POC accepted as circled 8/18/12 AmstarPN</i></p>					

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

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F 164	Continued From page 8 file for the LNA on 5/16/12, the file indicated that the LNA was terminated from the facility for posting pictures of Resident #8 on the LNA's personal Facebook account on the computer on 5/7/12 without Resident #8's permission. Per interview with the DNS and Administrator on 5/16/12, the DNS and Administrator confirmed that on 5/7/12 a staff LNA was terminated for posting pictures the LNA had taken of Resident #8's picture from the medical record with his/her cell phone, on the LNA's computer Facebook account. The DNS and Administrator stated that she was terminated for violating the rights of Resident #8 and posting his/her picture on a computer Facebook account with out permission from the resident. Per interview with the DNS and Administrator on 5/17/12 they confirmed that the posting of a picture of Resident #8 without permission on a computer Facebook account was a violation of the rights of Resident #8.	F 164			
F 224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION 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 observation, staff interview and record review the facility failed to ensure that 7 residents were free from mistreatment and/or neglect (Residents #1, 2, 3, 4, 5, 6 and 7). The findings	F 224	<u>F224</u> The Facility has developed and continues to implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents. The facility did not violate 42 C.F.R. § 483.13(c): Abuse, and should not have received a J level deficiency at Tag F224 Allegation of Substantial Compliance Vernon Green Nursing Home, herein after sometimes "facility", 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.		

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F 224	<p>Continued From page 9 include:</p> <p>1. Per review of the medical record on 4/26/12, Resident #1 was admitted to the facility on 3/16/11 with diagnoses that included: dementia, hypertension, history of gastric bleeding, and history of a gastric ulcer. Review of the nurses notes dated 4/11/12 at 12:45 AM, Resident #1 had a temperature of 100.6 F (Fahrenheit) and Tylenol 650 mg (milligrams) suppository was given for an increased temperature. At 2:00 AM, Resident #1 had a "small amount of drool from the corner of the right mouth, clear mucous with brown stripes, Guiac positive (a test done on stool to identify blood), vital signs: temperature: 99.3 [F], pulse: 68 [bpm (beats per minute)], respiratory rate: 18 , blood pressure: 180/100 after care given, SPO2 [oxygen saturation]95%, makes eye contact but non verbal."</p> <p>At 2:15 AM, the nurse's notes indicate, "large amount of brown slimy emesis." Vital signs: Blood pressure: 150/80, temperature: 99.3 F, pulse: 86 bpm, respiratory rate: 28, Spo2 95%. At 5:30 AM, temperature was 100.4 F, pulse: 86 bpm, respiratory rate: 22, Spo2 94%, Tylenol given for increased temperature. Per the nurses notes dated 4/11/12 at change of shift, "respiratory status changed, reassessment of temperature 101.1, respiratory rate 24, labored breathing, breathing very moist and audible, resident moaning, SPO2 87-88% on room air, oxygen applied via facemask at 4 liters, SPO2 increases to 90-91% however labored breathing continues, resident lethargic, diaphoretic, call placed to Grace Cottage Emergency Room after speaking with family received order from physician to transport resident to Brattleboro Memorial</p>	F 224	<p><u>Continued from page 9</u> 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 June 9, 2012.</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>The facility requests independent informal dispute resolution for Tag F 224; respectfully maintains that it was and is in substantial compliance with federal regulations in respect to F 224; respectfully denies and disputes the allegation that it was deficient in respect to F 224; respectfully denies and disputes that any action or inaction on the part of the facility in respect to F 224 caused any harm or potential for any harm to any facility residents; and requests that F 224 be deleted from the public record or at the very least that the scope and severity be reduced.</p> <p>Resident #1 was admitted to the facility on March 16, 2011, with diagnoses that included dementia and hypertension. The resident did suffer a gastric ulcer and gastric bleeding in 2001. Resident #1 also had a history of low-grade fevers and vomiting which frequently resolved without the need for hospitalization.</p> <p>For example, Resident #1 returned to Vernon Green from a five-day hospital stay on March 1, 2012. On the date of discharge her</p>		

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F 224	<p>Continued From page 10</p> <p>Hospital , rescue received [Resident #1] at approximately 7:40 AM". Per nurses notes dated 4/11/12 at 9:45 AM, the facility received a call from the hospital reporting that Resident #1 had expired.</p> <p>Per review of the 4/11/12 emergency room documentation, the notes by the physician indicate that Resident #1 arrived to the hospital in "severe distress, unresponsive and presenting to be experiencing a terminal event on arrival." The emergency room documentation indicates that Resident #1 "expired at 9:37 AM and "physician's clinical impression was terminal episode? perforated ulcer." Per interview on 4/27/12, the Medical Examiner indicated that Resident #1's cause of death to be Gastric Ulcer/Gastric Bleed.</p> <p>Per review of the nurse's notes and the facilities notification log, there was no evidence that the facility on-call physician was notified from 12:00 AM until 7:05 AM that Resident #1 had a change in medical status. Per review of the nurse's notes and the facility's notification log, there was no evidence that Resident #1's appointed emergency contact was notified of Resident's #1 change in medical condition.</p> <p>Per review of the facility policy and procedure titled "Change in Resident Condition or Status" dated 9/27/10, the "Charge Nurse/ House Supervisor will notify the resident's Attending Physician or the On-Call Physician when there has been a significant change in the resident's physical/emotional/mental condition". The policy also indicates that the "Charge Nurse /House Supervisor unless otherwise instructed by the resident, the Charge Nurse/House Supervisor will</p>	F 224	<p><u>Continued from page 10</u></p> <p>temperature was 98.2 Degrees F; pulse was 70, blood pressure 149/66, respirations at 18 and SpO2 91%. The resident had tested negative for gastric bleeding during the hospital stay. In addition, nearly every day the resident cried out for help, and yet was unable to identify the help that she needed. In these instances, nursing staff provided 1:1 care for the resident, tried to redirect, and soothe the resident in a variety of ways.</p> <p>From January 1, 2012 to April 11, 2012, Resident #1's blood pressure was recorded in a range between 180/100 and 120/60. Resident #1's temperature fell in the following range 97.0-101.1 degrees F. Resident #1's respiration rate was between 18 and 28. On April 10, 2012, Vernon Green notified Resident #1's physician that she had a low-grade fever, and the nursing home received instructions to monitor the resident's condition. Therefore, Resident #1's physician was aware of the condition and was monitoring it. As was often her habit, Resident #1 took her medicine mixed with chocolate pudding. Over the course of the early morning of April 11, 2012, Resident #1's vital signs fluctuated as follows:</p> <table border="1" data-bbox="917 1396 1380 1585"> <thead> <tr> <th>Time</th> <th>temp</th> <th>BP</th> <th>SPO2</th> <th>Res.</th> <th>Pulse</th> </tr> </thead> <tbody> <tr> <td>9:00pm</td> <td>99.3</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>12:45am</td> <td>100.6</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>2:00am</td> <td>99.3</td> <td>180/100</td> <td>95%</td> <td>18</td> <td>68</td> </tr> <tr> <td>2:15am</td> <td>99.3</td> <td>150/80</td> <td>95%</td> <td>28</td> <td>86</td> </tr> <tr> <td>4:00am</td> <td></td> <td></td> <td>94%</td> <td></td> <td></td> </tr> <tr> <td>5:30am</td> <td>100.4</td> <td></td> <td>94%</td> <td>22</td> <td>86</td> </tr> <tr> <td>7:00am</td> <td>101.1</td> <td></td> <td>87-88%</td> <td>24</td> <td></td> </tr> </tbody> </table> <p>In addition the surveyor correctly notes that the resident had drool streaked with a brown substance at 2:00 AM and at 2:15 AM vomited a large amount of brown slimy emesis.</p>	Time	temp	BP	SPO2	Res.	Pulse	9:00pm	99.3					12:45am	100.6					2:00am	99.3	180/100	95%	18	68	2:15am	99.3	150/80	95%	28	86	4:00am			94%			5:30am	100.4		94%	22	86	7:00am	101.1		87-88%	24		
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F 224	<p>Continued From page 11</p> <p>notify the resident's family when there is a significant change in the resident's physical, mental, or psychosocial status".</p> <p>Per review of the 2012 Physician Standing Orders for Resident #1, Tylenol 650 mg can be given per rectum for discomfort or elevated temperature every 4 hours as needed until physician is notified. The nurses notes dated 4/11/12 show that Tylenol 650 mg was given per rectum at 12:45 AM for an elevated temperature and again at 5:30 AM. There was no evidence in the nurse's notes that the primary or on-call physician was notified of the increase in temperature and the need to re-administer Tylenol at 5:30 AM.</p> <p>Per interview with the night Registered Nurse (RN) on duty the early morning of 4/11/12 via phone on 5/16/12 at 7:30 AM, the RN indicated that the LNA's notified him/her that Resident #1 had drool streaked with a brown substance on his/her right shoulder at 2:00 AM on 4/11/12. The RN stated that that he/she knew that the test he/she used to test the brown substance in the drool was used to test for blood in stool, but that he/she used it to test the drool to identify if the brown substance was blood or stomach content. The RN stated that the test showed positive for blood. The RN stated that he/she did not notify the physician of Resident #1's vomiting of a brown substance that was determined to be blood. The RN stated that he/she knew that Resident #1 had an increased temperature of 100.6 F at 12:45 AM. The RN stated he/she knew that Resident #1 had an elevated blood pressure at 2:00 AM of 180/100 and was non-verbal. The RN stated that he/she knew at 2:15 AM that Resident #1 vomited a large amount of slimy</p>	F 224	<p><u>Continued from page 11</u></p> <p>However, the resident's temperature, and Spo2 remained unchanged, and the resident's blood pressure had improved. It should also be noted that the nursing notes indicate that the resident was "resting quietly" at 4:00 AM and 5:30 AM, and again at 6:30 AM.</p> <p>When viewed in the context of the resident's history, without the benefit of hindsight, it was not an unreasonable nursing judgment to decide to monitor the resident's respirations and pulse as directed by the physician before concluding that the resident had a significant change in condition.</p> <p>At 7:05 AM, the day nurse identified a significant change in condition. As soon as a significant change in condition, as defined in the interpretive guidelines was identified, the resident's primary care physician was notified as were the resident's family. The resident records demonstrate that Resident #1 had had slightly elevated temperatures and bouts of vomiting and that the Nursing Home had notified her physician of these symptoms frequently, including but not limited to the notification on April 10, 2012.</p> <p>Interpretive guidelines in SOM manual define neglect as the "failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." 42 C.F.R. § 488.301.</p> <p>"Abuse means the willful infliction of injury unreasonable confinement intimidation or punishment with resulting physical harm, pain or mental anguish." 42 C.F.R. § 488.301.</p> <p>The Statement of Deficiencies does not specify whether it judges this incident to be abuse or neglect, but the incident described above</p>		

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F 224	<p>Continued From page 12</p> <p>brown emesis and Resident #1 had an elevated respiration rate of 28. The RN stated that he/she knew that at 5:30 AM, Resident #1 had a temperature of 100.4 F and an elevated respiration rate of 22.</p> <p>During the same interview, the RN stated that he/she "did not know that [Resident #1] had a medical history of gastric bleeds and gastric ulcers, and that [he/she] could not possibly know the medical histories of all of the residents that [he/she] was assigned to". The RN stated that the physician on call would probably just tell him/her to monitor Resident #1. The RN also stated per interview that "the on-coming day shift nurse would notify the physician of [Resident #1's] condition and notify the family."</p> <p>Per review of the comprehensive care plan dated 3/8/12 and titled; "Will demonstrate an effective respiratory rate, depth, and pattern", the care plan indicates to monitor for increased temperature, monitor for signs and symptoms of aspiration, and report any signs and symptoms to the physician.</p> <p>Per interview with the Director of Nursing Services (DNS) on 4/26/12 at 11:27 AM, he/she reviewed the nurses notes dated 4/11/12 and the facility notification log and confirmed that there was no documentation by the overnight nurse that the primary physician or on-call physician was notified of Resident #1's change in medical condition. Per review of the notification log and the nurses' notes, the on-coming day nurse called the primary physician at 7:05 AM. The DNS also indicated that his/her expectation would be that a call be placed to the primary or on-call physician</p>	F 224	<p><u>Continued from page 12</u></p> <p>cannot be categorized as either abuse or neglect as defined by the regulations or the interpretive guidelines. There is no evidence of any conduct that meets the definition of verbal abuse. SOM Appendix PP at Tag F 223. Nothing in the medical record or the statement of deficiencies demonstrates any willful infliction of injury, or any unreasonable confinement, intimidation or punishment, as the regulations require. Nor does the medical record demonstrate a failure to provide goods and services necessary to avoid physical harm. The nursing notes demonstrate that on the night of April 10, and the morning of April 11, 2012, Resident # 1 received the same attentive and respectful care that she had received throughout her stay at the facility. The night nurse frequently checked on him/her, came to him/her when she called out for help, and tried to provide soothing and calming interactions.</p> <p>The surveyors' allegations are "unsupported by the facility's contemporaneous treatment records," and therefore, the immediate jeopardy finding lacks support. See <i>Grace Healthcare v. U.S. HHS</i>, 603 F.3d at 420-21. The facility has shown that it has been and remains in substantial compliance in regards to keeping residents free from abuse and neglect, and therefore respectfully requests that this tag be removed from the 2567 and the public record.</p> <p>The deficiencies related to Resident # 6, and #7 arise out of the conduct of one staff member, over the course of more than a year. In April of 2011, one of the night nurses was disciplined for a number of issues. Included in the list of concerns was a description of an interaction with Resident #6 as the night nurse</p>		

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F 224	<p>Continued From page 13</p> <p>whenever there is a change in medical condition of a resident and that a call be placed to the DNS also. The DNS indicated that he/she received a phone call regarding Resident #1 at 6:00 AM on 4/11/12 informing him/her that Resident #1 was having a respiratory change and being transferred to the hospital. Resident #1 was transferred to the hospital via ambulance at approximately 7:40 AM per the nurse's late entry note dated 4/11/12 at 10:00 AM. The DNS confirmed that he/she was not made aware of Resident #1's temperature increase, blood pressure changes, or the vomiting of a "brown substance" that was Guaiac positive for blood.</p> <p>2. Per review of the employee file of a staff RN on 5/15/12, the file indicated that the RN on 3/6/12 the DNS reprimanded the RN for inappropriately speaking to a resident (Resident #7). The "notice of reprimand" dated 3/6/12 stated that the RN said to Resident #7 when he/she was asked by the RN to get out of bed "You're ugly and you would get better treatment with honey that with vinegar." The reprimand also stated that "this or any other comment that is inappropriate will not be tolerated."</p> <p>Per review of the facility policy and procedure dated 1/3/11 and titled; "Resident Abuse, Neglect and Exploitation", abuse includes deprivation by an individual, including care takers, of goods and services that are necessary to attain or maintain physical, mental and psychosocial well-being and that the resident has the right to be free from verbal, sexual, physical and mental abuse by anyone. The policy also indicates verbal abuse is defined as "the use of oral, written or gestured language that willfully includes disparaging or</p>	F 224	<p><u>Continued from page 13</u></p> <p>was attempting to remove a catheter. This interaction was not witnessed by the staff member who reported it to the Director of Nursing, and therefore, the DON's information was third-hand. The DON investigated the incident and concluded that he/she could not verify that the incident had happened as described, because the relationship between the reporting staff member is known to harbor animosity toward the nurse in question. Nevertheless, the DON chose to include the alleged behavior in the warning out of an abundance of caution.</p> <p>This is also true of the comments allegedly made to Resident #7 and reported to the DON on March 6, 2012. The DON received this report third-hand, not from the staff who overheard the comment, but from another staff-member who allegedly was told about the comment by a staff member who did overhear it. As the employment record notes, the night nurse denies having made the comment, and offers a plausible explanation as to how what was said might have been misinterpreted.</p> <p>The regulation requires that all nursing home residents be "free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion." 42 C.F.R. § 483.13(b). Furthermore, "the facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property." Id. § 483.13(c). "Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish." 42 C.F.R. § 488.301. The interpretive guidelines define "neglect" as the</p>	

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F 224	<p>Continued From page 14</p> <p>derogatory terms to residents or within the resident's hearing distance."</p> <p>Per interview with the DNS on 5/17/12, he/she stated he/she was aware of the notice of reprimand dated 3/6/12 concerning the RN and the comment by the RN to Resident #7 of, "You're ugly and you would get better treatment with honey that with vinegar." The DNS confirmed that no thorough internal investigation had been done and no call was placed to APS (Adult Protective Services) or the State Survey Agency reporting the suspected mistreatment/abuse. The RN is currently employed by the facility.</p> <p>3. Per review of the employee file of a staff RN on 5/15/12, the file indicated that, on 3/25/11 when removing a internal urinary catheter from a resident (Resident #6), staff overheard the RN say to Resident #6, "You need to move your hand, do you want this out of your peeker or not." The 3/25/11 document also stated that, "the internal catheter was not coming out and the RN was pulling on the catheter instead of repositioning Resident #6 to aid in comfort. Resident #6 was yelling and flailing in discomfort."</p> <p>Per review of the facility policy and procedure dated 1/3/11 and titled; Resident Abuse, Neglect and Exploitation, verbal abuse is defined as "the use of oral, written or gestured language that willfully includes disparaging or derogatory terms to residents or within the resident's hearing distance." Per review of the facility policy and procedure dated 1/3/11 and titled: Resident Abuse, Neglect and Exploitation, dated 1/3/11, "abuse also means the willful infliction of injury,</p>	F 224	<p><u>Continued from page 14</u></p> <p>"failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." 42 C.F.R. § 488.301.</p> <p>The facility maintains that it has complied with 42 C.F.R. § 483.13(c) because it has policies in place that prohibit mistreatment, abuse and neglect. In particular, facility policies and procedures contain strict codes as to how staff may address residents. In these two instances, the Director of Nursing received second or third-hand reports that a staff member had engaged in prohibited conduct. After conducting her investigation, the DON concluded that there was not sufficient evidence to conclude that abuse had occurred. Nevertheless, out of an abundance of caution, she issued a written warning to the staff member on each occasion. The charts for the residents involved show that they suffered no adverse consequences. Therefore, no neglect, abuse or mistreatment resulted from these alleged violations of policy and procedure.</p> <p>Resident #2 was admitted to the facility with a history of constipation, among other things, and with a physician order for Glycolax or another stool softener. Administration of bowel medications is also indicated in the resident's comprehensive care plan. On May 15, 2012, the surveyors noted a discrepancy between the twenty-nine doses remaining in resident's Glycolax bottle, which originally contained thirty-one doses, and the twenty-three doses that the nurses documented that they had administered between April 20, 2012 and May 14, 2012. (CMS 2567 at 17-18). A 180-day bowel report demonstrates that Resident #2 had no difficulties during this</p>		

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F 224	<p>Continued From page 15 unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish."</p> <p>Per interview with the DNS on 5/17/12, he/she reviewed the 3/25/11 reprimand and stated he/she was aware of the notice of reprimand dated 3/25/11 concerning the RN and the comment by the RN to Resident #7, " You need to move your hand, do you want this out of your peeker or not." The DNS confirmed that he/she was aware of the RN's actions when attempting to remove Resident #6's internal catheter. The DNS confirmed that no internal investigation was conducted and no call was placed to APS or the State Survey Agency reporting suspected mistreatment/abuse. The RN is currently employed by the facility.</p> <p>4. Per review of the medical record, Resident #2 was admitted to the facility on 2/11/08 with diagnoses that included: Alzheimer's, depression with psychosis, delusional disorder, and constipation. Per observation of the medication carts on A-wing on 5/15/12 at 9:59 AM, a medication identified within the medication cart labeled for Resident #2 contained more doses of medication than it should have contained per review of the medication administration record, indicating the prescribed medication was not administered as ordered by the physician.</p> <p>Per observation on 5/15/12 at 9:59 AM an open bottle of Glycolax (fiber supplement to prevent constipation) that was labeled for Resident #2 was noted to be dated as opened on 4/20/12. The manufacturer label on the bottle indicated that the bottle contained, when full and unopened, 31</p>	F 224	<p><u>Continued from page 15</u> time. Bowel reports are monitored daily because of the facility's narrow window for treating potential blockage. Nevertheless, the surveyors concluded that those 23 doses had not been given.</p> <p>Resident #5. The Statement of Deficiencies alleges that Resident #5 was not administered Glycolax, however, the facility's records indicated that Resident #5 received Glycolax as scheduled. The unit manager does not recall measuring Resident #5's Glycolax on the morning of May 15, 2012 when the surveyor was present. She recalls measuring ferrous sulphate, and the MAR for Resident #5's ferrous sulphate match the dates used in the statement of deficiencies. (CMS 2567 at 18-20). Therefore, we believe that the statement of deficiencies is in error, and should refer to ferrous sulphate for Resident #5.</p> <p>Resident # 5 was admitted to the facility on January 6, 2009 with a diagnosis of anemia and a physician order for ferrous sulphate to be administered daily. On December 16, 2011, staff opened a bottle of ferrous sulphate for Resident #5. From December 17 through December 23, 2011, the resident's physician ordered the ferrous sulphate to be held because he had prescribed the resident a course of antibiotics. Upon completion of the course of antibiotics, the nursing home resumed administration of ferrous sulphate, as evidenced both by the MAR and the orders for more ferrous sulphate from the pharmacy in January, February, March and April. Throughout this time, Resident #5's blood levels for iron were monitored, and they continued to improve. In late May, the</p>	

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F 224	<p>Continued From page 16</p> <p>daily doses and a daily dose is 17 grams of Glycolax. Per review of the medication administration record (MAR) dated 4/20/12 to 5/14/12, Resident #2 was identified by the nurses signatures that Resident #2 had been administered 23 doses of Glycolax. Per observation on 5/15/12 the Glycolax left in the opened bottle labeled 4/20/12 as opened was dispensed by the UM (Unit Manager) into plastic cups, the UM confirmed the number of doses remaining in the opened bottle was 29 daily doses.</p> <p>Per confirmation by the UM, when the bottle was opened on 4/20/12 it contained 31 daily doses, the MAR indicates that 23 doses were administered to Resident #2. The UM confirmed that if all the doses had been given as signed per the signed MAR there would only be 8 doses left in the open container and there were 29 daily doses left in the container. The UM confirmed that the doses that were recorded on the MAR as administered did not reflect the actual doses of Glycolax received by Resident #2. The UM confirmed that there was one refusal to take the Glycolax by Resident #2 from 4/20/12 to 5/14/12. The UM confirmed on 5/15/12 that the Glycolax was not administered per physician orders for Resident #2. The UM confirmed on 5/15/12 that several separate nurses had signed the MAR for Resident #2 as having administered 17 grams of Glycolax daily at 5 PM and did not, based on the 29 remaining doses left in the open bottle labeled for Resident #2.</p> <p>Per review of the MAR and the nurse signature sheet, 6 separate nurses were identified as signing they administered 17 grams of Glycolax</p>	F 224	<p><u>Continued from page 16</u></p> <p>resident's levels had improved so much that the dose was reduced to three times per week. Despite this clear evidence that Resident #5 was receiving ferrous sulphate in accordance with the care plan, the surveyors concluded that 108 doses listed on the MAR had not been given. It should be noted that it would have been impossible for the facility to give 108 doses since there were only 105 days between February 1 and May 15, 2012.</p> <p>Resident #3 was admitted to the facility with a history of constipation, among other things, and with a physician order for Glycolax or another stool softener. Administration of bowel medications is also indicated in the resident's comprehensive care plan. On May 15, 2012, the surveyors noted a discrepancy between the twelve doses remaining in resident's Glycolax bottle which originally contained thirty-one doses, and the twenty-four doses that the nurses documented that they had administered between April 22, 2012 and May 15, 2012. (CMS 2567 at 20-21). A 180-day bowel report demonstrates that Resident #3 had no difficulties during this time. Bowel reports are monitored daily because of the facility's narrow window for treating potential blockage. Nevertheless, the surveyors concluded that those 23 doses had not been given.</p> <p>Resident #4 was admitted to the facility with a history of constipation, among other things, and with a physician order for Glycolax or another stool softener. Bowel reports are monitored daily because of the facility's narrow window for treating potential blockage. Administration of bowel medications is also indicated in the resident's comprehensive care</p>	

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F 224	<p>Continued From page 17</p> <p>daily at 5 PM in the time period specified above. Per review of the comprehensive care plan, dated 4/12/12 and titled: "Tendency towards constipation", the care plan indicates that staff is to provide bowel medications per order.</p> <p>Though the UM confirmed Resident #2 did not receive medications as ordered, per review of the facility notification log on 5/15, 5/16, and 5/17 there was no evidence that the primary physician was notified that Resident #2 did not receive 23 daily doses of Glycolax that was ordered by the physician. Per interview with the UM on 5/17/12, he/she indicated that the primary physician and interested family members had not been notified that Resident #2 had not received 23 daily doses of Glycolax.</p> <p>5. Per review of the medical record, Resident #5 was admitted to the facility on 1/6/2009 with diagnoses that include: cognitive impairment/dementia, major depressive disorder, dementia with behavior issues and psychotic features and constipation. Per observation of the medication carts on A-wing on 5/15/12 at 9:59 AM, a medication identified within the medication cart labeled for Resident #5 contained more doses of medication than they should have contained per review of the medication administration record, indicating the prescribed medication was not administered as ordered by the physician.</p> <p>Per observation on 5/15/12 at 9:59 AM an open bottle of Glycolax (fiber supplement to prevent constipation) that was labeled for Resident #5 was noted to be dated as opened on 12/16/11. The manufacturer label on the bottle indicated</p>	F 224	<p><u>Continued from page 17</u></p> <p>plan. On May 15, 2012, the surveyors noted a discrepancy between the twenty-five doses remaining in resident's Glycolax bottle which originally contained thirty-one doses, and the twenty-four doses that the nurses documented that they had administered between April 20, 2012 and May 14, 2012. (CMS 2567 at 21-23). A 180-day bowel report demonstrates that Resident #4 had no difficulties during this time. Bowel reports are monitored daily because of the facility's narrow window for treating potential blockage. Nevertheless, the surveyors concluded that the appropriate number of doses had not been given.</p> <p>Residents #2, 3, 4, & 5: The regulation requires that all nursing home residents be "free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion." 42 C.F.R. § 483.13(b). Furthermore, "the facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property." Id. § 483.13(c).</p> <p>Again, "Abuse means the willful infliction of injury unreasonable confinement intimidation or punishment with resulting physical harm, pain or mental anguish." 42 C.F.R. § 488.301.</p> <p>The interpretive guidelines define neglect as the "failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." 42 C.F.R. § 488.301.</p> <p>The facility maintains that it has complied with 42 C.F.R. § 483.13(c) because it has policies and in place that prohibits mistreatment, abuse and neglect. In particular, facility policies and</p>	

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F 224	<p>Continued From page 18</p> <p>that the bottle contained when full and unopened 31 daily doses and a daily dose is 17 grams of Glycolax. Per review of the medication administration record (MAR) dated 2/01/12 to 5/15/12, Resident #5 was identified by the nurses signatures that Resident #5 had been administered 108 doses of Glycolax. The UM confirmed on 5/15/12 at 11:12 AM the bottle was opened on 12/16/11 and the UM confirmed there was no other open container for Resident #5 in the medication carts. The UM confirmed that if all the doses had been given as signed per the signed MAR there would not be an open bottle dated 12/16/11 because the unopened container contains 31 daily doses. The UM confirmed that the doses that were recorded on the MAR as administered did not reflect the actual doses of Glycolax received by Resident #5. The UM confirmed that there was one refusal by Resident #5 to take the Glycolax from 2/1/12 to 5/15/12. The UM confirmed on 5/15/12 that Resident #5 did not receive the Glycolax per physician orders. The UM confirmed on 5/15/12 that several separate nurses had signed the MAR for Resident #5 as having administered 17 grams of Glycolax daily at in the AM and did not, based on the date the Glycolax was opened on 12/16/11.</p> <p>Per review of the MAR on 5/15/12 and the nurse signature sheet, 4 separate nurses were identified as signing they administered 17 grams of Glycolax daily in the AM.</p> <p>Per review of the comprehensive care plan, dated 4/12/12 and titled: "Episodes of Constipation", the care plan indicates that staff is to provide bowel medications per order.</p>	F 224	<p><u>Continued from page 18</u></p> <p>procedures require that staff abide by the 5 Rights of Medication Administration. In this instance, the staff involved had all been questioned and disciplined before the survey. Furthermore, as discussed above, assuming that the doses were not administered as they should have been, the facility has demonstrated that this failure did not create any physical harm, mental anguish or mental illness, since all 180 day bowel reports for the residents involved show that they suffered no adverse consequences. Furthermore, because facility monitors bowel reports daily, there was no potential for more than minimal harm. Therefore, no neglect, abuse or mistreatment resulted from these violations of policy and procedure.</p> <p>The facility notes that allegations numbered 8 and 9 under Tag F224 on the Statement of Deficiencies allege no conduct that has not already been alleged in allegations numbered 4 and 7 for that Tag. Because these allegations add no new information they are redundant, and should be considered as part of those prior allegations.</p> <p>Again, here, the surveyors' allegations are "unsupported by the facility's contemporaneous treatment records," and therefore, the immediate jeopardy finding lacks support. <i>See Grace Healthcare v. U.S. HHS</i>, 603 F.3d at 420-21</p> <p>The facility has shown that it has been and remains in substantial compliance in regards to F224, keeping residents free from abuse, and therefore respectfully requests that this tag be removed from the 2567 and the public record.</p>		

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F 224	<p>Continued From page 19</p> <p>Per review of the facility notification log on 5/15, 5/16, and 5/17 there was no evidence that the primary physician was notified that Resident #5 did not receive 108 daily doses of Glycolax per the physician's orders during the time frame of 12/2/11 to 5/15/12. Per interview with the UM on 5/17/12, he/she indicated that the primary physician and interested family members had not been notified that Resident #5 had not received 108 daily doses of Glycolax per physician's orders.</p> <p>6. Per review of the medical record, Resident #3 was admitted to the facility on 6/16/03 with diagnoses that include: Alzheimer's/dementia, depression, general anxiety and constipation. Per observation of the medication carts on A-wing on 5/15/12 at 9:59 AM, a medication identified within the medication cart labeled for Resident #3 contained more doses of medication than they should have contained per review of the medication administration record, indicating the prescribed medication was not administered as ordered by the physician.</p> <p>Per observation on 5/15/12 at 9:59 AM an open bottle of Glycolax (fiber supplement to prevent constipation) that was labeled for Resident #3 was noted to be dated as opened on 4/22/12. The manufacturer label on the bottle indicated that the bottle contained, when full and unopened, 31 daily doses and a daily dose is 17 grams of Glycolax. Per review of the medication administration record (MAR) dated 4/22/12 to 5/15/12, Resident #3 was identified by the nurses signatures that Resident #3 had been administered 24 doses of Glycolax. The UM confirmed on 5/15/12 at 11:12 AM the bottle was</p>	F 224	<p><u>Continued from page 19</u></p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>1.: The facility put the nurse in question regarding physician notification on administrative leave pending the outcome of a follow-up investigation. 5/17/12</p> <p>2., and 3.: The facility put the nurse in question regarding patient dignity on administrative leave pending the outcome of a follow-up investigation. 5/17/12</p> <p>4., 5., 6., and 7.: Medication cart audits were initiated at 4:00 pm 5/16/2012 and were repeated again on 5/16/12 at the beginning of 11-7 shift and again on 5/17/12 during the 7-3 shift. These audits are to determine if all medication have been administered correctly and shall be overseen by the Director of Nursing and certain RN nursing supervisors. 5/17/12</p> <p>8. and 9.: A final written warning was given to LPN #1 and #2 on not following professional standards of medication administration. 5/29/12</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. 5/17/12</p>		

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F 224	<p>Continued From page 20.</p> <p>opened on 4/22/12 and the UM confirmed there was no other open container for Resident #3 in the medication carts. The UM after measuring the amount of daily doses in the open container into plastic cups, he/she confirmed that the open bottle of Glycolax dated 4/22/12 contained 12 daily doses. The UM confirmed that the doses that were recorded on the MAR as administered did not reflect the actual doses of Glycolax received by Resident #3. The UM confirmed that there were 12 does in the opened Glycolax bottle and there should have only been 7. The UM confirmed that 5 daily doses were not administered and the UM confirmed that there were no refusals by Resident #3 to take the medication. The UM confirmed on 5/15/12 that Resident #3 did not receive the Glycolax per physician orders.</p> <p>Per review of the comprehensive care plan, dated 6/28/12 and titled: "Incontinent of Bowel and Bladder", indicates constipation is a problem and to provide bowel medications as ordered.</p> <p>Per review of the facility notification log on 5/15, 5/16, and 5/17 there was no evidence that the primary physician was notified that Resident #3 did not receive 5 daily doses of Glycolax per the physician's orders during the time frame of 4/22/12 to 5/15/12. Per interview with the UM on 5/17/12, he/she indicated that the primary physician and interested family members had not been notified that Resident #3 had not received 5 daily doses of Glycolax.</p> <p>7. Per review of the medical record, Resident #4 was admitted to the facility on 3/21/11 with diagnoses that included: Alzheimer's, paranoid</p>	F 224	<p><u>Continued from page 20</u></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>1.: Nursing staff will be re-educated regarding identification of a significant change in physical status of a resident and physician consultation and responsible party notification when a resident has a significant change in physical status. 5/22/12</p> <p>2.,and 3.: The facility implemented a written policy on professional misconduct which includes detailed investigation procedures. 5/22/12</p> <p>4., 5., 6., 7., 8., and 9.: Medication nurses have been in-serviced by a RN nurse supervisor on the classic Five Rights of Medication Administration: right drug, right dose, right route, right time and right patient. This in-service also included a review of Vernon Green Nursing Home's Statement of Purpose, a brief summary of expected Professional Conduct and Standards of Practice. Each nurse will sign the in-service attendance form and receive a pamphlet containing additional detail for study. 5/17/12</p> <p>1., 2., 3., 4., 5., 6., 7., 8., and 9.: The facility implemented a written policy on professional misconduct which includes detailed investigation procedures. 5/22/12</p>	

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F 224	<p>Continued From page 21</p> <p>delusions, and constipation. Per observation of the medication carts on A-wing on 5/15/12 at 9:59 AM, a medication identified within the medication cart labeled for Resident #4 contained more doses of medication than they should have contained per review of the medication administration record, indicating the prescribed medication was not administered as ordered by the physician.</p> <p>Per observation on 5/15/12 at 9:59 AM an open bottle of Glycolax (fiber supplement to prevent constipation) that was labeled for Resident #4 was noted to be dated as opened as 4/20/12. The manufacturer label on the bottle indicated that the bottle contained when full and unopened 31 daily doses and a daily dose is 17 grams of Glycolax. Per review of the medication administration record (MAR) dated 4/20/12 to 5/14/12. Resident #4 was identified by the nurses signatures that Resident #4 had been administered 24 doses of Glycolax. Per observation on 5/15/12 the Glycolax left in the opened bottle labeled 4/20/12 as opened was dispensed by the UM into plastic cups, the UM confirmed the number of doses remaining in the opened bottle was 25 daily doses. Per confirmation by the UM, When the bottle was opened on 4/20/12 it contained 31 daily doses, the MAR indicates that 24 doses were administered to Resident #4. The UM confirmed that if all the doses had been given as signed per the signed MAR there would only be 7 doses left in the open container and there were 25 daily doses left in the container.</p> <p>The UM confirmed that the doses that were recorded on the MAR as administered did not</p>	F 224	<p><u>Continued from page 21</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>Director of Nursing or designated RNs will conduct Quality Assurance/Quality Improvement audits to assure notifications are made in timely manner until 100% compliance has been achieved. Thereafter, audits will be conducted on a monthly schedule for one year and after that on a schedule to be determined by the Quality Assurance Committee.</p> <p>Director of Nursing or designated RNs will conduct Quality Assurance/Quality Improvement audits to assure compliance with medication administration. These audits will be conducted weekly on each medication cart until 100% compliance has been achieved. Thereafter, audits will be conducted on a monthly schedule for one year and after that on a schedule to be determined by the Quality Assurance Committee.</p> <p>The Director of Human Service shall report to the Quality Assurance Committee all episodes of professional misconduct for one year. The Quality Assurance Committee shall determine further monitoring if needed.</p>	<p>5/22/12</p> <p>5/22/12</p> <p>5/22/12</p>
<p><i>F224 POC accepted as circled 5/18/12 Pmcotarn</i></p>				

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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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F 224	<p>Continued From page 22</p> <p>reflect the actual doses of Glycolax received by Resident #4. The UM confirmed that there was one refusals to take the Glycolax by Resident #4 on 5/10/12 during the time frame of from 4/20/12 to 5/14/12. The UM confirmed on 5/15/12 that the Glycolax was not administered per physician orders for Resident #4. The UM confirmed on 5/15/12 that several separate nurses had signed the MAR for Resident #4 as having administered 17 grams of Glycolax daily at 5 PM and did not, based on the 25 remaining doses left in the open bottle labeled for Resident #4.</p> <p>Per review of the MAR and the nurse signature sheet 4 separate nurses were identified as signing they administered 17 grams of Glycolax daily at 5 PM.</p> <p>Per review of the comprehensive care plan, dated 4/12/12 and titled: "Tendency towards constipation", the care plan indicates that staff is to provide bowel medications per order.</p> <p>Per review of the facility notification log on 5/15, 5/16, and 5/17 there was no evidence that the primary physician was notified that Resident #4 did not receive 18 daily doses of Glycolax were not administered per the physician's order . Per interview with the UM on 5/17/12, he/she indicated that the primary physician and interested family members had not been notified that Resident #4 had not received 18 daily doses of Glycolax.</p> <p>8. Per interview with the UM on 5/15/12, he/she stated that he/she had reprimanded a staff Licensed Practical Nurse (LPN #1) on 4/23/12 for signing for having administered Miralax (a</p>	F 224			

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F 224	<p>Continued From page 23</p> <p>medication to prevent constipation) on the MAR but not administering it to Resident #4 and Resident #2. The UM stated that he/she had found open bottles of Miralax dated 12/3/11 and 10/3/11. The UM stated he/she switched these bottles out for new ones with the seals in place on 4/23/12. The UM indicated that when the MAR was checked, LPN #1 had signed the Miralax was given on 4/23/12 and the UM indicated the bottles were still sealed. Per the UM, the LPN #1 was given a written reprimand and a medication error for not passing medications to Resident #2 and Resident #4.</p> <p>Per review of the employee file on 5/15/12, there was a written reprimand dated 4/23/12. The reprimand indicated that LPN #1 had signed for Miralax (Glycolax) on 4/23/12 as given and the bottles of Miralax for Resident #2 and Resident #4 where still sealed shut when checked on 4/23/12 by the UM.</p> <p>Per interview with the DNS and QA Nurse on 5/17/12, the DNS confirmed that he/she was aware of the reprimand and medication error given to LPN #1 on 4/23/12. The DNS confirmed that he/she was informed of it on 4/23/12.</p> <p>9. Per interview with the UM on 5/15/12, he/she stated that he/she had reprimanded a staff Licensed Practical Nurse (LPN #2) on 4/23/12 for for Miralax on the MAR but not administering it to Resident #4 and Resident #2. The UM stated that he/she had found open bottles of Miralax dated 12/3/11 and 10/3/11. The UM stated he/she switched these bottles out for new ones with the seals in place on 4/16/12. The UM indicated that when the MAR was checked LPN #2 had signed</p>	F 224			

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F 224	Continued From page 24 the Miralax was given on 4/16, 4/17, 4/18, 4/21 and 4/22/12 and the UM indicated the bottles were still sealed. Per review of the employee file on 5/15/12, there was a written reprimand dated 4/23/12. The reprimand indicated that LPN #1 had signed for Miralax (Glycolax) on 4/19 and 4/20 as given and the bottles of Miralax for Resident #2 and Resident #4 where still sealed shut when checked on 4/23/12 by the UM.	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	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. The Facility did not violate 42 C.F.R. § 483.13(c)(1)(iii): Reporting Alleged Violations, and should not have received an E level deficiency at Tag F225 Allegation of Substantial Compliance Vernon Green Nursing Home, herein after sometimes "facility", 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 June 9, 2012.	

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F 225	<p>Continued From page 25 to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported 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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed 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 (including the State Survey Agency) for 6 residents identified (Residents #2, 3, 4, 5, 6, and 7). The findings include:</p> <p>1. Per review of the employee file of a staff RN on 5/15/12, the file indicated that the RN on 3/6/12 the DNS reprimanded the RN for inappropriately speaking to a resident (Resident #7). The "notice of reprimand" dated 3/6/12 stated that the RN said to Resident #7 when he/she was asked by the RN to get out of bed "You're ugly and you</p>	F 225	<p><u>Continued from page 25</u></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>The facility requests independent informal dispute resolution for Tag F 225; respectfully maintains that it was and is in substantial compliance with federal regulations in respect to F 225; respectfully denies and disputes the allegation that it was deficient in respect to F 225; respectfully denies and disputes that any action or inaction on the part of the facility in respect to F 225 caused potential for any harm to any facility residents; and requests that F 225 be deleted from the public record.</p> <p>The deficiencies related to Resident # 6 and #7 arise out of the conduct of one staff member, over the course of more than a year. In April of 2011, one of the night nurses was disciplined for a number of issues. Included in the list of concerns was a description of an interaction with Resident #6 as the night nurse was attempting to remove a catheter. This interaction was not witnessed by the staff member who reported it to the Director of Nursing, and therefore, the DON's information was third-hand. The DON investigated the incident and concluded that he/she could not verify that the incident had happened as described, because the relationship between the reporting staff member is known to harbor animosity toward the nurse in question. Nevertheless, the DON chose to include the</p>	

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F 225	<p>Continued From page 26</p> <p>would get better treatment with honey that with vinegar." The reprimand also stated that "this or any other comment that is inappropriate will not be tolerated."</p> <p>Per review of the facility policy and procedure dated 1/3/11 and titled; "Resident Abuse, Neglect and Exploitation", abuse includes deprivation by an individual, including care takers, of goods and services that are necessary to attain or maintain physical, mental and psychosocial well-being and that the resident has the right to be free from verbal, sexual, physical and mental abuse by anyone. The policy also indicates verbal abuse is defined as "the use of oral, written or gestured language that willfully includes disparaging or derogatory terms to residents or within the resident's hearing distance."</p> <p>Per interview with the DNS on 5/17/12, he/she stated he/she was aware of the notice of reprimand dated 3/6/12 concerning the RN and the comment by the RN to Resident #7 of, "You're ugly and you would get better treatment with honey that with vinegar." The DNS confirmed that no thorough internal investigation had been done and no call was placed to APS (Adult Protective Services) or the State Survey Agency reporting the suspected mistreatment/abuse. The RN is currently employed by the facility.</p> <p>2. Per review of the employee file of a staff RN on 5/15/12, the file indicated that, on 3/25/11 when removing a internal urinary catheter from a resident (Resident #6), staff overheard the RN say to Resident #6, "You need to move your hand, do you want this out of your peeker or not." The 3/25/11 document also stated that, "the</p>	F 225	<p><u>Continued from page 26</u></p> <p>alleged behavior in the warning out of an abundance of caution.</p> <p>This is also true of the comments allegedly made to Resident #7 and reported to the DON on March 6, 2012. The DON received this report third-hand, not from the staff who overheard the comment, but from another staff-member who allegedly was told about the comment by a staff member who did overhear it. As the employment record notes, the night nurse denies having made the comment, and offers a plausible explanation as to how what was said might have been misinterpreted.</p> <p>These two incidents were cited as J level deficiencies at Tag F224, but were also cited at Tag F241 as E level deficiencies. The facility objects to receiving three tags from one set of circumstances. These incidents, if indeed they are violations, are more properly classified as affronts to the residents' dignity than as abuse or neglect.</p> <p>"The facility must insure 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)." 42 C.F.R. § 483.13 (c)(2).</p> <p>"The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further abuse while the investigation is in progress." 42 C.F.R. § 483.13 (c)(2).</p> <p>33 V.S.A. § 6903 requires any person "who knows or has received information of abuse,</p>	

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F 225	<p>Continued From page 27</p> <p>internal catheter was not coming out and the RN was pulling on the catheter instead of repositioning Resident #6 to aid in comfort. Resident #6 was yelling and flailing in discomfort."</p> <p>Per review of the facility policy and procedure dated 1/3/11 and titled; Resident Abuse, Neglect and Exploitation, verbal abuse is defined as "the use of oral, written or gestured language that willfully includes disparaging or derogatory terms to residents or within the resident's hearing distance." Per review of the facility policy and procedure dated 1/3/11 and titled: Resident Abuse, Neglect and Exploitation, dated 1/3/11, "abuse also means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish."</p> <p>Per interview with the DNS on 5/17/12, he/she reviewed the 3/25/11 reprimand and stated he/she was aware of the notice of reprimand dated 3/25/11 concerning the RN and the comment by the RN to Resident #7, " You need to move your hand, do you want this out of your peeker or not." The DNS confirmed that he/she was aware of the RN's actions when attempting to remove Resident #6's internal catheter. The DNS confirmed that no internal investigation was conducted and no call was placed to APS or the State Survey Agency reporting suspected mistreatment/abuse. The RN is currently employed by the facility.</p> <p>3. Per review of the medical record, Resident #2 was admitted to the facility on 2/11/08 with diagnoses that included: Alzheimer's, depression</p>	F 225	<p><u>Continued from page 27</u></p> <p>neglect, or exploitation of a vulnerable adult, or who has reason to suspect that any vulnerable adult has been abused, neglected or exploited shall report or cause a report to be made. . ."</p> <p>As discussed above, the Director of Nursing received second or third-hand reports that a staff member had engaged in prohibited conduct. After conducting her investigation, the DON concluded that there was not sufficient evidence to conclude that abuse had occurred. The results of her investigations were reported to the Administrator within 5 days as required by 42 C.F.R. § 483.13(c)(4). The nurse in question received written warnings that he/she must change his/her conduct regarding resident relations.</p> <p>Upon completion of the internal investigation, the Director of Nursing and the Administrator concluded that these violations of facility policy did not constitute neglect because they were not a "failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness," 42 C.F.R. § 488.301; nor did they constitute abuse because they were not a "willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish." 42 C.F.R. § 488.301.</p> <p>Resident #2 was admitted to the facility with a history of constipation, among other things, and with a physician order for Glycolax or another stool softener. Administration of bowel medications is also indicated in the resident's comprehensive care plan. On May 15, 2012, the surveyors noted a discrepancy between the twenty-nine doses remaining in resident's Glycolax bottle, which originally</p>	

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F 225	<p>Continued From page 28</p> <p>with psychosis, delusional disorder, and constipation. Per observation of the medication carts on A-wing on 5/15/12 at 9:59 AM, a medication identified within the medication cart labeled for Resident #2 contained more doses of medication than it should have contained per review of the medication administration record, indicating the prescribed medication was not administered as ordered by the physician.</p> <p>Per observation on 5/15/12 at 9:59 AM an open bottle of Glycolax (fiber supplement to prevent constipation) that was labeled for Resident #2 was noted to be dated as opened on 4/20/12. The manufacturer label on the bottle indicated that the bottle contained, when full and unopened, 31 daily doses and a daily dose is 17 grams of Glycolax. Per review of the medication administration record (MAR) dated 4/20/12 to 5/14/12, Resident #2 was identified by the nurses signatures that Resident #2 had been administered 23 doses of Glycolax. Per observation on 5/15/12 the Glycolax left in the opened bottle labeled 4/20/12 as opened was dispensed by the UM (Unit Manager) into plastic cups, the UM confirmed the number of doses remaining in the opened bottle was 29 daily doses.</p> <p>Per confirmation by the UM, when the bottle was opened on 4/20/12 it contained 31 daily doses, the MAR indicates that 23 doses were administered to Resident #2. The UM confirmed that if all the doses had been given as signed per the signed MAR there would only be 8 doses left in the open container and there were 29 daily doses left in the container. The UM confirmed that the doses that were recorded on the MAR as</p>	F 225	<p><u>Continued from page 28</u></p> <p>contained thirty-one doses, and the twenty-three doses that the nurses documented that they had administered between April 20, 2012 and May 14, 2012. (CMS 2567 at 17-18). A 180-day bowel report demonstrates that Resident #2 had no difficulties during this time. Bowel reports are monitored daily because of the facility's narrow window for treating potential blockage. Nevertheless, the surveyors concluded that those 23 doses had not been given.</p> <p>Resident #5. The Statement of Deficiencies alleges that Resident #5 was not administered Glycolax, however, the facility's records indicated that Resident #5 received Glycolax as scheduled. The unit manager does not recall measuring Resident #5's Glycolax on the morning of May 15, 2012 when the surveyor was present. She recalls measuring ferrous sulphate, and the MAR for Resident #5's ferrous sulphate match the dates used in the statement of deficiencies. (CMS 2567 at 18-20). Therefore, we believe that the statement of deficiencies is in error, and should refer to ferrous sulphate for Resident #5.</p> <p>Resident # 5 was admitted to the facility on January 6, 2009 with a diagnosis of anemia and a physician order for ferrous sulphate to be administered daily. On December 16, 2011, staff opened a bottle of ferrous sulphate for Resident #5. From December 17 through December 23, 2011, the resident's physician ordered the ferrous sulphate to be held because he had prescribed the resident a course of antibiotics. Upon completion of the course of antibiotics, the nursing home resumed administration of ferrous sulphate, as</p>	

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F 225	<p>Continued From page 29</p> <p>administered did not reflect the actual doses of Glycolax received by Resident #2. The UM confirmed that there was one refusal to take the Glycolax by Resident #2 from 4/20/12 to 5/14/12. The UM confirmed on 5/15/12 that the Glycolax was not administered per physician orders for Resident #2. The UM confirmed on 5/15/12 that several separate nurses had signed the MAR for Resident #2 as having administered 17 grams of Glycolax daily at 5 PM and did not, based on the 29 remaining doses left in the open bottle labeled for Resident #2.</p> <p>Per review of the MAR and the nurse signature sheet, 6 separate nurses were identified as signing they administered 17 grams of Glycolax daily at 5 PM in the time period specified above. Per review of the comprehensive care plan, dated 4/12/12 and titled: "Tendency towards constipation", the care plan indicates that staff is to provide bowel medications per order.</p> <p>Though the UM confirmed Resident #2 did not receive medications as ordered, per review of the facility notification log on 5/15, 5/16, and 5/17 there was no evidence that the primary physician was notified that Resident #2 did not receive 23 daily doses of Glycolax that was ordered by the physician. Per interview with the UM on 5/17/12, he/she indicated that the primary physician and interested family members had not been notified that Resident #2 had not received 23 daily doses of Glycolax. The UM confirmed on 5/17/12 that no investigation had been conducted regarding the Glycolax not being given per physician order and that no call had been placed to APS or the State Survey Agency.</p>	F 225	<p><u>Continued from page 29</u></p> <p>evidenced both by the MAR and the orders for more ferrous sulphate from the pharmacy in January, February, March and April. Throughout this time, Resident #5's blood levels for iron were monitored, and they continued to improve. In late May, the resident's levels had improved so much that the dose was reduced to three times per week. Despite this clear evidence that Resident #5 was receiving ferrous sulphate in accordance with the care plan, the surveyors concluded that 108 doses listed on the MAR had not been given. It should be noted that it would have been impossible for the facility to give 108 doses since there were only 105 days between February 1 and May 15, 2012.</p> <p>Resident #3 was admitted to the facility with a history of constipation, among other things, and with a physician order for Glycolax or another stool softener. Administration of bowel medications is also indicated in the resident's comprehensive care plan. On May 15, 2012, the surveyors noted a discrepancy between the twelve doses remaining in resident's Glycolax bottle which originally contained thirty-one doses, and the twenty-four doses that the nurses documented that they had administered between April 22, 2012 and May 15, 2012. (CMS 2567 at 20-21). A 180-day bowel report demonstrates that Resident #3 had no difficulties during this time. Bowel reports are monitored daily because of the facility's narrow window for treating potential blockage. Nevertheless, the surveyors concluded that those 23 doses had not been given.</p> <p>Resident #4 was admitted to the facility with a history of constipation, among other things,</p>		

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F 225	<p>Continued From page 30</p> <p>Per interview with the DNS and Quality Assurance Nurse (QA) on 5/17/12, he/she confirmed that the DNS was aware that Resident #2 did not receive medications as ordered by the primary physician. Per interview on 5/17/12 the QA nurse confirmed and the DNS confirmed that no medication error reports had been completed as per facility policy and that no investigation was opened related to Resident #2 not receiving Glycolax as per physician order. Per interview on 5/17/12 the DNS confirmed that no call had been placed to APS or the State Survey Agency reporting the failure to administer medication to Resident #2.</p> <p>4. Per review of the medical record, Resident #5 was admitted to the facility on 1/6/2009 with diagnoses that include: cognitive impairment/dementia, major depressive disorder, dementia with behavior issues and psychotic features and constipation. Per observation of the medication carts on A-wing on 5/15/12 at 9:59 AM, a medication identified within the medication cart labeled for Resident #5 contained more doses of medication than they should have contained per review of the medication administration record, indicating the prescribed medication was not administered as ordered by the physician.</p> <p>Per observation on 5/15/12 at 9:59 AM an open bottle of Glycolax (fiber supplement to prevent constipation) that was labeled for Resident #5 was noted to be dated as opened on 12/16/11. The manufacturer label on the bottle indicated that the bottle contained when full and unopened 31 daily doses and a daily dose is 17 grams of Glycolax. Per review of the medication</p>	F 225	<p><u>Continued from page 30</u></p> <p>and with a physician order for Glycolax or another stool softener. Bowel reports are monitored daily because of the facility's narrow window for treating potential blockage. Administration of bowel medications is also indicated in the resident's comprehensive care plan. On May 15, 2012, the surveyors noted a discrepancy between the twenty-five doses remaining in resident's Glycolax bottle which originally contained thirty-one doses, and the twenty-four doses that the nurses documented that they had administered between April 20, 2012 and May 14, 2012. (CMS 2567 at 21-23). A 180-day bowel report demonstrates that Resident #4 had no difficulties during this time. Bowel reports are monitored daily because of the facility's narrow window for treating potential blockage. Nevertheless, the surveyors concluded that the appropriate number of doses had not been given.</p> <p>"The facility must insure 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)." 42 C.F.R. § 483.13 (c)(2). "The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further abuse while the investigation is in progress." 42 C.F.R. § 483.13 (c)(2). The interpretive guidelines define neglect as the "failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." 42 C.F.R. § 488.301.</p>	

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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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F 225	<p>Continued From page 31</p> <p>administration record (MAR) dated 2/01/12 to 5/15/12, Resident #5 was identified by the nurses signatures that Resident #5 had been administered 108 doses of Glycolax. The UM confirmed on 5/15/12 at 11:12 AM the bottle was opened on 12/16/11 and the UM confirmed there was no other open container for Resident #5 in the medication carts. The UM confirmed that if all the doses had been given as signed per the signed MAR there would not be an open bottle dated 12/16/11 because the unopened container contains 31 daily doses. The UM confirmed that the doses that were recorded on the MAR as administered did not reflect the actual doses of Glycolax received by Resident #5. The UM confirmed that there was one refusal by Resident #5 to take the Glycolax from 2/1/12 to 5/15/12. The UM confirmed on 5/15/12 that Resident #5 did not receive the Glycolax per physician orders. The UM confirmed on 5/15/12 that several separate nurses had signed the MAR for Resident #5 as having administered 17 grams of Glycolax daily at in the AM and did not, based on the date the Glycolax was opened on 12/16/11.</p> <p>Per review of the MAR on 5/15/12 and the nurse signature sheet, 4 separate nurses were identified as signing they administered 17 grams of Glycolax daily in the AM.</p> <p>Per review of the comprehensive care plan, dated 4/12/12 and titled: "Episodes of Constipation", the care plan indicates that staff is to provide bowel medications per order.</p> <p>Per review of the facility notification log on 5/15, 5/16, and 5/17 there was no evidence that the primary physician was notified that Resident #5</p>	F 225	<p><u>Continued from page 31</u></p> <p>The facility did not receive allegations of abuse or neglect related to these medication issues until the survey on May 16, 2012. (CMS 2567 at 28-40). When the unit manager reported her concerns to the DON and the Administrator, she raised concerns about the practice in administering medications, not a complete failure to administer medications. Nor did the unit manager allege willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish." 42 C.F.R. § 488.301.</p> <p>The Regulation only requires a facility to report to state officials when it receives an allegation of mistreatment, neglect or abuse, injuries of unknown source, or misappropriation of property. 42 C.F.R. § 483.13 (c)(2). Without clear allegations of "mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property" the facility had no obligation to report the findings of its investigation further than to the administrator.</p> <p>The medication administration irregularities were investigated as soon as the Unit Manager discovered them, and the results of her investigations were reported to the Director of Nursing and the Administrator within 5 days as required by 42 C.F.R. § 483.13(c)(4). The nurses in question received written warnings that they must change their medication administration practices.</p> <p>Upon completion of the internal investigation the Director of Nursing and the Administrator concluded that these violations of facility policy did not constitute neglect because they</p>		

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F 225	<p>Continued From page 32</p> <p>did not receive 108 daily doses of Glycolax per the physician's orders during the time frame of 12/2/11 to 5/15/12. Per interview with the UM on 5/17/12, he/she indicated that the primary physician and interested family members had not been notified that Resident #5 had not received 108 daily doses of Glycolax per physician's orders. The UM confirmed on 5/17/12 that no investigation had been conducted regarding the Glycolax not being given per physician order and that no call had been placed to APS or the State Survey Agency.</p> <p>Per interview with the DNS and Quality Assurance Nurse (QA) on 5/17/12, he/she confirmed that the DNS was aware that Resident #5 did not receive medications as ordered by the primary physician. Per interview on 5/17/12 the QA nurse confirmed and the DNS confirmed that no medication error reports had been completed as per facility policy and that no investigation was opened related to Resident #5 not receiving Glycolax as per physician order. Per interview on 5/17/12 the DNS confirmed that no call had been placed to APS or the State Survey Agency reporting the failure to administer medication to Resident #5.</p> <p>5. Per review of the medical record, Resident #3 was admitted to the facility on 6/16/03 with diagnoses that include: Alzheimer's/dementia, depression, general anxiety and constipation. Per observation of the medication carts on A-wing on 5/15/12 at 9:59 AM, a medication identified within the medication cart labeled for Resident #3 contained more doses of medication than they should have contained per review of the medication administration record, indicating the</p>	F 225	<p><u>Continued from page 32</u></p> <p>were not a "failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness," 42 C.F.R. § 488.301; nor did they constitute abuse because they were not a "willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish." 42 C.F.R. § 488.301.</p> <p>The facility also notes that allegations numbered 7 and 8 under Tag F225 on the Statement of Deficiencies allege no conduct that has not already been alleged in allegations numbered 3 and 6 for that Tag. Because these allegations add no new information they are redundant, and should be considered as part of those prior allegations.</p> <p>For these reasons, the facility has shown that it has been and remains in substantial compliance in regards to reporting abuse, and therefore respectfully requests that this tag be removed from the 2567 and the public record.</p>	

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F 225	<p>Continued From page 33</p> <p>prescribed medication was not administered as ordered by the physician.</p> <p>Per observation on 5/15/12 at 9:59 AM an open bottle of Glycolax (fiber supplement to prevent constipation) that was labeled for Resident #3 was noted to be dated as opened on 4/22/12. The manufacturer label on the bottle indicated that the bottle contained, when full and unopened, 31 daily doses and a daily dose is 17 grams of Glycolax. Per review of the medication administration record (MAR) dated 4/22/12 to 5/15/12, Resident #3 was identified by the nurses signatures that Resident #3 had been administered 24 doses of Glycolax. The UM confirmed on 5/15/12 at 11:12 AM the bottle was opened on 4/22/12 and the UM confirmed there was no other open container for Resident #3 in the medication carts. The UM after measuring the amount of daily doses in the open container into plastic cups, he/she confirmed that the open bottle of Glycolax dated 4/22/12 contained 12 daily doses. The UM confirmed that the doses that were recorded on the MAR as administered did not reflect the actual doses of Glycolax received by Resident #3. The UM confirmed that there were 12 does in the opened Glycolax bottle and there should have only been 7. The UM confirmed that 5 daily doses were not administered and the UM confirmed that there were no refusals by Resident #3 to take the medication. The UM confirmed on 5/15/12 that Resident #3 did not receive the Glycolax per physician orders.</p> <p>Per review of the comprehensive care plan, dated 6/28/12 and titled: "Incontinent of Bowel and Bladder", indicates constipation is a problem and</p>	F 225	<p><u>Continued from page 33</u></p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>1. and 2.: The administrator has been made aware of these events. The Director of Nursing put the nurse in question regarding the use of inappropriate language on administrative leave pending the outcome of a follow-up investigation.</p> <p>A report to State of Vermont's Adult Protective Service (APS) has been made.</p> <p>3., 4., 5., and 6.: The administrator has been made aware of these events. The Director of Nursing filed a report with the State of Vermont's APS of licensed nursing staff that may not have administered residents' medication per standards of practice.</p> <p>The investigation was completed and reported to the APS.</p> <p>7. and 8.: The administrator has been made aware of these events. The Director of Nursing filed a report with the State of Vermont's APS of licensed nursing staff that may not have administered residents' medication per standards of practice.</p> <p>The investigation was completed and reported to the APS.</p> <p>A final written warning was given to LPN #1 and #2 on not flowing professional standards of medication administration.</p>	<p>5/17/12</p> <p>6/3/12</p> <p>5/17/12</p> <p>5/21/12</p> <p>5/17/12</p> <p>5/21/12</p> <p>5/29/12</p>

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F 225	Continued From page 34 to provide bowel medications as ordered. Per review of the facility notification log on 5/15, 5/16, and 5/17 there was no evidence that the primary physician was notified that Resident #3 did not receive 5 daily doses of Glycolax per the physician's orders during the time frame of 4/22/12 to 5/15/12. Per interview with the UM on 5/17/12, he/she indicated that the primary physician and interested family members had not been notified that Resident #3 had not received 5 daily doses of Glycolax. The UM confirmed on 5/17/12 that no investigation had been conducted regarding the Glycolax not being given per physician order and that no call had been placed to APS or the State Survey Agency. Per interview with the DNS and Quality Assurance Nurse (QA) on 5/17/12, he/she confirmed that the DNS was aware that Resident #3 did not receive medications as ordered by the primary physician. Per interview on 5/17/12 the QA nurse confirmed and the DNS confirmed that no medication error reports had been completed as per facility policy and that no investigation was opened related to Resident #3 not receiving Glycolax as per physician order. Per interview on 5/17/12 the DNS confirmed that no call had been placed to APS or the State Survey Agency reporting the failure to administer medication to Resident #3. 6. Per review of the medical record, Resident #4 was admitted to the facility on 3/21/11 with diagnoses that included: Alzheimer's, paranoid delusions, and constipation. Per observation of the medication carts on A-wing on 5/15/12 at 9:59 AM, a medication identified within the medication	F 225	Continued from page 34 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. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; The facility implemented a written policy on professional misconduct which includes detailed investigation procedures. 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 Director of Human Service shall report to the Quality Assurance Committee all episodes of professional misconduct for one year. The Quality Assurance Committee shall determine further monitoring if needed.	5/17/12 5/22/12 6/19/12
<i>F225 POC accepted as cited 8/18/12 Pmc-tapw</i>				

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F 225	<p>Continued From page 35</p> <p>cart labeled for Resident #4 contained more doses of medication than they should have contained per review of the medication administration record, indicating the prescribed medication was not administered as ordered by the physician.</p> <p>Per observation on 5/15/12 at 9:59 AM an open bottle of Glycolax (fiber supplement to prevent constipation) that was labeled for Resident #4 was noted to be dated as opened as 4/20/12. The manufacturer label on the bottle indicated that the bottle contained when full and unopened 31 daily doses and a daily dose is 17 grams of Glycolax. Per review of the medication administration record (MAR) dated 4/20/12 to 5/14/12. Resident #4 was identified by the nurses signatures that Resident #4 had been administered 24 doses of Glycolax. Per observation on 5/15/12 the Glycolax left in the opened bottle labeled 4/20/12 as opened was dispensed by the UM into plastic cups, the UM confirmed the number of doses remaining in the opened bottle was 25 daily doses. Per confirmation by the UM, When the bottle was opened on 4/20/12 it contained 31 daily doses, the MAR indicates that 24 doses were administered to Resident #4. The UM confirmed that if all the doses had been given as signed per the signed MAR there would only be 7 doses left in the open container and there were 25 daily doses left in the container.</p> <p>The UM confirmed that the doses that were recorded on the MAR as administered did not reflect the actual doses of Glycolax received by Resident #4. The UM confirmed that there was one refusals to take the Glycolax by Resident #4</p>	F 225			

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F 225	<p>Continued From page 36</p> <p>on 5/10/12 during the time frame of from 4/20/12 to 5/14/12. The UM confirmed on 5/15/12 that the Glycolax was not administered per physician orders for Resident #4. The UM confirmed on 5/15/12 that several separate nurses had signed the MAR for Resident #4 as having administered 17 grams of Glycolax daily at 5 PM and did not, based on the 25 remaining doses left in the open bottle labeled for Resident #4.</p> <p>Per review of the MAR and the nurse signature sheet 4 separate nurses were identified as signing they administered 17 grams of Glycolax daily at 5 PM.</p> <p>Per review of the comprehensive care plan, dated 4/12/12 and titled: "Tendency towards constipation", the care plan indicates that staff is to provide bowel medications per order.</p> <p>Per review of the facility notification log on 5/15, 5/16, and 5/17 there was no evidence that the primary physician was notified that Resident #4 did not receive 18 daily doses of Glycolax were not administered per the physician's order. Per interview with the UM on 5/17/12, he/she indicated that the primary physician and interested family members had not been notified that Resident #4 had not received 18 daily doses of Glycolax. The UM confirmed on 5/17/12 that no investigation had been conducted regarding the Glycolax not being given per physician order and that no call had been placed to APS or the State Survey Agency.</p> <p>Per interview with the DNS and Quality Assurance Nurse (QA) on 5/17/12, he/she confirmed that the DNS was aware that Resident</p>	F 225		

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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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F 225	<p>Continued From page 37</p> <p>#4 did not receive medications as ordered by the primary physician. Per interview on 5/17/12 the QA nurse confirmed and the DNS confirmed that no medication error reports had been completed as per facility policy and that no investigation was opened related to Resident #4 not receiving Glycolax as per physician order. Per interview on 5/17/12 the DNS confirmed that no call had been placed to APS or the State Survey Agency reporting the failure to administer medication to Resident #2.</p> <p>7. Per interview with the UM on 5/15/12, he/she stated that he/she had reprimanded a staff Licensed Practical Nurse (LPN #1) on 4/23/12 for signing for having administered Miralax (a medication to prevent constipation) on the MAR but not administering it to Resident #4 and Resident #2. The UM stated that he/she had found open bottles of Miralax dated 12/3/11 and 10/3/11. The UM stated he/she switched these bottles out for new ones with the seals in place on 4/23/12. The UM indicated that when the MAR was checked, LPN #1 had signed the Miralax was given on 4/23/12 and the UM indicated the bottles were still sealed. Per the UM, the LPN #1 was given a written reprimand and a medication error, for not passing medications to Resident #2 and Resident #4.</p> <p>Per review of the employee file on 5/15/12, there was a written reprimand dated 4/23/12. The reprimand indicated that LPN #1 had signed for Miralax (Glycolax) on 4/23/12 as given and the bottles of Miralax for Resident #2 and Resident #4 where still sealed shut when checked on 4/23/12 by the UM.</p>	F 225		
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F 225	<p>Continued From page 38</p> <p>Per interview with the DNS and QA Nurse on 5/17/12, the DNS confirmed that he/she was aware of the reprimand and medication error given to LPN #1 on 4/23/12. The DNS confirmed that he/she was informed of it on 4/23/12. The DNS stated that no internal investigation had been conducted regarding the LPN #1 signing for medications not administered and had not notified APS or the State Survey Agency.</p> <p>8. Per interview with the UM on 5/15/12, he/she stated that he/she had reprimanded a staff Licensed Practical Nurse (LPN #2) on 4/23/12 for for Miralax on the MAR but not administering it to Resident #4 and Resident #2. The UM stated that he/she had found open bottles of Miralax dated 12/3/11 and 10/3/11. The UM stated he/she switched these bottles out for new ones with the seals in place on 4/16/12. The UM indicated that when the MAR was checked LPN #2 had signed the Miralax was given on 4/16, 4/17, 4/18, 4/21 and 4/22/12 and the UM indicated the bottles were still sealed.</p> <p>Per review of the employee file on 5/15/12, there was a written reprimand dated 4/23/12. The reprimand indicated that LPN #1 had signed for Miralax (Glycolax) on 4/19 and 4/20 as given and the bottles of Miralax for Resident #2 and Resident #4 where still sealed shut when checked on 4/23/12 by the UM.</p> <p>Per interview with the DNS and QA Nurse on 5/17/12, the DNS confirmed that he/she was aware of the reprimand and medication error given to LPN#2 on 4/23/12. The DNS confirmed that he/she was informed of it on 4/23/12. The DNS stated that no internal investigation had</p>	F 225			

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F 225	Continued From page 39 been conducted regarding the LPN #2 signing for medications not administered and had not notified APS or the State Survey Agency.	F 225			
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to promote care for 3 residents identified (Resident #6, 7, and 8) in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. 1. Per review of the employee file of a staff RN on 5/15/12, the file indicated that the RN on 3/6/12 the DNS reprimanded the RN for inappropriately speaking to a resident (Resident #7). The "notice of reprimand" dated 3/6/12 stated that the RN said to Resident #7 when he/she was asked by the RN to get out of bed "You're ugly and you would get better treatment with honey that with vinegar." The reprimand also stated that "this or any other comment that is inappropriate will not be tolerated." Per review of the facility policy and procedure dated 1/3/11 and titled; "Resident Abuse, Neglect and Exploitation", abuse includes deprivation by an individual, including care takers, of goods and services that are necessary to attain or maintain	F 241	<u>F241</u> The Facility has and continues to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The Facility did not violate 42 C.F.R. § 483.15(a): Dignity, and should not have received an E level Deficiency at Tag F241 Allegation of Substantial Compliance Vernon Green Nursing Home, herein after sometimes "facility", 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 June 9, 2012. 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. The facility requests independent informal dispute resolution for Tag F 241; respectfully		

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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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F 241	<p>Continued From page 40</p> <p>physical, mental and psychosocial well-being and that the resident has the right to be free from verbal, sexual, physical and mental abuse by anyone. The policy also indicates verbal abuse is defined as "the use of oral, written or gestured language that willfully includes disparaging or derogatory terms to residents or within the resident's hearing distance."</p> <p>Per interview with the DNS on 5/17/12, he/she stated he/she was aware of the notice of reprimand dated 3/6/12 concerning the RN and the comment by the RN to Resident #7 of, "You're ugly and you would get better treatment with honey that with vinegar."</p> <p>2. Per review of the employee file of a staff RN on 5/15/12, the file indicated that, on 3/25/11 when removing a internal urinary catheter from a resident (Resident #6), staff overheard the RN say to Resident #6, "You need to move your hand, do you want this out of your peeker or not." The 3/25/11 document also stated that, "the internal catheter was not coming out and the RN was pulling on the catheter instead of repositioning Resident #6 to aid in comfort. Resident #6 was yelling and flailing in discomfort."</p> <p>Per review of the facility policy and procedure dated 1/3/11 and titled; Resident Abuse, Neglect and Exploitation, verbal abuse is defined as "the use of oral, written or gestured language that willfully includes disparaging or derogatory terms to residents or within the resident's hearing distance." Per review of the facility policy and procedure dated 1/3/11 and titled: Resident Abuse, Neglect and Exploitation, dated 1/3/11,</p>	F 241	<p><u>Continued from page 40</u></p> <p>maintains that it was and is in substantial compliance with federal regulations in respect to F 241; respectfully denies and disputes the allegation that it was deficient in respect to F 241; respectfully denies and disputes that any action or inaction on the part of the facility in respect to F 241 caused potential for any harm to any facility residents; and requests that F 241 be deleted from the public record.</p> <p>The deficiencies related to Resident # 6, #7 and # 9 (incorrectly identified in the 2567 at 42 as Resident #8) all arise out of the conduct of one staff member, over the course of more than a year. In April of 2011, one of the night nurses was disciplined for a number of issues. Included in the list of concerns was a description of an interaction with Resident #6 as the night nurse was attempting to remove a catheter. This interaction was not witnessed by the staff member who reported it to the Director of Nursing, and therefore, the DON's information was third-hand. The DON investigated the incident and concluded that he/she could not verify that the incident had happened as described, because the relationship between the reporting staff member is known to harbor animosity toward the nurse in question. Nevertheless, the DON chose to include the alleged behavior in the warning out of an abundance of caution.</p> <p>This is also true of the comments allegedly made to Resident #7 and reported to the DON on March 6, 2012. The DON received this report third-hand, not from the staff who overheard the comment, but from another staff-member who allegedly was told about the comment by a staff member who did overhear it. As the employment record notes, the night</p>		

Continued from page 41

nurse denies having made the comment, and offers a plausible explanation as to how what was said might have been misinterpreted.

The incidents involving Resident #6 and #7 were cited as J level deficiencies at Tag F224, but were also cited as E level deficiencies at F225. The facility objects to receiving three tags from one set of circumstances. These incidents, if indeed they are violations, are more properly classified as affronts to the residents' dignity than as abuse or neglect.

Finally, as noted in the same personnel file, the night nurse was charged with changing Resident # 9 (incorrectly identified as Resident #8 in the 2567) in the day room. This incident occurred in the middle of the night. Resident #9 had soiled his incontinence briefs and refused to leave the day room to be changed. No-one else was around, the lights were low, and the nurse had a privacy blanket ready in case any other resident got up. Under these circumstances, it would have been an affront to the resident's dignity to either force him to go to his room to be changed or to allow him to remain in the soiled briefs. Nevertheless, the surveyors cited this conduct as an E level deficiency at Tag F241. (CMS 2567 at 42).

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in fully recognition of his/her individuality. 42 C.F.R. 483.15(a). The interpretive guidelines explain that "'Dignity' means that in their interactions with residents staff carries out activities that assist the resident to maintain and enhance his/her self esteem or self-worth." SOM Appendix PP Tag F241.

As discussed above, with regard to Resident # 6 and #7, the Director of Nursing received second or third-hand reports that a staff member had engaged in prohibited conduct. After conducting her investigation, the DON concluded that there was not sufficient evidence to conclude that abuse had occurred. The results of her investigations were reported to the Administrator within 5 days as required by 42 C.F.R. § 483.13(c)(4). The nurse in question received written warnings that he/she must change his/her conduct regarding resident relations.

Finally, as it pertains to Resident # 9, it would have been an equal affront to the resident's dignity to either force him to go to his room to be changed or to allow him to remain in the soiled briefs. No actual harm resulted and there existed only the potential for minimal negative impact.

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F 241	Continued From page 41 "abuse also means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish." Per interview with the DNS on 5/17/12, he/she reviewed the 3/25/11 reprimand and stated he/she was aware of the notice of reprimand dated 3/25/11 concerning the RN and the comment by the RN to Resident #7, "You need to move your hand, do you want this out of your peeker or not." The DNS confirmed that he/she was aware of the RN's actions when attempting to remove Resident #6's internal catheter. 3. Per review of the employee file of a staff RN on 5/15/12, the file indicated that the RN on 3/25/11 was given a document of areas of concern by the DNS. The document indicated that the staff RN had not assured that Resident #8 was "single padded" and the RN failed to ensure that Resident #8 was not having his/her incontinence brief changed in the dayroom. The document indicated that this was "a dignity/privacy issue and is just wrong." Per interview with the DNS and facility Administrator on 5/17/12, the DNS stated that "single padded" meant that a resident did not have more than one adult incontinence brief on at a time for incontinence. The DNS confirmed that he/she was aware of the incident of the staff RN not ensuring that Resident #8 was single padded and was aware that the RN was not ensuring that Resident #8 was changed in his/her room and not in the dayroom. The DNS confirmed this was a dignity and privacy issue.	F 241	<u>Continued from page 41a</u> The facility has shown that it has been and remains in substantial compliance in regards to F241, Dignity, and therefore respectfully requests that this tag be removed from the 2567 and the public record. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? 1. and 2., and 3.: The Director of Nursing put the RN in question regarding these residents dignity on administrative leave pending the outcome of a follow-up investigation. 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. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; The facility implemented a written policy on professional misconduct which includes detailed investigation procedures. 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 Director of Human Service shall report to the Quality Assurance Committee all episodes of professional misconduct for one year. The Quality Assurance Committee shall determine further monitoring if needed.	5/17/12 5/17/21 5/22/12 6/19/12
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F241 POC accepted as circled 8/8/12 pncotaRN

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F 241	Continued From page 42	F 241		
F 281 SS=J	<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 staff interview and record review the facility failed to provide services that meet professional standards of quality regarding failure to communicate a significant change in a resident's condition to the appropriate professional, failure to prevent mistreatment, and failure to administer medications per physician orders for 7 residents (Residents #1, 2, 3, 4, 5, 6, and 7.) The findings include:</p> <p>1. Per review of the medical record on 4/26/12, Resident #1 was admitted to the facility on 3/16/11 with diagnoses that included: dementia, hypertension, history of gastric bleeding, and history of a gastric ulcer. Review of the nurses notes dated 4/11/12 at 12:45 AM, Resident #1 had a temperature of 100.6 F (Fahrenheit) and Tylenol 650 mg (milligrams) suppository was given for an increased temperature. At 2:00 AM, Resident #1 had a "small amount of drool from the corner of the right mouth, clear mucous with brown stripes, Guaiac positive (a test done on stool to identify blood), vital signs: temperature: 99.3 [F], pulse: 68 [bpm (beats per minute)], respiratory rate: 18, blood pressure: 180/100 after care given, SPO2 [oxygen saturation]95%, makes eye contact but non verbal."</p>	F 281	<p><u>F281</u></p> <p>The Facility has and continues to ensure that it meets professional standards of care. The Facility did not violate 42 C.F.R. § 483.20(k): Professional Standards, and should not have received a J level Deficiency at Tag F281.</p> <p>Allegation of Substantial Compliance</p> <p>Vernon Green Nursing Home, herein after sometimes "facility", 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 June 9, 2012.</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>The facility requests informal dispute resolution for Tag F 281; respectfully maintains that it was and is in substantial compliance with federal regulations in respect to F 281; respectfully denies and disputes the allegation that it was deficient in respect to</p>	

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F 281	<p>Continued From page 43</p> <p>At 2:15 AM, the nurse's notes indicate, "large amount of brown slimy emesis." Vital signs: Blood pressure: 150/80, temperature: 99.3 F, pulse: 86 bpm, respiratory rate: 28, Spo2 95%. At 5:30 AM, temperature was 100.4 F, pulse: 86 bpm, respiratory rate: 22, Spo2 94%, Tylenol given for increased temperature. Per the nurses notes dated 4/11/12 at change of shift, "respiratory status changed, reassessment of temperature 101.1, respiratory rate 24, labored breathing, breathing very moist and audible, resident moaning, SPO2 87-88% on room air, oxygen applied via facemask at 4 liters, SPO2 increases to 90-91% however labored breathing continues, resident lethargic, diaphoretic, call placed to Grace Cottage Emergency Room after speaking with family received order from physician to transport resident to Brattleboro Memorial Hospital, rescue received [Resident #1] at approximately 7:40 AM". Per nurses notes dated 4/11/12 at 9:45 AM, the facility received a call from the hospital reporting that Resident #1 had expired.</p> <p>Per review of the 4/11/12 emergency room documentation, the notes by the physician indicate that Resident #1 arrived to the hospital in "severe distress, unresponsive and presenting to be experiencing a terminal event on arrival." The emergency room documentation indicates that Resident #1 "expired at 9:37 AM" and "the physician's clinical impression was terminal episode? perforated ulcer." Per interview on 4/27/12, the Medical Examiner indicated that Resident #1's cause of death to be Gastric Ulcer/Gastric Bleed.</p>	F 281	<p><u>Continued from page 43</u></p> <p>F 281; respectfully denies and disputes that any action or inaction on the part of the facility in respect to F 281 caused any harm or potential for any harm to any facility residents; and requests that F 281 be deleted from the public record or at the very least that the scope and severity be reduced.</p> <p>Resident #1 was admitted to the facility on March 16, 2011, with diagnoses that included dementia and hypertension. The resident did suffer a gastric ulcer and gastric bleeding in 2001. Resident #1 also had a history of low-grade fevers and vomiting which frequently resolved without the need for hospitalization.</p> <p>For example, Resident #1 returned to Vernon Green from a five-day hospital stay on March 1, 2012. On the date of discharge her temperature was 98.2 Degrees F; pulse was 70, blood pressure 149/66, respirations at 18 and SpO2 91%. The resident had tested negative for gastric bleeding during the hospital stay. In addition, nearly every day the resident cried out for help, and yet was unable to identify the help that she needed. In these instances, nursing staff provided 1:1 care for the resident, tried to redirect, and soothe the resident in a variety of ways.</p> <p>From January 1, 2012 to April 11, 2012, Resident #1's blood pressure was recorded in a range between 180/100 and 120/60. Resident #1's temperature fell in the following range 97.0-101.1 degrees F. Resident #1's respiration rate was between 18 and 28. On April 10, 2012, Vernon Green notified Resident #1's physician that she had a low-grade fever, and the nursing home received instructions to monitor the resident's condition. Therefore, Resident #1's physician</p>		

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F 281	<p>Continued From page 44</p> <p>Per review of the nurse's notes and the facilities notification log, there was no evidence that the facility on-call physician was notified from 12:00 AM until 7:05 AM that Resident #1 had a change in medical status. Per review of the nurse's notes and the facility's notification log, there was no evidence that Resident #1's appointed emergency contact was notified of Resident's #1 change in medical condition.</p> <p>Per review of the facility policy and procedure titled "Change in Resident Condition or Status" dated 9/27/10, the "Charge Nurse/ House Supervisor will notify the resident's Attending Physician or the On-Call Physician when there has been a significant change in the resident's physical/emotional/mental condition". The policy also indicates that the "Charge Nurse /House Supervisor unless otherwise instructed by the resident, the Charge Nurse/House Supervisor will notify the resident's family when there is a significant change in the resident's physical, mental, or psychosocial status".</p> <p>Per review of the 2012 Physician Standing Orders for Resident #1, Tylenol 650 mg can be given per rectum for discomfort or elevated temperature every 4 hours as needed until physician is notified. The nurses notes dated 4/11/12 show that Tylenol 650 mg was given per rectum at 12:45 AM for an elevated temperature and again at 5:30 AM. There was no evidence in the nurse's notes that the primary or on-call physician was notified of the increase in temperature and the need to re-administer Tylenol at 5:30 AM.</p> <p>Per interview with the night Registered Nurse (RN) on duty the early morning of 4/11/12 via</p>	F 281	<p><u>Continued from page 44</u></p> <p>was aware of the condition and was monitoring it. As was often her habit, Resident #1 took her medicine mixed with chocolate pudding. Over the course of the early morning of April 11, 2012, Resident #1's vital signs fluctuated as follows:</p> <table border="1"> <thead> <tr> <th>Time</th> <th>temp</th> <th>BP</th> <th>SPO2</th> <th>Res.</th> <th>Pulse</th> </tr> </thead> <tbody> <tr> <td>9:00pm</td> <td>99.3</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>12:45am</td> <td>100.6</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>2:00am</td> <td>99.3</td> <td>180/100</td> <td>95%</td> <td>18</td> <td>68</td> </tr> <tr> <td>2:15am</td> <td>99.3</td> <td>150/80</td> <td>95%</td> <td>28</td> <td>86</td> </tr> <tr> <td>4:00am</td> <td></td> <td></td> <td>94%</td> <td></td> <td></td> </tr> <tr> <td>5:30am</td> <td>100.4</td> <td></td> <td>94%</td> <td>22</td> <td>86</td> </tr> <tr> <td>7:00am</td> <td>101.1</td> <td></td> <td>87-88%</td> <td>24</td> <td></td> </tr> </tbody> </table> <p>In addition the surveyor correctly notes that the resident had drool streaked with a brown substance at 2:00 AM and at 2:15 AM vomited a large amount of brown slimy emesis. However, the resident's temperature, and Spo2 remained unchanged, and the resident's blood pressure had improved. It should also be noted that the nursing notes indicate that the resident was "resting quietly" at 4:00 AM and 5:30 AM, and again at 6:30 AM.</p> <p>When viewed in the context of the resident's history, without the benefit of hindsight, it was not an unreasonable nursing judgment to decide to monitor the resident's respirations and pulse as directed by the physician before concluding that the resident had a significant change in condition.</p> <p>At 7:05 AM, the day nurse identified a significant change in condition. As soon as a significant change in condition, as defined in the interpretive guidelines was identified, the resident's primary care physician was notified as were the resident's family. The resident records demonstrate that Resident #1 had had slightly elevated temperatures and bouts of</p>	Time	temp	BP	SPO2	Res.	Pulse	9:00pm	99.3					12:45am	100.6					2:00am	99.3	180/100	95%	18	68	2:15am	99.3	150/80	95%	28	86	4:00am			94%			5:30am	100.4		94%	22	86	7:00am	101.1		87-88%	24			
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F 281	<p>Continued From page 45</p> <p>phone on 5/16/12 at 7:30 AM, the RN indicated that the LNA's notified him/her that Resident #1 had drool streaked with a brown substance on his/her right shoulder at 2:00 AM on 4/11/12. The RN stated that that he/she knew that the test he/she used to test the brown substance in the drool was used to test for blood in stool, but that he/she used it to test the drool to identify if the brown substance was blood or stomach content. The RN stated that the test showed positive for blood. The RN stated that he/she did not notify the physician of Resident #1's vomiting of a brown substance that was determined to be blood. The RN stated that he/she knew that Resident #1 had an increased temperature of 100.6 F at 12:45 AM. The RN stated he/she knew that Resident #1 had an elevated blood pressure at 2:00 AM of 180/100 and was non-verbal. The RN stated that he/she knew at 2:15 AM that Resident #1 vomited a large amount of slimy brown emesis and Resident #1 had an elevated respiration rate of 28. The RN stated that he/she knew that at 5:30 AM, Resident #1 had a temperature of 100.4 F and an elevated respiration rate of 22.</p> <p>During the same interview, the RN stated that he/she "did not know that [Resident #1] had a medical history of gastric bleeds and gastric ulcers, and that [he/she] could not possibly know the medical histories of all of the residents that [he/she] was assigned to". The RN stated that the physician on call would probably just tell him/her to monitor Resident #1. The RN also stated per interview that "the on-coming day shift nurse would notify the physician of [Resident #1's] condition and notify the family."</p>	F 281	<p><u>Continued from page 45</u></p> <p>vomiting and that the Nursing Home had notified her physician of these symptoms frequently, including but not limited to the notification on April 10, 2012.</p> <p>This regulation requires that "The services provided or arranged by the facility must (i) Meet professional standards of quality. . . ." 42 C.F.R. § 483.20(k)(3)(i).</p> <p>The interpretive guidelines state that, " 'Professional standards of quality' means services that are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting. Standards regarding quality care practices may be published by a professional organization, licensing board, accreditation body or other regulatory agency. Recommended practices to achieve desired resident outcomes may also be found in clinical literature. . . . If a negative resident outcome is determined to be related to the facility's failure to meet professional standards, and the team determines a deficiency has occurred, it should be cited under the appropriate quality of care or other requirement."</p> <p>The Statement of Deficiencies does not explain how the care provided fell short of the standards of the profession. Merely citing to the Lippincott Manual of Nursing Practice in its entirety is not a sufficient allegation of substandard care. (CMS 2567 at 59). It gives the facility and the nurse no ability to improve the quality of care in any meaningful way. As discussed above, the facility had already been in contact with Resident #1's physician on April 10, 2012. The night nurse was aware of</p>		

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F 281	<p>Continued From page 46</p> <p>Per review of the comprehensive care plan dated 3/8/12 and titled; "Will demonstrate an effective respiratory rate, depth, and pattern", the care plan indicates to monitor for increased temperature, monitor for signs and symptoms of aspiration, and report any signs and symptoms to the physician.</p> <p>Per interview with the Director of Nursing Services (DNS) on 4/26/12 at 11:27 AM, he/she reviewed the nurses notes dated 4/11/12 and the facility notification log and confirmed that there was no documentation by the overnight nurse that the primary physician or on-call physician was notified of Resident #1's change in medical condition. Per review of the notification log and the nurses' notes, the on-coming day nurse called the primary physician at 7:05 AM. The DNS also indicated that his/her expectation would be that a call be placed to the primary or on-call physician whenever there is a change in medical condition of a resident and that a call be placed to the DNS also. The DNS indicated that he/she received a phone call regarding Resident #1 at 6:00 AM on 4/11/12 informing him/her that Resident #1 was having a respiratory change and being transferred to the hospital. Resident #1 was transferred to the hospital via ambulance at approximately 7:40 AM per the nurse's late entry note dated 4/11/12 at 10:00 AM. The DNS confirmed that he/she was not made aware of Resident #1's temperature increase, blood pressure changes, or the vomiting of a "brown substance" that was Guaiac positive for blood.</p> <p>2. Per review of the employee file of a staff RN on 5/15/12, the file indicated that the RN on 3/6/12 the DNS reprimanded the RN for inappropriately</p>	F 281	<p><u>Continued from page 46</u></p> <p>those orders, monitored Resident #1's condition throughout the evening and documented her findings in the medical record. The day nurse also monitored Resident #1's condition and when the change in status occurred, she documented it and notified the resident's physician and family.</p> <p>The surveyors' allegations are "unsupported by the facility's contemporaneous treatment records," and therefore, the immediate jeopardy finding lacks support. See Grace Healthcare v. U.S. HHS, 603 F.3d at 420-21.</p> <p>The deficiencies related to Resident # 6, and #7 arise out of the conduct of one staff member, over the course of more than a year. In April of 2011, one of the night nurses was disciplined for a number of issues. Included in the list of concerns was a description of an interaction with Resident #6 as the night nurse was attempting to remove a catheter. This interaction was not witnessed by the staff member who reported it to the Director of Nursing, and therefore, the DON's information was third-hand. The DON investigated the incident and concluded that he/she could not verify that the incident had happened as described, because the relationship between the reporting staff member is known to harbor animosity toward the nurse in question. Nevertheless, the DON chose to include the alleged behavior in the warning out of an abundance of caution.</p> <p>This is also true of the comments allegedly made to Resident #7 and reported to the DON on March 6, 2012. The DON received this report third-hand, not from the staff who overheard the comment, but from another staff-member who allegedly was told about the</p>	
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F 281	<p>Continued From page 47</p> <p>speaking to a resident (Resident #7). The "notice of reprimand" dated 3/6/12 stated that the RN said to Resident #7 when he/she was asked by the RN to get out of bed "You're ugly and you would get better treatment with honey that with vinegar." The reprimand also stated that "this or any other comment that is inappropriate will not be tolerated."</p> <p>Per review of the facility policy and procedure dated 1/3/11 and titled; "Resident Abuse, Neglect and Exploitation", abuse includes deprivation by an individual, including care takers, of goods and services that are necessary to attain or maintain physical, mental and psychosocial well-being and that the resident has the right to be free from verbal, sexual, physical and mental abuse by anyone. The policy also indicates verbal abuse is defined as "the use of oral, written or gestured language that willfully includes disparaging or derogatory terms to residents or within the resident's hearing distance."</p> <p>Per interview with the DNS on 5/17/12, he/she stated he/she was aware of the notice of reprimand dated 3/6/12 concerning the RN and the comment by the RN to Resident #7 of, "You're ugly and you would get better treatment with honey that with vinegar." The DNS confirmed that no thorough internal investigation had been done and no call was placed to APS (Adult Protective Services) or the State Survey Agency reporting the suspected mistreatment/abuse. The RN is currently employed by the facility.</p> <p>3. Per review of the employee file of a staff RN on 5/15/12, the file indicated that, on 3/25/11 when removing a internal urinary catheter from a</p>	F 281	<p><u>Continued from page 47</u></p> <p>comment by a staff member who did overhear it. As the employment record notes, the night nurse denies having made the comment, and offers a plausible explanation as to how what was said might have been misinterpreted.</p> <p>These two incidents were cited as J level deficiencies at Tag F224, but were also cited at Tag F241 as E level deficiencies. In addition, they were also cited as E level deficiencies at F225 for failure to report. The facility objects to receiving three tags from one set of circumstances.</p> <p>Resident #2 was admitted to the facility with a history of constipation, among other things, and with a physician order for Glycolax or another stool softener. Administration of bowel medications is also indicated in the resident's comprehensive care plan. On May 15, 2012, the surveyors noted a discrepancy between the twenty-nine doses remaining in resident's Glycolax bottle, which originally contained thirty-one doses, and the twenty-three doses that the nurses documented that they had administered between April 20, 2012 and May 14, 2012. (CMS 2567 at 17-18). A 180-day bowel report demonstrates that Resident #2 had no difficulties during this time. Bowel reports are monitored daily because of the facility's narrow window for treating potential blockage. Nevertheless, the surveyors concluded that those 23 doses had not been given.</p> <p>Resident #5. The Statement of Deficiencies alleges that Resident #5 was not administered Glycolax, however, the facility's records indicated that Resident #5 received Glycolax as scheduled. The unit manager does not recall measuring Resident #5's Glycolax on</p>	

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F 281	<p>Continued From page 48</p> <p>resident (Resident #6), staff overheard the RN say to Resident #6, "You need to move your hand, do you want this out of your peeker or not." The 3/25/11 document also stated that, "the internal catheter was not coming out and the RN was pulling on the catheter instead of repositioning Resident #6 to aid in comfort. Resident #6 was yelling and flailing in discomfort."</p> <p>Per review of the facility policy and procedure dated 1/3/11 and titled; Resident Abuse, Neglect and Exploitation, verbal abuse is defined as "the use of oral, written or gestured language that willfully includes disparaging or derogatory terms to residents or within the resident's hearing distance." Per review of the facility policy and procedure dated 1/3/11 and titled: Resident Abuse, Neglect and Exploitation, dated 1/3/11, "abuse also means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish."</p> <p>Per interview with the DNS on 5/17/12, he/she reviewed the 3/25/11 reprimand and stated he/she was aware of the notice of reprimand dated 3/25/11 concerning the RN and the comment by the RN to Resident #7, "You need to move your hand, do you want this out of your peeker or not." The DNS confirmed that he/she was aware of the RN's actions when attempting to remove Resident #6's internal catheter. The DNS confirmed that no internal investigation was conducted and no call was placed to APS or the State Survey Agency reporting suspected mistreatment/abuse. The RN is currently employed by the facility.</p>	F 281	<p><u>Continued from page 48</u></p> <p>the morning of May 15, 2012 when the surveyor was present. She recalls measuring ferrous sulphate, and the MAR for Resident #5's ferrous sulphate match the dates used in the statement of deficiencies. (CMS 2567 at 18-20). Therefore, we believe that the statement of deficiencies is in error, and should refer to ferrous sulphate for Resident #5.</p> <p>Resident # 5 was admitted to the facility on January 6, 2009 with a diagnosis of anemia and a physician order for ferrous sulphate to be administered daily. On December 16, 2011, staff opened a bottle of ferrous sulphate for Resident #5. From December 17 through December 23, 2011, the resident's physician ordered the ferrous sulphate to be held because he had prescribed the resident a course of antibiotics. Upon completion of the course of antibiotics, the nursing home resumed administration of ferrous sulphate, as evidenced both by the MAR and the orders for more ferrous sulphate from the pharmacy in January, February, March and April. Throughout this time, Resident #5's blood levels for iron were monitored, and they continued to improve. In late May, the resident's levels had improved so much that the dose was reduced to three times per week. Despite this clear evidence that Resident #5 was receiving ferrous sulphate in accordance with the care plan, the surveyors concluded that 108 doses listed on the MAR had not been given. It should be noted that it would have been impossible for the facility to give 108 doses since there were only 105 days between February 1 and May 15, 2012.</p>		

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F 281	<p>Continued From page 49</p> <p>4. Per review of the medical record, Resident #2 was admitted to the facility on 2/11/08 with diagnoses that included: Alzheimer's, depression with psychosis, delusional disorder, and constipation. Per observation of the medication carts on A-wing on 5/15/12 at 9:59 AM, a medication identified within the medication cart labeled for Resident #2 contained more doses of medication than it should have contained per review of the medication administration record, indicating the prescribed medication was not administered as ordered by the physician.</p> <p>Per observation on 5/15/12 at 9:59 AM an open bottle of Glycolax (fiber supplement to prevent constipation) that was labeled for Resident #2 was noted to be dated as opened on 4/20/12. The manufacturer label on the bottle indicated that the bottle contained, when full and unopened, 31 daily doses and a daily dose is 17 grams of Glycolax. Per review of the medication administration record (MAR) dated 4/20/12 to 5/14/12, Resident #2 was identified by the nurses signatures that Resident #2 had been administered 23 doses of Glycolax. Per observation on 5/15/12 the Glycolax left in the opened bottle labeled 4/20/12 as opened was dispensed by the UM (Unit Manager) into plastic cups, the UM confirmed the number of doses remaining in the opened bottle was 29 daily doses.</p> <p>Per confirmation by the UM, when the bottle was opened on 4/20/12 it contained 31 daily doses, the MAR indicates that 23 doses were administered to Resident #2. The UM confirmed that if all the doses had been given as signed per</p>	F 281	<p><u>Continued from page 49</u></p> <p>Resident #3 was admitted to the facility with a history of constipation, among other things, and with a physician order for Glycolax or another stool softener. Administration of bowel medications is also indicated in the resident's comprehensive care plan. On May 15, 2012, the surveyors noted a discrepancy between the twelve doses remaining in resident's Glycolax bottle which originally contained thirty-one doses, and the twenty-four doses that the nurses documented that they had administered between April 22, 2012 and May 15, 2012. (CMS 2567 at 20-21). A 180-day bowel report demonstrates that Resident #3 had no difficulties during this time. Bowel reports are monitored daily because of the facility's narrow window for treating potential blockage. Nevertheless, the surveyors concluded that those 23 doses had not been given.</p> <p>Resident #4 was admitted to the facility with a history of constipation, among other things, and with a physician order for Glycolax or another stool softener. Bowel reports are monitored daily because of the facility's narrow window for treating potential blockage. Administration of bowel medications is also indicated in the resident's comprehensive care plan. On May 15, 2012, the surveyors noted a discrepancy between the twenty-five doses remaining in resident's Glycolax bottle which originally contained thirty-one doses, and the twenty-four doses that the nurses documented that they had administered between April 20, 2012 and May 14, 2012. (CMS 2567 at 21-23). A 180-day bowel report demonstrates that Resident #4 had no difficulties during this time. Bowel reports are monitored daily</p>		

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F 281	<p>Continued From page 50</p> <p>the signed MAR there would only be 8 doses left in the open container and there were 29 daily doses left in the container. The UM confirmed that the doses that were recorded on the MAR as administered did not reflect the actual doses of Glycolax received by Resident #2. The UM confirmed that there was one refusal to take the Glycolax by Resident #2 from 4/20/12 to 5/14/12. The UM confirmed on 5/15/12 that the Glycolax was not administered per physician orders for Resident #2. The UM confirmed on 5/15/12 that several separate nurses had signed the MAR for Resident #2 as having administered 17 grams of Glycolax daily at 5 PM and did not, based on the 29 remaining doses left in the open bottle labeled for Resident #2.</p> <p>Per review of the MAR and the nurse signature sheet, 6 separate nurses were identified as signing they administered 17 grams of Glycolax daily at 5 PM in the time period specified above. Per review of the comprehensive care plan, dated 4/12/12 and titled: "Tendency towards constipation", the care plan indicates that staff is to provide bowel medications per order.</p> <p>Though the UM confirmed Resident #2 did not receive medications as ordered, per review of the facility notification log on 5/15, 5/16, and 5/17 there was no evidence that the primary physician was notified that Resident #2 did not receive 23 daily doses of Glycolax that was ordered by the physician. Per interview with the UM on 5/17/12, he/she indicated that the primary physician and interested family members had not been notified that Resident #2 had not received 23 daily doses of Glycolax.</p>	F 281	<p><u>Continued from page 50</u></p> <p>because of the facility's narrow window for treating potential blockage. Nevertheless, the surveyors concluded that the appropriate number of doses had not been given.</p> <p>Again, the interpretive guidelines state that, " 'Professional standards of quality' means services that are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting. Standards regarding quality care practices may be published by a professional organization, licensing board, accreditation body or other regulatory agency. Recommended practices to achieve desired resident outcomes may also be found in clinical literature. . . . If a negative resident outcome is determined to be related to the facility's failure to meet professional standards, and the team determines a deficiency has occurred, it should be cited under the appropriate quality of care or other requirement." SOM Appendix PP at Tag F281.</p> <p>The Statement of Deficiencies does not explain how the care provided fell short of the standards of the profession. Merely citing to the Lippincott Manual of Nursing Practice in its entirety is not a sufficient allegation of substandard care. (2567 at 59). The facility's documentation demonstrates that the residents in question, were in most instances receiving the appropriate medications, and their conditions were being monitored daily for adverse consequences that might have arisen without the medication. None were found.</p> <p>With regard to medication administration, the facility has demonstrated that it was actively engaged in trying to correct an erroneous</p>		

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F 281	<p>Continued From page 51</p> <p>5. Per review of the medical record, Resident #5 was admitted to the facility on 1/6/2009 with diagnoses that include: cognitive impairment/dementia, major depressive disorder, dementia with behavior issues and psychotic features and constipation. Per observation of the medication carts on A-wing on 5/15/12 at 9:59 AM, a medication identified within the medication cart labeled for Resident #5 contained more doses of medication than they should have contained per review of the medication administration record, indicating the prescribed medication was not administered as ordered by the physician.</p> <p>Per observation on 5/15/12 at 9:59 AM an open bottle of Glycolax (fiber supplement to prevent constipation) that was labeled for Resident #5 was noted to be dated as opened on 12/16/11. The manufacturer label on the bottle indicated that the bottle contained when full and unopened 31 daily doses and a daily dose is 17 grams of Glycolax. Per review of the medication administration record (MAR) dated 2/01/12 to 5/15/12, Resident #5 was identified by the nurses signatures that Resident #5 had been administered 108 doses of Glycolax. The UM confirmed on 5/15/12 at 11:12 AM the bottle was opened on 12/16/11 and the UM confirmed there was no other open container for Resident #5 in the medication carts. The UM confirmed that if all the doses had been given as signed per the signed MAR there would not be an open bottle dated 12/16/11 because the unopened container contains 31 daily doses. The UM confirmed that the doses that were recorded on the MAR as administered did not reflect the actual doses of Glycolax received by Resident #5. The UM</p>	F 281	<p><u>Continued from page 51</u></p> <p>practice that two staff were engaged in. The facility admits that these two staff members had not provided this service at a professional standard of quality. However, because there have been no negative resident outcomes related to this deficiency, nor was there potential for more than minimal harm, the facility respectfully requests that the scope and severity be reduced to an E level.</p> <p>The facility has shown that it has been and remains in substantial compliance in regards to F281, professional standards of quality, and therefore respectfully requests that this tag be removed from the 2567 and the public record.</p>		

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F 281	<p>Continued From page 52</p> <p>confirmed that there was one refusal by Resident #5 to take the Glycolax from 2/1/12 to 5/15/12. The UM confirmed on 5/15/12 that Resident #5 did not receive the Glycolax per physician orders. The UM confirmed on 5/15/12 that several separate nurses had signed the MAR for Resident #5 as having administered 17 grams of Glycolax daily at in the AM and did not, based on the date the Glycolax was opened on 12/16/11.</p> <p>Per review of the MAR on 5/15/12 and the nurse signature sheet, 4 separate nurses were identified as signing they administered 17 grams of Glycolax daily in the AM.</p> <p>Per review of the comprehensive care plan, dated 4/12/12 and titled: "Episodes of Constipation", the care plan indicates that staff is to provide bowel medications per order.</p> <p>Per review of the facility notification log on 5/15, 5/16, and 5/17 there was no evidence that the primary physician was notified that Resident #5 did not receive 108 daily doses of Glycolax per the physician's orders during the time frame of 12/2/11 to 5/15/12. Per interview with the UM on 5/17/12, he/she indicated that the primary physician and interested family members had not been notified that Resident #5 had not received 108 daily doses of Glycolax per physician's orders.</p> <p>6. Per review of the medical record, Resident #3 was admitted to the facility on 6/16/03 with diagnoses that include: Alzheimer's/dementia, depression, general anxiety and constipation. Per observation of the medication carts on A-wing on 5/15/12 at 9:59 AM, a medication identified within</p>	F 281	<p><u>Continued from page 52</u></p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>1.: The resident's physician was consulted and responsible party was notified at 7:05 a.m. regarding the change of status of Resident #1. 4/11/12</p> <p>The facility put the RN in question regarding physician notification on administrative leave pending the outcome of a follow-up investigation. 5/17/12</p> <p>2. and 3.: The Director of Nursing put the RN in question regarding resident dignity on administrative leave pending the outcome of a follow-up investigation. 5/17/12</p> <p>4., 5., 6., and 7.: Medication cart audits were initiated at 4:00 pm 5/16/2012 and were repeated again on 5/16/12 at the beginning of 11-7 shift and again on 5/17/12 during the 7-3 shift. These audits are to determine if all medication have been administered correctly and shall be overseen by the Director of Nursing and certain RN nursing supervisors. 5/17/12</p> <p>The resident's physician and responsible party were notified of medication administration errors. 5/17/12</p> <p>8. and 9.: Medication cart audits were initiated at 4:00 pm 5/16/2012 and were repeated again on 5/16/12 at the beginning of 11-7 shift and again on 5/17/12 during the 7-3 shift. These audits are to determine if all medication have been administered correctly and shall be overseen by the Director of Nursing and certain RN nursing supervisors. 5/17/12</p> <p>The resident's physician and responsible party were notified of medication administration errors. 5/17/12</p>	

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F 281	<p>Continued From page 53</p> <p>the medication cart labeled for Resident #3 contained more doses of medication than they should have contained per review of the medication administration record, indicating the prescribed medication was not administered as ordered by the physician.</p> <p>Per observation on 5/15/12 at 9:59 AM an open bottle of Glycolax (fiber supplement to prevent constipation) that was labeled for Resident #3 was noted to be dated as opened on 4/22/12. The manufacturer label on the bottle indicated that the bottle contained, when full and unopened, 31 daily doses and a daily dose is 17 grams of Glycolax. Per review of the medication administration record (MAR) dated 4/22/12 to 5/15/12, Resident #3 was identified by the nurses signatures that Resident #3 had been administered 24 doses of Glycolax. The UM confirmed on 5/15/12 at 11:12 AM the bottle was opened on 4/22/12 and the UM confirmed there was no other open container for Resident #3 in the medication carts. The UM after measuring the amount of daily doses in the open container into plastic cups, he/she confirmed that the open bottle of Glycolax dated 4/22/12 contained 12 daily doses. The UM confirmed that the doses that were recorded on the MAR as administered did not reflect the actual doses of Glycolax received by Resident #3. The UM confirmed that there were 12 does in the opened Glycolax bottle and there should have only been 7. The UM confirmed that 5 daily doses were not administered and the UM confirmed that there were no refusals by Resident #3 to take the medication. The UM confirmed on 5/15/12 that Resident #3 did not receive the Glycolax per physician orders.</p>	F 281	<p><u>Continued from page 53</u></p> <p>A final written warning was given to LPN #1 and #2 on not following professional standards of medication administration.</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>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 have been re-educated on physician notification and when a resident has a significant change in physical status.</p> <p>Medication nurses have been in-serviced by a RN nurse supervisor on the classic Five Rights of Medication Administration: right drug, right dose, right route, right time and right patient. This in-service also included a review of Vernon Green Nursing Home's Statement of Purpose, a brief summary of expected Professional Conduct and Standards of Practice. Each nurse will sign the in-service attendance form and receive a pamphlet containing additional detail for study.</p> <p>The facility implemented a written policy on professional misconduct which includes detailed investigation procedures.</p>	<p>5/29/12</p> <p>5/17/12</p> <p>5/22/12</p> <p>5/17/12</p> <p>5/22/12</p>

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F 281	<p>Continued From page 54</p> <p>Per review of the comprehensive care plan, dated 6/28/12 and titled: "Incontinent of Bowel and Bladder", indicates constipation is a problem and to provide bowel medications as ordered.</p> <p>Per review of the facility notification log on 5/15, 5/16, and 5/17 there was no evidence that the primary physician was notified that Resident #3 did not receive 5 daily doses of Glycolax per the physician's orders during the time frame of 4/22/12 to 5/15/12. Per interview with the UM on 5/17/12, he/she indicated that the primary physician and interested family members had not been notified that Resident #3 had not received 5 daily doses of Glycolax.</p> <p>7. Per review of the medical record, Resident #4 was admitted to the facility on 3/21/11 with diagnoses that included: Alzheimer's, paranoid delusions, and constipation. Per observation of the medication carts on A-wing on 5/15/12 at 9:59 AM, a medication identified within the medication cart labeled for Resident #4 contained more doses of medication than they should have contained per review of the medication administration record, indicating the prescribed medication was not administered as ordered by the physician.</p> <p>Per observation on 5/15/12 at 9:59 AM an open bottle of Glycolax (fiber supplement to prevent constipation) that was labeled for Resident #4 was noted to be dated as opened as 4/20/12. The manufacturer label on the bottle indicated that the bottle contained when full and unopened 31 daily doses and a daily dose is 17 grams of Glycolax. Per review of the medication administration</p>	F 281	<p><u>Continued from page 54</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>Director of Nursing or designated RNs will conduct Quality Assurance/Quality Improvement audits to assure notifications are made in timely manner until 100% compliance has been achieved. Thereafter, audits will be conducted on a monthly schedule for one year and after that on a schedule to be determined by the Quality Assurance Committee.</p> <p>Director of Nursing or designated RNs will conduct Quality Assurance/Quality Improvement audits to assure compliance with medication administration. These audits will be conducted weekly on each medication cart until 100% compliance has been achieved. Thereafter, audits will be conducted on a monthly schedule for one year and after that on a schedule to be determined by the Quality Assurance Committee.</p> <p>The Director of Human Service shall report to the Quality Assurance Committee all episodes of professional misconduct for one year. The Quality Assurance Committee shall determine further monitoring if needed.</p> <p><i>F281 POC accepted as circled 8/8/12 Pmeotarn</i></p>	<p>6/19/12</p> <p>6/19/12</p> <p>6/19/12</p>

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F 281	<p>Continued From page 55</p> <p>record (MAR) dated 4/20/12 to 5/14/12. Resident #4 was identified by the nurses signatures that Resident #4 had been administered 24 doses of Glycolax. Per observation on 5/15/12 the Glycolax left in the opened bottle labeled 4/20/12 as opened was dispensed by the UM into plastic cups, the UM confirmed the number of doses remaining in the opened bottle was 25 daily doses. Per confirmation by the UM, When the bottle was opened on 4/20/12 it contained 31 daily doses, the MAR indicates that 24 doses were administered to Resident #4. The UM confirmed that if all the doses had been given as signed per the signed MAR there would only be 7 doses left in the open container and there were 25 daily doses left in the container.</p> <p>The UM confirmed that the doses that were recorded on the MAR as administered did not reflect the actual doses of Glycolax received by Resident #4. The UM confirmed that there was one refusals to take the Glycolax by Resident #4 on 5/10/12 during the time frame of from 4/20/12 to 5/14/12. The UM confirmed on 5/15/12 that the Glycolax was not administered per physician orders for Resident #4. The UM confirmed on 5/15/12 that several separate nurses had signed the MAR for Resident #4 as having administered 17 grams of Glycolax daily at 5 PM and did not, based on the 25 remaining doses left in the open bottle labeled for Resident #4.</p> <p>Per review of the MAR and the nurse signature sheet 4 separate nurses were identified as signing they administered 17 grams of Glycolax daily at 5 PM.</p>	F 281		
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F 281	<p>Continued From page 56</p> <p>Per review of the comprehensive care plan, dated 4/12/12 and titled: "Tendency towards constipation", the care plan indicates that staff is to provide bowel medications per order.</p> <p>Per review of the facility notification log on 5/15, 5/16, and 5/17 there was no evidence that the primary physician was notified that Resident #4 did not receive 18 daily doses of Glycolax were not administered per the physician's order . Per interview with the UM on 5/17/12, he/she indicated that the primary physician and interested family members had not been notified that Resident #4 had not received 18 daily doses of Glycolax.</p> <p>8. Per interview with the UM on 5/15/12, he/she stated that he/she had reprimanded a staff Licensed Practical Nurse (LPN #1) on 4/23/12 for signing for having administered Miralax (a medication to prevent constipation) on the MAR but not administering it to Resident #4 and Resident #2. The UM stated that he/she had found open bottles of Miralax dated 12/3/11 and 10/3/11. The UM stated he/she switched these bottles out for new ones with the seals in place on 4/23/12. The UM indicated that when the MAR was checked, LPN #1 had signed the Miralax was given on 4/23/12 and the UM indicated the bottles were still sealed. Per the UM, the LPN #1 was given a written reprimand and a medication error for not passing medications to Resident #2 and Resident #4.</p> <p>Per review of the employee file on 5/15/12, there was a written reprimand dated 4/23/12. The reprimand indicated that LPN #1 had signed for Miralax (Glycolax) on 4/23/12 as given and the</p>	F 281		

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F 281	<p>Continued From page 57</p> <p>bottles of Miralax for Resident #2 and Resident #4 where still sealed shut when checked on 4/23/12 by the UM.</p> <p>Per interview with the DNS and QA Nurse on 5/17/12, the DNS confirmed that he/she was aware of the reprimand and medication error given to LPN #1 on 4/23/12. The DNS confirmed that he/she was informed of it on 4/23/12.</p> <p>9. Per interview with the UM on 5/15/12, he/she stated that he/she had reprimanded a staff Licensed Practical Nurse (LPN #2) on 4/23/12 for for Miralax on the MAR but not administering it to Resident #4 and Resident #2. The UM stated that he/she had found open bottles of Miralax dated 12/3/11 and 10/3/11. The UM stated he/she switched these bottles out for new ones with the seals in place on 4/16/12. The UM indicated that when the MAR was checked LPN #2 had signed the Miralax was given on 4/16, 4/17, 4/18, 4/21 and 4/22/12 and the UM indicated the bottles were still sealed.</p> <p>Per review of the employee file on 5/15/12, there was a written reprimand dated 4/23/12. The reprimand indicated that LPN #1 had signed for Miralax (Glycolax) on 4/19 and 4/20 as given and the bottles of Miralax for Resident #2 and Resident #4 where still sealed shut when checked on 4/23/12 by the UM.</p> <p>Per interview with the DNS and QA Nurse on 5/17/12, the DNS confirmed that he/she was aware of the reprimand and medication error given to LPN#2 on 4/23/12. The DNS confirmed that he/she was informed of it on 4/23/12.</p>	F 281		

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F 281	Continued From page 58	F 281		
F 282 SS=E	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written 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 services by a qualified person in accordance with each resident's plan of care regarding administration of medications to avoid constipation for 4 residents (Residents #2, 3, 4 and 5). Findings include:</p> <p>1. Per review of the medical record, Resident #2 was admitted to the facility on 2/11/08 with diagnoses that included: Alzheimer's, depression with psychosis, delusional disorder, and constipation. Per observation of the medication carts on A-wing on 5/15/12 at 9:59 AM, a medication identified within the medication cart labeled for Resident #2 contained more doses of medication than it should have contained per review of the medication administration record, indicating the prescribed medication was not administered as ordered by the physician.</p> <p>Per observation on 5/15/12 at 9:59 AM an open bottle of Glycolax (fiber supplement to prevent constipation) that was labeled for Resident #2 was noted to be dated as opened on 4/20/12. The</p>	F 282	<p><u>F282</u></p> <p>The Facility has developed and continues to provide resident care in accordance with each resident's written plan of care. The Facility did not violate 42 C.F.R. § 483.20(k)(3)(ii): Services According to Care Plan and should not have received an E level Deficiency at Tag F282</p> <p>Allegation of Substantial Compliance</p> <p>Vernon Green Nursing Home, herein after sometimes "facility", 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 June 9, 2012.</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>	

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F 282	<p>Continued From page 59</p> <p>manufacturer label on the bottle indicated that the bottle contained, when full and unopened, 31 daily doses and a daily dose is 17 grams of Glycolax. Per review of the medication administration record (MAR) dated 4/20/12 to 5/14/12, Resident #2 was identified by the nurses signatures that Resident #2 had been administered 23 doses of Glycolax. Per observation on 5/15/12 the Glycolax left in the opened bottle labeled 4/20/12 as opened was dispensed by the UM (Unit Manager) into plastic cups, the UM confirmed the number of doses remaining in the opened bottle was 29 daily doses.</p> <p>Per confirmation by the UM, when the bottle was opened on 4/20/12 it contained 31 daily doses, the MAR indicates that 23 doses were administered to Resident #2. The UM confirmed that if all the doses had been given as signed per the signed MAR there would only be 8 doses left in the open container and there were 29 daily doses left in the container. The UM confirmed that the doses that were recorded on the MAR as administered did not reflect the actual doses of Glycolax received by Resident #2. The UM confirmed that there was one refusal to take the Glycolax by Resident #2 from 4/20/12 to 5/14/12. The UM confirmed on 5/15/12 that the Glycolax was not administered per physician orders for Resident #2. The UM confirmed on 5/15/12 that several separate nurses had signed the MAR for Resident #2 as having administered 17 grams of Glycolax daily at 5 PM and did not, based on the 29 remaining doses left in the open bottle labeled for Resident #2.</p> <p>Per review of the MAR and the nurse signature</p>	F 282	<p><u>Continued from page 59</u></p> <p>The facility requests informal dispute resolution for Tag F 282; respectfully maintains that it was and is in substantial compliance with federal regulations in respect to F 282; respectfully denies and disputes the allegation that it was deficient in respect to F 282; respectfully denies and disputes that any action or inaction on the part of the facility in respect to F 282 caused potential for any harm to any facility residents; and requests that F 282 be deleted from the public record.</p> <p>Resident #2 was admitted to the facility with a history of constipation, among other things, and with a physician order for Glycolax or another stool softener. Administration of bowel medications is also indicated in the resident's comprehensive care plan. On May 15, 2012, the surveyors noted a discrepancy between the twenty-nine doses remaining in resident's Glycolax bottle, which originally contained thirty-one doses, and the twenty-three doses that the nurses documented that they had administered between April 20, 2012 and May 14, 2012. (CMS 2567 at 17-18). A 180-day bowel report demonstrates that Resident #2 had no difficulties during this time. Bowel reports are monitored daily because of the facility's narrow window for treating potential blockage. Nevertheless, the surveyors concluded that those 23 doses had not been given.</p> <p>Resident #5. The Statement of Deficiencies alleges that Resident #5 was not administered Glycolax, however, the facility's records indicated that Resident #5 received Glycolax as scheduled. The unit manager does not recall measuring Resident #5's Glycolax on the morning of May 15, 2012 when the</p>	

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F 282	<p>Continued From page 60</p> <p>sheet, 6 separate nurses were identified as signing they administered 17 grams of Glycolax daily at 5 PM in the time period specified above. Per review of the comprehensive care plan, dated 4/12/12 and titled: "Tendency towards constipation", the care plan indicates that staff is to provide bowel medications per order.</p> <p>Though the UM confirmed Resident #2 did not receive medications as ordered, per review of the facility notification log on 5/15, 5/16, and 5/17 there was no evidence that the primary physician was notified that Resident #2 did not receive 23 daily doses of Glycolax that was ordered by the physician. Per interview with the UM on 5/17/12, he/she indicated that the primary physician and interested family members had not been notified that Resident #2 had not received 23 daily doses of Glycolax.</p> <p>2. Per review of the medical record, Resident #5 was admitted to the facility on 1/6/2009 with diagnoses that include: cognitive impairment/dementia, major depressive disorder, dementia with behavior issues and psychotic features and constipation. Per observation of the medication carts on A-wing on 5/15/12 at 9:59 AM, a medication identified within the medication cart labeled for Resident #5 contained more doses of medication than they should have contained per review of the medication administration record, indicating the prescribed medication was not administered as ordered by the physician.</p> <p>Per observation on 5/15/12 at 9:59 AM an open bottle of Glycolax (fiber supplement to prevent constipation) that was labeled for Resident #5</p>	F 282	<p><u>Continued from page 60</u></p> <p>surveyor was present. She recalls measuring ferrous sulphate, and the MAR for Resident #5's ferrous sulphate match the dates used in the statement of deficiencies. (CMS 2567 at 18-20). Therefore, we believe that the statement of deficiencies is in error, and should refer to ferrous sulphate for Resident #5.</p> <p>Resident # 5 was admitted to the facility on January 6, 2009 with a diagnosis of anemia and a physician order for ferrous sulphate to be administered daily. On December 16, 2011, staff opened a bottle of ferrous sulphate for Resident #5. From December 17 through December 23, 2011, the resident's physician ordered the ferrous sulphate to be held because he had prescribed the resident a course of antibiotics. Upon completion of the course of antibiotics, the nursing home resumed administration of ferrous sulphate, as evidenced both by the MAR and the orders for more ferrous sulphate from the pharmacy in January, February, March and April. Throughout this time, Resident #5's blood levels for iron were monitored, and they continued to improve. In late May, the resident's levels had improved so much that the dose was reduced to three times per week. Despite this clear evidence that Resident #5 was receiving ferrous sulphate in accordance with the care plan, the surveyors concluded that 108 doses listed on the MAR had not been given. It should be noted that it would have been impossible for the facility to give 108 doses since there were only 105 days between February 1 and May 15, 2012.</p> <p>Resident #3 was admitted to the facility with a history of constipation, among other things,</p>	

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F 282	<p>Continued From page 61</p> <p>was noted to be dated as opened on 12/16/11. The manufacturer label on the bottle indicated that the bottle contained when full and unopened 31 daily doses and a daily dose is 17 grams of Glycolax. Per review of the medication administration record (MAR) dated 2/01/12 to 5/15/12, Resident #5 was identified by the nurses signatures that Resident #5 had been administered 108 doses of Glycolax. The UM confirmed on 5/15/12 at 11:12 AM the bottle was opened on 12/16/11 and the UM confirmed there was no other open container for Resident #5 in the medication carts. The UM confirmed that if all the doses had been given as signed per the signed MAR there would not be an open bottle dated 12/16/11 because the unopened container contains 31 daily doses. The UM confirmed that the doses that were recorded on the MAR as administered did not reflect the actual doses of Glycolax received by Resident #5. The UM confirmed that there was one refusal by Resident #5 to take the Glycolax from 2/1/12 to 5/15/12. The UM confirmed on 5/15/12 that Resident #5 did not receive the Glycolax per physician orders. The UM confirmed on 5/15/12 that several separate nurses had signed the MAR for Resident #5 as having administered 17 grams of Glycolax daily at in the AM and did not, based on the date the Glycolax was opened on 12/16/11.</p> <p>Per review of the MAR on 5/15/12 and the nurse signature sheet, 4 separate nurses were identified as signing they administered 17 grams of Glycolax daily in the AM.</p> <p>Per review of the comprehensive care plan, dated 4/12/12 and titled: "Episodes of Constipation", the care plan indicates that staff is to provide bowel</p>	F 282	<p><u>Continued from page 61</u></p> <p>and with a physician order for Glycolax or another stool softener. Administration of bowel medications is also indicated in the resident's comprehensive care plan. On May 15, 2012, the surveyors noted a discrepancy between the twelve doses remaining in resident's Glycolax bottle which originally contained thirty-one doses, and the twenty-four doses that the nurses documented that they had administered between April 22, 2012 and May 15, 2012. (CMS 2567 at 20-21). A 180-day bowel report demonstrates that Resident #3 had no difficulties during this time. Bowel reports are monitored daily because of the facility's narrow window for treating potential blockage. Nevertheless, the surveyors concluded that those 23 doses had not been given.</p> <p>Resident #4 was admitted to the facility with a history of constipation, among other things, and with a physician order for Glycolax or another stool softener. Bowel reports are monitored daily because of the facility's narrow window for treating potential blockage. Administration of bowel medications is also indicated in the resident's comprehensive care plan. On May 15, 2012, the surveyors noted a discrepancy between the twenty-five doses remaining in resident's Glycolax bottle which originally contained thirty-one doses, and the twenty-four doses that the nurses documented that they had administered between April 20, 2012 and May 14, 2012. (CMS 2567 at 21-23). A 180-day bowel report demonstrates that Resident #4 had no difficulties during this time. Bowel reports are monitored daily because of the facility's narrow window for treating potential blockage. Nevertheless, the</p>	

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F 282	<p>Continued From page 62</p> <p>medications per order.</p> <p>Per review of the facility notification log on 5/15, 5/16, and 5/17 there was no evidence that the primary physician was notified that Resident #5 did not receive 108 daily doses of Glycolax per the physician's orders during the time frame of 12/2/11 to 5/15/12. Per interview with the UM on 5/17/12, he/she indicated that the primary physician and interested family members had not been notified that Resident #5 had not received 108 daily doses of Glycolax per physician's orders.</p> <p>3. Per review of the medical record, Resident #3 was admitted to the facility on 6/16/03 with diagnoses that include: Alzheimer's/dementia, depression, general anxiety and constipation. Per observation of the medication carts on A-wing on 5/15/12 at 9:59 AM, a medication identified within the medication cart labeled for Resident #3 contained more doses of medication than they should have contained per review of the medication administration record, indicating the prescribed medication was not administered as ordered by the physician.</p> <p>Per observation on 5/15/12 at 9:59 AM an open bottle of Glycolax (fiber supplement to prevent constipation) that was labeled for Resident #3 was noted to be dated as opened on 4/22/12. The manufacturer label on the bottle indicated that the bottle contained, when full and unopened, 31 daily doses and a daily dose is 17 grams of Glycolax. Per review of the medication administration record (MAR) dated 4/22/12 to 5/15/12, Resident #3 was identified by the nurses signatures that Resident #3 had been</p>	F 282	<p><u>Continued from page 62</u></p> <p>surveyors concluded that the appropriate number of doses had not been given.</p> <p>The regulation requires that "services provided or arranged by the facility must be provided by qualified persons in accordance with the care plan." 42 C.F.R. § 483.20(k)(3)(ii).</p> <p>The Statement of Deficiencies does not specify whether the alleged failure was in the qualifications of the staff or that the medications were not provided in accordance with the care plan. Assuming that it is the latter, the 2567 provides no evidence that the medications were not being administered in accordance with the care plan. The residents' conditions were being monitored for adverse effects and none were demonstrated.</p> <p>The facility respectfully requests that the Deficiencies at Tag F282 be removed because they are duplicative of the deficiencies cited at F281. The same conduct should not be both a J level conduct at one tag but only an E level conduct here. For this reason, the facility respectfully requests that this tag be removed.</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., and 4.: Medication cart audits were initiated at 4:00 pm 5/16/2012 and were repeated again on 5/16/12 at the beginning of 11-7 shift and again on 5/17/12 during the 7-3 shift. These audits are to determine if all medication have been administered correctly and shall be overseen by the Director of Nursing and certain RN nursing supervisors.</p>	5/17/12

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F 282	<p>Continued From page 63</p> <p>administered 24 doses of Glycolax. The UM confirmed on 5/15/12 at 11:12 AM the bottle was opened on 4/22/12 and the UM confirmed there was no other open container for Resident #3 in the medication carts. The UM after measuring the amount of daily doses in the open container into plastic cups, he/she confirmed that the open bottle of Glycolax dated 4/22/12 contained 12 daily doses. The UM confirmed that the doses that were recorded on the MAR as administered did not reflect the actual doses of Glycolax received by Resident #3. The UM confirmed that there were 12 does in the opened Glycolax bottle and there should have only been 7. The UM confirmed that 5 daily doses were not administered and the UM confirmed that there were no refusals by Resident #3 to take the medication. The UM confirmed on 5/15/12 that Resident #3 did not receive the Glycolax per physician orders.</p> <p>Per review of the comprehensive care plan, dated 6/28/12 and titled: "Incontinent of Bowel and Bladder", indicates constipation is a problem and to provide bowel medications as ordered.</p> <p>Per review of the facility notification log on 5/15, 5/16, and 5/17 there was no evidence that the primary physician was notified that Resident #3 did not receive 5 daily doses of Glycolax per the physician's orders during the time frame of 4/22/12 to 5/15/12. Per interview with the UM on 5/17/12, he/she indicated that the primary physician and interested family members had not been notified that Resident #3 had not received 5 daily doses of Glycolax.</p> <p>4. Per review of the medical record, Resident #4</p>	F 282	<p><u>Continued from page 63</u></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>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>1., 2., 3., and 4.: Medication nurses have been in-serviced by a RN nurse supervisor on the classic Five Rights of Medication Administration: right drug, right dose, right route, right time and right patient. This in-service also included a review of Vernon Green Nursing Home's Statement of Purpose, a brief summary of expected Professional Conduct and Standards of Practice. Each nurse will sign the in-service attendance form and receive a pamphlet containing additional detail for study.</p> <p>1., 2., 3., and 4.: The facility implemented a written policy on professional misconduct which includes detailed investigation procedures.</p>	<p>5/17/12</p> <p>5/17/12</p> <p>5/22/12</p>

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F 282	Continued From page 65 The UM confirmed that the doses that were recorded on the MAR as administered did not reflect the actual doses of Glycolax received by Resident #4. The UM confirmed that there was one refusals to take the Glycolax by Resident #4 on 5/10/12 during the time frame of from 4/20/12 to 5/14/12. The UM confirmed on 5/15/12 that the Glycolax was not administered per physician orders for Resident #4. The UM confirmed on 5/15/12 that several separate nurses had signed the MAR for Resident #4 as having administered 17 grams of Glycolax daily at 5 PM and did not, based on the 25 remaining doses left in the open bottle labeled for Resident #4. Per review of the MAR and the nurse signature sheet 4 separate nurses were identified as signing they administered 17 grams of Glycolax daily at 5 PM. Per review of the comprehensive care plan, dated 4/12/12 and titled: "Tendency towards constipation", the care plan indicates that staff is to provide bowel medications per order. Per review of the facility notification log on 5/15, 5/16, and 5/17 there was no evidence that the primary physician was notified that Resident #4 did not receive 18 daily doses of Glycolax were not administered per the physician's order . Per interview with the UM on 5/17/12, he/she indicated that the primary physician and interested family members had not been notified that Resident #4 had not received 18 daily doses of Glycolax.	F 282		
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING	F 490		

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F 490	<p>Continued From page 66</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility administration failed to administer in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of 7 residents identified (Resident #1, 2, 3, 4, 5, 6, 7). The findings include:</p> <p>1. Per review of the medical record on 4/26/12, Resident #1 was admitted to the facility on 3/16/11 with diagnoses that included: dementia, hypertension, history of gastric bleeding, and history of a gastric ulcer. Review of the nurses notes dated 4/11/12 at 12:45 AM, Resident #1 had a temperature of 100.6 F (Fahrenheit) and Tylenol 650 mg (milligrams) suppository was given for an increased temperature. At 2:00 AM, Resident #1 had a "small amount of drool from the corner of the right mouth, clear mucous with brown stripes, Guaiac positive (a test done on stool to identify blood), vital signs: temperature: 99.3 [F], pulse: 68 [bpm (beats per minute)], respiratory rate: 18 , blood pressure: 180/100 after care given, SPO2 [oxygen saturation]95%, makes eye contact but non verbal."</p> <p>At 2:15 AM, the nurse's notes indicate, "large amount of brown slimy emesis." Vital signs: Blood</p>	F 490	<p><u>F490</u></p> <p>The facility has and will continue to ensure that it is administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility did not violate 42 C.F.R. § 483.75: Administration, and should not have received a J level deficiency at Tag F490</p> <p>Allegation of Substantial Compliance</p> <p>Vernon Green Nursing Home, herein after sometimes "facility", 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 June 9, 2012.</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>The facility requests independent informal dispute resolution for Tag F 490; respectfully maintains that it was and is in substantial compliance with federal regulations in respect to F 490; respectfully denies and disputes the</p>	
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F 490	<p>Continued From page 67</p> <p>pressure: 150/80, temperature: 99.3 F, pulse: 86 bpm, respiratory rate: 28, Spo2 95%. At 5:30 AM, temperature was 100.4 F, pulse: 86 bpm, respiratory rate: 22, Spo2 94%, Tylenol given for increased temperature. Per the nurses notes dated 4/11/12 at change of shift, "respiratory status changed, reassessment of temperature 101.1, respiratory rate 24, labored breathing, breathing very moist and audible, resident moaning, SPO2 87-88% on room air, oxygen applied via facemask at 4 liters, SPO2 increases to 90-91% however labored breathing continues, resident lethargic, diaphoretic, call placed to Grace Cottage Emergency Room after speaking with family received order from physician to transport resident to Brattleboro Memorial Hospital, rescue received [Resident #1] at approximately 7:40 AM". Per nurses notes dated 4/11/12 at 9:45 AM, the facility received a call from the hospital reporting that Resident #1 had expired.</p> <p>Per review of the 4/11/12 emergency room documentation, the notes by the physician indicate that Resident #1 arrived to the hospital in "severe distress, unresponsive and presenting to be experiencing a terminal event on arrival." The emergency room documentation indicates that Resident #1 "expired at 9:37 AM" and "the physician's clinical impression was terminal episode? perforated ulcer." Per interview on 4/27/12, the Medical Examiner indicated that Resident #1's cause of death to be Gastric Ulcer/Gastric Bleed.</p> <p>Per review of the nurse's notes and the facilities notification log, there was no evidence that the facility on-call physician was notified from 12:00</p>	F 490	<p><u>Continued from page 67</u></p> <p>allegation that it was deficient in respect to F 490; respectfully denies and disputes that any action or inaction on the part of the facility in respect to F 490 caused any harm or potential for any harm to any facility residents; and requests that F 490 be deleted from the public record or at the very least that the scope and severity be reduced.</p> <p>Resident #1 was admitted to the facility on March 16, 2011, with diagnoses that included dementia and hypertension. The resident did suffer a gastric ulcer and gastric bleeding in 2001. Resident #1 also had a history of low-grade fevers and vomiting which frequently resolved without the need for hospitalization.</p> <p>For example, Resident #1 returned to Vernon Green from a five-day hospital stay on March 1, 2012. On the date of discharge her temperature was 98.2 Degrees F; pulse was 70, blood pressure 149/66, respirations at 18 and SpO2 91%. The resident had tested negative for gastric bleeding during the hospital stay. In addition, nearly every day the resident cried out for help, and yet was unable to identify the help that she needed. In these instances, nursing staff provided 1:1 care for the resident, tried to redirect, and soothe the resident in a variety of ways.</p> <p>From January 1, 2012 to April 11, 2012, Resident #1's blood pressure was recorded in a range between 180/100 and 120/60. Resident #1's temperature fell in the following range 97.0-101.1 degrees F. Resident #1's respiration rate was between 18 and 28. On April 10, 2012, Vernon Green notified Resident #1's physician that she had a low-grade fever, and the nursing home received instructions to monitor the resident's</p>		

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F 490	<p>Continued From page 68</p> <p>AM until 7:05 AM that Resident #1 had a change in medical status. Per review of the nurse's notes and the facility's notification log, there was no evidence that Resident #1's appointed emergency contact was notified of Resident's #1 change in medical condition.</p> <p>Per review of the facility policy and procedure titled "Change in Resident Condition or Status" dated 9/27/10, the "Charge Nurse/ House Supervisor will notify the resident's Attending Physician or the On-Call Physician when there has been a significant change in the resident's physical/emotional/mental condition". The policy also indicates that the "Charge Nurse /House Supervisor unless otherwise instructed by the resident, the Charge Nurse/House Supervisor will notify the resident's family when there is a significant change in the resident's physical, mental, or psychosocial status".</p> <p>Per review of the 2012 Physician Standing Orders for Resident #1, Tylenol 650 mg can be given per rectum for discomfort or elevated temperature every 4-hours as needed until physician is notified. The nurses notes dated 4/11/12 show that Tylenol 650 mg was given per rectum at 12:45 AM for an elevated temperature and again at 5:30 AM. There was no evidence in the nurse's notes that the primary or on-call physician was notified of the increase in temperature and the need to re-administer Tylenol at 5:30 AM.</p> <p>Per interview with the night Registered Nurse (RN) on duty the early morning of 4/11/12 via phone on 5/16/12 at 7:30 AM, the RN indicated that the LNA's notified him/her that Resident #1 had drool streaked with a brown substance on</p>	F 490	<p><u>Continued from page 68</u></p> <p>condition. Therefore, Resident #1's physician was aware of the condition and was monitoring it. As was often her habit, Resident #1 took her medicine mixed with chocolate pudding. Over the course of the early morning of April 11, 2012, Resident #1's vital signs fluctuated as follows:</p> <table border="1"> <thead> <tr> <th>Time</th> <th>temp</th> <th>BP</th> <th>SPO2</th> <th>Res.</th> <th>Pulse</th> </tr> </thead> <tbody> <tr> <td>9:00pm</td> <td>99.3</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>12:45am</td> <td>100.6</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>2:00am</td> <td>99.3</td> <td>180/100</td> <td>95%</td> <td>18</td> <td>68</td> </tr> <tr> <td>2:15am</td> <td>99.3</td> <td>150/80</td> <td>95%</td> <td>28</td> <td>86</td> </tr> <tr> <td>4:00am</td> <td></td> <td></td> <td>94%</td> <td></td> <td></td> </tr> <tr> <td>5:30am</td> <td>100.4</td> <td></td> <td>94%</td> <td>22</td> <td>86</td> </tr> <tr> <td>7:00am</td> <td>101.1</td> <td></td> <td>87-88%</td> <td>24</td> <td></td> </tr> </tbody> </table> <p>In addition the surveyor correctly notes that the resident had drool streaked with a brown substance at 2:00 AM and at 2:15 AM vomited a large amount of brown slimy emesis. However, the resident's temperature, and Spo2 remained unchanged, and the resident's blood pressure had improved. It should also be noted that the nursing notes indicate that the resident was "resting quietly" at 4:00 AM and 5:30 AM, and again at 6:30 AM.</p> <p>When viewed in the context of the resident's history, without the benefit of hindsight, it was not an unreasonable nursing judgment to decide to monitor the resident's respirations and pulse as directed by the physician before concluding that the resident had a significant change in condition.</p> <p>At 7:05 AM, the day nurse identified a significant change in condition. As soon as a significant change in condition, as defined in the interpretive guidelines was identified, the resident's primary care physician was notified as were the resident's family. The resident records demonstrate that Resident #1 had had</p>	Time	temp	BP	SPO2	Res.	Pulse	9:00pm	99.3					12:45am	100.6					2:00am	99.3	180/100	95%	18	68	2:15am	99.3	150/80	95%	28	86	4:00am			94%			5:30am	100.4		94%	22	86	7:00am	101.1		87-88%	24		
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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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F 490	<p>Continued From page 69</p> <p>his/her right shoulder at 2:00 AM on 4/11/12. The RN stated that that he/she knew that the test he/she used to test the brown substance in the drool was used to test for blood in stool, but that he/she used it to test the drool to identify if the brown substance was blood or stomach content. The RN stated that the test showed positive for blood. The RN stated that he/she did not notify the physician of Resident #1's vomiting of a brown substance that was determined to be blood. The RN stated that he/she knew that Resident #1 had an increased temperature of 100.6 F at 12:45 AM. The RN stated he/she knew that Resident #1 had an elevated blood pressure at 2:00 AM of 180/100 and was non-verbal. The RN stated that he/she knew at 2:15 AM that Resident #1 vomited a large amount of slimy brown emesis and Resident #1 had an elevated respiration rate of 28. The RN stated that he/she knew that at 5:30 AM, Resident #1 had a temperature of 100.4 F and an elevated respiration rate of 22.</p> <p>During the same interview, the RN stated that he/she "did not know that [Resident #1] had a medical history of gastric bleeds and gastric ulcers, and that [he/she] could not possibly know the medical histories of all of the residents that [he/she] was assigned to". The RN stated that the physician on call would probably just tell him/her to monitor Resident #1. The RN also stated per interview that "the on-coming day shift nurse would notify the physician of [Resident #1's] condition and notify the family."</p> <p>Per review of the comprehensive care plan dated 3/8/12 and titled; "Will demonstrate an effective respiratory rate, depth, and pattern", the care plan</p>	F 490	<p><u>Continued from page 69</u></p> <p>slightly elevated temperatures and bouts of vomiting and that the Nursing Home had notified her physician of these symptoms frequently, including but not limited to the notification on April 10, 2012.</p> <p>Because the facility has demonstrated that it was in substantial compliance with Tags F157, F224, and F281 as they relate to Resident #1, it should also have the Tag at F490 removed for this incident. Even if the IIDR panel declines to remove the tags discussed above, the F490 tag is inappropriate with regard to these facts, because there was nothing the facility could have done differently. The facility's policy and procedure clearly requires that physicians and families be notified in accordance with 42 C.F.R. § 483.10, and in this instance the procedure was carried out correctly.</p> <p>The deficiencies related to Resident # 6, and #7 arise out of the conduct of one staff member, over the course of more than a year. In April of 2011, one of the night nurses was disciplined for a number of issues. Included in the list of concerns was a description of an interaction with Resident #6 as the night nurse was attempting to remove a catheter. This interaction was not witnessed by the staff member who reported it to the Director of Nursing, and therefore, the DON's information was third-hand. The DON investigated the incident and concluded that he/she could not verify that the incident had happened as described, because the relationship between the reporting staff member is known to harbor animosity toward the nurse in question. Nevertheless, the DON chose to include the alleged behavior in the warning out of an abundance of caution.</p>	

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F 490	Continued From page 70 indicates to monitor for increased temperature, monitor for signs and symptoms of aspiration, and report any signs and symptoms to the physician. Per interview with the Director of Nursing Services (DNS) on 4/26/12 at 11:27 AM, he/she reviewed the nurses notes dated 4/11/12 and the facility notification log and confirmed that there was no documentation by the overnight nurse that the primary physician or on-call physician was notified of Resident #1's change in medical condition. Per review of the notification log and the nurses' notes, the on-coming day nurse called the primary physician at 7:05 AM. The DNS also indicated that his/her expectation would be that a call be placed to the primary or on-call physician whenever there is a change in medical condition of a resident and that a call be placed to the DNS also. The DNS indicated that he/she received a phone call regarding Resident #1 at 6:00 AM on 4/11/12 informing him/her that Resident #1 was having a respiratory change and being transferred to the hospital. Resident #1 was transferred to the hospital via ambulance at approximately 7:40 AM per the nurse's late entry note dated 4/11/12 at 10:00 AM. The DNS confirmed that he/she was not made aware of Resident #1's temperature increase, blood pressure changes, or the vomiting of a "brown substance" that was Guaiac positive for blood. 2. Per review of the employee file of a staff RN on 5/15/12, the file indicated that the RN on 3/6/12 the DNS reprimanded the RN for inappropriately speaking to a resident (Resident #7). The "notice of reprimand" dated 3/6/12 stated that the RN said to Resident #7 when he/she was asked by	F 490	<u>Continued from page 70</u> This is also true of the comments allegedly made to Resident #7 and reported to the DON on March 6, 2012. The DON received this report third-hand, not from the staff who overheard the comment, but from another staff-member who allegedly was told about the comment by a staff member who did overhear it. As the employment record notes, the night nurse denies having made the comment, and offers a plausible explanation as to how what was said might have been misinterpreted. Because the facility has demonstrated that it was in substantial compliance with Tags F224, and F225, and that it was actively addressing the deficiency at Tag F241 as they relate to Resident #6 and #7, it should also have the Tag at F490 removed for these incidents. Even if the IIDR panel declines to remove the tags discussed above, the F490 tag is inappropriate with regard to these facts. The facility's policies and procedures requires that staff treat residents with dignity and respect, and the evidence of investigation and discipline spans more than a year. Because of the nature of the relationships among staff members in this case, the administration had difficulty determining whether the alleged conduct even took place. On the assumption that it did, the facility took appropriate steps to prevent the conduct from happening again. Resident #2 was admitted to the facility with a history of constipation, among other things, and with a physician order for Glycolax or another stool softener. Administration of bowel medications is also indicated in the resident's comprehensive care plan. On May 15, 2012, the surveyors noted a discrepancy between the twenty-nine doses		

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F 490	<p>Continued From page 71</p> <p>the RN to get out of bed "You're ugly and you would get better treatment with honey that with vinegar." The reprimand also stated that "this or any other comment that is inappropriate will not be tolerated."</p> <p>Per review of the facility policy and procedure dated 1/3/11 and titled; "Resident Abuse, Neglect and Exploitation", abuse includes deprivation by an individual, including care takers, of goods and services that are necessary to attain or maintain physical, mental and psychosocial well-being and that the resident has the right to be free from verbal, sexual, physical and mental abuse by anyone. The policy also indicates verbal abuse is defined as "the use of oral, written or gestured language that willfully includes disparaging or derogatory terms to residents or within the resident's hearing distance."</p> <p>Per interview with the DNS on 5/17/12, he/she stated he/she was aware of the notice of reprimand dated 3/6/12 concerning the RN and the comment by the RN to Resident #7 of, "You're ugly and you would get better treatment with honey that with vinegar." The DNS confirmed that no thorough internal investigation had been done and no call was placed to APS (Adult Protective Services) or the State Survey Agency reporting the suspected mistreatment/abuse. The RN is currently employed by the facility.</p> <p>3. Per review of the employee file of a staff RN on 5/15/12, the file indicated that, on 3/25/11 when removing a internal urinary catheter from a resident (Resident #6), staff overheard the RN say to Resident #6, "You need to move your hand, do you want this out of your peeker or not."</p>	F 490	<p><u>Continued from page 71</u></p> <p>remaining in resident's Glycolax bottle, which originally contained thirty-one doses, and the twenty-three doses that the nurses documented that they had administered between April 20, 2012 and May 14, 2012. (CMS 2567 at 17-18). A 180-day bowel report demonstrates that Resident #2 had no difficulties during this time. Bowel reports are monitored daily because of the facility's narrow window for treating potential blockage. Nevertheless, the surveyors concluded that those 23 doses had not been given.</p> <p>Resident #5. The Statement of Deficiencies alleges that Resident #5 was not administered Glycolax, however, the facility's records indicated that Resident #5 received Glycolax as scheduled. The unit manager does not recall measuring Resident #5's Glycolax on the morning of May 15, 2012 when the surveyor was present. She recalls measuring ferrous sulphate, and the MAR for Resident #5's ferrous sulphate match the dates used in the statement of deficiencies. (CMS 2567 at 18-20). Therefore, we believe that the statement of deficiencies is in error, and should refer to ferrous sulphate for Resident #5.</p> <p>Resident # 5 was admitted to the facility on January 6, 2009 with a diagnosis of anemia and a physician order for ferrous sulphate to be administered daily. On December 16, 2011, staff opened a bottle of ferrous sulphate for Resident #5. From December 17 through December 23, 2011, the resident's physician ordered the ferrous sulphate to be held because he had prescribed the resident a course of antibiotics. Upon completion of the course of antibiotics, the nursing home resumed</p>		

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F 490	<p>Continued From page 72</p> <p>The 3/25/11 document also stated that, "the internal catheter was not coming out and the RN was pulling on the catheter instead of repositioning Resident #6 to aid in comfort. Resident #6 was yelling and flailing in discomfort."</p> <p>Per review of the facility policy and procedure dated 1/3/11 and titled; Resident Abuse, Neglect and Exploitation, verbal abuse is defined as "the use of oral, written or gestured language that willfully includes disparaging or derogatory terms to residents or within the resident's hearing distance." Per review of the facility policy and procedure dated 1/3/11 and titled: Resident Abuse, Neglect and Exploitation, dated 1/3/11, "abuse also means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish."</p> <p>Per interview with the DNS on 5/17/12, he/she reviewed the 3/25/11 reprimand and stated he/she was aware of the notice of reprimand dated 3/25/11 concerning the RN and the comment by the RN to Resident #7, "You need to move your hand, do you want this out of your peeker or not." The DNS confirmed that he/she was aware of the RN's actions when attempting to remove Resident #6's internal catheter. The DNS confirmed that no internal investigation was conducted and no call was placed to APS or the State Survey Agency reporting suspected mistreatment/abuse. The RN is currently employed by the facility.</p> <p>4. Per review of the medical record, Resident #2 was admitted to the facility on 2/11/08 with</p>	F 490	<p><u>Continued from page 72</u></p> <p>administration of ferrous sulphate, as evidenced both by the MAR and the orders for more ferrous sulphate from the pharmacy in January, February, March and April. Throughout this time, Resident #5's blood levels for iron were monitored, and they continued to improve. In late May, the resident's levels had improved so much that the dose was reduced to three times per week. Despite this clear evidence that Resident #5 was receiving ferrous sulphate in accordance with the care plan, the surveyors concluded that 108 doses listed on the MAR had not been given. It should be noted that it would have been impossible for the facility to give 108 doses since there were only 105 days between February 1 and May 15, 2012.</p> <p>Resident #3 was admitted to the facility with a history of constipation, among other things, and with a physician order for Glycolax or another stool softener. Administration of bowel medications is also indicated in the resident's comprehensive care plan. On May 15, 2012, the surveyors noted a discrepancy between the twelve doses remaining in resident's Glycolax bottle which originally contained thirty-one doses, and the twenty-four doses that the nurses documented that they had administered between April 22, 2012 and May 15, 2012. (CMS 2567 at 20-21). A 180-day bowel report demonstrates that Resident #3 had no difficulties during this time. Bowel reports are monitored daily because of the facility's narrow window for treating potential blockage. Nevertheless, the surveyors concluded that those 23 doses had not been given.</p>	
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F 490	<p>Continued From page 73</p> <p>diagnoses that included: Alzheimer's, depression with psychosis, delusional disorder, and constipation. Per observation of the medication carts on A-wing on 5/15/12 at 9:59 AM, a medication identified within the medication cart labeled for Resident #2 contained more doses of medication than it should have contained per review of the medication administration record, indicating the prescribed medication was not administered as ordered by the physician.</p> <p>Per observation on 5/15/12 at 9:59 AM an open bottle of Glycolax (fiber supplement to prevent constipation) that was labeled for Resident #2 was noted to be dated as opened on 4/20/12. The manufacturer label on the bottle indicated that the bottle contained, when full and unopened, 31 daily doses and a daily dose is 17 grams of Glycolax. Per review of the medication administration record (MAR) dated 4/20/12 to 5/14/12, Resident #2 was identified by the nurses signatures that Resident #2 had been administered 23 doses of Glycolax. Per observation on 5/15/12 the Glycolax left in the opened bottle labeled 4/20/12 as opened was dispensed by the UM (Unit Manager) into plastic cups, the UM confirmed the number of doses remaining in the opened bottle was 29 daily doses.</p> <p>Per confirmation by the UM, when the bottle was opened on 4/20/12 it contained 31 daily doses, the MAR indicates that 23 doses were administered to Resident #2. The UM confirmed that if all the doses had been given as signed per the signed MAR there would only be 8 doses left in the open container and there were 29 daily doses left in the container. The UM confirmed</p>	F 490	<p><u>Continued from page 73</u></p> <p>Resident #4 was admitted to the facility with a history of constipation, among other things, and with a physician order for Glycolax or another stool softener. Bowel reports are monitored daily because of the facility's narrow window for treating potential blockage. Administration of bowel medications is also indicated in the resident's comprehensive care plan. On May 15, 2012, the surveyors noted a discrepancy between the twenty-five doses remaining in resident's Glycolax bottle which originally contained thirty-one doses, and the twenty-four doses that the nurses documented that they had administered between April 20, 2012 and May 14, 2012. (CMS 2567 at 21-23). A 180-day bowel report demonstrates that Resident #4 had no difficulties during this time. Bowel reports are monitored daily because of the facility's narrow window for treating potential blockage. Nevertheless, the surveyors concluded that the appropriate number of doses had not been given.</p> <p>Because the facility has demonstrated that it was in substantial compliance with Tags F224, and F225 as they relate to Residents #2,#3, #4, and #5, and that it was actively addressing the deficiency at Tag F281, it should also have the Tag at F490 removed for these incidents. Even if the IIDR panel declines to remove the tags discussed above, the F490 tag is inappropriate with regard to these facts. The facility's policy and procedure clearly requires that staff abide by the 5 Rights of Medication Administration. In addition, the staff that had failed to comply with this policy had already received written warnings at the time that the surveyors arrived.</p>		

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F 490	<p>Continued From page 74</p> <p>that the doses that were recorded on the MAR as administered did not reflect the actual doses of Glycolax received by Resident #2. The UM confirmed that there was one refusal to take the Glycolax by Resident #2 from 4/20/12 to 5/14/12. The UM confirmed on 5/15/12 that the Glycolax was not administered per physician orders for Resident #2. The UM confirmed on 5/15/12 that several separate nurses had signed the MAR for Resident #2 as having administered 17 grams of Glycolax daily at 5 PM and did not, based on the 29 remaining doses left in the open bottle labeled for Resident #2.</p> <p>Per review of the MAR and the nurse signature sheet, 6 separate nurses were identified as signing they administered 17 grams of Glycolax daily at 5 PM in the time period specified above. Per review of the comprehensive care plan, dated 4/12/12 and titled: "Tendency towards constipation", the care plan indicates that staff is to provide bowel medications per order.</p> <p>Though the UM confirmed Resident #2 did not receive medications as ordered, per review of the facility notification log on 5/15, 5/16, and 5/17 there was no evidence that the primary physician was notified that Resident #2 did not receive 23 daily doses of Glycolax that was ordered by the physician. Per interview with the UM on 5/17/12, he/she indicated that the primary physician and interested family members had not been notified that Resident #2 had not received 23 daily doses of Glycolax.</p> <p>5. Per review of the medical record, Resident #5 was admitted to the facility on 1/6/2009 with diagnoses that include: cognitive</p>	F 490	<p><u>Continued from page 74</u></p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>1.: The resident's physician was consulted and responsible party was notified at 7:05 a.m. regarding the change of status of Resident #1. 4/11/12</p> <p>The facility put the RN in question regarding physician notification on administrative leave pending the outcome of a follow-up investigation. 5/17/12</p> <p>2. and 3.: The Director of Nursing put the RN in question regarding the resident dignity on administrative leave pending the outcome of a follow-up investigation. 5/17/12</p> <p>4., 5., 6., and 7.: Medication cart audits were initiated at 4:00 pm 5/16/2012 and were repeated again on 5/16/12 at the beginning of 11-7 shift and again on 5/17/12 during the 7-3 shift. These audits are to determine if all medication have been administered correctly and shall be overseen by the Director of Nursing and certain RN nursing supervisors. 5/17/12</p> <p>The resident's physician and responsible party were notified of medication administration errors. 5/17/12</p> <p>8. and 9.: Medication cart audits were initiated at 4:00 pm 5/16/2012 and were repeated again on 5/16/12 at the beginning of 11-7 shift and again on 5/17/12 during the 7-3 shift. These audits are to determine if all medication have been administered correctly and shall be overseen by the Director of Nursing and certain RN nursing supervisors. 5/17/12</p> <p>The resident's physician and responsible party were notified of medication administration errors. 5/17/12</p> <p>A final written warning was given to LPN #1 and #2 on not flowing professional standards of medication administration. 5/29/12</p>	

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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 C 05/17/2012
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 490	Continued From page 75 impairment/dementia, major depressive disorder, dementia with behavior issues and psychotic features and constipation. Per observation of the medication carts on A-wing on 5/15/12 at 9:59 AM, a medication identified within the medication cart labeled for Resident #5 contained more doses of medication than they should have contained per review of the medication administration record, indicating the prescribed medication was not administered as ordered by the physician. Per observation on 5/15/12 at 9:59 AM an open bottle of Glycolax (fiber supplement to prevent constipation) that was labeled for Resident #5 was noted to be dated as opened on 12/16/11. The manufacturer label on the bottle indicated that the bottle contained when full and unopened 31 daily doses and a daily dose is 17 grams of Glycolax. Per review of the medication administration record (MAR) dated 2/01/12 to 5/15/12, Resident #5 was identified by the nurses signatures that Resident #5 had been administered 108 doses of Glycolax. The UM confirmed on 5/15/12 at 11:12 AM the bottle was opened on 12/16/11 and the UM confirmed there was no other open container for Resident #5 in the medication carts. The UM confirmed that if all the doses had been given as signed per the signed MAR there would not be an open bottle dated 12/16/11 because the unopened container contains 31 daily doses. The UM confirmed that the doses that were recorded on the MAR as administered did not reflect the actual doses of Glycolax received by Resident #5. The UM confirmed that there was one refusal by Resident #5 to take the Glycolax from 2/1/12 to 5/15/12. The UM confirmed on 5/15/12 that Resident #5	F 490	Continued from page 75 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. 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 have been re-educated on physician notification and when a resident has a significant change in physical status. Medication nurses have been in-serviced by a RN nurse supervisor on the classic Five Rights of Medication Administration: right drug, right dose, right route, right time and right patient. This in-service also included a review of Vernon Green Nursing Home's Statement of Purpose, a brief summary of expected Professional Conduct and Standards of Practice. Each nurse will sign the in-service attendance form and receive a pamphlet containing additional detail for study. The facility implemented a written policy on professional misconduct which includes detailed investigation procedures.	5/17/12 5/22/12 5/17/12 5/22/12

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F 490	<p>Continued From page 76</p> <p>did not receive the Glycolax per physician orders. The UM confirmed on 5/15/12 that several separate nurses had signed the MAR for Resident #5 as having administered 17 grams of Glycolax daily at in the AM and did not, based on the date the Glycolax was opened on 12/16/11.</p> <p>Per review of the MAR on 5/15/12 and the nurse signature sheet, 4 separate nurses were identified as signing they administered 17 grams of Glycolax daily in the AM.</p> <p>Per review of the comprehensive care plan, dated 4/12/12 and titled: "Episodes of Constipation", the care plan indicates that staff is to provide bowel medications per order.</p> <p>Per review of the facility notification log on 5/15, 5/16, and 5/17 there was no evidence that the primary physician was notified that Resident #5 did not receive 108 daily doses of Glycolax per the physician's orders during the time frame of 12/2/11 to 5/15/12. Per interview with the UM on 5/17/12, he/she indicated that the primary physician and interested family members had not been notified that Resident #5 had not received 108 daily doses of Glycolax per physician's orders.</p> <p>6. Per review of the medical record, Resident #3 was admitted to the facility on 6/16/03 with diagnoses that include: Alzheimer's/dementia, depression, general anxiety and constipation. Per observation of the medication carts on A-wing on 5/15/12 at 9:59 AM, a medication identified within the medication cart labeled for Resident #3 contained more doses of medication than they should have contained per review of the</p>	F 490	<p><u>Continued from page 76</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>Director of Nursing or designated RNs will conduct Quality Assurance/Quality Improvement audits to assure notifications are made in timely manner until 100% compliance has been achieved. Thereafter, audits will be conducted on a monthly schedule for one year and after that on a schedule to be determined by the Quality Assurance Committee.</p> <p>Director of Nursing or designated RNs will conduct Quality Assurance/Quality Improvement audits to assure compliance with medication administration. These audits will be conducted weekly on each medication cart until 100% compliance has been achieved. Thereafter, audits will be conducted on a monthly schedule for one year and after that on a schedule to be determined by the Quality Assurance Committee.</p> <p>The Director of Human Service shall report to the Quality Assurance Committee all episodes of professional misconduct for one year. The Quality Assurance Committee shall determine further monitoring if needed.</p>	<p>6/19/12</p> <p>6/19/12</p> <p>6/19/12</p>

F490 POC accepted as circled 8/8/12 Pmcastr-RW

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F 490	<p>Continued From page 77</p> <p>medication administration record, indicating the prescribed medication was not administered as ordered by the physician.</p> <p>Per observation on 5/15/12 at 9:59 AM an open bottle of Glycolax (fiber supplement to prevent constipation) that was labeled for Resident #3 was noted to be dated as opened on 4/22/12. The manufacturer label on the bottle indicated that the bottle contained, when full and unopened, 31 daily doses and a daily dose is 17 grams of Glycolax. Per review of the medication administration record (MAR) dated 4/22/12 to 5/15/12, Resident #3 was identified by the nurses signatures that Resident #3 had been administered 24 doses of Glycolax. The UM confirmed on 5/15/12 at 11:12 AM the bottle was opened on 4/22/12 and the UM confirmed there was no other open container for Resident #3 in the medication carts. The UM after measuring the amount of daily doses in the open container into plastic cups, he/she confirmed that the open bottle of Glycolax dated 4/22/12 contained 12 daily doses. The UM confirmed that the doses that were recorded on the MAR as administered did not reflect the actual doses of Glycolax received by Resident #3. The UM confirmed that there were 12 does in the opened Glycolax bottle and there should have only been 7. The UM confirmed that 5 daily doses were not administered and the UM confirmed that there were no refusals by Resident #3 to take the medication. The UM confirmed on 5/15/12 that Resident #3 did not receive the Glycolax per physician orders.</p> <p>Per review of the comprehensive care plan, dated 6/28/12 and titled: "Incontinent of Bowel and</p>	F 490			

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F 490	<p>Continued From page 78</p> <p>Bladder", indicates constipation is a problem and to provide bowel medications as ordered.</p> <p>Per review of the facility notification log on 5/15, 5/16, and 5/17 there was no evidence that the primary physician was notified that Resident #3 did not receive 5 daily doses of Glycolax per the physician's orders during the time frame of 4/22/12 to 5/15/12. Per interview with the UM on 5/17/12, he/she indicated that the primary physician and interested family members had not been notified that Resident #3 had not received 5 daily doses of Glycolax.</p> <p>7. Per review of the medical record, Resident #4 was admitted to the facility on 3/21/11 with diagnoses that included: Alzheimer's, paranoid delusions, and constipation. Per observation of the medication carts on A-wing on 5/15/12 at 9:59 AM, a medication identified within the medication cart labeled for Resident #4 contained more doses of medication than they should have contained per review of the medication administration record, indicating the prescribed medication was not administered as ordered by the physician.</p> <p>Per observation on 5/15/12 at 9:59 AM an open bottle of Glycolax (fiber supplement to prevent constipation) that was labeled for Resident #4 was noted to be dated as opened as 4/20/12. The manufacturer label on the bottle indicated that the bottle contained when full and unopened 31 daily doses and a daily dose is 17 grams of Glycolax. Per review of the medication administration record (MAR) dated 4/20/12 to 5/14/12. Resident #4 was identified by the nurses signatures that Resident #4 had been</p>	F 490		

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F 490	<p>Continued From page 79</p> <p>administered 24 doses of Glycolax. Per observation on 5/15/12 the Glycolax left in the opened bottle labeled 4/20/12 as opened was dispensed by the UM into plastic cups, the UM confirmed the number of doses remaining in the opened bottle was 25 daily doses. Per confirmation by the UM, When the bottle was opened on 4/20/12 it contained 31 daily doses, the MAR indicates that 24 doses were administered to Resident #4. The UM confirmed that if all the doses had been given as signed per the signed MAR there would only be 7 doses left in the open container and there were 25 daily doses left in the container.</p> <p>The UM confirmed that the doses that were recorded on the MAR as administered did not reflect the actual doses of Glycolax received by Resident #4. The UM confirmed that there was one refusals to take the Glycolax by Resident #4 on 5/10/12 during the time frame of from 4/20/12 to 5/14/12. The UM confirmed on 5/15/12 that the Glycolax was not administered per physician orders for Resident #4. The UM confirmed on 5/15/12 that several separate nurses had signed the MAR for Resident #4 as having administered 17 grams of Glycolax daily at 5 PM and did not, based on the 25 remaining doses left in the open bottle labeled for Resident #4.</p> <p>Per review of the MAR and the nurse signature sheet 4 separate nurses were identified as signing they administered 17 grams of Glycolax daily at 5 PM.</p> <p>Per review of the comprehensive care plan, dated 4/12/12 and titled: "Tendency towards constipation", the care plan indicates that staff is</p>	F 490		

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F 490	<p>Continued From page 80 to provide bowel medications per order.</p> <p>Per review of the facility notification log on 5/15, 5/16, and 5/17 there was no evidence that the primary physician was notified that Resident #4 did not receive 18 daily doses of Glycolax were not administered per the physician's order . Per interview with the UM on 5/17/12, he/she indicated that the primary physician and interested family members had not been notified that Resident #4 had not received 18 daily doses of Glycolax.</p> <p>8. Per interview with the UM on 5/15/12, he/she stated that he/she had reprimanded a staff Licensed Practical Nurse (LPN #1) on 4/23/12 for signing for having administered Miralax (a medication to prevent constipation) on the MAR but not administering it to Resident #4 and Resident #2. The UM stated that he/she had found open bottles of Miralax dated 12/3/11 and 10/3/11. The UM stated he/she switched these bottles out for new ones with the seals in place on 4/23/12. The UM indicated that when the MAR was checked, LPN #1 had signed the Miralax was given on 4/23/12 and the UM indicated the bottles were still sealed. Per the UM, the LPN #1 was given a written reprimand and a medication error for not passing medications to Resident #2 and Resident #4.</p> <p>Per review of the employee file on 5/15/12, there was a written reprimand dated 4/23/12. The reprimand indicated that LPN #1 had signed for Miralax (Glycolax) on 4/23/12 as given and the bottles of Miralax for Resident #2 and Resident #4 where still sealed shut when checked on 4/23/12 by the UM.</p>	F 490		

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F 490	<p>Continued From page 81</p> <p>Per interview with the DNS and QA Nurse on 5/17/12, the DNS confirmed that he/she was aware of the reprimand and medication error given to LPN #1 on 4/23/12. The DNS confirmed that he/she was informed of it on 4/23/12.</p> <p>9. Per interview with the UM on 5/15/12, he/she stated that he/she had reprimanded a staff Licensed Practical Nurse (LPN #2) on 4/23/12 for for Miralax on the MAR but not administering it to Resident #4 and Resident #2. The UM stated that he/she had found open bottles of Miralax dated 12/3/11 and 10/3/11. The UM stated he/she switched these bottles out for new ones with the seals in place on 4/16/12. The UM indicated that when the MAR was checked LPN #2 had signed the Miralax was given on 4/16, 4/17, 4/18, 4/21 and 4/22/12 and the UM indicated the bottles were still sealed.</p> <p>Per review of the employee file on 5/15/12, there was a written reprimand dated 4/23/12. The reprimand indicated that LPN #1 had signed for Miralax (Glycolax) on 4/19 and 4/20 as given and the bottles of Miralax for Resident #2 and Resident #4 where still sealed shut when checked on 4/23/12 by the UM.</p> <p>Per interview with the DNS and QA Nurse on 5/17/12, the DNS confirmed that he/she was aware of the reprimand and medication error given to LPN#2 on 4/23/12. The DNS confirmed that he/she was informed of it on 4/23/12.</p>	F 490			