



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

August 26, 2010

Mr. Robert Sterling, Administrator
Green Mountain Nursing Home
475 Ethan Allen Avenue
Colchester, VT 05446

Dear Mr. Sterling:

Enclosed is a copy of your acceptable plans of correction for the annual survey conducted on August 12, 2010. 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,

A handwritten signature in cursive script that reads "Pamela M. Cota".

Pamela M. Cota, RN
Licensing Chief



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

PRINTED: 08/23/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2010
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NAME OF PROVIDER OR SUPPLIER GREEN MOUNTAIN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS An unannounced onsite annual recertification survey was completed by the Division of Licensing and Protection from 8/9/10 - 8/12/10. Based on the information obtained through interviews and record reviews, an Immediate Jeopardy situation was determined to exist based upon the facility's failure to provide resuscitation according to a resident's predetermined status. As a result, an extended survey was conducted on 8/11/10 - 8/12/10.	F 000	F242 Assuming for the moment that the findings and the determination of the deficiency are accurate, without admitting or denying that they are, our proposed plan of correction is as follows: Resident # 137 has had a shower which is his preference. Physical therapy did an evaluation of resident # 137 on 7/28/2010 for bed mobility and transfers by slide board which would cover bed to shower chair or wheelchair. Physical therapy reviewed transfer for toileting/shower with LNA with return demonstrations on 8/11/2010. Occupational therapy preformed an evaluation on 7/29/2010 for transfers, mobility ADL's and feeding with follow up visits between 7/30/2010 and 8/5/2010. All residents who need assistance with bathing have a potential to be affected by this alleged practice. To assure that the alleged practice does not occur, we are taking the following measures: A professional nurses meeting was held on 8/20/2010 to remind the nurses on proper supervision and documentation in LNA records on ADL's. The day supervisor and MDS coordinator will audit LNA flow sheets two times per week for six weeks and report findings to the Quality Assessments and Assurance Committee for further actions if needs. DON to monitor Completion Date: 8/20/2010	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and record review, the facility failed to assure each resident's right to make choices for 1 of 24 residents in the Stage II sample (Resident #137). Findings include: During Resident interview on 8/10/10 at 9:40 AM, Resident #137, identified as interviewable by surveyor screening and the QIS (Quality Indicator Survey) tool, stated that despite several requests to various staff for a shower, the resident was offered only assistance with a sponge bath. A record review of Licensed Nurse Aide (LNA) flowsheets since admission reveals bathing	F 242		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Robert C. Stebbins</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8-25-10</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

F242 POC Accepted 8/20/10 *AMC/turn/R. Tremblay RN*

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F 242	Continued From page 1 coded as "8" (did not occur) for all shifts. In an interview on 8/10/10 at 10:30 AM, the 1st floor Charge Nurse confirmed that there is no evidence of showers being administered to this resident and stated that s/he was unaware that they had requested or preferred showers. A preference for showers is also not reflected in the bathing section of the admission care plan, dated 7/27/10.	F 242	F246 Assuming for the moment that the findings and the determination of the deficiency are accurate, without admitting or denying that they are, our proposed plan of correction is as follows: Resident # 137 has had a shower which is his preference. Physical therapy did an evaluation of resident # 137 on 7/28/2010 for bed mobility and transfers by slide board which would cover bed to shower chair or wheelchair. Physical therapy reviewed transfer for toileting/shower with LNA with return demonstrations on 8/11/2010. Occupational therapy preformed and evaluation on 7/29/2010 for transfers, mobility ADL's and feeding with follow up visits between 7/30/2010 and 8/5/2010. All residents who need assistance with bathing have a potential to be affected by this alleged practice. To assure that the alleged practice does not occur, we are taking the following measures; A professional nurses meeting was held on 8/20/2010 to remind the nurses on proper supervision and documentation in LNA records on ADL's. The day supervisor and MDS coordinator will audit LNA flow sheets for bathing compliance two times per week for six weeks and report findings to the Quality Assessments and Assurance Committee for further actions if needed.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview on 8/10/10, the facility failed to assure an accommodation of needs and self-determination for 1 resident of 24 in the Stage II sample (Resident #137). Findings include: During resident interview on 8/10/10 at 9:40 AM, Resident #137, identified as interviewable by QIS (Quality Indicator Survey) tool and surveyor screening, stated that in response to several requests for a shower facility staff stated they could not shower the resident because they did not have a method to transfer him/her into the shower. During staff interview on 8/10/10 at 10:30 AM, the charge nurse stated that s/he was unaware that the resident had been denied a	F 246		

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F 246	Continued From page 2 shower on this basis. A record review showed no evidence of a Physical Therapy (PT) or Occupational Therapy evaluation or recommendations for bathing or showering this resident. After the interview between the surveyor and the charge nurse a PT referral was made for recommendations for showering Resident #137.	F 246	DON to monitor Completion Date: 8/20/2010 <i>FA46 POC Accepted 8/20/2010 by [Signature] RT, RN</i>	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a comprehensive plan of care to meet the needs of 1 of 24 residents in the Stage II sample (Resident #137), who is receiving hemodialysis. Findings include:	F 279	Assuming for the moment that the findings and the determination of the deficiency are accurate, without admitting or denying that they are, our proposed plan of correction is as follows: Resident #137 has had the care plan updated to address vital sign monitoring, other monitoring before and after dialysis, risk for adverse medication effects and interactions with dialysis, instructions for medication administration prior to dialysis, center protocols and coordination between dialysis center and facility. The dialysis unit was consulted for this update. All residents who have dialysis have a potential to be affected by this alleged practice. To assure that the alleged practice does not occur, we are taking the following measures: The dialysis unit at FAHC has been consulted to obtain guidelines in care plan development. The MDS coordinator and care planner obtained this information. A separate care plan has been developed for dialysis residents. The DON will audit the records of the dialysis residents to assure the necessary information is included and report any findings to the Quality Assessment and Assurance committee for further action if	

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F 279	Continued From page 3	F 279	needed. The audits will continue for 4 months.	
F 281 SS=J	<p>During record review on 8/10/10, the comprehensive care plan for Resident #137 does not address all aspects of care related to dialysis. The admission care plan, dated 7/27/10, addresses only that dialysis occurs on Monday, Wednesday and Friday each week. The care plan dated 8/5/10 fails to address the following: Care of the access site, vital sign monitoring, other monitoring before and after dialysis, risk for adverse medication effects and interactions with dialysis, instructions for medication administration prior to dialysis, dialysis center protocols, and co-ordination between dialysis center and the facility.</p> <p>Per interview with the 1st floor charge nurse on 8/10/10 at 3:20 PM, s/he could not locate a care plan that addressed the above mentioned areas.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility staff failed to provide services that meet professional standards of quality for 1 of 13 applicable residents in the sample (Resident #38). Findings include:</p> <p>Per record review on 8/10/10 at 4:00 P.M., facility staff failed to follow advance directives and physician's orders to resuscitate Resident #38, whose code status was resuscitate, do not intubate (DNI). Per record review, Resident #38 was at the facility for short-term rehab and was</p>	F 281	<p>DON to monitor Completion Date 8/24/2010 F279 POC Accepted 8/24/10 by RN R.T. RN F281</p> <p>Assuming for the moment that the findings and the determination of the deficiency are accurate, without admitting or denying that they are, our proposed plan of correction is as follows:</p> <p>Resident #38 expired on May 17th 2010.</p> <p>Per statement: a red dot could not have been observed on the resident #38 chart, as the reviewed record was a closed record, in a manila folder was off the unit.</p> <p>During an interview with the RN in charge on the night of 5/17/2010, a detailed account of her assessment was obtained.</p> <p>Both the RN and LPN that evening were current in their CPR certification.</p> <p>The RN arrived at the bedside of resident #38, resident # 38 was found without apical pulse, breath, while assessing for breath RN felt face cold and in stage of rigor. Upon further assessment RN found lower front extremities cold and in various stages of dependent lividity, upon assessing back side of resident further confirmation of dependent lividity in further stages was confirmed.</p> <p>The RN's complete assessment in her clinical expertise, determined that CPR</p>	

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F 281	<p>Continued From page 4</p> <p>seeking placement in an assisted living facility. Per a 2:00 A.M. nursing note on 5/17/10, Resident #38 was found by staff at 1:45 A.M. on 5/17/10 without a pulse or respirations. There is no documentation in the clinical record that the Licensed Practical Nurse (LPN) who responded made any attempt at resuscitation (Initiating Cardio Pulmonary Resuscitation (CPR)) or notified Emergency Medical Services (EMS). The facility Registered Nurse (RN) was contacted, responded to the resident's room, and also did not make any attempt at resuscitation or notify EMS.</p> <p>There is a "Green Mountain Nursing Home MD DNR Form" signed by a physician on 4/23/10 that indicates that Resident #38 is a resuscitate, do not intubate code status. The resident's care plan for advanced directives, dated 5/3/10, states "Resident is a full resuscitative measures/DNI." During an interview at 8:50 A.M. on 8/11/10, the Charge Nurse stated that residents who are a full code are identified by a red dot on the spine of the resident's clinical record, and per observation on 8/11/10 at 8:52 A.M., Resident #38's chart had a red dot on the spine.</p> <p>Per an 8/11/10, 9:45 A.M. interview with a Licensed Nurse Aide (LNA) who was on duty at the time of the incident, there was no EMS notification or CPR done to his/her knowledge. During a 8/11/10, 11:40 A.M. interview with the RN who responded to the resident's death, s/he confirmed that s/he did not perform CPR or notify EMS. The LPN who responded to the resident's death was not able to be contacted for an interview.</p> <p>During an 8:33 A.M. interview on 8/11/10, the</p>	F 281	<p>was futile. Resident # 38 had been dead for a period of time.</p> <p>She immediately telephoned the covering physician and explained the situation and state of resident # 38. The physician gave her the order to pronounce.</p> <p>A short time later, the state medical examiner on duty was contacted. Her reply was that this would not be an unexpected or untimely death, and she would not review the case.</p> <p>All residents in a Full Code status have a potential to be affected by this alleged practice.</p> <p>To ensure this alleged practice does not occur, we are taking the following measures;</p> <p>A "RED DOT" is placed on the spine of the medical record to indicate "Full Code" status. A list of "Full Code" residents is posted at each nursing station indicating the names of the "Full Code" residents on that unit. A "Red Dot" has been placed on the LNA care plan sheet to indicate "Full Code" status and LNA's have been reminded so they may respond if needed.</p> <p>If a resident does not have a DNR form signed they will, by default be a full resuscitate.</p> <p>A policy has been instituted on CPR and has been communicated to each nurse.</p>	

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F 281	Continued From page 5 Director of Nursing (DON) stated that it is her expectation that staff call EMS and initiate CPR immediately when a resident is found without pulse or respirations. The DON confirmed during this interview that there was no documentation in Resident #38's clinical record that indicates EMS was notified or that CPR was done. The DON stated that there was no internal investigation conducted or incident report completed regarding this event. The DON also confirmed that the facility does not have a policy or procedure in place to address staff response when a resident is found without pulse or respirations. Per correspondence on 8/11/10 between the Assistant Director of the State Survey Agency and the Executive Director of the Vermont State Board of Nursing, an order for a code (CPR) is the same as any other order, and that the nurses (the LPN and RN) did not have the authority to change physician orders.	F 281	The majority of professional staff have been recertified by the American Red Cross in CPR. An investigation was conducted via the Quality Assessment and Assurance Committee. A professional nurses meeting was conducted on 8/20/2010 to review "Full Code" status procedures and new revised policies. The Quality Assessment and Assurance committee will monitor along with the Administrator for six months and take action as needed. Completion Date: 8/26/2010 F281 POC Accepted & edits per above B1a/b10c Pmcota RN/ R.T. RN	
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide services in accordance with the written plan of care for 1 of 24 residents in the stage 2 sample (Resident #38). Findings include: Per record review on 8/10/10 at 4:00 P.M., Resident #38, who was a full code status, was	F 282	F282 Assuming for the moment that the findings and the determination of the deficiency are accurate, without admitting or denying that they are, our proposed plan of correction is as follows: Resident #38 expired on May 17 th 2010. During an interview with the RN in charge of the night of 5/17/2010, a detailed account of her assessment was obtained. Both the RN and LPN that evening were current in their CPR certification. The RN arrived at the bedside of resident #38, resident # 38 was found without	

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F 282	Continued From page 6 found by staff without pulse or respirations at 1:45 A.M. on 5/17/10 and did not receive full resuscitative measures as indicated on the advanced directives care plan. The resident's care plan for advanced directives, dated 5/3/10, states "Resident is a full resuscitative measure/DNI." Further, there is a "Green Mountain Nursing Home MD DNR Form" signed by a physician on 4/23/10 that indicates that Resident #38 is a resuscitate, do not intubate code status. During a 8:33 A.M. interview on 8/11/10, the DON stated that it is her expectation that staff call EMS and initiate Cardio Pulmonary Resuscitation (CPR) immediately when a resident is found without pulse or respirations. The DON confirmed during this interview that there was no documentation in Resident #38's clinical record that indicates EMS was notified or that CPR was done. Per an 8/11/10, 9:45 A.M. interview with a Licensed Nurse Aide (LNA) who was on duty at the time of the incident, there was no EMS notification or CPR done to his/her knowledge. During a 8/11/10, 11:40 A.M. interview with the RN who pronounced the resident's death, s/he confirmed that s/he did not perform CPR or notify EMS. The LPN that first responded to the resident at 1:45 AM on 5/17/10 was not able to be contacted for an interview.	F 282	apical pulse, breath, while assessing for breath RN felt face cold and in stage of rigor. Upon further assessment RN found lower front extremities cold and in various stages of dependent lividity, upon assessing back side of resident further confirmation of dependent lividity in further stages was confirmed. The RN's complete assessment in her clinical expertise, determined that CPR was futile. Resident # 38 had been dead for a period of time. She immediately telephoned the covering physician and explained the situation and state of resident # 38. The physician gave her the order to pronounce. A short time later, the state medical examiner on duty was contacted. Her reply was that this would not be an unexpected or untimely death, and she would not review the case. All residents in a Full Code status have a potential to be affected by this alleged practice. To ensure this alleged practice does not occur, we are taking the following measures;	
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	A "RED DOT" is placed on the spine of the medical record to indicate "Full Code" status. A list of "Full Code" residents is posted at each nursing station indicating the names of the "Full Code" residents on that unit. A "Red Dot" has been placed on the LNA care plan sheet to indicate "Full Code" status and LNA's have been reminded so they may respond if needed.	

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F 309	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide the necessary care and services to attain the highest physical well-being for 1 of 13 residents in the applicable sample (resident #38). Findings include:</p> <p>Per record review on 8/10/10 at 4:00 P.M., facility staff failed to follow advance directives and physician's orders to resuscitate Resident #38, whose code status was resuscitate, do not intubate (DNI). Per record review, Resident #38 was at the facility for short-term rehab and was seeking placement in an assisted living facility. Per a 2:00 A.M. nursing note on 5/17/10, Resident #38 was found by staff at 1:45 A.M. on 5/17/10 without a pulse or respirations. There is no documentation in the clinical record that the Licensed Practical Nurse (LPN) who responded made any attempt at resuscitation (initiating Cardio Pulmonary Resuscitation (CPR)) or notified Emergency Medical Services (EMS). The facility Registered Nurse (RN) was contacted, responded to the resident's room, and also did not make any attempt at resuscitation or notify EMS.</p> <p>There is a "Green Mountain Nursing Home MD DNR Form" signed by a physician on 4/23/10 that indicates that Resident #38 is a resuscitate, do not intubate code status. The resident's care plan for advanced directives, dated 5/3/10, states "Resident is a full resuscitative measures/DNI." During an interview at 8:50 A.M. on 8/11/10, the Charge Nurse stated that residents who are a full</p>	F 309	<p>If a resident does not have a DNR form signed they will, by default be a full resuscitate.</p> <p>A policy has been instituted on CPR and has been communicated to each nurse.</p> <p>The majority of professional staff has been recertified by the American Red Cross in CPR.</p> <p>An investigation was conducted via the Quality Assessment and Assurance Committee.</p> <p>A professional nurses meeting was conducted on 8/20/2010 to review "Full Code" status procedures and new or revised policies.</p> <p>The Quality Assessment and Assurance committee will monitor along with the Administrator for six months and take action as needed.</p> <p>Completion Date: 8/26/2010 F309 POC accepted & above edits 8/26/10 P.MOSTERN / R.T. RN</p> <p>Assuming for the moment that the findings and the determination of the deficiency are accurate, without admitting or denying that they are, our proposed plan of correction is as follows:</p> <p>Resident #38 expired on May 17th 2010.</p>	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 8 code are identified by a red dot on the spine of the resident's clinical record, and per observation on 8/11/10 at 8:52 A.M., Resident #38's chart had a red dot on the spine. Per an 8/11/10, 9:45 A.M. interview with a Licensed Nurse Aide (LNA) who was on duty at the time of the incident, there was no EMS notification or CPR done to his/her knowledge. During a 8/11/10, 11:40 A.M. interview with the RN who responded to the resident's death, s/he confirmed that s/he did not perform CPR or notify EMS. The LPN who responded to the resident's death was not able to be contacted for an interview. During an 8:33 A.M. interview on 8/11/10, the Director of Nursing (DON) stated that it is her expectation that staff call EMS and initiate CPR immediately when a resident is found without pulse or respirations. The DON confirmed during this interview that there was no documentation in Resident #38's clinical record that indicates EMS was notified or that CPR was done. The DON stated that there was no internal investigation conducted or incident report completed regarding this event. The DON also confirmed that the facility does not have a policy or procedure in place to address staff response when a resident is found without pulse or respirations. Per correspondence on 8/11/10 between the Assistant Director of the State Survey Agency and the Executive Director of the Vermont State Board of Nursing, an order for a code (CPR) is the same as any other order, and that the nurses (the LPN and RN) did not have the authority to change physician orders.	F 309	During an interview with the RN in charge of the night of 5/17/2010, a detailed account of her assessment was obtained. Both the RN and LPN that evening were current in their CPR certification. The RN arrived at the bedside of resident #38, resident # 38 was found without apical pulse, breath, while assessing for breath RN felt face cold and in stage of rigor. Upon further assessment RN found lower front extremities cold and in various stages of dependent lividity, upon assessing back side of resident further confirmation of dependent lividity in further stages was confirmed. The RN's complete assessment in her clinical expertise, determined that CPR was futile. Resident # 38 had been dead for a period of time. She immediately telephoned the covering physician and explained the situation and state of resident # 38. The physician gave her the order to pronounce. A short time later, the state medical examiner on duty was contacted. Her reply was that this would not be an unexpected or untimely death, and she would not review the case. All residents in a Full Code status have a potential to be affected by this alleged practice. To ensure this alleged practice does not occur, we are taking the following measures;	
F 387 SS=E	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT	F 387		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 387	<p>Continued From page 9</p> <p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>This REQUIREMENT is not met as evidenced by: Resident 1: Cited for out of compliance frequency of MD visits for 3 residents in St 2 sample.</p> <p>Based on record review and interview, the facility failed to ensure that 3 of 24 residents in the applicable sample were seen by a physician at least once every 60 days. (Residents #56, #78, #97) Findings include:</p> <p>1. Per record review on 8/10/10, the last signed physician progress note for Resident #97 was dated 5/13/10 with a lapse of 88 days. Per interview on 8/10/10 at 4:14 PM, the Director of Nursing confirmed the last signed physician progress note for Resident #97 was dated 5/13/10.</p> <p>2. Per record review on 8/11/10, Resident #56 had a progress note signed by the Medical Director on 10/2/09. The next Progress Note signed by the Medical Director was 110 days later on 1/21/10. The next MD visit was made by the attending physician on 4/8/10, 74 days later. The next two MD visits were made by the medical Director in June 2010, and the Attending</p>	F 387	<p>A "RED DOT" is placed on the spine of the medical record to indicate "Full Code" status. A list of "Full Code" residents is posted at each nursing station indicating the names of the "Full Code" residents on that unit. A "Red Dot" has been placed on the LNA care plan sheet to indicate "Full Code" status and LNA's have been reminded so they may respond if needed.</p> <p>If a resident does not have a DNR form signed they will, by default be a full resuscitate.</p> <p>A policy has been instituted on CPR and has been communicated to each nurse.</p> <p>The majority of professional staff has been recertified by the American Red Cross in CPR.</p> <p>An investigation was conducted via the Quality Assessment and Assurance Committee.</p> <p>A professional nurses meeting was conducted on 8/20/2010 to review "Full Code" status procedures and new or revised policies.</p> <p>The Quality Assessment and Assurance committee will monitor along with the Administrator for six months and take action as needed. 8/26/10</p> <p><i>F309 POC Accepted w above edits. P. Motta RN / R.T. RN</i></p> <p>Completion Date: 8/26/2010</p> <p>F387 Assuming for the moment that the findings and the determination of the deficiency are</p>	
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F 387	Continued From page 10 Physician finally saw the resident and signed the Progress Note on 8/23/10. Per interview on 8/11/10 at 9:45 AM, the Charge nurse confirmed that the MD visits were not within the prescribed frequency according to the regulations, that the facility had sent out requests to the Attending MD to see the resident, and that the Medical Director had to make the visit to the resident when the Attending Physician did not come within the regulatory time frame. 3. Per record review on 8/12/10 Resident #78 was admitted on 3/24/09 and an admission visit was made on 3/31/09. Physician Progress notes reflect an MD visit for 5/23/09, a period of 57 days after admission. The next MD visit was made on 07/24/09, a lapse of 62 days since the last visit. The next Physician Progress Note reflects a visit on 10/13/09, which is a lapse of 81 days. The next MD visit was made on 12/31/09, a lapse of 79 days. The record contains Nurses notes and faxes requesting the Attending MD to make visits. The facility Medical Director visited the Resident once on 5/21/09 when a visit by the attending physician was out of compliance. Per interview on 8/12/10 at 1:10 PM, the Charge Nurse confirmed that these were the only documented physician visits made to the resident.	F 387	accurate, without admitting or denying that they are, our proposed plan of correction is as follows: Resident #97 was seen by the physician on 8/10/2010 and is current. Resident # 56 was seen on 8/24/2010 and is current. Resident # 78 was seen on 7/29/2010 and is in compliance. All residents have a potential to be affected by this alleged practice. To assure that the alleged practice does not occur, we are taking the following measures: Physician visit policy has been updated to reflect the current Regulations and new practice. A nurses meeting was held on 8/20/2010 to communicate this policy as well as a memo to each professional staff. The DON and Day supervisor will monitor physician visits on a weekly basis for 6 months and report findings to the Quality Assurance and Assessment committee for action if needed. Completion Date: → F387 poc Accepted 8/26/10 8/26/2010 P. MONTARIN R.T. RN	
F 502 SS=E	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by:	F 502	F502 Assuming for the moment that the findings and the determination of the deficiency are accurate, without admitting or denying that they are, our proposed plan of correction is as follows: All lab supplies have been checked for date and discarded if out dated.	

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<p>F 502</p> <p>F 520 SS=J</p>	<p>Continued From page 11</p> <p>Based upon observation and interview, the facility failed to ensure the quality of laboratory services on two of three units (Cabot Cove and Champlain). Findings include:</p> <p>1. Per observation on 8/11/10, three red top tubes used for therapeutic drug levels were outdated as of 12/09 on the Cabot Cove unit. Per interview on 8/11/10 at 10:15 AM, the charge nurse confirmed that three red top lab tubes used for therapeutic drug levels were outdated as of 12/09.</p> <p>2. Per observation on 8/11/10, sixty-seven red top tubes used for therapeutic drug levels were outdated as of 12/09 in the medication stock room for Champlain East and West. Per interview on 8/11/10 at 10:41 AM, the charge nurse confirmed that sixty-seven red red tops used for therapeutic drug levels were outdated as of 12/09.</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p>	<p>F 502</p> <p>F 520</p>	<p>All residents who have lab services have a potential to be affected by this alleged practice.</p> <p>To assure that the alleged practice does not occur, we are taking the following measures:</p> <p>All Laboratory supplies will be checked each week to assure dates are current; any found to be outdated or close to expiration will be discarded. Nurses who draw blood will be reminded to check dates prior to using. A reminder will be posted in the area that laboratory supplies are housed.</p> <p>The supply room audit will be recorded each week and a report submitted to the Quality Assessment and Assurance committee each month.</p> <p>The DON to monitor Completion Date: 8/24/2010</p> <p>F502 POC Accepted 8/26/10 P. Metarn / R.T. RN</p> <p>F 520</p> <p>Assuming for the moment that the findings and the determination of the deficiency are accurate, without admitting or denying that they are, our proposed plan of correction is as follows:</p>	
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F 520	<p>Continued From page 12</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility's quality assessment committee failed to identify issues and develop and implement appropriate plans of action regarding resuscitation for residents with a full code status. Findings include:</p> <p>Per record review on 8/10/10 at 4:00 P.M., facility staff failed to follow a physician's order to resuscitate Resident #38, whose code status was resuscitate, do not intubate. Per record review on 8/10/10 at 4:00 P.M., Resident #38 was at the facility for short-term rehab and was seeking placement in an assisted living facility. Per a 2:00 A.M. nursing note on 5/17/10, Resident #38 was found by staff at 1:45 A.M. on 5/17/10 without a pulse or respirations. There is no documentation in the clinical record that the LPN who responded made any attempt at resuscitation (CPR) or contacted Emergency Medical Services (EMS). The RN who responded to the resident after being notified by the LPN also failed to make any attempt at resuscitation or contact EMS.</p> <p>The Director of Nursing (DON) confirmed during</p>	F 520	<p>Resident #38 is deceased</p> <p>All residents have a potential to be affected by this alleged practice.</p> <p>To assure that the alleged practice does not occur, we are taking the following measures:</p> <p>The goal of the QAA committee is to make a good faith attempt to identify quality deficiencies and develop and implement plans of action to correct these concerns, including monitoring the effect of implemented changes and make needed revisions to the action plans. (42 CFR 483.75(o) Quality Assessments and Assurance)</p> <p>QAA will meet on a monthly basis. All committee members must be present for the quarterly meetings, April, July, October, and December and during specific meetings according to their reporting schedule (attached), unless excused prior to start of meeting by Administrator or designee.</p> <p>Initiation of QAA review will start with an incident/accident reporting form or a complaint/grievance report along with the victim/witness statement. These reports must be submitted to your departmental supervisor.</p> <p>The initial reporting form is then should be copied and given to Administrator and one to QAA chair person.</p> <p>The QAA chair person and Administrator will start the investigation process by using the investigation reporting form. Once the investigation is complete the QAA committee will decide on the</p>	

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F 520	<p>Continued From page 13</p> <p>an 8:33 A.M. interview on 8/11/10, that there was no internal investigation conducted or incident report completed regarding this event. The DON stated that the facility did not investigate the Resident's death. The DON also confirmed that the facility does not have a policy or procedure in place to address staff response when a resident is found without pulse or respirations.</p> <p>This is a repeat deficiency. F520 was cited at the last annual recertification survey, completed 8/27/09, for failing to identify an issue and failure to develop and implement appropriate plans of action in regards to an environmental hazard.</p>	F 520	<p>corrective actions to take. And follow up on a monthly basis until issue is resolved.</p> <p>Completion Date: 8/26/2010</p> <p>F520 POC Accepted 8/26/10 R. T. RN</p>