

Division of Licensing and Protection  
103 South Main Street  
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

March 17, 2015

Ms. Heather Filonow, Administrator  
Redstone Villa  
7 Forest Hill Drive  
St Albans, VT 05478-1615

Dear Ms. Filonow:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 17, 2015**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN  
Licensing Chief

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/17/2015
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NAME OF PROVIDER OR SUPPLIER  REDSTONE VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 7 FOREST HILL DRIVE ST ALBANS, VT 05478
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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

F 000

**F223 FREE FROM ABUSE/INVOLUNTARY SECLUSION**

An unannounced onsite complaint investigation was conducted by the Division of Licensing and Protection from 2/11/15 through 2/17/15. Based on information gathered, regulatory violations were cited as follows.

**1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?**

Resident #2 had no negative effects from this alleged deficient practice.

F 223  
SS=D

483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION

F 223

**2. How will the facility identify other residents having the potential to be affected by the same deficient practice?**

All Residents have the potential to be affected by this alleged deficient practice.

The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

**3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?**

The LPN involved in this alleged incident received written counseling. Re-education to be provided to staff regarding abuse prevention and reporting and resident rights.

The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.

**4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?**

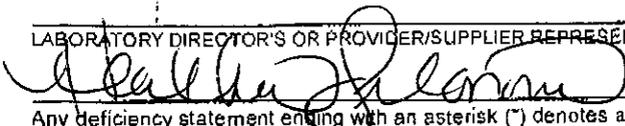
Executive Director or designee will conduct random interviews with staff and residents three times per week for three months to monitor effectiveness of plan. The results of this audit will be reported at QA meeting and the QA committee will determine continued duration of audits after three months.

This REQUIREMENT is not met as evidenced by:  
Based on record review and staff interview, the facility failed to ensure that residents were free from verbal abuse for 1 of 5 residents ( Resident #2) Findings include:

**5. Include dates when a corrective action will be completed.**

Corrective Action to be completed by 3/17/15.

Per record review on 2/11/15 and 2/12/15, there was an allegation by staff persons that on 12/5/14 one of the Licensed Practical Nurses (LPN) had verbally abused Resident #2. According to different versions of witnesses, the LPN was on the third floor speaking with a Registered Nurse and the Head of Maintenance, who were sitting at a table outside the upstairs offices. Resident #2 was being watched by a staff member on the third floor, as the resident was on one to one supervision due to behaviors that affected the welfare of other residents.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Interim Executive Director	(X8) DATE 3/13/2015
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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.

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

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OMB NO. 0938-0391

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F 223 Continued From page 1

Per all staff written statements, including that of the LPN alleged to have committed the verbal abuse, the resident came up behind the nurse and placed their hands on the nurse's shoulders/neck area. All four statements were in agreement that the nurse asked the resident "What is the rule about touching me? No man may put his hands on me uninvited". Per two of the staff statements, the nurse was alleged to have called the resident a "creep". In the third statement by other staff present and also by the nurse alleged to have said this, the statement was that the resident "should not be creeping up on people." The nurse alleged to have committed the verbal abuse said in a written statement that they told the resident that creeping up on people "could lead to someone taking them out." Another staff person that was within hearing distance but did not visually witness the event wrote in a statement that they heard the nurse say that the resident was lucky that they did not "lay [him/her] flat out on the floor" and also said "You are a creep, a creep". The other witness who was in visual sight of the incident stated that the nurse asked Resident #2 what was the rule about touching him/her, but then started walking down the stairs. The witness stated that the nurse turned around, came back up the stairs and said "You are a creep!" and threw a small object, or motioned that they were throwing a small object at the resident, and then went downstairs.

Per the witnesses, this was reported to both the Director of Nursing and the Administrator. The Administrator asked all the witnesses and the nurse in question to write up statements recalling the incident. On 2/11/15 at 2:15 PM, the Administrator confirmed that there were differing versions of what happened, but that two of the

F 223 F223 POC accepted 3/16/15 JHosmerRN/AME

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F 223 Continued From page 2  
statements alleged direct verbal abuse of Resident #2. The nurse who allegedly committed the verbal abuse was given an "Employee Performance Improvement Notification" that was checked off as a verbal notice, cautioning the nurse to "immediately refrain from letting emotions get the best of you and to remain calm and treat all residents with respect like you normally do." The Administrator also confirmed at that time that this allegation was not reported to the state agency as required, and the nurse was allowed to continue working their regular shifts during the course of the internal investigation. The Administrator also confirmed that the facility policies regarding abuse allegations mandated that they be reported to the state agency even if the evidence was inconclusive.

F 223

F 225 SS=D 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

**F225 Investigation/report allegations/Individuals**

**1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?**

Resident #1 and resident #2 had no negative effects from this alleged deficient practice.

**2. How will the facility identify other residents having the potential to be affected by the same deficient practice?**

All residents residing at this facility have the potential to be affected by this alleged deficient practice.

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F 225 Continued From page 3  
to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:  
Based on record review and staff interview, the facility failed to ensure that allegations of abuse, neglect, and exploitation were reported as required, and that residents were protected from potential abuse during the course of an investigation for 2 of 5 residents reviewed (Residents #1, #2). Findings include:

- Per record review on 2/11 and 2/12/15, Resident #1 was found with a tourniquet left on their arm after a blood draw. Per review by the facility, it was determined that the blood draw occurred at approximately 5:00 PM, and the Licensed Nursing Assistant (LNA) found the tourniquet on the arm of the resident at approximately 10:45 PM while providing care. The LNA told the Registered Nurse on duty, who proceeded to assess the resident's arm. Per

F 225

**3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?**

The LPN involved in this alleged incident received written counseling. Re-education to be provided to licensed nurses regarding policies and procedures for blood draws. The Regional Director of Clinical Services has provided education and reviewed policies, procedures, and requirements for investigating and reporting allegations of abuse with facility administration. Re-education of staff on abuse policies and procedures.

**4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?**

DNS or designee will conduct random interviews with staff and residents three times per week for three months to monitor effectiveness of plan. Random weekly audits and observations during blood draws for three months to monitor effectiveness of plan. The results of this audit will be reported at QA meeting and the QA committee will determine continued duration of audits after three months.

**5. Include dates when a corrective action will be completed.**

Corrective action will be completed by 3/17/15.

*F025 POC accepted 3/16/15 JHC/mern/PML*

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F 225 Continued From page 4

interview by telephone on 2/12/15 at 2:30 PM, the Registered Nurse stated that they assessed the resident's arm, and other than a red mark and indentation where the band had been left, there was no apparent injury to the arm related to circulatory function or range of motion. The RN stated that the resident's physician was called, and the on-call MD told the nurse to monitor the resident for any ill effects, but no further intervention was recommended unless there was a concern detected.

According to this RN, the Director of Nursing (DNS) was notified of this incident, and the DNS told the nurse since there was no harm to the resident, there was no need to write an incident report or record the follow up that was conducted by the RN such as calling the doctor or documenting the resident's status in the medical record.

Per interview on 2/12/15 at 1:15 PM, the Director of Nursing confirmed that the RN told the DNS the following day after the incident, and that the DNS did not require a written incident report nor documentation in the medical record as there had been no harm to Resident #1. The DNS also stated that the only follow up with the LPN who had left the tourniquet on the resident was a written statement that it was discussed with the LPN, but no other record of staff inservicing or other corrective action to avoid a reoccurrence of this incident.

2. Per record review on 2/11 and 2/12/15, there was an allegation by staff persons that on 12/5/14 one of the nurses had verbally abused Resident #2. Per the witnesses, this was reported to both the Director of Nursing and the Administrator. The

F 225

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F 225 Continued From page 5  
Administrator asked all the witnesses and the nurse in question to write up statements recalling the incident. On 2/11/15 at 2:15 PM, the Administrator confirmed that there were differing versions of what happened, but that two of the statements alleged direct verbal abuse of Resident #2. The Administrator also confirmed at that time that this allegation was not reported to the state agency as required, and the nurse was allowed to continue working their regular shifts during the course of the internal investigation. The Administrator also confirmed that the policies regarding abuse allegations mandated that they be reported to the state agency even if the evidence was inconclusive.

F 225

See also F223.  
F 226 483.13(c) DEVELOP/IMPLMENT  
SS=D ABUSE/NEGLECT, ETC POLICIES

F 226

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:  
Based on record review and staff interview, the facility failed to implement facility policy, report two allegations of neglect or abuse to the state agency, and protect residents during the course of an abuse investigation for 2 of 5 residents (Residents #1, #2). Findings include:  
  
1. Per record review on 2/11 and 2/12/15, there was an allegation by staff persons that on 12/5/14

**F226**  
**DEVELOP/IMPLEMENT ABUSE/NEGLECT**

**1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?**  
Resident #1 and Resident #2 had no negative effects from this alleged deficient practice.

**2. How will the facility identify other residents having the potential to be affected by the same deficient practice?**  
All residents have the potential to be affected by this alleged deficient practice.

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F 226

Continued From page 6

one of the nurses had verbally abused Resident #2. Per the witnesses, this was reported to both the Director of Nursing and the Administrator. The Administrator asked all the witness and the nurse in question to write up statements recalling the incident. On 2/11/15 at 2:15 PM, the Administrator confirmed that there were differing versions of what happened, but that two of the statements alleged direct verbal abuse of Resident #2. The nurse who allegedly committed the verbal abuse was given an "Employee Performance Improvement Notification" that was checked off as a verbal notice, cautioning the nurse to "immediately refrain from letting emotions get the best of you and to remain calm and treat all residents with respect like you normally do." The Administrator also confirmed at that time that this allegation was not reported to the state agency as required, and the nurse was allowed to continue working their regular shifts during the course of the internal investigation. The Administrator also confirmed that the policies regarding abuse allegations mandated that they be reported to the state agency even if the evidence was inconclusive.

2. Per record review on 2/11 and 2/12/15, Resident #1 was found with a tourniquet left on their arm after a blood draw. Per review by the facility, it was determined that the blood draw occurred at approximately 5:00 PM, and the Licensed Nursing Assistant (LNA) found the tourniquet on the arm of the resident at approximately 10:45 PM while providing care. The LNA told the Registered Nurse on duty, who proceeded to assess the resident's arm. Per interview by telephone on 2/12/15 at 2:30 PM, the Registered Nurse stated that they assessed the

F 226

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

The Regional Director of Clinical Services has provided education and reviewed policies, procedures, and requirements for investigating and reporting allegations of abuse with facility administration.

4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?

Executive Director or designee will conduct random interviews with staff and residents three times per week for three months to monitor effectiveness of plan. The results of this audit will be reported at QA meeting and the QA committee will determine continued duration of audits after three months.

5. Include dates when a corrective action will be completed.

Corrective action will be completed by 3/17/15.

*F226 POC accepted 3/16/15 JHsmar/RW/PMC*

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F 226 Continued From page 7  
resident's arm, and other than a red mark and indentation where the band had been left, there was no apparent injury to the arm related to circulatory function or range of motion. The RN stated that the resident's physician was called, and the on-call MD told the nurse to monitor the resident for any ill effects, but no further intervention was recommended unless there was a concern detected.

According to this RN, the Director of Nursing (DNS) was notified of this incident, and the DNS told the nurse since there was no harm to the resident, there was no need to write an incident report or record the follow up that was conducted by the RN such as calling the doctor or documenting the resident's status in the medical record.

Per interview on 2/12/15 at 1:15 PM, the Director of Nursing confirmed that the RN told the DNS the following day after the incident, and that the DNS did not require a written incident report nor documentation in the medical record as there had been no harm to Resident #1. The DNS also stated that the only follow up with the LPN who had left the tourniquet on the resident was a written statement that it was discussed with the LPN, but no other record of staff inservicing or other corrective action to avoid a reoccurrence of this incident. The DNS also confirmed at this time that the incident had not been reported to the state agency.

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET SS=D PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

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F 281 Continued From page 8

This REQUIREMENT is not met as evidenced by:  
Based on record review and staff Interview, the facility failed to provide services that met professional standards of quality for 1 of 5 residents sampled (Resident #1). Findings include:

- Per record review on 2/11 and 2/12/15, Resident #1 was found with a tourniquet left on their arm after a blood draw. Per review by the facility, it was determined that the blood draw occurred at approximately 5:00 PM, and the Licensed Nursing Assistant (LNA) found the tourniquet on the arm of the resident at approximately 10:45 PM while providing care. The LNA told the Registered Nurse on duty, who proceeded to assess the resident's arm. Per interview by telephone on 2/12/15 at 2:30 PM, the Registered Nurse stated that they assessed the resident's arm, and other than a red mark and indentation where the band had been left, there was no apparent injury to the arm related to circulatory function or range of motion. The RN stated that the resident's physician was called, and the on-call MD told the nurse to monitor the resident for any ill effects, but no further intervention was recommended unless there was a concern detected.

According to this RN, the Director of Nursing (DNS) was notified of this incident, and the DNS told the nurse since there was no harm to the resident, there was no need to write an incident report or record the follow up that was conducted by the RN such as calling the doctor or documenting the resident's status in the medical

F 281

F281 Services Provided meet Professional Standards.

**1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?**

Resident #1 had no negative effects related to this alleged deficient practice.

**2. How will the facility identify other residents having the potential to be affected by the same deficient practice?**

Residents with orders for blood draws have the potential to be affected by this alleged deficient practice.

**3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?**

The LPN involved in this alleged deficient practice received written counseling. Re-education provided to licensed nurses regarding policies and procedures for drawing blood.

**4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?**

DNS or designee will conduct random weekly audits during blood draws for three months to monitor effectiveness of the plan. The results of this audit will be reported at QA meeting and the QA committee will determine continued duration of audits after three months.

**5. Include dates when a corrective action will be completed.**

Corrective action will be completed by 3/17/15.

F281 POC accepted 3/16/15 jll/merrill/pmc

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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 281 Continued From page 9 record. F 281

Per interview on 2/12/15 at 1:15 PM, the Director of Nursing confirmed that the RN told the DNS the following day after the incident, and that the DNS did not require a written incident report nor documentation in the medical record as there had been no harm to Resident #1. The DNS also stated that the only follow up with the LPN who had left the tourniquet on the resident was a written statement that it was discussed with the LPN, but no other record of staff inservicing or other corrective action to avoid a reoccurrence of this incident.

Reference: Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins.

F 353 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS F 353

The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.

**F353 Sufficient 24 HR Nursing Staff Per care Plans.**

**1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?**

No residents were negatively affected as a result of this alleged deficient practice.

**2. How will the facility identify other residents having the potential to be affected by the same deficient practice?**

All residents have the potential to be affected by this alleged deficient practice.

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/17/2015
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NAME OF PROVIDER OR SUPPLIER  REDSTONE VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 7 FOREST HILL DRIVE ST ALBANS, VT 05478
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F 353 Continued From page 10

Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

This REQUIREMENT is not met as evidenced by:  
Based on staff interview and record review, the facility failed to provide licensed nursing staff on a 24-hour basis when a Licensed Practical Nurse (LPN) [who was the only nurse on duty for the night shift of 1/28/15 going to the morning of 1/29/15] was known to be extremely tired and at times soundly asleep during the tour of duty. This has the potential to affect all residents of the facility. Findings include:

1. Per review of actual staffing schedules provided by the facility on 2/11/15, the duty roster for the night shift of 1/28/15 going into the morning of 1/29/15 (11 PM to 7 AM) showed that one LPN and two Licensed Nurse Assistants (LNA) were assigned to duty. This staffing schedule and the identities of the LPN and LNA staff were confirmed by the Director of Nursing Services (DNS) on 2/11/15 at 11:40 AM. The DNS confirmed knowledge that the LPN had required rides to and from the facility because of a driver's license suspension for an undetermined period, at least dating back to Christmas, 2014. The DNS further confirmed having received reports from concerned staff that the LPN was extremely tired and often fell asleep while outdoors in the staff designated smoking area, while elevating his/her feet in the living room of the facility, or while completing documentation at the nurses' station. The DNS confirmed having counseled the LPN about taking more frequent breaks than the

F 353

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

The LPN involved in the incident is not currently working in the facility. Education provided to staff regarding safe staffing to include sleeping while on duty.

4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?

DNS or designee will conduct random observations and interviews with staff three times per week for three months to determine effectiveness of plan. The results of this audit will be reported at QA meeting and the QA committee will determine continued duration of audits after three months.

5. Include dates when a corrective action will be completed.

Corrective action will be completed by 3/17/15.

*F353 POC accepted 3/16/15 JH-smar RN/pmc*

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F 353 Continued From page 11

expectation of two 15 minute breaks and a 30 minute meal break per tour of duty. The DNS confirmed awareness that the LPN was extremely tired and had been having personal coping difficulties since summer, 2014.

The DNS also confirmed during the interview that the Registered Nurse (RN) who was going off duty (having worked 3 PM to 11 PM on 1/28/15) had called the DNS prior to leaving duty and reported concern about the condition of the LPN coming on duty. Per interview at 3:45 PM on 2/11/15, the RN had notified the DNS that s/he had been unable to awaken the LPN in order to complete the medication count and shift change procedures to transition from second to third shift. The RN further confirmed by interview that s/he had attempted for approximately 15 minutes, with assistance by one of the LNA staff, to awaken the LPN who had fallen asleep in the living room area, after being dropped off before the night shift. The RN further confirmed having felt uncomfortable about the condition of the LPN and having called the DNS to report this. Per the DNS and the RN, the LPN got up and came to the nurses' station while the RN and DNS were on the telephone at approximately 11:50 PM on 1/28/15. At that time, the RN and LPN completed the medication counts and the change of shift, and the RN left the building shortly after midnight.

Per interview 2/17/15 at 1:15 PM with an LNA who worked the night shift of 1/28-29/15, s/he witnessed times during that shift when the LPN was asleep. S/he confirmed having participated at one point with the pharmacy delivery person in attempts to awaken the LPN; following this effort, there was at least one call placed to a nurse who was off duty to report the situation. During the

F 353

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/17/2015
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F 353 Continued From page 12  
2/11/15 11:40 AM interview with the DNS, s/he confirmed having been called by the off duty nurse at approximately 4:30 AM on 1/29/15, at which time the DNS got ready for work and was at the facility by 6:30 AM. Procedures to place the LPN on a leave of absence were initiated.

F 353

F 490 483.75 EFFECTIVE  
SS=F ADMINISTRATION/RESIDENT WELL-BEING

F 490

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.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview, the facility failed to ensure effective administration to maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 2 of 5 residents sampled (Resident #1, #2), and regarding the performance of a licensed nurse that has the potential to effect all residents of the facility. Findings include:

Per record review on 2/11 and 2/12/15, there was evidence of two incidents that did not receive appropriate responses from the Administrator and the Director of Nursing.

1. In the instance of Resident #1, who had a tourniquet left on their arm for at least five hours on 1/5/15, there was no incident report written, nor documentation in the resident's medical record of an assessment, notification to the MD, or any follow up with staff documented. Per

**F490 Effective**  
**Administration/Resident well being**

**1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?**

No residents were negatively affected by this alleged deficient practice.

**2. How will the facility identify other residents having the potential to be affected by the same deficient practice?**

All residents have the potential to be affected by this alleged deficient practice.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER

**REDSTONE VILLA**

STREET ADDRESS, CITY, STATE, ZIP CODE

**7 FOREST HILL DRIVE  
ST ALBANS, VT 05478**

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F 490

Continued From page 13

telephone interview on 2/12/15 at 2:30 PM, the Registered Nurse who was on duty the evening of 1/5/15 assessed Resident #1's arm after the tourniquet was removed, the doctor on call was notified, and the resident was monitored for any ill effects after the incident. The nurse stated that the Director of Nursing told the nurse that an incident report and documentation of interventions after the incident was not needed as there was no harm to the resident. Per interview on 2/12/15 at 1:15 PM, the Director of Nursing confirmed that an incident report had not been written, and that there was no documentation in Resident #1's medical record that indicated a tourniquet had been left on for hours and what follow up was done as a result of the incident.

2. Per record review on 2/11 and 2/12/15, Resident #2 was alleged to have been verbally abused by one of the nurses, witnessed by other staff members. Per interview on 2/12/15, the Administrator stated that this allegation had not been reported to the state agency, due to there being different versions of the incident which the Administrator found to be inconclusive. The nurse who allegedly abused the resident was not removed from duty during the investigation. Per interview on 2/12/15 at 2:15 PM, the Administrator confirmed that the regulations and company policy state that an allegation of abuse, whether confirmed or not, was to be reported to the state agency, and measures taken to protect the residents during the course of an investigation.

3. The Director of Nursing Services (DNS) delayed effective action regarding a pattern of performance reports and concerns for a Licensed Practical Nurse (LPN) who was often the only licensed nurse on duty in facility. Per review of

F 490

**3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?**

The Executive Director operating the building at the time the alleged deficient practice no longer works at this facility. The Regional Director of Clinical Services has provided education and reviewed policies, procedures, and requirements for investigating and reporting allegations of abuse with facility administration. The Regional Director of Clinical Services has also provided education regarding appropriate responses involving incidents and performance of staff to facility administration.

**4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?**

The current Executive Director or designee will conduct random audits 3 times per week for three months to monitor effectiveness of plan. The results of this audit will be reported at QA meeting and the QA committee will determine continued duration of audits after three months.

**5. Include dates when a corrective action will be completed.**

Corrective action will be completed by 3/17/15.

*F490 POC accepted 3/16/15 JHosmer RN/pme*

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F 490	<p>Continued From page 14</p> <p>actual staffing schedules provided by the facility on 2/11/15, the duty roster for the night shift of 1/28/15 going into the morning of 1/29/15 (11 PM to 7 AM) showed that one LPN and two Licensed Nurse Assistants (LNA) were assigned to duty. This staffing schedule and the identities of the LPN and LNA staff were confirmed by the Director of Nursing Services (DNS) on 2/11/15 at 11:40 AM. The DNS confirmed knowledge that the LPN had required rides to and from the facility because of a driver's license suspension for an undetermined period, at least dating back to Christmas, 2014. The DNS further confirmed having received reports from concerned staff that the LPN was extremely tired and often fell asleep while outdoors in the staff designated smoking area, while elevating his/her feet in the living room of the facility, or while completing documentation at the nurses' station. The DNS confirmed having counseled the LPN about taking more frequent breaks than the expectation of two 15 minute breaks and a 30 minute meal break per tour of duty. The DNS confirmed awareness that the LPN was extremely tired and had been having personal coping difficulties since summer, 2014. The DNS also confirmed during the interview that the Registered Nurse (RN) who was going off duty (having worked 3 PM to 11 PM on 1/28/15) had called the DNS prior to leaving duty and reported concern about the condition of the LPN coming on duty. Per interview at 3:45 PM on 2/11/15, the RN had notified the DNS that s/he had been unable to awaken the LPN in order to complete the medication count and shift change procedures to transition from second to third shift. The RN further confirmed by interview that s/he had attempted for approximately 15 minutes, with assistance by one of the LNA staff, to awaken the LPN who had fallen asleep in the living room</p>	F 490		
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F 490 Continued From page 15  
area, after being dropped off before the night shift. The RN further confirmed having felt uncomfortable about the condition of the LPN and having called the DNS to report this. Per the DNS and the RN, the LPN got up and came to the nurses' station while the RN and DNS were on the telephone at approximately 11:50 PM on 1/28/15. At that time, the RN and LPN completed the medication counts and the change of shift, and the RN left the building shortly after midnight. During the 2/11/15 11:40 AM interview with the DNS, s/he confirmed having been called by the off duty nurse at approximately 4:30 AM on 1/29/15, at which time the DNS got ready for work and was at the facility by 6:30 AM. Procedures to place the LPN on a leave of absence were initiated.

F 490

Refer to F223, F225, F226, F281, F353, and F514.

F 514 483.75(l)(1) RES  
SS=D RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

F 514

**F514 Resident Records- Complete/Accurate/Accessible**

**1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?**

Resident #1 had no negative effects from this alleged deficient practice.

**2. How will the facility identify other residents having the potential to be affected by the same deficient practice?**

All resident have the potential to be affected by this alleged deficient practice.

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

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F 514 Continued From page 16

F 514

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview, the facility failed to ensure that documentation was complete and accurate with regards to an incident for 1 of 5 residents sampled (Resident #1). Findings include:

1. Per record review on 2/11 and 2/12/15, Resident #1 was found with a tourniquet left on their arm after a blood draw on the evening of 1/5/15. Per review by the facility, it was determined that the blood draw occurred at approximately 5:00 PM, and the Licensed Nursing Assistant (LNA) found the tourniquet on the arm of the resident at approximately 10:45 PM while providing care. The LNA told the Registered Nurse on duty, who proceeded to assess the resident's arm. Per interview by telephone on 2/12/15 at 2:30 PM, the Registered Nurse stated that they assessed the resident's arm, and other than a red mark and indentation where the band had been left, there was no apparent injury to the arm related to circulatory function or range of motion. The RN stated that the resident's physician was called, and the on-call MD told the nurse to monitor the resident for any ill effects, but no further intervention was recommended unless there was a concern detected. According to this RN, the Director of Nursing was notified of this incident, and the DNS told the nurse since there was no harm to the resident, there was no need to write an incident report or record the follow up that was conducted by the RN such as calling the doctor or documenting the resident's status in the medical record.

Per interview on 2/12/15 at 1:15 PM, the Director

**3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?**

The Regional Director of Clinical Services has provided education regarding the policies, procedures, and requirements for accurate and complete documentation to facility administration. Re-education to be provided to licensed nurses regarding policies, procedures and requirements for accurate and complete documentation.

**4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?**

DNS or designee will audit documentation three times per week for three months to determine effectiveness of plan. The results of this audit will be reported at QA meeting and the QA committee will determine continued duration of audits after three months.

**5. Include dates when a corrective action will be completed.**

Corrective action will be completed by 3/17/15.

F514 POC accepted 3/16/15 JHosmer/PAC

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

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STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

475055

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED

C

02/17/2015

NAME OF PROVIDER OR SUPPLIER

REDSTONE VILLA

STREET ADDRESS, CITY, STATE, ZIP CODE

7 FOREST HILL DRIVE  
ST ALBANS, VT 05478

(X4) ID  
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PROVIDER'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE  
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DEFICIENCY)

(X5)  
COMPLETION  
DATE

F 514 : Continued From page 17

of Nursing confirmed that the RN told the DNS the following day after the incident, and that the DNS did not require a written incident report nor documentation in the medical record as there had been no harm to Resident #1. The DNS also stated that the only follow up with the LPN who had left the tourniquet on the resident was a written statement that it was discussed with the LPN, but no other record of staff inservicing or other corrective action to avoid a reoccurrence of this incident.

F 514 :