

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

October 8, 2014

Ms. Patricia Russell, Administrator
Union House Nursing Home
3086 Glover Street
Glover, VT 05839-9701

Dear Ms. Russell:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 17, 2014**. Please post this document in a prominent place in your facility.

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

Sincerely,



Pamela M. Cota, RN
Licensing Chief

PC:kc



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

PRINTED: 09/24/2014
RECEIVED FORM APPROVED
Division of OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475036 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | 0CT -7 14 Licensing and Protection | (X3) DATE SURVEY COMPLETED 09/17/2014 |
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| NAME OF PROVIDER OR SUPPLIER UNION HOUSE NURSING HOME | STREET ADDRESS, CITY, STATE, ZIP CODE 3086 GLOVER STREET GLOVER, VT 05839 |
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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 re-certification survey and the investigation of one entity report and one complaint were completed by the Division of Licensing and Protection from 9/15/14 through 9/17/14. There were no findings related to allegations in either the entity report or the complaint. Findings related to the re-certification survey are as follows. | F 000 | | |
| F 282 SS=D | 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 medical record review and staff interview, the facility failed to assure that services were provided according to the written plan of care for 1 of 17 residents in the survey sample (Resident #5). Findings include: Per 9/17/14 medical record review, Resident #5 was admitted to the facility on 10/1/12; his/her diagnoses included "Brittle diabetes" with a history of multiple hypoglycemic reactions, (Brittle Diabetes is characterized by instability of blood glucose levels with frequent and unpredictable episodes of hypoglycemia [low blood sugar] and/or ketoacidosis that disrupt quality of life). His/her other diagnoses included End Stage Renal Disease with dialysis treatments, atrial fibrillation (cardiac arrhythmia) and other chronic medical conditions. | F 282 | F282 A medication error has been completed for resident #5 and reviewed with the nurse. The diabetic careplans of all other insulin dependent diabetics have been reviewed and interventions have been met. Audits for compliance to the diabetic plan of care will be done weekly X 4, then monthly X 3, then random audits to be done quarterly with results reviewed at the Quality Assurance Meetings. Person responsible DValiquette RN DNS A mandatory inservice on diabetic nursing care/care plans and the facility's hypoglycemic protocol will be held on October 8 and October 10, 2014 for all nursing staff. Person responsible: DValiquette RN DNS F282 POC accepted 10/9/14 JHassman RN/PMC | |

Colette
10/10/14
PER

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i> | TITLE <i>Asst</i> | (X6) DATE 10/2/14 |
|---|----------------------|----------------------|

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 282 | Continued From page 1 Per review, Resident #5's care plan for "...Brittle Diabetes with history of multiple hypoglycemic episodes" lists "...need for close monitoring of blood sugars." The plan includes: "...obtain blood sugars [BS] AC [before meals], HS [at bedtime] and prn [as needed]. See current MAR [Medication Administration Record] for insulin & sliding scale. Goes into hypoglycemic episodes easily...May use standing orders." Per 9/17/14 review, the Union House Hypoglycemia Protocol, for low blood glucose (less than 70...), states "Hold diabetic meds (including insulin and oral)...Repeat blood glucose in 10-15 minutes..." Per review of the physician's orders, Resident #5 had orders for Novolog 100 units/ml insulin by injection, 6 units twice daily with breakfast and lunch. The order included specific instructions to "hold" the Novolog insulin "if [the resident's] blood sugar [is] \leq 70 [less than or equal to 70] ..." The MAR also specifies that the 6 units of Novolog with breakfast and lunch be held if the resident's blood sugar is less than or equal to 70. Per review of the nursing progress notes, on 9/2/14 at 11:30 AM Resident #5 reported feeling dizzy after showering and lowered [him/herself] to a sitting position in the hallway. His/her blood sugar (BS) was taken and found to be 68 (low). Per review of the Blood Sugar Flow sheet, on 9/2/14 Resident #5 was administered his/her scheduled (6 units) of Novolog insulin at 11:45 AM. There is no documentation that the care plan was followed and that Resident #5's blood sugar level was monitored, that his/her BS was rechecked in 10-15 minutes following his/her low BS reading of 68 or that his/her Novolog was given according to the MAR. The next | F 282 | | |

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| F 282 | Continued From page 2 documentation that a BS was taken on 9/2/14 was at 1600 (4:00 PM) when the resident's BS was 101. On 9/17/14 at 9:05 AM, a staff nurse confirmed that Resident #5 was given 6 units of Novolog insulin on 9/2/14 and confirmed that the insulin should have been held based on the resident's low BS result and physician orders. S/he also confirmed that Resident #5's BS should have been rechecked following the low reading and confirmed that the next documented BS occurred at 1600 (4 PM). On 9/17/14 at 9:47 AM, the facility Director of Nursing (DNS) confirmed that Resident #5's Novolog insulin should not have been administered and confirmed that the resident's care plan for BS monitoring and the facility protocol for low blood sugars was not followed. (Refer F329) < http://www.uptodate.com/contents/the-adult-patient-with-brittle-diabetes-mellitus > | F 282 | | | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a | F 329 | | | |

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F 329 Continued From page 3
resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility failed to assure that 1 of 17 residents was free from unnecessary drugs. (Resident # 5). Per 9/17/14 medical record review, Resident #5 was admitted to the facility on 10/1/12; his/her diagnoses included "Brittle diabetes" with a history of multiple hypoglycemic reactions, (Brittle Diabetes is characterized by instability of blood glucose levels with frequent and unpredictable episodes of hypoglycemia [low blood sugar] and/or ketoacidosis that disrupt quality of life). His/her other diagnoses included End Stage Renal Disease with dialysis treatments, atrial fibrillation and other chronic medical conditions. Per review of the physician's orders, Resident #5 had orders for scheduled Novolog 100 units/ml insulin by injection, 6 units twice daily with breakfast and lunch. The order included specific instructions to "hold" the Novolog insulin "if [the resident's] blood sugar [is] <= 70 [less than or equal to 70] ..."
Per review of the nursing progress notes, on

F 329

F329

A medication error has been completed for resident #5 and reviewed with the nurse. No other residents have been affected. Audits for compliance to the diabetic plan of care and the hypoglycemic protocol, which includes the administration (or not) of insulin will be done weekly X 4, then monthly X 3, then random audits to be done quarterly with results reviewed at the Quality Assurance Meetings.
Person responsible
DValiquette RN DNS

A mandatory inservice on diabetic nursing care/care plans and the facility's hypoglycemic protocol will be held on October 8 and October 10, 2014 for all nursing staff.
Person responsible:
DValiquette RN DNS

F329 POC accepted 10/8/14 JHamer/pw/PMC

Completed
10/10/2014
1/24

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| F 329 | Continued From page 4 9/2/14 at 11:30 AM Resident #5 reported feeling dizzy after showering and lowered him/herself to a sitting position in the hallway. His/her blood sugar (BS) was taken and found to be 68 (low). Per review of the Blood Sugar Flow sheet, on 9/2/14 Resident #5 was administered his/her scheduled Novolog insulin (6 units) at 11:45 AM. There is no documentation that another blood sugar level was taken following the low BS result of 68 or after the insulin was administered until 1600 (4:00 PM). On 9/17/14 at 9:05 AM, a staff nurse confirmed that Resident #5 was given 6 units of Novolog insulin and confirmed that the insulin should have been held based on the resident's low BS and physician orders stating to hold the insulin in the event of a BS reading less than 70. On 9/17/14 at 9:47 AM, the facility Director of Nursing (DNS) confirmed that the Novolog insulin should not have been administered. (Refer F282) < http://www.uptodate.com/contents/the-adult-patient-with-brittle-diabetes-mellitus > | F 329 | | |