

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

October 21, 2016

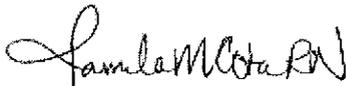
Mr. Bradford Ellis, Administrator
Vernon Green Nursing Home
61 Greenway Drive
Vernon, VT 05354-9474

Dear Mr. Ellis:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 28, 2016**. 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

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

PRINTED: 10/10/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/28/2016
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NAME OF PROVIDER OR SUPPLIER VERNON GREEN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 61 GREENWAY DRIVE VERNON, VT 05354
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F 280	Continued From page 1 #11's plan of care to reflect recommendations by the consulting dentist or speech therapist. Resident #11 requires staff assistance for oral health care. A dental consult on 5/3/16 noted that the remaining 3 teeth appeared tolerated but need to be brushed more consistently. Recommend staff assist twice daily (BID). No toothettes (a foam oral healthcare device) should be used. The care plan for dental care did not contain the dental consultant recommendations. Per an interview with a unit Licensed Nursing Assistant (LNA) on 09/27/2016 at 1:48 PM, the LNA stated that staff used a toothettes to provide Resident #11's oral care because h/she had no teeth. The LNA was not aware of that Resident #11 had remaining teeth and was unaware of the no toothette recommendation nor the recommendation to brush BID. Additionally, Swallowing precautions were initiated 9/17/14 by a Speech therapist (SLP). The precautions included direct supervision while eating and sitting upright @90 degrees with a pillow behind his/her back while eating. During interview, the unit LNA was aware of supervision but not positioning requirements as per SLP recommendation. During interview on 09/27/2016 at 1:57 PM, the Unit Charge Nurse stated that the SLP positioning requirements should be on the care plan and confirmed that the SLP recommendations are not on the care plan. The Charge Nurse also also confirmed that staff are not following dentist recommendations from the 5/3/16 consult.	F 280	How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; A mailbox for the unit charge nurse has been established to place faxes, consults, MD orders to assure proper recommendations are put into place and followed. Nursing staff have been educated to enter interventions on the care plan itself instead of using the paper forms. New recommendations will also be entered into point of care with sign off by the nursing assistants. Director of Nurses (DON) or designee will conduct audits to assure information is on care plans and staff is updated on changes through huddles, meetings, the communication book and the point of care. DON or designee will also do audits to assure information is on the care plan and not on a piece of paper aside from the care plan. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The results of the audits will be reviewed monthly at the Quality Assurance (QA) meeting until 100% compliance has been achieved and until such time the QA Committee deems ongoing compliance can be sustained.	10/12/2016 09/29/2016 10/14/2016 10/18/2016
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281	F880 POC accepted 10/19/16 MBBotmandRN/PMC	

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F 281	Continued From page 3 not being given.	F 281	quality assurance program will be put into place? The results of these audits will be reviewed monthly at the Quality Assurance meeting until 100% compliance has been achieved and until such time the Quality Assurance Committee deems ongoing compliance can be sustained.	10/18/2016	
F 329 SS=D	483.25(I) 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 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 staff interview and record review, the facility failed to insure that 1 of 19 residents in	F 329	FAB1 POC accepted 10/19/16 M.Bertrand/PMC F329 The facility has and will continue to ensure each resident's drug regime continues to be free from unnecessary medications. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #72's physician and family has been notified of the medication error. Medication orders are correct and resident #72 is receiving the correct dose. Medication errors regarding resident #72's Ferrous Sulfate have been completed. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential of being affected by this alleged deficient practice.	09/28/2016	

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F 329	Continued From page 4 the Stage Two sample, (Resident #72), had a drug regimen that was free from unnecessary drugs. Findings include: Resident #72 was admitted to the facility from an acute care hospital on 8/8/16 after sustaining a fracture from a fall. The listed discharge medications included Ferrous Sulfate 325 milligrams (mg) to be given every other day. A review of the August electronic Medication Administration Record (MAR) on 9/28/16, presented that Ferrous Sulfate was given once a day and was documented as being administered 8/9-8/12/16. Further review of the MAR presents that on 8/14/16 the Ferrous Sulfate was to be given every other day and began that day. During interview with the Assistant Director of Nursing (ADNS), on 9/28/16 at 11:20 AM, the signed discharge orders from the hospital are accepted orders. S/he further stated that there is no medication error report that has been presented regarding the resident receiving the Ferrous Sulfate daily instead of as ordered every other day.	F 329	What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; Staff has been educated when entering admission orders, adding new orders and/or order changes to slow down and reread what they have entered for accuracy. Post admission audits will be performed which will include assuring all admission orders/new orders and/or order changes are transcribed correctly to the medication administration record. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The results of these audits will be reviewed monthly at the Quality Assurance meeting until 100% compliance has been achieved and until such time the Quality Assurance Committee deems ongoing compliance can be sustained. <i>F329 POC accepted 10/19/16 M Betrand R. Hand</i>	10/03/2016 10/18/2016	
F 372 SS=E	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to dispose of garbage and refuse properly for 2 out of 4 dumpsters. Findings include:	F 372	F372 Vernon Green continues to assure that garbage and refuse are properly disposed. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The compactor/dumpster behind the facility was removed from service until the previously scheduled repairs can be completed. It was replaced with an intact container. The dumpster behind the kitchen was replaced with an intact container.	09/27/2016	

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F 372	<p>Continued From page 5</p> <p>Per observation on 9/27/16 at 2:45 PM, the dumpster located in the back of the facility adjacent to the maintenance garage, was noted to have an odor of refuse. Per inspection of the dumpster by two (2) surveyors, identified that the bottom front and left side panel of the dumpster, was found with several rusted/corroded areas and two holes in the steel. A white congealed substance was noted on the ground under these corroded areas. The substance was also located on the pavement and extended several feet away from the dumpster. Per staff interview on 9/27/16 at approximately 2:45 PM confirmation was made, that staff had to walk and/or jump over the substance on the pavement to avoid tracking waste material into the building. Per interview with the Administrator at approximately 3:15 PM, s/he stated that s/he was aware the dumpster had been leaking since the Summer of 2015 and that it was on "the list" to be fixed. S/he stated that trash, lunch and dinner food scraps, and soiled briefs were put into the dumpster. The dumpster had no cooking waste. S/he confirmed that nothing was in place to help prevent tracking of the waste material into the facility.</p> <p>Per observation on 9/28/16 at 8:16 AM there were three dumpsters located approximately 20-30 feet from the back door of the facility's kitchen, if a person was standing with their back to the kitchen door entrance, the dumpster located on the far right and was used for food and cooking waste. This dumpster had two dime size corroded areas on the front panel with holes in the steel approximately one inch from the bottom of the panel. The dumpster had an odor of refuse and a white congealed substance was</p>	F 372	<p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>All residents have the potential to be affected by this alleged deficient practice.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;</p> <p>A monthly audit will be conducted by the maintenance department to assure that the refuse containers are intact. If leakage is discovered, the container will be removed from service as soon as possible.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>The refuse container audit will be conducted monthly and the results will be reviewed at Quality Assurance meetings to ensure ongoing compliance until the Quality Assurance committee has determined that 100% compliance has been achieved.</p> <p><i>F372 PDC accepted 10/19/16 MR Betrand RN/PMC</i></p>	<p>10/18/16</p> <p>10/18/16</p>	

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F 372	Continued From page 6 on the ground in front of it. Per interview on 9/28/16 at 8:16 AM with the Hospitality Services Director, s/he confirmed that there were holes in the dumpster and a white substance was on the ground in front of it. S/he stated that s/he did not know how long the holes had been in the dumpster or how long the dumpster had been leaking, and stated that s/he would replace the dumpster.	F 372			
F 520 SS=C	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS 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. 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. 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. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520	<u>F 520</u> The facility has and will continue to ensure that it maintains a quality assessment and assurance committee. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Medical Director was consulted regarding participation and attendance at scheduled quarterly Quality Assurance Committee Meeting. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by this alleged deficient practice.	10/06/16	

