

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

May 1, 2012

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

Provider #: 475008

Dear Mr. Ellis:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 21, 2012**. Please post this document in a prominent place in your facility.

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

Sincerely,



Pamela M. Cota, RN, MS
Licensing Chief

PC:ne

Enclosure



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

PRINTED: 04/05/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/21/2012
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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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(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 000	INITIAL COMMENTS	F 000	Allegation of Substantial Compliance	
F 250 SS=D	<p>An unannounced on-site recertification survey was conducted by the Division of Licensing and Protection from 03/19/2012 to 03/21/2012. The following regulatory issues were identified:</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and staff interview the facility failed to provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being for 1 resident (Resident #36) of 3 identified in the Stage 2 sample. The findings include:</p> <p>1. Per record review, Resident #36 was admitted on 12/13/11 with diagnosis that included Alzheimer dementia, anxiety and major depressive disorder (added on 1/25/12). Per interview with Resident #36's spouse on 3/19/12, he/she indicated that Resident #36 was not attending social activities and was upset related to the separation of Resident #36 and his/her spouse after 69 years of marriage. Review of the MDS assessment dated 1/10/12 indicates Resident #36 was coded as depressed, feeling bad about self, shows little interest in doing things. The MDS assessment dated 1/17/12 was</p>	F 250	<p>Vernon Green Nursing Home has and continues to be in substantial compliance with 42 CFR Part 483 subpart B. Vernon Green Nursing Home has or will have substantially corrected the alleged deficiencies and achieved substantial compliance by the date specified herein.</p> <p>This Plan of Correction constitutes Vernon Green Nursing Home's allegation of substantial compliance.</p> <p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To continue to remain in substantial compliance with state and federal regulations, Vernon Green Nursing Home has taken or will take the actions set forth in this plan of correction.</p> <p>F250</p> <p>The facility requests informal dispute resolution for Tag F250; respectfully maintains that it was and is in substantial compliance with federal regulations in respect to F250; respectfully denies and disputes the allegation that it was deficient in respect to F250; respectfully denies and disputes that any action or inaction on the part of the facility in respect to F250 caused any minimal harm or potential for any minimal harm to any facility residents; and requests that F250 be deleted from the public record.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *M. Bradford Ellis* TITLE *Executive Director* (X6) DATE *April 14, 2012*

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.

PMC

The facility will demonstrate it has fully met its' responsibility based on the regulatory requirement and the long term care survey guidelines:

- (A) substantial compliance with F250 by showing the facility was in compliance with the CMS State Operators Manual for the requirements of providing medically-related social services;
- (B) medically-related social services where provided to the resident;
- (C) psychological services had been recommended.

The facility has obtained and will continue to obtain medically-related social services through the facility's interdisciplinary services and involvement of the resident, resident's family and, primary care physician.

The regulation simply states that **“the facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.”** The regulatory language only states that this service be provided and does not specify a particular means, discipline and/or professional field in meeting this requirement.

Per SOM, Appendix PP, F250 regulatory Interpretive Guidelines **““Medically-related social services” means services provided by the facility’s staff to assist residents in maintaining or improving their ability to manage their everyday physical, mental, and psychosocial needs.”** In addition to medically-related social services provided by the facility staff Resident #36 has also been seen by the Dietitian, Dentist, Ophthalmologist, Radiologist, Occupational, Physical and Speech Therapy meeting the guidelines for medically-related social activities.

The surveyor states per the interview with Resident #36's spouse on 3/19/12 **“he/she indicated that Resident #36 was not attending social activities”**. Resident #36 is asked daily about coming to activities and will participate as well as decline. Although sporadic at times, Resident #36 has participated 53 days in the facility planned activities from 12/14/11 to 3/21/12. Resident #36 is less likely to attend planned activities when his/her spouse is visiting as they spend their time together dining or in Resident #36's room. The facility has and continues to provide social activities for Resident #36. Residents who are unable or do not wish to participate in group activities are offered 1:1. On 3/19/12 Resident #36 attended an afternoon social event while surveyors were in the facility.

The surveyor writes **“Review of the SS documentation, there is no evidence in the medical record that SS discussed the issues with the resident and family and created a plan of care to assist Resident #36 with his/her issues”**. Here the surveyor maybe indicating that the SS documentation should include all discussions of clinical discussions/interventions in SS documentation or indicating that the medical records did not include SS discussion of issues with the resident and family. Neither position is accurate as both the medical record and the SS documentation indicate the issues being addressed with the resident and family. Resident #36 and his/her family were invited to all care plan meetings and participated in 3 of the 5 of those meetings through 3/21/12. Clinical Conference Notes mention two occasions that family received updates other than care plan meetings, 3/8/12 **“(Spouse) updated during visits”**, 1/19/12 SSD spoke with Resident #36's son. The nursing documentation indicates that staff spoke with Resident #36 family over 20 times from 12/13/11 to 3/8/12.

The surveyor also states **“created a plan of care to assist Resident #36 with his/her issues”**. A plan of care for Resident #36 has been discussed with the family involvement. On 3/8/12 and per the Clinical Conference Note Resident #36 refused to participate. Included in the Clinical Conference on 3/8/12 the following areas where discussed:

Cognitive Loss:

Goal:(Resident) will actively participate in diversional activities of his choice daily

Mood/Behavior:

Goal: Will accept redirection during episodes of increased restlessness

Communication:

Goal: Demonstrate ability to understand as evidenced appropriate response or action

The facility has and continues to work with Resident #36's and his/her family.

Please note there is no indication that the surveyor interviewed Resident #36 or documented any social service concerns expressed by Resident #36. The surveyor does indicate that Resident #36 should be recommended for psychosocial services which would imply that Resident #36 is able to appropriately communicate his/her feelings.

The surveyor states "no psychological services had been recommended". This statement is inaccurate; the surveyor asked the SSD if the services of "Deer Oaks" had been recommended. The SSD answered correctly in that the service of Deer Oaks had not been recommended by him/her. The SSD was aware that Resident #36 was being seen by the facility's consulting APRN-CS. The Clinical Conference Note on 3/8/12 states "consult with Vicki Wilk, APRN-CS as needed". The SSD works in collaboration with the other facility disciplines in making that this type of recommendation.

Vicki Wilk APRN-CS has a M.S. Psychiatric Mental Health Nursing and is member of the Psychiatric Clinical Nurse Specialists. The National Panel for Psychiatric-Mental Health NP Competencies defines part of Nurse Practitioner's competencies as:

DOMAIN 1. MANAGEMENT OF PATIENT HEALTH/ILLNESS STATUS

COMPETENCIES

The nurse practitioner demonstrates competence in the domain of management of patient health/illness status when s/he performs the following behaviors in the following areas.

A. Health Promotion/Health Protection and Disease Prevention

3. Provides anticipatory guidance and counseling to promote health, reduce risk factors, and prevent disease and disability, based on age, developmental stage, family history, and ethnicity.

Resident #36 was seen by facilities consulting APRN-CS on 12/21/11, 1/4/12, 1/18/12, 1/25/12, 2/15/12, 3/7/12 and 3/21/12. In the APRN-CS consultation report dated 3/21/12, it was noted that it had been suggested that Resident #36 be seen by "Deer Oaks" and that suggestion had been refused by Resident #36. It should also be noted that Resident's #36 primary care physician had seen Resident #36 three times and he did not consider any further psychological services than those already being provided by the facilities consulting APRN-CS.

The facility's consulting APRN-CS does recommend residents to be evaluated by "Deer Oaks" as needed and warranted.

In addition, five surveyors spent over 110 hours over 3 days at the facility observing facility staff duties and documentation. The surveyors have provided no substantiate evidence that the medically-related social services were not met per the regulation. The survey finding was based on misleading questions, no evident communication with the resident, a misunderstanding of the scope of professional practices and incomplete review of the medical record.

The facility has demonstrated:

- (A) substantial compliance with F250 by showing the facility was in compliance with the CMS State Operators Manual for the requirements of providing medically-related social services;
- (B) medically-related social services where provided to the resident;
- (C) psychological services had been recommended and refused.

The facility respectively disputes this finding and has and will continue to provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

It is the position of the facility that this finding extended beyond the scope of the requirement and respectfully request that this finding, F250, be removed from the CMS form 2567 and public record for the March 21, 2012 survey at Vernon Green Nursing Home.

The facility request a clean (new) copy is generated of CMS form 2567 Statement of Deficiencies to reflect any changes and/or deletions made as a result of the informal dispute resolution/informal review.

F250 continued from page 1b

F250

The Facility has and continues to ensure that residents are provided medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

What corrective action will be accomplished for those residents found to have been affected by the deficient practice?

The resident continues to be seen by his/her physician, V. Wilk, APRN-CS. The psychological service of Deer Oaks have been recommended and initiated.

04/02/12

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 that are admitted with history or diagnosis of depression have the potential to be affected by this alleged deficient practice.

04/16/12

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;

When a resident is newly admitted or is believed to be having depressive features the resident will be referred to V. Wilk, APRN-CS for evaluation of current treatment/new treatment and to asses if the resident could benefit from Deer Oaks.

04/16/12

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F 250	Continued From page 1 coded that Resident #36 was feeling down and depressed, little interest in doing things and physically and verbally abusive towards others. The MDS assessment dated 2/28/12 indicates Resident #36 feels down and depressed, rejects care and is verbally and physically aggressive toward others. Per review of the Social Service (SS) notes from 12/29/11 through 3/8/12, the documentation indicates that Resident #36 is restless, asks to go home, asks for spouse, has reactive depression, rude/sarcastic/demanding behavior towards staff, resistive to getting out of bed, and refusing social interaction. Review of the SS documentation, there is no evidence in the medical record that SS discussed the issues with the resident and family and created a plan of care to assist Resident #36 with his/her issues. Per interview with the Social Service Director (SSD) on 3/21/12, he/she confirmed that there was no documentation in the Social Service (SS) notes indicating that any of the issues listed in the documentation (asking to go home, asks for wife, is depressed, is restless, resistive to care and rude/sarcastic/demanding towards staff, and thinking he/she was going to die.) were addressed with Resident #36 by SS. Per interview with the SSD on 3/21/12 he/she confirmed that no psychological services had been recommended for Resident #36.	F 250	F250 continued from page 1c How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Director of Nurses or designee will conduct Quality Assurance/Quality Improvement audits to ensure continued compliance of staff to ensure the residents highest practicable physical, mental, and psychosocial well-being is being attained or maintained. The audits will be conducted weekly for one month, and then bi-monthly for three months until 100% compliance is obtained. The Director of Nurses or designee will report the results of the audits to the Quality Assurance Committee which will determine the need for further monitoring.	04/16/12
F 280 SS=D	Refer also to F319. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280	<i>F250 POC accepted as circled 4/26/12 G. Coleman RN / Director RN</i> F 280 The Facility has and continues to ensure that the care plans are developed/ revised and/or reviewed as needed and that residents can participate in their plan of care. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; The resident's falls will be documented on the resident's care plan and dated with new intervention/or to continue current interventions if appropriate. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;	04/16/12

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F 280	Continued From page 2 participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to revise the comprehensive care plan for 1 of 3 residents with a history of falls in the targeted sample. (Resident #35) The findings include: 1. Per record review on 3/20/12, Resident #35 was admitted on 8/4/11, with diagnoses that included history of falls, difficulty walking, and generalized muscle weakness. Per review of the nurses' notes dated 3/8/2012 at 7:00 PM, Resident #35 was "found on the floor, sitting leaning [his/her] head against the bed". Per review of the Fall risk assessment form dated 2/2/12, Resident #35 scored a 20, indicating that Resident #35 was a high risk for falls. Review of the comprehensive care plan, the fall on 3/8/12	F 280	F280 continued from page 2 All residents at risks for falls have the potential to be affected by this alleged deficient practice. Nursing staff will comply with Policy and Procedure and update care plans with each resident's fall. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; Licensed nurses will be educated on the importance of following the policy and procedure pertaining to falls and all steps to be followed. Education will be provided on care plan compliance and the importance of dating any/all care plan when changes are made at an in-service for all nursing staff and will be reviewed at the RN/LPN meeting. During falls meetings the care plans will be brought to the meeting and reviewed to assure the changes are accurate/appropriate and dated. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Director of Nurses or designee will conduct Quality Assurance/Quality Improvement audits to ensure continued compliance of staff and that the plan of care is being followed. The audits will be conducted weekly for one month, and then bi-monthly for 3 months until 100% compliance is obtained. The DON or designee will report the results of the audits to the Quality Assurance committee which will determine the need for further monitoring. <i>F380 POC accepted 4/26/12 Gademan RN / P. McTear</i>	04/16/12 04/18/12 04/18/12

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F 318	<p>Continued From page 4</p> <p>Resident #35 had a contracted finger (abnormal shortening of muscle tissue, rendering the muscle highly resistant to passive stretching) on his/her right hand and that Resident #35 received range of motion (ROM) but did not have a splint. Per observation on 3/20/12, the surveyor observed that Resident #35 had a contracted fourth finger on the right hand. Per review of the medical record on 3/20/12, the Occupational Therapy Initial Evaluation dated 8/8/11, indicated that Resident #35 had a "Dupuytren's contracture (a flexion deformity of the fingers or toes, due to shortening, thickening, and fibrosis of the palmar or plantar fascia, of the fourth digit.)</p> <p>Per review of the Occupational Therapy notes there was no evidence that the facility determined whether Resident #35 was in need of therapy services related to the finger contracture. Per interview on 3/21 at 9:06 AM with the supervisor for the Therapy Department, he/she reviewed the Occupational Therapy Evaluation dated 8/8/11 and reviewed all the occupational therapy notes and confirmed that there was no documentation of what the treatment plan was for Resident #35 concerning the contracture. The Therapy Supervisor indicated that his/her expectation was that after the initial evaluation was conducted that documentation of a treatment plan for Resident #35 should have occurred. Per review of the comprehensive care plan titled ADL (Activities of Daily Living)/Falls, the care plan indicated that staff was to "provide gentle range of motion" to the contracted ring finger on the right hand as "the resident will tolerate". Per interview with the Unit Manager on 3/20/12, he/she indicated that ROM was documented in the nurses notes and in the LNA's (Licensed Nursing Assistant) ADL</p>	F 318	<p>F318 continued from page 4</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>Residents that have Dupuytren's contracture or other types of contractures will be screened by the therapy department and their recommendations will be implemented unless not approved by the attending MD.</p> <p>Staff will have a re-education at nursing meeting. A Range of Motion In-service was held on March 20th, 2012.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Director of Nurses or designee will conduct Quality Assurance/Quality Improvement audits to ensure continued compliance of the staff and that the plan of care is being followed. The audits will be conducted weekly for one month then bi-monthly for three months until 100% compliance is obtained. The Director of Nurses or designee will report the results of the audits to the Quality Assurance Committee which will determine the need for further monitoring.</p> <p><i>F318 POC accepted 4/26/12 G Coleman RN / P. Mactar RN</i></p>	03/22/12 04/16/12

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F 318	Continued From page 5 documentation under ROM. Per review of the nurses notes and the LNA's ADL documentation for ROM, there was no evidence that ROM had been offered, or attempted with Resident #35's contracted finger. Per interview with the UM on 3/21/12, he/she reviewed the Nurses Notes and the LNA's ADL ROM documentation and confirmed that there was no documentation that ROM was offered or attempted for Resident #35, for the contracted fourth finger on the right hand.	F 318		
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that 1 resident (Resident #36) of 3 who displays mental or psychosocial adjustment difficulties receives appropriate treatment and services to address the assessed problem. The findings include: 1. Per record review, Resident #36 was admitted on 12/13/11 with diagnoses that included Alzheimer dementia, anxiety and major depressive disorder (added on 1/25/12). Per interview with Resident #36's spouse on 3/19/12, he/she indicated that Resident #36 was not attending social activities and was upset related to the separation of Resident #36 and his/her	F 319	F319 The facility requests informal dispute resolution for Tag F319; respectfully maintains that it was and is in substantial compliance with federal regulations in respect to F319; respectfully denies and disputes the allegation that it was deficient in respect to F319; respectfully denies and disputes that any action or inaction on the part of the facility in respect to F319 caused any minimal harm or potential for any minimal harm to any facility residents; and requests that F319 be deleted from the public record. The facility will demonstrate it has fully met its' responsibility based on the regulatory requirement and the long term care survey guidelines: (A) substantial compliance with F319 by showing the facility was in compliance with the CMS State Operators Manual for the requirements of providing appropriate treatment and services to correct assessed problem; (B) psychological services had been recommended.	

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F 319	<p>Continued From page 6</p> <p>spouse after 69 years of marriage. Per review of the physician's progress notes dated 1/5/12 indicated that Resident #36 is very sad, misses his wife, this makes him bitter at times, that Resident #36 stated "I don't like this place" and that the physicians impression was that Resident #36 was depressed related to separation from his/her spouse. On 2/2/12, the physician's notes indicate that Resident #36 continues to miss his/her spouse, is resistive to care, worries about spouse and is agitated secondary to separation from spouse. Per documentation on 3/8/12, the physician indicates that Resident #36 is "generally withdrawn and prefers to stay in bed, some episodes of striking out and sometimes angry when pushed".</p> <p>Per review of the consultation notes on 12/21/11 by the facility Nurse Practitioner (NP), he/she indicates that Resident #36 stated he/she is sad. The NP consult report dated 1/18/12 indicates that Resident #36 has a low mood, was sad and low motivation. The physicians note on the consult report dated 1/18/12 indicated that Resident #36 is perpetually upset by not being with his/her spouse, and that the physician did not believe that Resident #36's grief could be medicated away and that the spouse would be visiting again soon.</p> <p>Per review of the Nurses Notes from 12/13/11 to 3/20/12 indicates numerous episodes that Resident #36 is withdrawn, asking where wife is, resistive to care, refusing to participate in social activities, refusing to speak with staff at times, demanding to be left alone refusing to get out of bed, verbally abusive toward staff, refusing to eat and on 12/27/11 indicated to staff that he/she was</p>	F 319	<p>F319 continued from page 6</p> <p>The regulation simply states that "A resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem;" The regulatory language only states that appropriate treatment and service be provided and does not specify a particular means, discipline and/or professional field in meeting this requirement.</p> <p>The surveyor is correct in stating that Resident #36 was admitted to the facility with the diagnoses of Alzheimer's dementia. The Appendix PP of the SOM under F319 identifies one of the "clinical conditions that may produce apathy, malaise, and decreased energy levels that can be mistaken as depression with mental or psychosocial adjustment difficulty are:... • Central nervous system diseases (e.g. ..., Alzheimer's disease,...)" As a diagnoses for Resident #36, Alzheimer's disease needs to be an important consideration when addressing Resident #36 plan of care. Due to memory loss associated with Alzheimer's psychosocial counseling has limited effectiveness in adapting to changes in life's circumstances.</p> <p>The surveyor states per the interview with Resident #36's spouse on 3/19/12 "he/she indicated that Resident #36 was not attending social activities". Resident #36 is asked daily about coming to activities and will participate as well as decline. Although sporadic at times, Resident #36 has participated 53 days in the facility</p>	

planned activities from 12/14/11 to 3/21/12. Resident #36's spouse visit approximately 3 times per week. Resident #36 is less likely to attend planned activities when his/her spouse is visiting as they spend their time together dining or in Resident #36's room. The facility has and continues to provide social activities for Resident #36. Residents who are unable or do not wish to participate in group activities are offered 1:1. On 3/19/12 Resident #36 attended an afternoon social event while surveyors were in the facility.

In review of the physician's progress notes the surveyor correctly documents the following "notes dated 1/5/12 indicated that Resident #36 is very sad, misses his wife, this makes him bitter at times ... "I don't like this place"" and then from a physician note from 3/8/12 "generally withdrawn and prefers to stay in bed...". The surveyor did not include from the same physician's progress note dated 3/8/12 that the physician also stated "weight is slightly increased", "says (he/she) is comfortable", sleeps well", enjoys (his/her) food", "denies any physical complaints", and "not as sad/angry/negative as on admission". Also in the Clinical Conference Notes dated 2/9/12, "Writer spent some time with (Resident #36) and asked (him/her) about how (he/she) feels about being here and whether or not (he/she) feels content. (Resident #36) responded that (he/she) feels things are pretty good, (he/she) like the food and (he/she) says (he/she) has what he needs."

Per review of the consultant notes by the facility Nurse Practitioner (NP)" the surveyor states "The NP consult report dated 1/18/12 indicates that Resident #36 has a low mood, was sad and low motivation." The NP (Vicki Wilk APRN-CS) did state in a Consultation note on 3/21/12, "Met with Mr. and Mrs. (Resident #36 last name), today, (Resident #36) is feeling a bit better, attended activities today, stayed with his wife in dining room" also in that note it was stated "(Resident #36) mood has improved".

Please note there is no indication that the surveyor interviewed Resident #36 or documented any social service concerns expressed by Resident #36. The surveyor does indicate that Resident #36 should be recommended for psychosocial services which would imply that Resident #36 is able to appropriately communicate his/her feelings.

The surveyor points out many areas that are part of the accurate assessment of Resident #36's usual routine, verbal communication and behaviors. The facility documents these areas to assist in accurately document and assess Resident #36 usual and customary routines. The facility uses this information to appropriately care plan for the Resident #36's assessed needs:

Cognitive Loss:

Goal:(Resident) will actively participate in diversional activities of his choice daily

Mood/Behavior:

Goal: Will accept redirection during episodes of increased restlessness

Communication:

Goal: Demonstrate ability to understand as evidenced appropriate response or action

ADL/Rehap

Goals: Will complete ADL care with extensive nursing assist

Will have no fall resulting in injury in the next 90 days

Will have safe ambulation utilizing rolling walker to destinations

Activities

Goal: Will attend activities of interest daily

Nutritional Status:

Goal: Will have no significant weight loss or gain

Psychotropic Medication Use:

Goal: Will demonstrate reduced feelings of anxiety

Will demonstrate no s/sx of adverse side effects R/T antianxiety med us

Will demonstrate improved appetite on current antidepressant med

Will demonstrate reduced feelings of agitation on current antidepressant med

Will demonstrate no s/sx of adverse side effects R/T antidepressant med use

Will demonstrate decreased episodes of restless agitation

Will demonstrate no s/sx of adverse side effects R/T antipsychotic med use

The surveyor states per the interview with the Unit Manager (UM) "Resident #36 could probably benefit from a psychological evaluation". This statement is inaccurate; the surveyor asked the UM "would you offer Deer Oaks?" To which the UM responded "yes, if these interventions don't work". The UM did correctly confirm that there was no documentation in medical record that a recommendation to Deer Oaks had been made. The UM is very aware of the resident status and full

range of services being provided and available to Resident #36 and that Resident #36 is being seen by the facility's consulting APRN-CS. The Clinical Conference Note on 3/8/12 states "consult with Vicki Wilk, APRN-CS as needed". The SSD works in collaboration with the other facility disciplines in making this type of recommendation.

The surveyor states "no psychological services had been recommended". This statement is inaccurate; the surveyor asked the SSD if the services of "Deer Oaks" had been recommended. The SSD answered correctly in that the service of Deer Oaks had not been recommended by him/her. The SSD was aware that Resident #36 was being seen by the facility's consulting APRN-CS. The Clinical Conference Note on 3/8/12 states "consult with Vicki Wilk, APRN-CS as needed". The SSD works in collaboration with the other facility disciplines in making this type of recommendation.

Vicki Wilk APRN-CS has a M.S. Psychiatric Mental Health Nursing and is member of the Psychiatric Clinical Nurse Specialists. The National Panel for Psychiatirc-Mental Health NP Competencies defines part of Nurse Practitioner's competencies as:

**DOMAIN 1. MANAGEMENT OF PATIENT HEALTH/ILLNESS STATUS
COMPETENCIES**

The nurse practitioner demonstrates competence in the domain of management of patient health/illness status when s/he performs the following behaviors in the following areas.

A. Health Promotion/Health Protection and Disease Prevention

3. Provides anticipatory guidance and counseling to promote health, reduce risk factors, and prevent disease and disability, based on age, developmental stage, family history, and ethnicity.

Resident #36 was seen by facilities consulting APRN-CS on 12/21/11, 1/4/12, 1/18/12, 1/25/12, 2/15/12, 3/7/12 and 3/21/12. In the APRN-CS consultation report dated 3/21/12, it was noted that it had been suggested to Resident #36 that he/she be seen by "Deer Oaks" and that suggestion had been refused by Resident #36. It should also be noted that Resident's #36 primary care physician had seen Resident #36 three times and he did not consider any further psychological services than those already being provided by the facilities consulting APRN-CS.

The facility's consulting APRN-CS does recommend residents to be evaluated by "Deer Oaks" as needed and warranted. APRN-CS confirmation "that there was no documentation in the medical record that psychological services had been recommended to Resident #36" would have been accurate as the APRN-CS is the facilities consulting Psychiatric Nurse Practitioner and does refer resident to "Deer Oaks". Again, the Clinical Conference Note on 3/8/12 states "consult with Vicki Wilk, APRN-CS as needed".

In addition, five surveyors spent over 110 hours over 3 days at the facility observing facility staff duties and documentation. The surveyors have provided no substantiate evidence that the medically-related social services were not met per the regulation. The survey finding was based on misleading questions, no evident communication with the resident, a misunderstanding of the scope of professional practices and incomplete review of the medical record.

The facility has demonstrated:

- (A) substantial compliance with F319 by showing the facility was in compliance with the CMS State Operators Manual for the requirements of providing appropriate treatment and services to correct assessed problem;
- (B) psychological services had been recommended.

The facility respectively disputes this finding and has and will continue to provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

It is the position of the facility that this finding extended beyond the scope of the requirement and respectfully request that this finding, F319, be removed from the CMS form 2567 and public record for the March 21, 2012 survey at Vernon Green Nursing Home.

The facility request a clean (new) copy is generated of CMS form 2567 Statement of Deficiencies to reflect any changes and/or deletions made as a result of the informal dispute resolution/informal review.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/21/2012
NAME OF PROVIDER OR SUPPLIER VERNON GREEN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 61 GREENWAY DRIVE VERNON, VT 05354	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 319	<p>Continued From page 7</p> <p>going to die today. Per review of the Social Services notes, the notes from 12/29/11 to 3/8/12 indicate that Resident #36 ask to go home and asks for wife, is depressed, would like to spend more time with wife, looks for family frequently, is restless, resistive to care and rude/sarcastic/demanding towards staff.</p> <p>Review of the MDS assessment dated 1/10/12 indicates Resident #36 was coded as depressed, feeling bad about self, shows little interest in doing things. The MDS assessment dated 1/17/12 was coded that resident #36 was feeling down and depressed, little interest in doing things and physically and verbally abusive towards others. The MDS assessment dated 2/28/12 indicated Resident #36 feels down and depressed, rejects care and is verbally and physically aggressive toward others.</p> <p>Per interview with the Unit Manager of 'A' wing on 3/21/12, he/she indicated that Resident #36 was depressed related to the separation from his/her spouse, was resistive to care and social interaction and that Resident #36 could probably benefit from a psychological evaluation. The UM confirmed that any member of the interdisciplinary team (the nurse, activities, social worker, physician, administration, therapy) could recommend an evaluation and that there was no documentation in the medical record that this had been done.</p> <p>Per interview with the Social Service Director (SSD) on 3/21/12, he/she indicated that there was no documentation in the Social Service (SS) notes indicating that any of the issues listed in the documentation (asking to go home, asks for wife,</p>	F 319	<p>F 319 continued from page 7b</p> <p>The facility has and continues to ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The resident continues to be seen by his/her physician, V. Wilk, APRN-CS. The psychological service of Deer Oaks have been recommended and initiated.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>All residents that are admitted with history or diagnosis of depression 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>When a resident is newly admitted or is believed to be having depressive features the resident will be referred to V. Wilk, APRN-CS for evaluation of current treatment/new treatment and to asses if the resident could benefit from Deer Oaks.</p>	<p>04/02/12</p> <p>04/16/12</p> <p>04/16/12</p>

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NAME OF PROVIDER OR SUPPLIER VERNON GREEN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 61 GREENWAY DRIVE VERNON, VT 05354
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F 319	Continued From page 8 is depressed, is restless, resistive to care and rude/sarcastic/demanding towards staff, thinking he/she was going to die.) were addressed with Resident #36 by SS. Per interview with the SSD he/she confirmed that no psychological services had been recommended for Resident #36 and did not know why. Per interview with the facility NP on 3/21/12 he/she confirmed that Resident #36 was depressed related to the separation from his/her wife and that there was no documentation in the medical record that psychological services had been offered to Resident #36. Refer also to F250.	F 319	F 319 continued from page 8 How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Director of Nurses or designee will conduct Quality Assurance/Quality Improvement audits to ensure continued compliance of staff to ensure the residents highest practicable physical, mental, and psychosocial well-being is being attained or maintained. The audits will be conducted weekly for one month, and then bi-monthly for three months until 100% compliance is obtained. The Director of Nurses or designee will report the results of the audits to the Quality Assurance Committee which will determine the need for further monitoring.	04/16/12
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to assess and/or provide assistance monitoring devices to ensure 1 of 3 applicable residents (Resident #61) in the stage 2 sample remain as free from accidents as possible. Findings include: 1. Per observation during the initial tour on	F 323	F 319 POC accepted as circled 4/26/12 F 323 The facility has and continues to ensure that the resident's environment is free of accidents, hazards and provides adequate supervision and assistance devices to prevent accidents. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; All residents that have alarms will be monitored and checked off on a flow sheet each shift for those residents that are care planned to have an alarm to assure the alarm is on when the person is care planned to have it on. There will no longer be any PRN alarms.	04/16/12

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F 323	Continued From page 9 03/19/12 at 11:15 AM, Resident #61's laser alarm was not on. When asked by the nurse surveyor at that time, the LNA (Licensed Nursing Assistant) stated "it should be on when [Resident #61] is in bed" and proceeded to turn the alarm on. Per observation and subsequent interview on 3/19/12 at 5:00 PM, the laser monitor alarm was again not on and the LNA stated that if [Resident #61] "is restless we turn it on". Per record review, the resident had 29 falls from 01/09/11 through 02/26/12. The falls ranged from slipping from wheelchair or bed, unsteady gait or transfers, to unwitnessed falls out of bed or in the bathroom. The care plan for impaired mobility, originally dated 01/20/11, requires total assist with all transfer/mobility related to falls, call bell within reach when in room at all times, bed alarm PRN [as needed], laser alarm, in depth eval [evaluation] if fall occurs, falling star on doorway". The care plan had a notation dated 11/16/11 which states 'laser alarm put in place'. Per a nursing note dated 02/23/12 at 11:15 am, states Resident #61 was "found on right side knees down up to chest". Another nursing note dated 02/26/12 at 7:20 am states the Resident was "found by staff on floor, lying on right side near cabinet, laser alarm did not go off as resident went off bed on other side [right side] of bed... bed alarm placed on bed as intervention." On 02/26/12 the care plan was changed from bed alarm PRN to 'bed alarm when in bed'. Per interview on 03/20/12 at 2:36 PM the Unit nurse confirmed that staff did not consistently apply monitoring devices or monitor the effectiveness of the interventions to prevent accidents, based on lack of documentation and the surveyor's observations and interviews above.	F 323	F 323 continued from page 9 How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. Any resident that needs any type of alarm for safety will have alarm checks done every shift to assure it is on and in working condition. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur; Nursing staff will be re-educated for their role to ensure the care plan is implemented as recommended. Nursing staff will be re-educated as to their role in the process of assuring the alarms are on and functional. If the resident has an intervention to utilize an alarm, whether it be clothing, bed, chair or laser it alarm it will be monitored every shift to assure it is on and in working order where and when it needs to be utilized per care plan. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? Director of Nurses or designee will conduct Quality Assurance/Quality Improvement audits to ensure continued compliance of staff and that the care plan is being followed and the alarms are checked for placement and working order. The audits will be conducted weekly for one month, and then bi-monthly for three months until 100% compliance is obtained. The Director of Nurses or designee	04/16/12 04/16/12 04/18/12	

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F 329	Continued From page 11 the resident received Depakote for agitation and impulsive behaviors and Lithium for Bi-polar disorder. The care plan for mood disorder directed staff to monitor side effects and attempt to identify the cause of anxiety and/or agitation. Per the pharmacy's medication regimen review dated 1/30/12, Depakote was decreased due to the resident having falls. A fax sent to the primary provider on 02/09/12 states "there has been increased behaviors since the decreased Depakote ... recommendation to give Lithium 300 mg [milligrams] at PM and HS [hour of sleep]". Per nursing notes from 01/25/12 - 02/8/12 there was no evidence that there was an increase in the behaviors, with 2 notations on 02/05/12 & 02/06/12 of "resistive to incontinent care but was able to be re-directed". In addition, the facility's Behavior Detail report sheet from 01/29/12 through 02/09/12 throughout all shifts shows no evidence of increase in behaviors. Per interview on 03/21/12 at 10:00 AM the DNS (Director of Nursing Services) confirmed that there was not adequate indications for the increase in dosage for the psychotropic medication Lithium.	F 329	F 329 continued from page 11 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; The licensed nurses will be re-educated on the importance of documenting when a resident has behavior that would recommend an increase in a psychoactive medication. The goal is to reduce psychoactive medications and the documentation of behaviors needs to be documented as such. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Director of Nurses or designee will conduct Quality Assurance/Quality Improvement audits to ensure continued compliance of staff and that the plan of care is being followed. The audits will be conducted weekly for one month, and then bi-monthly for three months until 100% compliance is obtained. The Director of Nurses or designee will report the results of the audits to the Quality Assurance Committee which will determine the need for further monitoring. <i>F329 POC accepted 4/12/12 G Coleman RN Director RN</i>	04/18/12 04/18/12