VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

September 25, 2018

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 **August 29, 2018.** 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475008	A. BUILDING _____ B. WING _____	08/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERNON GREEN NURSING HOME	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
E 000	Initial Comments During an unannounced onsite re-certification survey between 8/27 through 8/29/18, the facility was found in substantial regulatory compliance regarding emergency preparedness.	E 000	Allegation of Substantial Compliance Vernon Green Nursing Home, herein after sometimes "facility", has and continues to be in substantial compliance with 42 CFR Part 483 subpart B and State of Vermont *Licensing and Operation Rules for Nursing Homes*. Vernon Green Nursing Home has or will have substantially corrected the alleged deficiencies and achieved substantial compliance by the date specified herein. This Plan of Correction constitutes Vernon Green Nursing Home's allegation of substantial compliance such that the alleged deficiencies cited have been or will be substantially corrected on or before October 12, 2018. 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.	
F 000	INITIAL COMMENTS An unannounced onsite re-certification survey was conducted by the Division of Licensing and Protection between 8/27 through 8/29/18. There were regulatory findings.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880	**F 880** The facility has and will continue to ensure that it has established and will maintain an infection prevention and control program. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** All residents were screened upon admission for Tuberculosis (TB). No residents currently residing within the facility show any signs or symptoms of active TB disease. A two-step TB Mantoux screening process has been initiated for all residents upon their admission.	09/11/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

POC sent 9-24-18 BB/SP

M. Bradford Ellis — Executive Director — 9.20.18

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 880	Continued From page 1 procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its	F 880	**F880 Continued from page 1** **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 will be provided with a two-step TB Mantoux screening process upon admission to the facility unless otherwise indicated.	09/11/18
			What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; The facility's TB exposure control plan has been reviewed and revised. All nursing staff will be educated on the facility's TB exposure control plan and to the requirements of the facility's two-step TB Mantoux screening.	10/05/18
			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 Infection Control Preventionist (or DON designee) will provide ongoing monitoring of this process to ensure compliance. Results of this audit will be brought to the QAPI meeting monthly and/or until 100% compliance is achieved.	10/05/18
			POC 9.24.18 BB/SH	

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F 880	Continued From page 2	F 880		

IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:
Based on staff interview, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Findings include:

Per observation on 08/29/18 at 9:22 AM, accompanied by the Licensed Practical Nurse (LPN), an open vial of Tuberculin Purified Protein Derivative (TPPD used for testing for (TB) tuberculosis) was found in the "A wing" refrigerator and there was no date to indicate when the vial was opened. The LPN stated that the vial was only used for newly hired staff. Upon inquiring about the TPPD used for newly admitted residents the LPN stated that they don't test the residents for TB. Interview with the Assistant Director of Nurses, s/he stated that the TB testing has not been done on residents since s/he was hired nine years ago. The Director of Nurses (DON) confirmed on 8/29/18 at 10:42 AM that the facility does not test residents for TB upon admission. The DON further stated that if a resident is admitted from another facility or from home, there is not always information available to determine if TB testing had been previously done.

Reference: CDC recommendations and guidelines
Morbidity and Mortality Weekly Report
Centers for Disease Control and Prevention
1600 Clifton Rd, MailStop E-90, Atlanta, GA 30333, U.S.A
July 13, 1990 / 39(RR-10);7-20

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F 880	Continued From page 3 Skin tests should be administered to all new residents and employees as soon as their residency or employment begins unless they have documentation of a previous positive reaction. A two-step procedure is advisable for the initial testing of residents and employees in order to establish a reliable baseline (11-13).	~~F 880~~	**F 881** The facility has and will continue to ensure that it has established and will maintain an infection prevention and control program, which includes antibiotic stewardship. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** The facility has reviewed all residents who are currently on antibiotics and have been found to be 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;** All residents within the facility who are currently on antibiotic therapy have been reviewed for appropriate use of antibiotics. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** An Infection Control Preventionist position has been established and a monitoring program has been developed. Nursing staff are being educated on antibiotic stewardship guidelines, and how to maintain a surveillance program. **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?** Antibiotic and infection surveillance will be ongoing by the Infection Control Preventionist (or DON/designee) and results will be brought to the QAPI meeting monthly for six months and/or until 100% compliance is achieved.	09/11/18 09/11/18 10/12/18 10/02/18
F 881 SS=C	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility policies and procedures, the facility failed to develop a comprehensive antibiotic stewardship program. Findings include: Per review of the guidelines for the formation of an antibiotic stewardship program, the facility has not yet established a program that addresses the requirements that include antibiotic use protocols and a system to monitor antibiotic use. The Director of Nurses (DON) confirms this during interview on 8/29/2018.	F 881		
F9999	FINAL OBSERVATIONS LICENSING AND OPERATING RULES FOR NURSING HOMES (STATE REGULATIONS) 2.7 Special Care Units	F9999	9-24-18 AC amnt BB/BL	

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F9999	Continued From page 4 a. The facility must obtain approval from the licensing agency prior to establishing and operating a Special Care Unit. Approval will be based on a demonstration that the Unit will provide specialized services to a specific population. b. A request for approval must include all of the following: 1. A statement outlining the philosophy and purpose of the unit, including a description of the form of care, treatment, program or scope of services to be provided that distinguishes it as being especially applicable to or suitable for residents; 2. A definition of the categories of residents to be served; 3. A description of the organizational structure of the unit consistent with the unit's philosophy, purpose and scope of services; 4. A description and identification of physical environment; 5. The criteria for admission, continued stay and discharge which shall also include any criteria used for moving residents within the facility, into or out of a unit; and 6. A description of unit staffing to include: i. staff qualifications; ii. orientation; iii. in-service education and specialized training; and iv. medical management and credentialing as necessary. c. In addition to the requirements set forth in 2.7 a. and b., dementia units are required to have: 1. Secured outdoor space and walkways that allow residents to ambulate but prevent undetected egress; 2. High visual contrasts between floors and walls and doorways in resident use areas. Except for fire exits, doors, and access ways may be designed to minimize contrast. 3. Non-reflective floors, walls and ceilings to minimize glare; 4. Adequate and even lighting which minimizes glare and shadows; Based on observations, record reviews, and staff interviews the facility failed to assure that the	F9999	**F 9999** The facility has and will continue to ensure that it has established and will maintain a Special Care Unit (SNU) General Operating Policy (GOP) that provides guidance which meets the needs of the SNU residents. It is the assessment of the facility that this finding of noncompliance with the State of Vermont's *Licensing and Operation Rules for Nursing Homes* is correct as it relates to the facility's SNU GOP being dated. The SNU programming has, however, evolved through the years to continually meet the SNU residents' needs. Staffing for the SNU has been adjusted to address the current acuity of the resident population. In the past few years 12 hours per week of activity programming has been added through the evening hours. In addition to the Licensed Nursing Assistant (LNA) scheduled on the SNU, other LNA's are consistently assigned to the SNU to assist with mealtimes. The Center for Medicare and Medicaid Services' State Operations Manual Appendix PP-Guidance to Surveyors for Long Term Care Facilities provides direction that residents should not be transferred to other rooms in the facility "if that transfer is solely for the convenience of staff". While being mindful of aging-in-place, residents are allowed to remain on the unit longer than outlined in the dated SNU GOP. Also, it is often the desire for the families of SNU residents to leave their loved one on the SNU as the residents are familiar with the staff, other residents and the surroundings even when the resident is no longer able to participate in the SNU programming. POC amt 9.24.18 BB/BA	

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F9999	Continued From page 5 facility Special Care Unit was sufficiently staffed according to resident acuity and that residents residing on the special care unit met the criteria for admission/retention as outlined in the request for approval for the operation of a special care unit. Findings include: Per observations from 8/27-8/29/18, residents on the locked Dementia unit are observed to exhibit behaviors including, but not limited to, agitation, resistance to care, and perseveration. Residents are present on the unit whose care needs include assistance to be mobile, staff were observed feeding 8 residents during the first lunch observation, and residents are observed transferring via mechanical lift. In a review of records and information provided by the Director of Nursing Services (DNS) there are a number of residents who require significant assistance. Of nine residents selected for inclusion in the initial pool, 5 residents had a Brief Interview of Mental Status (BIMS) score that indicated the test could not be performed, 2 residents had a BIMS score of 5, 1 resident had a BIMS score of 4, and 1 resident had a BIMS score of 2. Those scores indicate a level of severe cognitive impairment. The unit had 18 residents at the time of survey. In a review of the Census and Conditions of those residents for the category of Bathing, 8 residents need an assist of 1 or 2 staff and 10 are totally dependent; Dressing, 17 need an assist of 1 or 2 staff and 1 is totally dependent; Transferring, 13 need an assist of 1 or 2 staff and 5 are totally dependent (mechanical lift); Toilet use, 18 need the assist of 1 or 2 staff; Eating, 9 are independent with set-up and cuing, 6 need an	F9999	**F9999 Continued from page 5** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** The facility will ensure that the SNU meets the minimum staffing criteria established by the *Licensing and Operation Rules for Nursing Homes* and adjust staffing levels to meet resident acuity. **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 on the facility's SNU could have been impacted by the dated GOP and staffing criteria. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** The facility's SNU GOP will be revised to meet the facility's current practices as they relate to Section 2.7 of the *Licensing and Operation Rules for Nursing Homes*: 2. defining the residents to be served, 5. criteria for continued stay and discharge, and 6. the description of staffing for the Special Care Unit. The facility will also establish a system to assure the SNU meets the minimum staffing criteria established by the *Licensing and Operation Rules for Nursing Homes* and adjust staffing levels to meet resident acuity. POC amnt 9-24-18 BB/BV	09/11/18 09/11/18 10/05/18

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F9999	Continued From page 6 assist of 1 or 2 staff, and 3 are totally dependent. For Mental Status it is revealed that 18 residents have some form of Dementia and 15 have behavioral healthcare needs. In Bowel and Bladder Status 17 are occasionally or frequently incontinent of bladder and 12 are occasionally or frequently incontinent of bowel and 17 are on a urinary toileting program and 13 are on a bowel toileting program. Under mobility, 13 residents are in a chair all or most of the time and only 5 are independently ambulatory. In a review of staffing the unit has 2 Licensed Nurses Assistants (LNA's) on the day shift (7 AM-3 PM), 2 LNA's on the evening shift (3 PM-11 PM), and 1 LNA on the night shift (11 PM-7 AM). There is a nurse on the unit for the day and evening shift but no nurse on the unit on the night shift. There is one nurse and 3 LNA's in the entire building for 50 residents on the night shift. In a review of the facility's SPECIAL NEEDS UNIT (SNU) General Operating Policy, dated 1/30/02, there are specific criteria for admission, continued stay, and discharge as well as specified staffing levels. The above policy states that residents being admitted must: "1. Participate in a pre-admission assessment, which includes a). an interview with SNU staff at home or on-site and b). providing pertinent information regarding the individual's medical, psychiatric, and personal history. 2). Have a diagnosis of some type of irreversible Dementia; 3). Be ambulatory or be able to use assistive devices independently; 4). Require minimal assistance with ADL's (Activities of Daily Living);	F9999	**F9999 Continued from page 6** **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 Human Resources Director, the Administrator and the DON will monitor staffing levels on the SNU weekly. The Quality Assurance Committee will monitor for a period of six months and/or until 100% compliance is maintained to assure that staffing levels meet the facility's SNU GOP and Vermont's *Licensing and Operation Rules for Nursing Homes*. POC amt 9.24.18 BB/BL	10/02/18

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F9999	Continued From page 7	F9999		

5). Be a non-smoker;
6). Be able to participate in planned group activities;
7). Be able to understand and participate in the toileting process."

The continued stay criteria references "the above criteria (admission criteria) within reasonable limits" and the criteria for discharge includes:
"a. an increase in level of care needs;
b. a change from ambulatory to non-ambulatory status;
c. extremely disruptive behavior;
d. inability to follow single-step directions;
e. total inability to feed self;
f. inability to understand the mechanics of toileting."

The "Description of Unit Staffing" calls for:
"7-3- Charge Nurse, Programmer (9-5), LNA's (3 on weekdays, 2 on weekends)
3-11- Charge Nurse, LNA's (2 on weekdays and weekends)
11-7- LNA (1 seven days) with assistance from "A" wing Charge."
The current staffing, as described above, does not take into account the fact that the level of acuity and care needs of the residents has exceeded the original needs listed in the policy and staffing has not been adjusted to meet current needs.
The DNS confirmed that the staffing pattern in the unit proposal/policy is the staffing pattern in effect.

VERNON HOMES

A COMMUNITY OF CARING. SEASONED WITH GRACE.

September 21, 2018

U.S. Mail and E-mail

Pamela M. Cota RN, MS
Licensing Chief
Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060

RE: Vernon Green Nursing Home
Titles XVII & XIX (Medicare & Medicaid) Certification
Plan of Correction
Provider ID #475008
Health Survey Completed on 08/29/2018

Dear Ms. Cota:

Enclosed please find Vernon Green Nursing Home's plan of correction (POC) for the Health Survey completed on August 29, 2018.

I would request that you accept this POC as Vernon Green's allegation of compliance for the deficiencies stated in the Form CMS-2567 sent on September 10, 2018 from your office.

Thank you for your time and attention to this. If you have any questions or need any additional information, please contact me.

Sincerely,

Brad Ellis

M. Bradford Ellis
Executive Director

Enclosure (attachment):