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

December 11, 2019

Ms. April Furlow, Administrator
The Villa Rehab
7 Forest Hill Drive
St Albans, VT 05478-1615

Dear Ms. Furlow:

Enclosed is a copy of your acceptable plans of correction for the Federal portion of the Re-certification survey conducted on **November 20, 2019.** 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

Pamela M. Cota, RN
Licensing Chief

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475055	A. BUILDING _____ B. WING _____	C 11/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA REHAB	7 FOREST HILL DRIVE ST ALBANS, VT 05478

(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 An unannounced onsite recertification survey with Emergency Preparedness review was conducted by the Division of Licensing and Protection from 11/18- 11/20/19. The facility was found in substantial compliance with regulations related to Emergency Preparedness.	E 000		
F 000	INITIAL COMMENTS An unannounced annual recertification survey and a complaint investigation was conducted by the Division of Licensing and Protection on 11/18 through 11/20/2019. The following regulatory violations were identified:	F 000	**F658** **1. What corrective action will be accomplished or those residents found to have been affected by the deficient practice?** DNS and NHA have provided re-training with all nurses (RN/ LPN) to ensure understanding of regulations and policies against LPN assessments. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents requiring assessments are potentially at risk. Corrective actions taken are; all RN/LPNs have been re-educated on regulations and policies against LPN completing assessments and policies have been updated to reflect the need for immediately calling in a RN to complete all assessments and prior to moving a resident after falls when a RN is not already present in the building.	
F 658 SS=G	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed meet professional standards of quality regarding nursing assessment by a registered nurse at the time of a fall and before transfer for 1 applicable resident, (Resident #20). The findings include the following: Per review of the medical record, Resident #20 has diagnoses of, but not limited to, Dementia, Alzheimer's Disease, Diabetes, Congestive Heart Failure and Fracture of the 10th rib right side. An incident report dated 09/12/19 at 06:57 AM, identifies that the resident fell from his/her bed while an LNA (Licensed Nursing Assisstant) was	F 658		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
April Pudvah, NHA	Administrator	12/5/19

For 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 658	Continued From page 1	F 658		

providing care independently to the resident. The facility failed to ensure an assessment of the resident was performed by a qualified professional at the time of the fall and prior to mechanically lifting the resident off the floor, for a resident who is unable to communicate injury or pain verbally.

Per review of Resident #20's Minimum Data Set Assessment (MDS), a Federal/State mandated assessment completed on 06/18/19, identifies the resident requires total dependence with one staff member for personal hygiene, bathing/dressing and two staff members for transfer utilizing a mechanical lift. The resident is unable to ambulate and does not require bed rails. Resident #20's person centered care plan, confirms the staff assistance required to provide activities of daily living (ADL).

Per review of the incident report dated 09/12/19 at 06:57 AM, Resident #20 was receiving personal ADL care by the LNA. At the time of the incident the resident was on the bed, facing away from the LNA, who had turned around to rinse out the washcloth in the wash basin. The resident rolled off the bed and onto the floor. Per interview with the LNA on 11/19/19 at approximately 3 PM and 09/12/19 at approximately 1 PM, the LNA identified that the resident was lying on the floor, landed on his/her right side with her upper body facing under his/her bed. The LNA confirms by demonstration, that the fall was some 25-30 inches from the height of the bed to the floor. The resident was not moved at this time and the LNA left the room to notify the Licensed Practical Nurse (LPN), who was in an adjacent room, of the incident. The LNA cannot recall if s/he turned the resident onto his/her back before the LPN

3. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**
NHA and DNS will track all incidents requiring RN assessment to ensure assessments are being completed timely by a RN. This will be tracked utilizing incident audit tools, and requiring a RN to sign off that she/he has assessed the resident.

4. **How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put in place?**
NHA and DNS will track all incidents requiring RN assessment to ensure assessments are being completed timely by a RN. This will be tracked utilizing incident audit tools, and requiring a RN to sign off that she/he has assessed the resident. This information will be reviewed with the IDT team weekly at QAPI meetings.

5. **The dates corrective action will be completed.**
Corrective action will be completed on 12/10/2019.

F658 POC accepted 12/10/19
M. Bertrand RN/S. Perry RN

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 658	Continued From page 2	F 658		

came in to the room of Resident #20.

Per interview with the LPN on 11/19/19 at 10:45 AM, the LNA had alerted him/her to the incident. S/he was in the adjacent room and immediately responded to the LNA's request. The LPN confirmed the resident was lying on the floor, on his/her right side beside the bed. S/he evaluated the resident by obtaining vital signs, began neurological checks and documented the incident. On mechanical lift transfer back to bed, the resident was found with a bruise to the right patella (knee cap), light blue in color, measuring, 5 cm. x 7 cm. (centimeters). Both the LNA and the LPN confirm that the resident did not complain of pain, for s/he was unable to express him/herself verbally.

Per facility policy, Post Fall Assessment effective 3/2019:
"1). First person with the resident witnessed or unwitnessed, will stay with the resident and call for assistance."
Per interview the LNA, confirmation was made that s/he left the resident unattended to alert the nurse of the fall.

"2). Avoid moving the resident until his/her status is fully evaluated to prevent further injury if an injury has occurred as a result of the fall."
Per interview with the LNA confirmation was made that s/he left the resident unattended to alert the nurse of the fall. Interviews with both the LPN and the LNA confirmed that the resident was transferred back to bed, via mechanical lift before the Registered Nurse conducted an assessment.

"5). The nurse will evaluate resident for injury and need for first aid. Complete vital signs, full

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F 658	Continued From page 3	F 658		

body check for bruising, abrasion, skin tears, changes in range of motion and sign of pain immediately as appropriate."
The RN, DNS confirmed that s/he was aware of the incident, had been informed of the information gathered by the LPN, but did not conduct a full assessment of the resident prior to transfer.

Per review of the progress notes dated 09/12/19 at 7:42 AM, identifies the physician and the Director of Nurses (DNS) were notified of the incident. Incident report dated 09/12/19 identifies that the resident was not examined by the physician, nor was the resident transferred to the hospital.

A chest x-ray was ordered on 09/16/17 to rule out pneumonia. Findings showed pulmonary congestion, with no significant change from prior chest x-ray on 08/20/19. It is unclear if the ribs were fully visualized in the first x-ray. Per request of Resident #20's family, a second portable x-ray of the chest and bilateral ribs was obtained on 09/20/19. The results identified a fractured lateral right 10th rib with moderate cardiomegaly (an enlarged heart).

In the State Board of Nursing Scope of Practice & Decision Tree for RN, APRN, and LPN the following is stated:
"LPN role in assessment, planning, and implementation of a strategy of care:
-LPNs may not independently assess the health status of an individual or group and may not independently develop or modify the plan of care. LPNs may contribute to the assessment and nursing care planning processes; however, patient assessment and care plan development or revision remain the responsibility of the

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F 658	Continued From page 4 RN/APRN/licensed physician/licensed dentist. -LPNs may not modify a patient care protocol. If the situation and/or data collected by the LPN are not clearly consistent with a protocol, the LPN must consult with the supervising professional or authorized provider before taking action or making a recommendation to a patient." *Reference: Based on Standards of Professional Nursing Practice, Lippincott Manual of Nursing Practice 19th edition, Wolters Kluwer Health/Lippincott Williams, Page #17, Standards of Practice was deviated with the failure of a RN assessment at the time of a fall and prior to transfer.	F 658		
F 689 SS=G	(see F689) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to provide adequate supervision or assistance devices to prevent accidents (falls) that resulted in a fractured rib, for one applicable resident, (Resident #20). The findings include the following: Per review of the medical record, Resident #20	F 689	**F689** 1. **How will you identify residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents who are at risk for falls have the potential to be affected by the deficient practice. The corrective actions implemented are: staff were re-educated on the falls management policy and procedures, safe practices such as proper positioning of residents and placement of necessary equipment and the need to use call systems to call for assistance when a resident has had a fall; to ensure residents are not left alone at any time during an incident, or moved without full RN assessment.	

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has diagnoses of, but not limited to, Dementia, Alzheimer's Disease, Diabetes, Congestive Heart Failure and Fracture of the 10th rib right side. An incident report dated 09/12/19 at 06:57 AM, identifies that the resident fell from his/her bed while an LNA (Licensed Nursing Assisstant) was providing care independently to the resident.

Per review of Resident #20's Minimum Data Set Assessment (MDS), a Federal/State mandated assessment completed on 06/18/19, identifies the resident requires total dependence with one staff member for personal hygiene, bathing/dressing and two staff members for transfer utilizing a mechanical lift. The resident is unable to ambulate and does not require bed rails. Resident #20's person centered care plan, confirms the staff assistance required to provide activities of daily living (ADL).

Per review of the incident report dated 09/12/19 at 06:57 AM, Resident #20 was receiving personal ADL care by the LNA. At the time of the incident the resident was on the bed, facing away from the LNA, who had turned around to rinse out the washcloth in the wash basin. The resident rolled off the bed and onto the floor. The LNA notified the nurse immediately who was in an adjacent room. Per interview with the LNA on 11/19/19 at approximately 3 PM and 09/12/19 at approximately 1 PM, confirmation was made that s/he was getting Resident #20 ready for breakfast, providing personal care and preparing to dress the resident for the day. The LNA turned the resident to his/her left side facing a tall dresser in the direction of the doorway. The LNA had washed the resident's back and bottom, s/he turned to rinse the washcloth (wash basin was on an over the bed table behind the LNA), when she

2. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**
Periodic education on falls management and policies with all nursing staff, as well as monitoring to ensure staff are using safe practices to ensure resident safety. Weekly QAPI reviews of falls to include full report of fall and processes during time of fall.

3. **How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put in place?**
The IDT will review falls weekly in QAPI meetings; to include full report of fall, processes during time of fall and assessments completed post fall.

4. **The dates corrective action will be completed.**
Corrective action will be completed on 12/10/2019.

F 689 POC accepted 12/10/19 M. Bernard RN/ Surveyor

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F 689	Continued From page 6	F 689		

heard a thud. The LNA identified that the resident was lying on the floor, landed on his/her right side with her upper body facing under his/her bed. The LNA confirms by demonstration, that the fall was some 25-30 inches from the height of the bed to the floor. S/he also confirms that while s/he was providing care s/he was aware that the resident was not positioned in the center of the bed, s/he was lying on the edge of the left side of the mattress. There were no pull/draw sheet or incontinent pads under the resident, therefore, s/he felt s/he was unable to position the resident properly, nor did she ask for assistance. The LNA confirmed s/he did not actually witness the fall, just the resident lying on the floor. The resident was not moved at this time and the LNA left the room to notify the Licensed Practical Nurse (LPN), who was in an adjacent room, of the incident. The LNA cannot recall if s/he turned the resident onto his/her back before the LPN assessed Resident #20.

Per interview with the LPN on 11/19/19 at 10:45 AM, the LNA had alerted him/her to the incident. S/he was in the adjacent room and immediately responded to the LNA's request. The LPN confirmed the resident was lying on the floor, on his/her right side beside the bed. S/he evaluated the resident by obtaining vital signs, began neurological checks and documented the incident. On mechanical lift transfer back to bed, the resident was found with a bruise to the right patella (knee cap), light blue in color, measuring, 5 cm. x 7 cm. (centimeters). Both the LNA and the LPN confirm that the resident did not complain of pain, for s/he was unable to express him/herself verbally.

Per facility policy, Post Fall Assessment effective

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F 689	Continued From page 7	F 689		

3/2019:
"1). First person with the resident witnessed or unwitnessed, will stay with the resident and call for assistance."
Per interview the LNA, confirmation was made that s/he left the resident unattended to alert the nurse of the fall.

"2). Avoid moving the resident until his/her status is fully evaluated to prevent further injury if an injury has occurred as a result of the fall."
Per interview with the LNA confirmation was made that s/he left the resident unattended to alert the nurse of the fall. Interviews with both the LPN and the LNA confirmed that the resident was transferred back to bed, via mechanical lift before the Registered Nurse conducted an assessment.

"5). The nurse will evaluate resident for injury and need for first aid. Complete vital signs, full body check for bruising, abrasion, skin tears, changes in range of motion and sign of pain immediately as appropriate."
The RN, DNS confirmed that s/he was aware of the incident, had been informed of the information gathered by the LPN, but did not conduct a full assessment of the resident prior to transfer.

Per review of the progress notes dated 09/12/19 at 7:42 AM, identifies the physician and the Director of Nurses (DNS) were notified of the incident. Incident report dated 09/12/19 identifies that the resident was not examined by the physician, nor was the resident transferred to the hospital. Per interview with the DNS on 11/20/19 at approximately 7:45 AM, confirms that the s/he conducted a 24 hour follow up related to the fall. S/he also confirms that the care plan was updated at that time identifying new initiatives

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F 689	Continued From page 8 such as proper positioning of residents in bed, placement of wash basin and necessary supplies when providing bed side care, all to avoid future occurrences. Education was provided by the DNS with the LNA who was involved in the incident. The Policy titled Fall Management was reviewed with both the LPN and the LNA during the interviews. The LPN was knowledgeable about the policy, but the LNA stated ["I think I have seen that when I first started"]. A chest x-ray was ordered on 09/16/17 to rule out pneumonia. Findings showed pulmonary congestion, with no significant change from prior chest x-ray on 08/20/19. It is unclear if the ribs were fully visualized in the first x-ray. Per request of Resident #20's family, a second portable x-ray of the chest and bilateral ribs was obtained on 09/20/19. The results identified a fractured lateral right 10th rib with moderate cardiomegaly (an enlarged heart).	F 689		

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December 11, 2019

Ms. April Furlow, Administrator
The Villa Rehab
7 Forest Hill Drive
St Albans, VT 05478-1615

Dear Ms. Furlow:

Enclosed is a copy of your acceptable plans of correction for the State portion of the Re-certification survey conducted on **November 20, 2019.** 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

Pamela M. Cota, RN
Licensing Chief

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S 000	Initial comments During an unannounced onsite CMS re-certification survey, completed by the Division of Licensing and Protection on 11/20/19, the following violation of the State of Vermont Licensing and Operating Rules for Nursing Homes was identified.	S 000		
S208 SS=A	2.9 (a - d) REPORTS TO LICENSING AGENCY The following reports must be filed with the licensing agency: 2.9 (a) At any time a fire occurs in the facility, regardless of the size or damage, the licensing agency and the Department of Labor and Industry must be notified by the next business day. A written report must be submitted to both departments by the next business day. A copy of the report shall be kept on file in the facility. 2.9 (b) Any untimely death that occurs as a result of an untoward event, such as an accident that results in hospitalization, equipment failure, use of restraint, etc., shall be reported to the licensing agency by the next business day, followed by a written report that details and summarizes the event. 2.9 (c) Any unexplained or unaccounted for absence of a resident for a period of more than 30 minutes shall be reported promptly to the licensing agency. A written report must be submitted by the close of the next business day. 2.9 (d) Any breakdown or cessation to the facility's physical plant that has a potential for harm to the residents, such as a loss of water, power, heat or telephone communications, etc., for four hours or more, shall be reported within 24	S208	**S208** 1. **What corrective actions will be put into place to ensure that the deficient practice does not recur?** Facility policy has been updated to reflect any death occurring within 60 days from a fall will be reported immediately to the Administrator, who will report within 1 business day to DLP. 2. **How the corrective actions will be monitored to ensure the deficient practice will not recur?** The DNS and Nursing staff will report all deaths immediately to the Administrator. The Administrator will track all death reports to ensure timely reporting and ensure policies are followed. 3. **The dates corrective action will be completed.** Corrective action was completed on 11/21/2019 S-208 POC accepted 12/9/19 M. Bertrand RN / S. Kemp RN	

on of Licensing and Protection

RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
April Fuller, NHA	Administrator	12/5/2019

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S208	Continued From page 1 hours to the licensing agency: This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to report to the licensing agency an untimely death, as a result of an untoward event (such as an accident/fall), for one applicable resident, (Resident #20). The findings include the following: Per review of the medical record, Resident #20 has diagnoses of, but not limited to, Dementia, Alzheimer's Disease, Congestive Heart Failure and Fracture of the 10th rib right side. An incident report dated 09/12/19 at 06:57 AM, identifies that the resident fell from his/her bed. Per interview with the Licensed Nurse Aide on 11/19/19 at approximately 1 PM, s/he confirms that the fall was some 25-30 inches from the height of the bed to the floor. A portable x-ray of the chest and bilateral ribs was obtained on 09/20/19 that identified a fractured lateral right 10th rib with moderate cadiomegaly (an enlarged heart). The resident died on 09/21/19 at approximately 9:30 PM, seven days after the fall. The Office of Medical Examiner's determined the cause of death to be Congestive Heart Failure secondary to rib fracture caused by blunt force trauma as a contributing factor. Confirmation was made on 11/19/19 at approximately 3 PM that a report was not made to the licensing agency. However, the Nursing Home Administrator acknowledges that the Medical Examiner was notified at the time of death 09/21/19 and did review the medical record two days after the death.	S208		

)ivision of Licensing and Protection

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475055	A. BUILDING: _____ B. WING _____	11/20/2019

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HE VILLA REHAB	7 FOREST HILL DRIVE ST ALBANS, VT 05478

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