

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

November 19, 2012

Mr. John Danforth, Administrator  
Redstone Villa  
7 Forest Hill Drive  
St Albans, VT 05478-1615

Dear Mr. Danforth:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 23, 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  
Licensing Chief

PC:jl



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

RECEIVED  
Division of PRINTED: 11/05/2012  
FORM APPROVED  
NOV 15 12 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475055</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	Licensing and Protection	(X3) DATE SURVEY COMPLETED  <b>10/23/2012</b>
--	---	--	--------------------------	---

NAME OF PROVIDER OR SUPPLIER  <b>REDSTONE VILLA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7 FOREST HILL DRIVE ST ALBANS, VT 05478</b>
---	---

(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	<b><u>F325 Maintain Nutritional Status unless unavoidable</u></b>	
F 325 SS=D	<p>The Division of Licensing and Protection conducted an unannounced onsite annual recertification 10/22/12 - 10/23/12. The following regulatory deficiencies were cited.</p> <p><b>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</b></p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, the facility failed to ensure 1 of 3 applicable residents in the stage 2 sample of 20 (Resident #47) received a therapeutic diet when there is a nutritional problem. Findings include:</p> <p>Per record review on 10/23/12, Resident #47 was not provided nutritional supplements as ordered by the physician and Registered Dietician (RD). Per the nutritional assessment done by the RD on 10/18/12, Resident #47 is a high nutrition risk and recommended Mighty Shakes on all meal trays and Power Potatoes on the lunch tray. There is a 10/19/12 physician order for Mighty Shakes on breakfast, lunch and dinner trays. During</p>	F 325	<p><b><u>1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</u></b></p> <p>Order for Power Potato on lunch tray was obtained from Physician and Dietary notified for Resident #47 on 10/23/12. Dietary was notified of Physician order for Mighty Shakes on breakfast, lunch, and dinner trays for Resident #47 on 10/23/12. Resident #47 was not harmed by this alleged deficient practice. Residents records were reviewed and other recommendations were followed.</p> <p><b><u>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?</u></b></p> <p>All Residents have the potential to be at risk who receive Dietary recommendations.</p> <p><b><u>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</u></b></p> <p>Re education of all Licensed Nurses, Dietician, and Dietary Supervisor on the protocol for initiating and following Dietary recommendations by 11/23/12.</p> <p><b><u>4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</u></b></p> <p>DNS/Designee will do random audits on charts receiving Dietary Recommendations for 3 months. Results will be reviewed at the quarterly QA meeting.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* (X6) DATE: *11/13/2012*

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*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475055</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/23/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>REDSTONE VILLA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>7 FOREST HILL DRIVE ST ALBANS, VT 05478</b>	
(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 325	Continued From page 1 interview on 10/23/12 at 9:32 A.M., the Food Services Director stated h/she was unaware of the above diet orders and confirmed the resident had not been receiving the Mighty Shakes or Power Potatoes as ordered.	F 325	<b>5. Include dates when a corrective action will be completed.</b> DNS will be responsible for monitoring to assure compliance with POC and regulatory requirements by 11/23/12. <i>F325 POC accepted 11/13/12 RTremida;RN/PMC</i>	
F 465 SS=E	483.70(h) <b>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</b>  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a safe environment for residents. Findings include:  Per observation, on 10/23/12 at 1:45 P.M. a gray metal mesh radiator cover in a first floor hallway felt hot to the touch. Per infrared thermometer reading, the temperature was 128 degrees Fahrenheit (F), creating the potential for injury to residents. The radiator is situated near the end of a hallway, across from a resident bathroom. There are 4 resident rooms in the hallway with a total of 3 ambulatory residents. The facility Administrator observed the surveyor testing the surface temperature of the radiator cover with an infrared thermometer on 10/23/12 at 2:05 P.M. and confirmed the reading of 128 degrees F. The Administrator also stated that h/she was not aware of high radiator temperatures and confirmed there was no process in place to assess the radiator temperatures.	F 465	<b>F465</b> <b>Safe/Functional/sanitary/comfo rtable environment</b> <b>1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</b> The Radiator cover was raised temporarily to decrease the heat on top of the radiator on Hall # 1 across from Resident Bathroom on 10/24/12. Wooden cover was placed on Radiator on Hall#1 across from bathroom on 11/9/12. Temperatures were taken of radiator covers in the building in hallways on 10/24/12. <b>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?</b> All Residents have the potential to be at risk by this alleged deficient practice. Residents were not harmed by this alleged deficient practice. <b>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</b> Education was done on 10/23/12 with interim Maintenance Director and education was done on 10/29/12 for Permanent Maintenance Director on routine monitoring of radiator surface temperatures.	

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

PRINTED: 11/05/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475055</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/23/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>REDSTONE VILLA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>7 FOREST HILL DRIVE ST ALBANS, VT 05478</b>		
(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	
			<p><b><u>4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</u></b></p> <p>Administrator or Designee will audit random radiator temperatures 5 times per week for 3 months. Results will be reviewed at quarterly QA meeting.</p> <p><b><u>5. Include dates when a corrective action will be completed.</u></b></p> <p>Administrator will be responsible for monitoring to assure compliance with POC and regulatory requirements by 11/23/12.</p> <p><i>F465 POC accepted 11/15/12 RTremblay/PMC</i></p>		