

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
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To Report Adult Abuse: (800) 564-1612
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January 22, 2014

Ms. Joyce Touchette, Administrator
Converse Home
272 Church Street
Burlington, VT 05401

Provider # 1010

Dear Ms. Touchette:

Enclosed is a copy of your acceptable plans of correction for the unannounced onsite investigation conducted on **November 25, 2013**. 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:ne

Enclosure

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/25/2013
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NAME OF PROVIDER OR SUPPLIER CONVERSE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 272 CHURCH STREET BURLINGTON, VT 05401
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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) COMPLETE DATE
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R100	Initial Comments: An unannounced onsite investigation of a self-reported incident was conducted on 11/25/13 to determine if the residence is in compliance with Assisted Living Residence requirements. The following regulatory deficiency was identified.	R100	<u>R126 5.5 General Care</u> It is responsibility of The Converse Home to ensure the care needs of each resident are met. We take this responsibility very seriously. We reported the incident to the appropriate State agencies and the LPN who was the subject of this incident is no longer an employee of The Converse Home.	
R126 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to provide necessary services to meet the medical needs of one resident sampled (Resident #1). Findings include: Per record review on 11/25/13, Resident#1 was assessed to be at a high risk of falls. The resident also had diagnoses that included cognitive decline, Macular Degeneration, and a pacemaker for Bradycardia. The resident had sustained multiple falls including on 9/25/13 and 11/2/13, with minor injury. On 11/10/13 at 1:15 AM, nurse's notes state that the LPN (Licensed Practical Nurse) on duty heard a thud from Resident #1's apartment. The nurse entered the room to find the resident lying on the floor with their head resting on a floor lamp base. The nurse paged the Resident Aide working also to come to the	R126	In addition to orientation and annual Inservices regarding Basic First Aid care for all direct care staff, we implemented the following: -Director of Nursing met with the night shift staff to review the Home's emergency protocol on November 13 th . -A certified EMT and Registered Nurse conducted education sessions on January 7 th and 8 th for all nurses, shift supervisors and night shift staff regarding Post-Fall Assessment and Management. (Syllabus attached.) -The Post-Fall Assessment education will be offered annually. -The Director of Nursing will review all fall reports to ensure the Home's protocol is being consistently followed on all shifts.	11/13 1/8/14 ongoing

Division of Licensing and Protection LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X8) DATE
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STATE FORM 0100 *Joyce Tardito* 1/8/2014
MIR211 Exec. Director

R126 POC accepted 1/16/14 Klampson/PML

PML

PRINTED: 12/26/2013
FORM APPROVED

Division of Licensing and Protection

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R128	<p>Continued From page 1</p> <p>room. The two staff persons assisted the resident to a sitting position, and noticed a gash to the back of the resident's head. The resident was then assisted to a standing position and then sat into a chair, where the resident became unresponsive and was making gurgling noises. The nurse wrote that the resident's pulse was not palpable.</p> <p>The nurse left the room to call the family, leaving the resident with an unlicensed staff person monitoring the resident. Upon return to the room of Resident #1, the resident was now responding to staff, and another call was placed to the family to request permission to call for an emergency transport, which was done. According to facility policy for Basic First Aid care, the resident was not to be moved until injuries were assessed by a Shift supervisor or an EMT. There is an on-call list of Registered Nurses available for consult as needed 24/7, and the nurse had this option available the night of the incident, however did not call for advice in this situation.</p> <p>Per interview on 11/25/13 at 2:10 PM, the Director of Nursing and Home Manager confirmed that the expectation was that the LPN would call 911 after realizing that the resident hit their head, and not move the resident until injury was assessed by EMTs, as well as not leaving the resident with the unlicensed staff person to call the family. Despite the orientation that was provided to the LPN regarding medical emergencies, the nurse did not follow the protocol of the home, and could have put the resident at risk by moving them with a head injury.</p>	R128			

RED FLAGS

- Unconscious resident
- Significant head injury
 - Especially if resident currently on aspirin or anticoagulant therapy
- Compromised airway
- Compromised breathing
- Uncontrollable bleeding
- Neck pain or cervical spine tenderness
- Acute change in mental status
- Uncontrollable pain
- Increased agitation, restlessness, or lethargy
- Signs of increased intracranial pressure: vomiting and headache
- Facial bruising can indicate TBI- may take hours to show up
 - Raccoon's Eyes
 - Battle signs (behind ears)
- Abnormal vital signs
- Abnormal blood sugar
- Obvious deformity/Fracture
- Glasgow Coma Scale < normal
 - Change in alertness, change in ability to carry out motor functions or verbal responses
- Signs of herniation: dilated, unreactive or unresponsive pupils

Post Fall Assessment Factors

Once you have finished the initial evaluation and determined the need for additional support (arranging for transport) you should complete a more comprehensive evaluation.

Things to include in your assessment and relay to EMT's/MD's

- Level of Consciousness/Mental Status before and after fall
 - Alert and Oriented to baseline?
- Vitals
- Blood Glucose- if history or suspicion of abnormal blood sugar
- Review of Current Symptoms
 - Dizziness, nausea, vomiting, headache, backache, neck pain, weakness, fatigue, incontinence
- Physical Examination
 - Head to toe assessment
 - Palpate entire body
 - Look for facial expressions that may indicate pain
 - Look for Hip injuries
 - Fractured hip will be shorter and externally rotated
 - Dislocated hip will be internally rotated and flexed
- Skin Assessment
- Events leading up to fall
 - Any recent changes in mobility/mental status/pain?
- Pattern
 - Was this an isolated injury or does this resident fall often?
- Intrinsic factors that may have contributed
 - Dementia
 - Recent injuries/pain/Parkinson's/Arthritis
 - Functional disability- use of assistive devices
 - Alteration in LOC
 - Visual Impairment
 - Incontinence
 - Medications
 - Any PRN's today
 - Recent changes
 - Bare feet/inappropriate footwear
- Extrinsic factors that may have contributed
 - Floor spills/wet areas/uneven flooring
 - Lack of lighting
 - Grab rails/bed rails in good repair
 - Patient clothing

IMMEDIATE RESPONSE - Initiate clinical care and call for assistance

- Basic Life Support: Danger, Responsive, Send for help, Airway, Breathing, CPR? Defib (DRSABCD)
- Rapid assessment - pain: bleeding: Injury (do not move until assessed: examine cervical spine, and Immobilise if there is an indication of injury)
- Base-line Observations: Full set: BP, P, R, T, SpO₂, Blood Glucose and Pain score, Neuro obs
- Notify Medical Officer of fall

If patients' observations are in **YELLOW** or **RED** zone you must **ACTION** your Local Clinical Emergency Response System

Observations & Ongoing Monitoring for ALL Patient Falls

- ❖ *Standard Adult General Observation Chart* include pain, and
- ❖ *Adult Neurological Observation Chart*

- *At least hourly for a minimum of 4 hours: REVIEW*
 - *4 hourly for the next 24 hours or as required, then*
 - *REVIEW - ongoing observations as required*
- (Seek clinical advice)*

If patients' observations move into **YELLOW** or **RED** zone you must **ACTION** your Local Clinical Emergency Response System

Clinical Review Action required for any following presenting signs

- ❖ Patients on anticoagulant/or antiplatelet therapy and patients with known coagulopathy are **HIGH RISK** for bleeding
- ❖ **Fluctuating Behaviours and/or increasing confusion:** Increased agitation, restlessness, or changes in level of alertness - lethargy, flattened: complete assessment for Delirium
- ❖ Injury- facial bruising, hit head when fell, fracture
- ❖ Vomiting, headache

CT Scan
Recommended

CLINICAL REVIEW

Ongoing Monitoring is important.

Note: there may be manifestations of head injury after 24hrs

- Change in level of consciousness - headache, vomiting
- Increasing confusion and fluctuating behaviours: increased agitation, restlessness, lethargy

Communication and Documentation

- Reassure the patient and explain all treatment and investigations.
- All patient falls are to be reported to medical officer for review.
- Is there a Substitute Decision Maker if the person is not able to communicate effectively?
- Notify the Person Responsible (family/carer/friend) with permission and inform them about the fall and plan of care.
- Is there an Advance Care Plan or Directive in place? Determine appropriate treatment options with person responsible.
- Write treatment, palliation/escalation process and outcome in the clinical record.
- Review falls status to: high risk and record in clinical record and **modify care plan.**
- Discuss at clinical bedside handover including noting ongoing observations and monitoring and change in falls risk status to high risk.
- Complete IIMS report.
- Complete a review of fall event with clinical leadership team.

Version 2 : DRAFT 21 Oct



POST FALL ASSESSMENT & MANAGEMENT



FALLS AND HITS HEAD	FALLS AND DOES NOT HIT HEAD	UNWITNESSED FALL
<p>SPECIAL CONSIDERATION – Patients on anticoagulant and/or antiplatelet therapy and patients with a known coagulopathy are at an increased risk of intracranial haemorrhage. Anticoagulants include: Warfarin, Heparin, Enoxaparin (Clexane), Dalteparin (Fragmin). Antiplatelet drugs include: Aspirin, Clopidogrel, Aspirin+Dipyridamole (Aasentin). Alcoholic patients are considered coagulopathic.</p>		
<ul style="list-style-type: none"> • Do not move initially • Call for assistance • Immobilise Cervical Spine and examine for injuries • Baseline Vital signs (BP, heart rate, respiratory rate, oxygen saturation, Blood Sugar Level (BSL)) • Neurological Observations - Initial Glasgow Coma Scale (GCS) • Observe for change in the level of consciousness, headache, amnesia or vomiting • Clean and dress any wounds <p style="text-align: center;">↓</p> <p>Contact Medical Officer for review</p> <p style="text-align: center;">↓</p> <p>Consider need for analgesia</p> <p style="text-align: center;">↓</p> <p>Liaise for appropriate test (consider CT Scan if patient has any high risk factors, see Section 6 of NSW Health PD2008_0081 Head Injury)</p> <p style="text-align: center;">↓</p> <p>Notify registrar / consultant (if required)</p> <p style="text-align: center;">↓</p> <p>Observations</p> <ul style="list-style-type: none"> • Record vital signs and neurological observations hourly for 4 hours then review • Continue observations at least 4 hourly for 24 hours or as required • Notify MO immediately if any change in observations <p style="text-align: center;">↓</p> <p>Notify family</p> <p style="text-align: center;">↓</p> <p>If not already flagged as high risk of fall injury, flag as per hospital protocol</p> <p style="text-align: center;">↓</p> <p>IIMS report</p> <p style="text-align: center;">↓</p> <p>Post Fall review Document in medical record strategies implemented</p>	<p>Potential injuries: fracture, soft tissue injury or no observable injury.</p> <ul style="list-style-type: none"> • Do not move initially • Call for assistance • Baseline Vital signs (BP, heart rate, respiratory rate, oxygen saturation, BSL) • Clean and dress any wounds <p style="text-align: center;">↓</p> <p>Contact Medical Officer for review</p> <p style="text-align: center;">↓</p> <p>Consider need for analgesia</p> <p style="text-align: center;">↓</p> <p>Liaise for appropriate test (eg X rays)</p> <p style="text-align: center;">↓</p> <p>Notify registrar / consultant (if required)</p> <p style="text-align: center;">↓</p> <p>Observations Monitor vital signs for 24 hours</p> <p style="text-align: center;">↓</p> <p>Notify family</p> <p style="text-align: center;">↓</p> <p>If not already flagged as high risk of fall injury, flag as per hospital protocol</p> <p style="text-align: center;">↓</p> <p>IIMS report</p> <p style="text-align: center;">↓</p> <p>Post Fall Review Document in medical record strategies implemented</p>	<p>Potential injuries: Head or neck injury, fracture, soft tissue injury or no observable injury.</p> <ul style="list-style-type: none"> • Do not move initially • Call for assistance • Immobilise Cervical Spine and examine for injuries • Baseline Vital signs (BP, heart rate, respiratory rate, oxygen saturation, BSL) • Neurological Observations - initial Glasgow Coma Scale (GCS) • Observe for change in the level of consciousness, headache, amnesia or vomiting • Clean and dress any wounds <p style="text-align: center;">↓</p> <p>Contact Medical Officer for review</p> <p style="text-align: center;">↓</p> <p>Consider need for analgesia</p> <p style="text-align: center;">↓</p> <p>Liaise for appropriate test (eg CT Scan if patient has any high risk factors, see Section 6 of NSW Health PD2008_0081 Head Injury)</p> <p style="text-align: center;">↓</p> <p>Notify registrar / consultant (if required)</p> <p style="text-align: center;">↓</p> <p>Observations</p> <ul style="list-style-type: none"> • Record vital signs and neurological observations hourly for 4 hours then review • Continue observations at least 4 hourly for 24 hours or as required • Notify MO immediately if any change in observations <p style="text-align: center;">↓</p> <p>Notify family</p> <p style="text-align: center;">↓</p> <p>If not already flagged as high risk of fall injury, flag as per hospital protocol</p> <p style="text-align: center;">↓</p> <p>IIMS report</p> <p style="text-align: center;">↓</p> <p>Post Fall review Document in medical record strategies implemented</p>
<p>Reasons Falls Risk Status – Refer to relevant staff to review, update care plan and implement Falls prevention strategies</p>		
<p>Communication – All staff involved in the care of the patient to be informed of incident outcome and revised care plan</p>		

ACKNOWLEDGMENTS:

1. Adapted From RNS and RNS Policy Per RN32003/48
2. Hook, ML., Winchel, S (2006) Fall Related Injuries In Acute Care: Reducing the Risk of Harm, MEDSURG Nursing, Vol 15/No.6
3. NSW Department of Health, Policy Directive: Initial Management of Closed Head Injury in Adults. PD2008_0081 Head Injury, 2008.
4. NSW Institute of Trauma and Injury Management www.iitm.nsw.gov.au