

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

October 1, 2013

Ms. Catherine Amarante, Administrator
Valley Terrace
2820 Christian Street
White River Junction, VT 05001

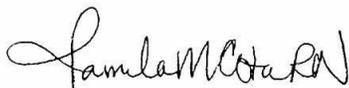
Provider #: 1004

Dear Ms. Amarante:

Enclosed is a copy of your acceptable plans of correction for the unannounced on-site complaint investigation conducted on July 9, 2013 and completed on **July 18, 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: 1004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 07/18/2013
NAME OF PROVIDER OR SUPPLIER VALLEY TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2820 CHRISTIAN STREET WHITE RIVER JUNCTION, VT 05001		
(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	
R145	Continued From page 1 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being. This REQUIREMENT is not met as evidenced by: Based on information gathered, the ALR failed to develop a written plan of care for 1 applicable resident in the sample that describes the care and services necessary to assist the resident to maintain independence and well-being. (Resident #1) Findings include, 1. Per record review on 07/09/13 the care plan for Resident #1 failed to have new and revised interventions for inappropriate behaviors and psychotropic medication. Per review of the care plans, which are not signed nor dated, contained behavior care plans related to refusing meals and hygiene care/showers and, after 03/23/13, for sexually inappropriate behavior. There was no care plan for the use of a new psychotropic medication which was ordered on 06/11/13. Per a letter faxed to the nurse surveyor from the ALR nurse dated 07/11/13 states "the HSD has made me aware that I hadn't signed and dated my last revision of [resident]'s behavior care plan". The letter further stated that the behavior revision happened after a sexually inappropriate incident on 03/23/13 and the family was made aware of the revision during the family care plan meeting of 04/03/13. However, there are no revisions after two additional incidents with	R145	<u>R145</u> Extended Behavior Care Plan for resident #1 was signed and dated, then faxed to DLP before receiving this report. All care plans and revisions will be signed and dated by RN. All PRN psychoactive medications will have a written plan for use per reg. 5.9.c (2) The Behavioral Flow Sheet and MAR fulfill this requirement for medication administration by unlicensed staff. In-service on care plans and criteria for revisions will be provided to all nurses. HSD will review, sign and date all care plans and revisions. A quarterly chart audit will be completed to ensure compliance. <i>R145 POC accepted 9/16/13 SEMMONS RN/PMC</i>	7.11.2013 10.15.13 10.15.13 Ongoing Ongoing	

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R145	Continued From page 2 residents. Per interview 5:00 PM the HSD confirmed that the care plans did not contain dates & signatures, no further revisions after 2 additional incidents of inappropriate sexually behavior and no care plan for the use of a psychotropic medication.	R145		
R167 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10 d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication, educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of reason for and specific results of the medication use This REQUIREMENT is not met as evidenced by. Based on information gathered, the ALR failed to develop a written plan for 1 applicable resident in the sample for the administration of as needed (PRN) psychoactive medication by unlicensed staff. (Resident #1) Findings include: 1 Per review of the Medication Administration record (MAR) for Resident #1 dated 06/12/13	R167	<u>R167</u> All PRN psychoactive medications will have a written plan for use per reg. 5.9.c (2)The Behavioral Flow Sheet and MAR fulfill this requirement for medication administration by unlicensed staff. In-service on Behavioral Flow Sheets and care plans will be provided to all nursing and activities staff. In-service on the use of prn psychotropic medications will be provided to all nurses and medication delegated resident assistants. The Behavioral Flow Sheet and MAR will be monitored monthly by licensed staff. R167 POC accepted 9/16/13 SEMmons RL/AME	10.15.13 10.15.13 10.15.13 Ongoing

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R167	Continued From page 3 states Trazadone 50 mg [by mouth] 1 tab 1 hour before care PRN. However, there is no written plan for the use of the medication that describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication, educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. Per interview 5:00 PM the HSD confirmed that the care plans did not contain the specific behaviors, circumstances or monitoring for the use of a psychoactive medication.	R167		
R188 SS=C	V RESIDENT CARE AND HOME SERVICES 5.12 b.(2) A record for each resident which includes resident's name, emergency notification numbers; name, address and telephone number of any legal representative or, if there is none, the next of kin; physician's name, address and telephone number; instructions in case of resident's death; the resident's assessment(s); progress notes regarding any accident or incident and subsequent follow-up; list of allergies, a signed admission agreement, a recent photograph of the resident, unless the resident objects; a copy of the resident's advance directives, if any completed; and a copy of the document giving legal authority to another, if any. This REQUIREMENT is not met as evidenced by Based on record review and interview, the facility	R188		

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R188 Continued From page 4

failed to ensure that residents' records contained a recent photograph for Residents on 2 special care units as required. This affected six of sixteen total resident records. Findings include

Per review of the clinical records and observations on 07/09/13 at 12 58 P.M. on 2 special care units designated for residents with cognitive impairments or other specialized care needs, there were no photographs for 4 out of 10 residents on Unit 1, and 1 out of 6 residents on Unit 2 in the MAR (Medication Administration Record) or clinical chart. There was no documentation that indicated that the Resident or the Resident's guardian objected to being photographed. The Unit manager stated at that time that the ALR " is in the process of getting the charts updated" and confirmed no pictures found on 2 special care units for 6 out of 16 total residents. The HSD confirmed at 1.30 P.M. that not all charts had pictures to identify the residents especially in the MARS

R188

R188

All MARS have a recent photograph for each resident. 7.15.13

Monthly checks will be done to ensure photo is present and will be replaced as needed to ensure a good likeness for identification purposes. Ongoing

R188 POC accepted 9/16/13
SEMMONS RN/MLC

R189
SS=D V RESIDENT CARE AND HOME SERVICES

5 12 b (3)

For residents requiring nursing care, including nursing overview or medication management, the record shall also contain: initial assessment; annual reassessment, significant change assessment; physician's admission statement and current orders; staff progress notes including changes in the resident's condition and action taken, and reports of physician visits, signed telephone orders and treatment documentation; and resident plan of care

R189

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R189	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the residential care home failed to assure the medical record includes signed current telephone orders, updates to the resident plan of care and notification of changes to resident's condition for 1 applicable sampled residents (Resident # 1) Findings include</p> <p>Per record review on 07/09 2013 at 12:42 PM, Resident #1's physician was called on 06/11/13 at 1:00 PM as noted on the "MD Consultation Form" for new orders for Trazadone 50 mg oral daily and as needed 1 hour before personal care. The nurse wrote "T.O. [telephone order] (physician's name) and signed his/her name. Per interview on 07/09/13 at 4:53 PM the Health Services Director (HSD) confirmed that the physician's telephone order dated 06/11/13 has not been countersigned within 15 days of the date the order was given.</p> <p>A behavior care plan was revision on 03/23/13 after a sexually inappropriate incident and the family was made aware of the revision during the family care plan meeting on 04/03/13. However, there are no revisions after two additional incidents with residents on 04/26/13 and 05/17/13. There is no notification to the physician nor family of these additional encounters. Per a nursing note dated 05/24/13 at 2:00 [10:00 P.M.] states "received call from [Nurse Practitioner] who is covering for [V.A. physician] who conferred with [primary physician]. [Primary Physician] is hesitant to start any psychotropic's due to hypotension would like to try the [antibiotic]. They were unaware however that this has been going on for month (combative behavior, refusing care) they will arrange meeting with family" Per a</p>	R189	<p><u>R189</u></p> <p>Telephone Order was sent via mail to resident's PCP on 9.6.13. Executive Director to follow up with this doctor if not received by 9.13.13 to ensure this signed order is in resident #1 chart.</p> <p>Current System in place to ensure all telephone orders are signed by MD within 15 days: Telephone orders are faxed to MD immediately and flagged in the chart. After 7 days HSD or designee follows up on any unsigned orders.</p> <p>Quarterly chart review by Health Services Director/Executive Director or designee will ensure compliance.</p> <p>Resident #1 discharged on 6/14/13. Families and providers will be notified of any change in resident's condition. Any change in resident condition or plan of care will be documented in the resident chart, signed and dated.</p> <p>In-service training with nursing staff direct care staff on resident incidents and change in condition protocol.</p> <p>Quarterly chart reviews to be conducted by ED/HSD/Designee.</p>	<p>10.1.13</p> <p>Ongoing</p> <p>Ongoing</p> <p>10/31/13</p> <p>Ongoing</p>
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R189 PDC accepted 9/16/13
SEMMONS RN / PML

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R189	Continued From page 6 telephone interview 07/11/13 at 11:35 A.M. a family member stated that "I am surprised [of the other incidents] no one called to let us know of them". Per interview 5 00 PM the HSD confirmed that the care plans did not contained dates & signatures, no further revisions and notification after 2 additional incidents of inappropriate sexually behavior and no care plan for the use of a new psychoactive medication	R189		
R208 SS=D	V RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18 c Incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse, or if an injury requiring physician intervention results, or if there is a pattern of abusive behavior. All resident-to-resident incidents, even minor ones, must be recorded in the resident's record. Families or legal representatives must be notified and a plan must be developed to deal with the behaviors This REQUIREMENT is not met as evidenced by Based on record reviews and interviews, the home did not report a pattern of resident to resident incidents in a timely manner in for 1 of 2 applicable records reviewed. (Residents #1) Findings include Per record review on 07/09/11 a pattern of sexually inappropriate behaviors involving Resident #1, which began on 03/23/13 was not	R208	R208 All incidents of resident to resident abuse, sexual abuse, or an injury requiring physician intervention, will be reported to the licensing agency/APS. MD and family will be notified of any abuse incidents. Documentation of resident incidents will be written in the resident record, dated and signed. Abuse, Neglect, and Exploitation policy and procedure will be reviewed with nursing staff. Chart reviews will be conducted by ED/HSD/ designee for any resident at risk. R208 POL accepted 9/16/13 SEMMONS RN PML	Ongoing 10/31/13 Ongoing

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R208	Continued From page 7 reported to the Licensing Agency. The resident who had cognitive impairment was discharged 06/14/13. A behavior care plan that addressed refusals of personal care was revised on 03/23/13 to include "an environment to avoid sexually inappropriate behaviors with other residents". The family was made aware of the revision during the family care plan meeting on 04/03/13. However, there are no revisions or notifications to the family after two additional incidents on 04/26/13 and 05/17/13. Per a nursing note of 04/26/13 states "touching a [opposite sex] resident in the private area" and on 05/17/13 at 7:30 P.M. states "found [opposite sex] resident trying to get [night clothes] out of [Resident#1]'s hands. [opposite sex] resident stated [resident #1] hit [him/her]". Per a telephone interview 07/11/13 at 11:35 A.M. a family member stated that "I am surprised [of the other incidents] no one called to let us know of them", and confirmed they were not notified of the incidents of 04/26/13 and 05/17/13. Per interview the V.P. of operation confirmed the 4:56 P.M. that the State Agency was not notified of the pattern of resident to resident incidents.	R208		
A 615 SS=D	VI Resident Care and Services 6.11 Uniform consumer Disclosure 6.11.d The disclosure shall be provided: (i) to residents prior to or at admission and at any time it is changed or requested by the resident, and (ii) to the public upon request. This Statute is not met as evidenced by Based on record review and interview the Assisted Living Residence (ALR) failed to provide	A 615		

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A 615	Continued From page 8 a Uniform consumer disclosure prior to and/or upon admission for 1 applicable resident in the sample [Resident #1] findings include: 1. Per record review on 07/09/13 Resident #1 was admitted on 07/24/12. The Uniform consumer disclosure [known as the admission agreement] was signed and dated 9 months later on 04/14/13 by the resident's family, who are the Power of Attorney (POA). The V.P. of Operations at 1:42 PM. stated that the agreement is suppose to be signed prior to or upon admission but stated that the resident came from another ALR and "was pretty sure the family had the agreement upon admission" S/he confirmed the admission agreement was not signed prior to or upon admission as expected.	A 615	<p><u>A615</u> All resident agreements are provided to resident/family prior to admission. All agreements will be signed prior to, or on day of admission.</p> <p>The Executive Director or Designee will be responsible for ensuring documentation of resident/family receipt of admission agreement.</p> <p>Resident agreement audit will be done annually by business office manager or designee.</p> <p><i>A615 POC accepted 9/16/13 SEMmons RN PML</i></p>	<p>Ongoing</p> <p>Ongoing</p> <p>9/1/13 & ongoing</p>