

Division of Licensing and Protection  
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January 5, 2011

Kelly Mazza, Administrator  
Arbors  
687 Harbor Road  
Shelburne, VT 05482

Provider ID #: 0102

Dear Ms. Mazza:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on  
**December 8, 2010.**

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,



Pamela M. Cota, RN  
Licensing Chief

PC:jl

Enclosure



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0102</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/08/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>ARBORS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>687 HARBOR ROAD SHELBURNE, VT 05482</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) COMPLETE DATE
R100	Initial Comments:  An unannounced on-site survey was completed on 12/8/10. The survey included investigation of 3 complaints and re-licensure survey. Based on the information obtained, the facility was cited the following deficiencies.	R100	Please see attached Plan of correction. <i>km</i>	
R126 SS=G	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 observation, staff interview and record review, the facility failed to assure that 4 of 10 residents in the applicable sample were consistently provided with nursing care to meet their medical needs. (Residents #1, 2, 7 & 8) Findings include:  1. Per record review on 12/7/10, Resident #2 sustained injuries causing swelling and leg pain after experiencing 2 falls on 11/16/10 and nursing staff failed to notify the physician in a timely manner. A progress note dated 11/17/10, 11-7 shift, stated "resident ecchymotic area to right knee... resident holding onto left leg and not letting us look at it...leg very stiff and causing pain". The 11-7 nurse did not notify the physician of this change in condition. At 10 AM the same day (per the progress notes), another nurse examined the left leg, "resident grimaced when	R126		

Division of Licensing and Protection

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

TNBP11

If continuation sheet 1 of 4

*K. Magga Senior Executive Director 12/24/10*

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R126	Continued From page 1  left leg...touched". The physician was called and gave orders to 'send to ER', where the resident was subsequently diagnosed with a fractured femur. During interview on 12/7/10 at 4 PM, the RN (Registered Nurse) Resident Care Director (RCD) confirmed that the 11-7 nurse erred by failing to notify the physician of a significant change in medical condition. Note: This deficiency resulted from a complaint related to a facility mandatory report.  2. Per observation of a dressing change for Resident #1's stage 2 pressure ulcer on 12/7/10 at 1:40 PM, the nurse failed to cleanse or sanitize hands before donning gloves, after removal of the old dressing and wound cleansing, and prior to application of a topical biologic and clean dressing to the wound. The observation of the failure to maintain aseptic technique was confirmed immediately after completion of the procedure with the Licensed Practical Nurse (LPN).  3. Per record review on 12/8/10, nursing staff failed to notify Resident #6's physician of elevated blood pressure readings after discontinuation of an antihypertensive medication. On 10/14/10, Resident #6's physician discontinued a daily antihypertensive medication (Lisinopril) and gave new orders to "check blood pressure daily for 1 week due to D/C Lisinopril". The blood pressure log documented the resident's blood pressure on 10/20/10 as 180/80 at 6 PM and on 10/21/10 as 154/78 at 1:30 PM. There was no evidence in the record that the physician had been made aware of the elevated blood pressures. This was confirmed with the RN Director on 12/8/10 at 2:40 PM.  4. Per record review on 12/8/10, Resident #8	R126		

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R126	Continued From page 2  was found "unresponsive" on the floor in the bedroom at 0400 on 11/21/10 by the LNA and the nurse failed to notify the physician. The LPN's progress note dated 11/21/10, 11-7, stated "LNA heard resident fall...went to rm to find resident lying on back on floor, this nurse called to rm...resident unresponsive at this time..." There was no evidence in the record that the physician and the resident's daughter were notified of this unwitnessed fall. This omission was confirmed with the RN RCD during interview on 12/8/10 at 3 PM.	R126		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES  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 observation, staff interview and record review, the care plans for 2 of 8 applicable resident's in the sample failed to address the residents' identified needs regarding skin integrity. (Residents #1 & 3). Findings include:  1. Per record review and observation of a treatment on 12/7/10 at 1:40 PM, Resident #1 had a stage 2 pressure sore on the right lateral malleolus (ankle) requiring daily dressing changes. The care plan failed to address the presence of the pressure sore, including measurable goals and specific interventions to	R145		

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R145	Continued From page 3 promote healing.  2. Per record review on 12/8/10, Resident #3 was noted to have a stage 2 pressure sore on the coccyx on 12/2/10. This was not addressed on the care plan.  The lack of care plans for these stage 2 pressure sores was confirmed during interview with the RN RCD on 12/8/10 at 3:45 PM.	R145		
R148 SS=D	V. RESIDENT CARE AND HOME SERVICES  5.9.c (5)  Assure that residents' medications are reviewed periodically and that all resident medications have either a supporting medical diagnosis or problem;  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, 2 of 8 residents in the total sample did not have a supporting diagnosis for each ordered medication. (Residents # 1 & 4) Findings include:  Per record reviews on 12/7/10 and 12/8/10, Resident #4 did not have a supporting diagnosis for the use of Lipitor (a cholesterol lowering medication) and Resident #1 did not have a supporting diagnosis for use of Celexa (an antidepressant medication). The lack of diagnoses for these medications was confirmed during interview with the RN RCD on 12/8/10 at 3:45 PM.	R148		

**The Arbors at Shelburne**  
**Plan of Correction**  
**Annual Survey of December 8, 2010**

**General Care**

**5.5a**

**For Resident #2:**

1. The nurse who assessed this resident on the 11-7 night shift will be coached in order to explain and confirm the importance in notifying the physician in a timely manner when a significant change in condition occurs.

**Completion Date:** January 1, 2011  
**Responsible Person:** Resident Care Coordinator

2. The expectation for notifying the physician when a significant change in condition occurs will be discussed at the next nurses' meeting.

**Completion Date:** December 23, 2010  
**Responsible Person:** Resident Care Director

3. A random audit will be performed to confirm that our nursing staff is consistently and correctly notifying the physician when a significant change in condition occurs. The findings will be reported to the Quality Assessment and Assurance Committee during the next two quarters.

**Completion Date:** July 1, 2011  
**Responsible Person:** Resident Care Director

**For Resident #1:**

1. The nurse who failed to properly follow infection control techniques while performing a dressing change will be coached to explain and confirm the proper technique.

**Completion Date:** January 1, 2011  
**Responsible Person:** Resident Care Director

2. A random audit will be performed to confirm that all nurses are following proper infection control procedures during dressing changes and the results will be reported to the Quality Assessment and Assurance Committee during the next two quarters.

**Completion Date:** July 1, 2011  
**Responsible Person:** Resident Care Coordinator

For Resident #6

1. During the survey on 12/8/10, the Resident Care Director called the resident's physician to review the blood pressure results. The resident was examined by the physician during the morning of 12/9/10 and new medication was prescribed for hypertension.

Completion Date: 12/9/10  
Responsible Person: Resident Care Director

2. Nurses will be informed of the importance of reviewing all blood pressure checks with the physician in a timely manner. Nurses will also be reminded to request parameters for informing the physician when monitoring a resident's blood pressure.

Completion Date: 12/23/10  
Responsible Person: Resident Care Director

3. Random audits will be performed during the first two quarters of 2011 to confirm that elevated blood pressure results are being reported to the physician in a timely manner.

Completion Date: July 1, 2011  
Responsible Person: Resident Care Coordinator

For Resident #8:

1. The nurse who assessed this resident on the night shift on 11/21/10 will be coached in order to explain and confirm the importance of notifying the physician in a timely manner when a significant change in condition occurs.

Completion Date: January 1, 2011  
Responsible Person: Resident Care Coordinator

2. Nurses will be reminded to document all conversations with the physician and family informing them when a resident falls.

Completion Date: December 23, 2010  
Responsible Person: Resident Care Director

3. Random audits will be performed during the first quarter of 2011 to confirm that when a fall occurs, the family and physician are being notified.

Completion Date: April 1, 2011  
Responsible Person: Resident Care Coordinator

R126 POC Accepted 12/30/10 M. BOTTORRN / AMGOTARN

**Resident Care and Home Services**

**5.9c (2)**

For Resident #1:

1. The care plan for this resident has been updated.

Completion Date: December 15, 2010

Responsible Person: Senior Nurse- East Meadows

2. The importance of updating all care plans with skin integrity needs will be reviewed with all nurses.

Completion Date: December 23, 2010

Responsible Person: Resident Care Director

3. Random audits will be performed during the first two quarters to confirm that care plans are being updated to include measurable goals and specific interventions.

Completion Date: July 1, 2011

Responsible Person: Resident Care Coordinator

For Resident #3:

1. The care plan for this resident has been updated (Please Note: the stage 2 ulcer has been resolved).

Completion Date: December 15, 2010

Responsible Person: Senior Nurse-Westwinds

2. The importance of updating care plans with skin integrity needs will be reviewed with all nurses.

Completion Date: December 23, 2010

Responsible Person: Resident Care Director

3. Random audits will be performed during the first two quarters of 2011 to confirm that care plans are being updated to include measurable goals and specific interventions.

Completion Date: July 1, 2011

Responsible Person: Resident Care Coordinator

R145 POC Accepted 12/30/10 M. BOTTOMRN / AMOSTARN

**Resident Care and Home Services**

**5.9.c (5)**

Residents # 1 & 4:

1. The clinical problem lists have been updated to include a supporting diagnosis.

Completion Date: December 15, 2010  
Responsible Person: Resident Care Director

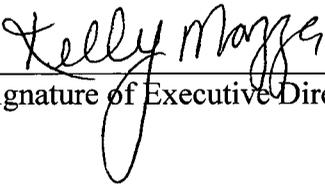
2. Nurses will be reminded to have the physician update the problem list as needed, specifically to have a supporting diagnosis for specific medication when ordered.

Completion Date: December 23, 2010  
Responsible Person: Resident Care Director

3. Random audits will be performed during the next two quarters of 2011 to confirm that a supporting diagnosis is listed on the clinical problem list when a specific medication is ordered.

Completion Date: July 1, 2011  
Responsible Person: Resident Care Coordinator

R140 POC Accepted 12/30/10 M. Bottom RN / P. Meota RN

  
\_\_\_\_\_  
Signature of Executive Director

12/24/10  
Date