

PRINTED: 06/01/2010  
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 05/27/2010
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NAME OF PROVIDER OR SUPPLIER  ATKINSON RESIDENCE	STREET ADDRESS, CITY, STATE, ZIP CODE 4717 MAIN STREET NEWBURY, VT 05051
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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 on-site complaint investigation was conducted by the Division of Licensing and Protection on 05/21/10 and completed on 5/27/10. The following regulatory violations were cited.	R100		
R128 SS=D	V. RESIDENT CARE AND HOME SERVICES  5.5 General Care  5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders.  This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to follow physician's orders for 1 applicable resident. (Resident #1) Findings include:  1. Per record review a physician order dated 03/10/10 stated 'take weekly B/P (blood pressure), call if >150/100. A physician visit note dated 02/09/10 stated 'give 100mcg (Vit. B12 injection) today. Per review of the MAR (Medication Administration Record) for March 2010 the B12 was not given and there was no evidence that weekly B/P's were done. Per interview on 5/27/10 at 11:30 AM the Administrator stated that the B/P should have been on the MAR or progress notes, and thought the Vit B12 was discontinued. The Administrator confirmed that there was no evidence that staff followed these physician orders.	R128	See Attached  POC accepted 7/1/10 by S. Emmens, RD S. Lemay, RD See attached POC's	
R139 SS=D	V. RESIDENT CARE AND HOME SERVICES	R139		

Division of Licensing and Protection

*Jane R. Emmens, R-R.*

TITLE *Director*

(X6) DATE

*6/19/10*

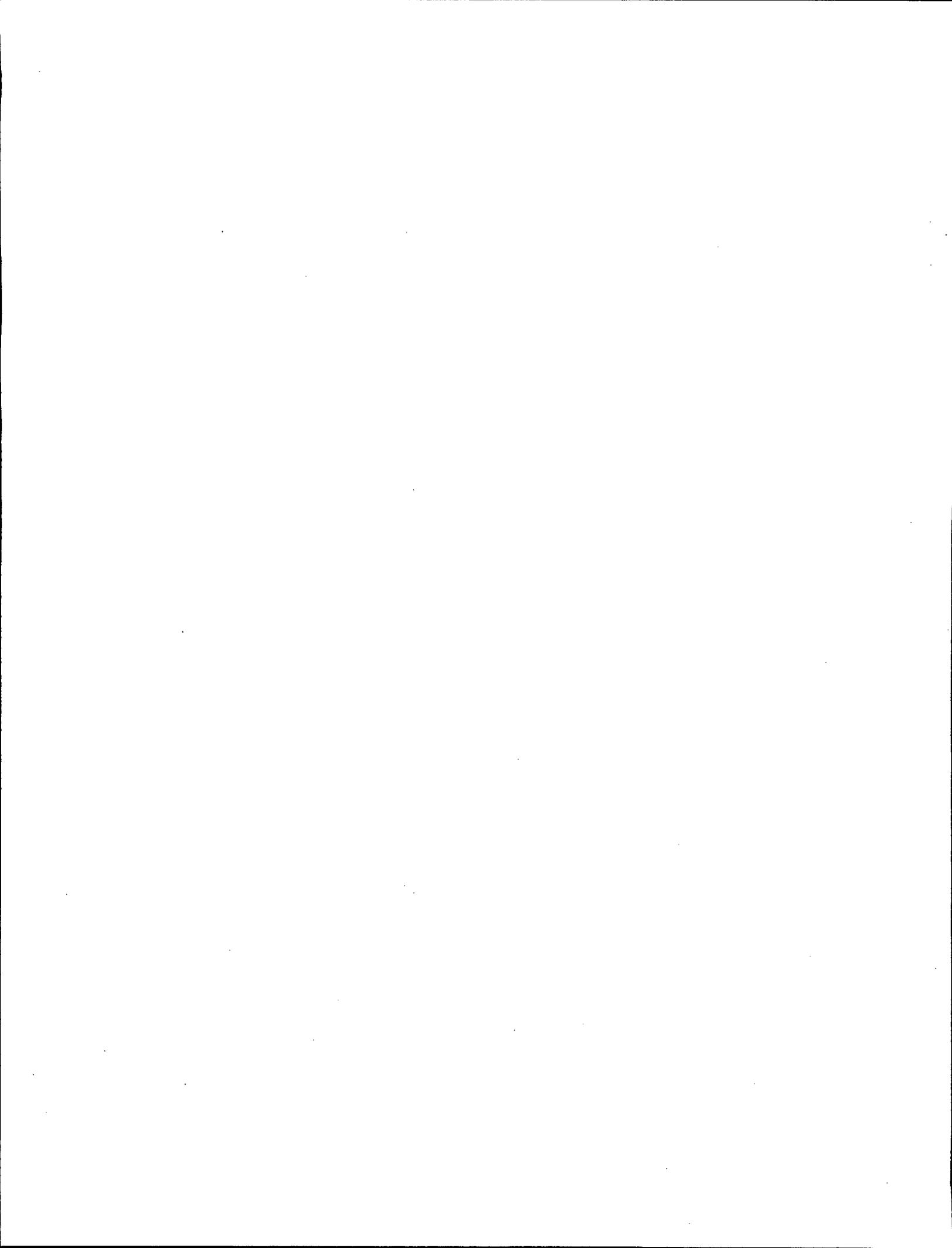
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

8899

303611

If continuation sheet 1 of 8



Division of Licensing and Protection

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R139 Continued From page 1

R139

5.8 Physician Services

5.8.c Any refusal of medical care and the reasons for the refusal must be documented in the resident's record. If the resident has an attending physician, the physician shall be notified.

This REQUIREMENT is not met as evidenced by:  
Based on interview and record review the facility failed to document and notify the physician of refusal of medical care for 1 applicable resident. (Resident #1) findings include:

1. Per review of the MAR (Medication Administration Record) for Resident #1, monthly Vitamins and B12 injections as well as 2 eye medications were not administered consistently. The MAR for February 2010, March 2010 and May 2010 had omissions for the monthly vitamin B12 injection. A physician order, upon admission on 01/04/10, directed staff to administer vitamin B12 monthly as well as a physician visit note dated 02/09/10 stating 'give 100mcg (B12) today'. There was no evidence that this was done. In addition, the April 2010 MAR is missing. Two eye medications, one to be given at night and one to be given 3 times a day were not consistently given. Per interview on 5/21/10 at 1:00 PM, the Administrator stated that the resident refused the medications. The Administrator confirmed that the MAR did not have documentation as to the refusal nor was the physician notified.

*See attached*

R171 V. RESIDENT CARE AND HOME SERVICES  
SS=D

R171

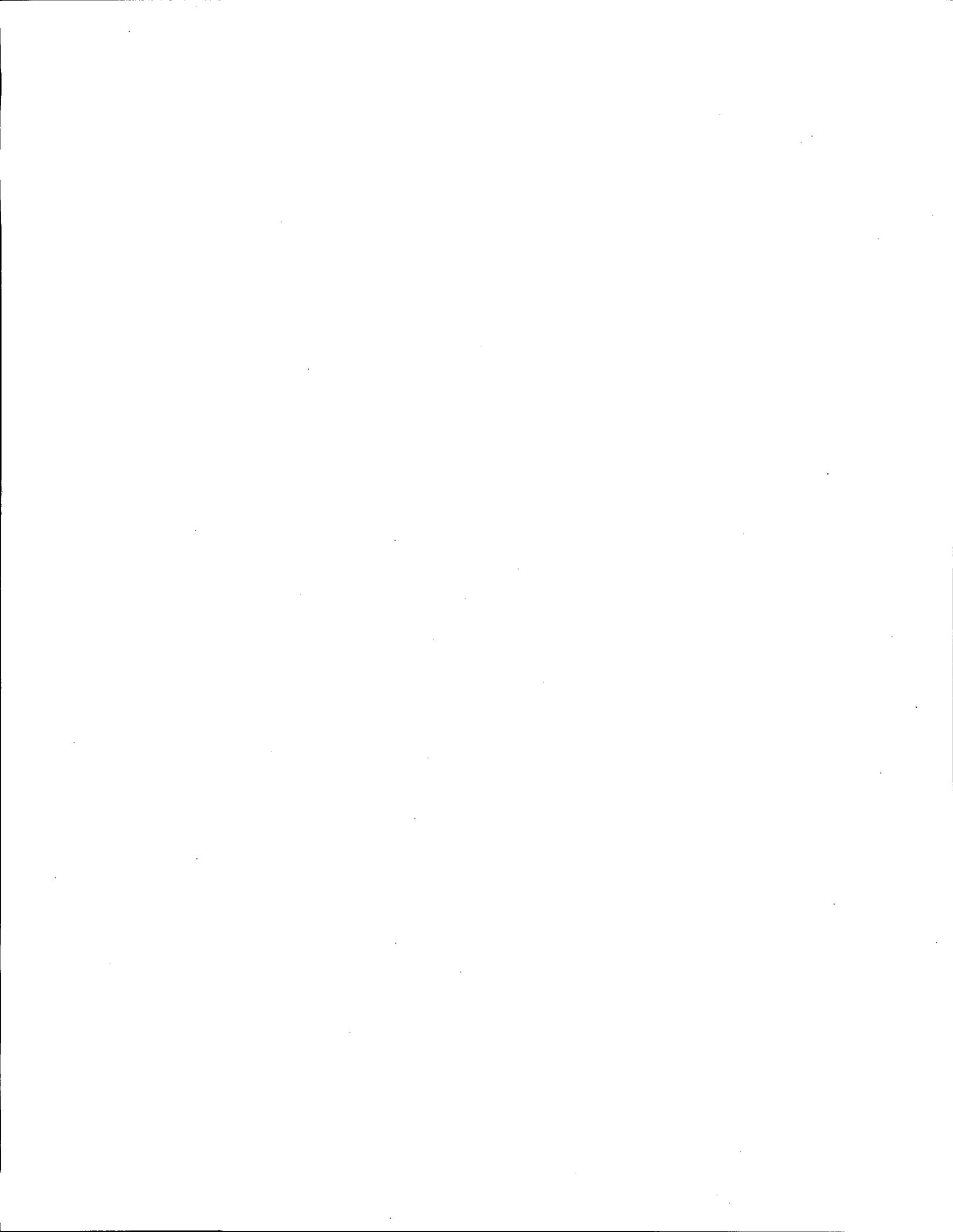
5.10 Medication Management



Division of Licensing and Protection

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R171	Continued From page 2  5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include:  (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, including the reason why and the actions taken by the home; (3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect; (4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and (5) For residents receiving psychoactive medications, a record of monitoring for side effects. (6) All incidents of medication errors.  This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to have sufficient documentation for medication administration for 1 applicable resident (Resident #1) Findings include:  1. Per record review , Resident #1 had physician orders for monthly Vitamins B12 injections, 2 eye medications and weekly B/P (blood pressure). These orders were not implemented consistently. In addition the April MAR is missing.  Per the MAR for February, March and May 2010 the monthly B12 was not given. No evidence of documentation could be found for the	R171		

*See attached*



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R171 Continued From page 3 R171

weekly B/P readings in the progress notes or MAR. The eye drops were not consistently given. The evening eye drops from May 1-6 were not given. Per interview on 5/27/10 at 11:30 AM the Administrator stated that the B/P should have been on the MAR or progress notes, but could not find evidence nor documentation that this was done. The Administrator also confirmed that there was no record that staff followed physician's orders for the eye drops nor Vitamin B12. The Administrator further confirmed that the MAR did not have documentation as to the refusal nor was the physician notified.  
Refer to R-128 & 139

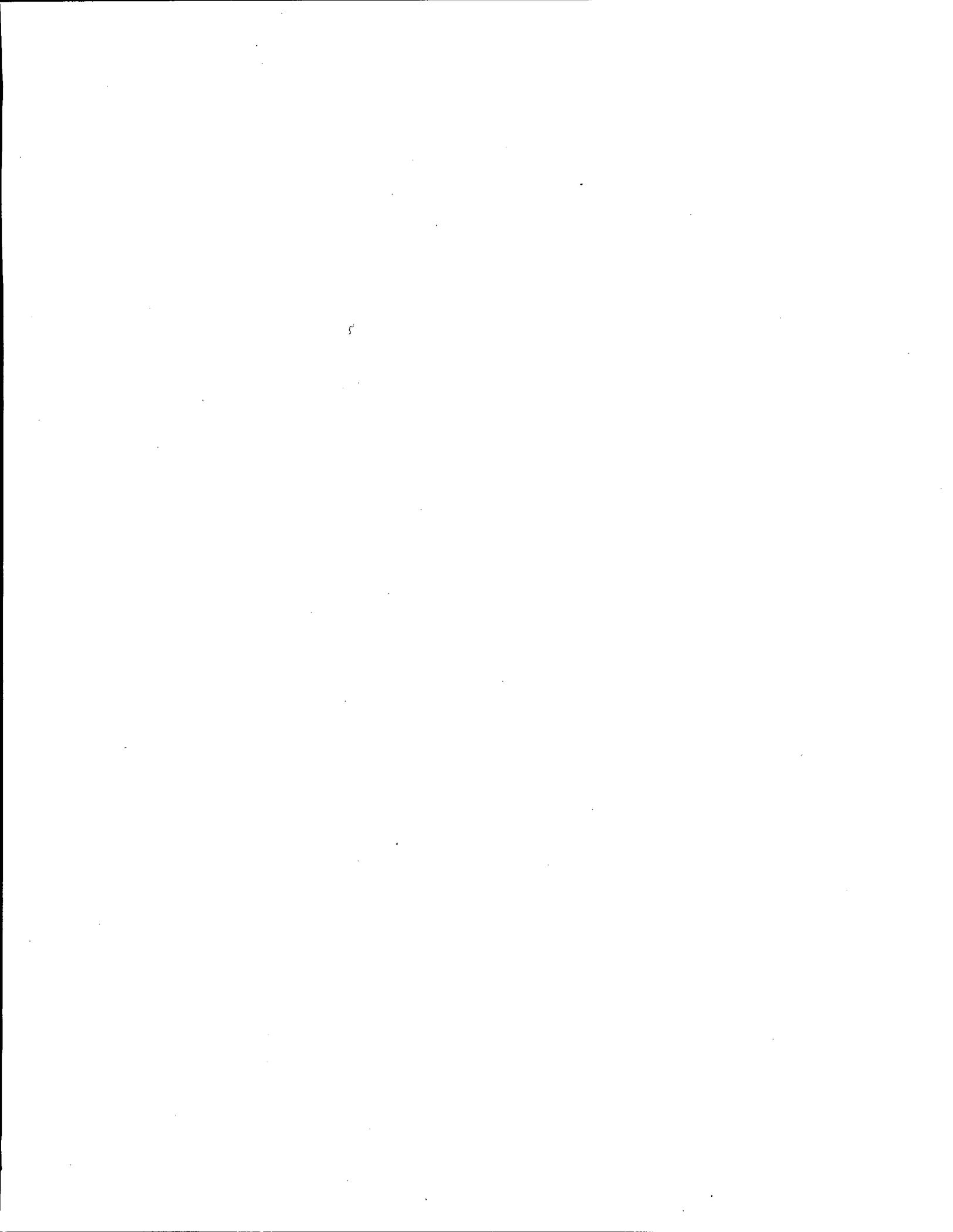
R179 V. RESIDENT CARE AND HOME SERVICES R179  
SS=D

5.11 Staff Services

5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following:

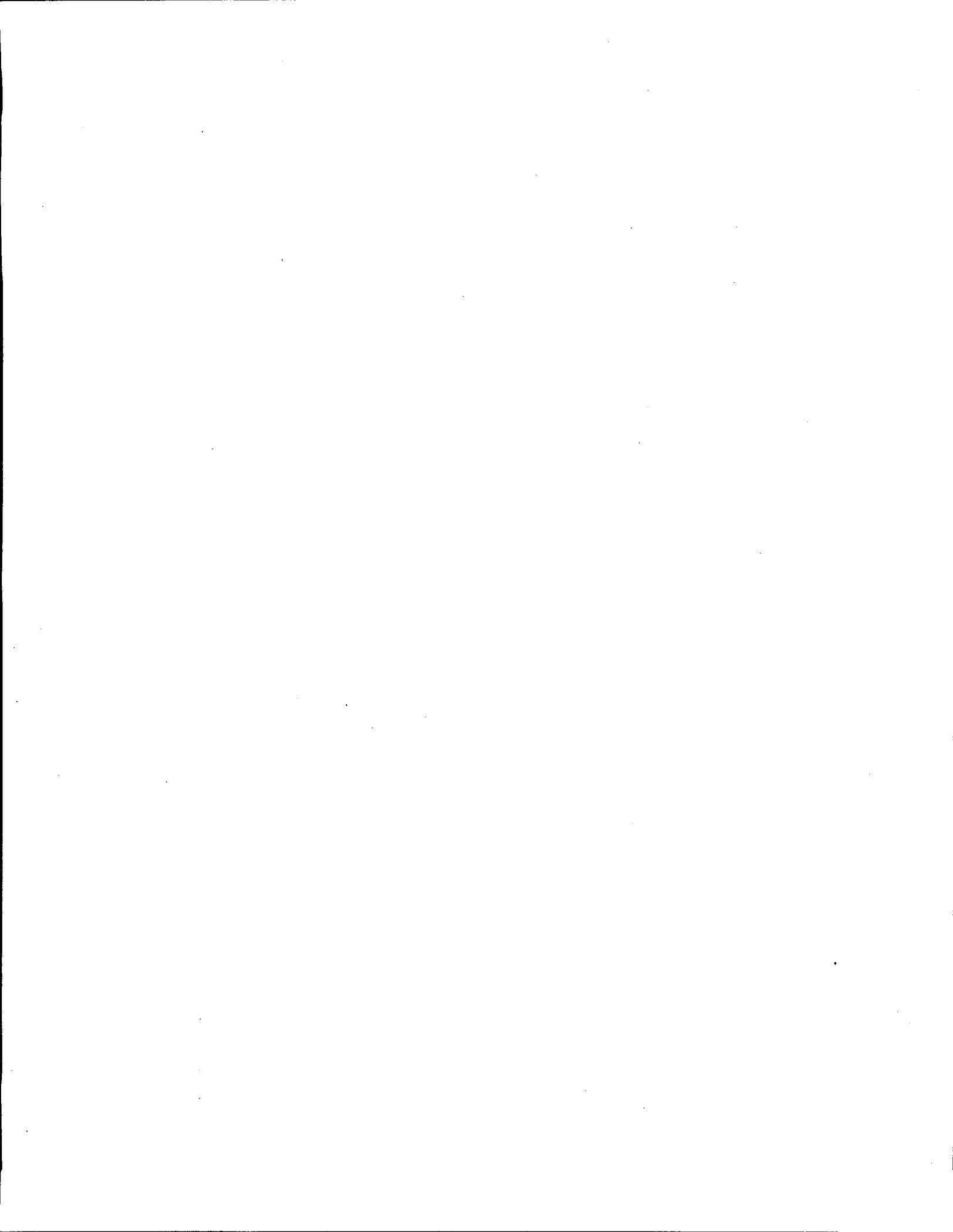
- (1) Resident rights;
- (2) Fire safety and emergency evacuation;
- (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid;
- (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation;
- (5) Respectful and effective interaction with residents;
- (6) Infection control measures, including but not limited to, handwashing, handling of linens,

*See Attached*



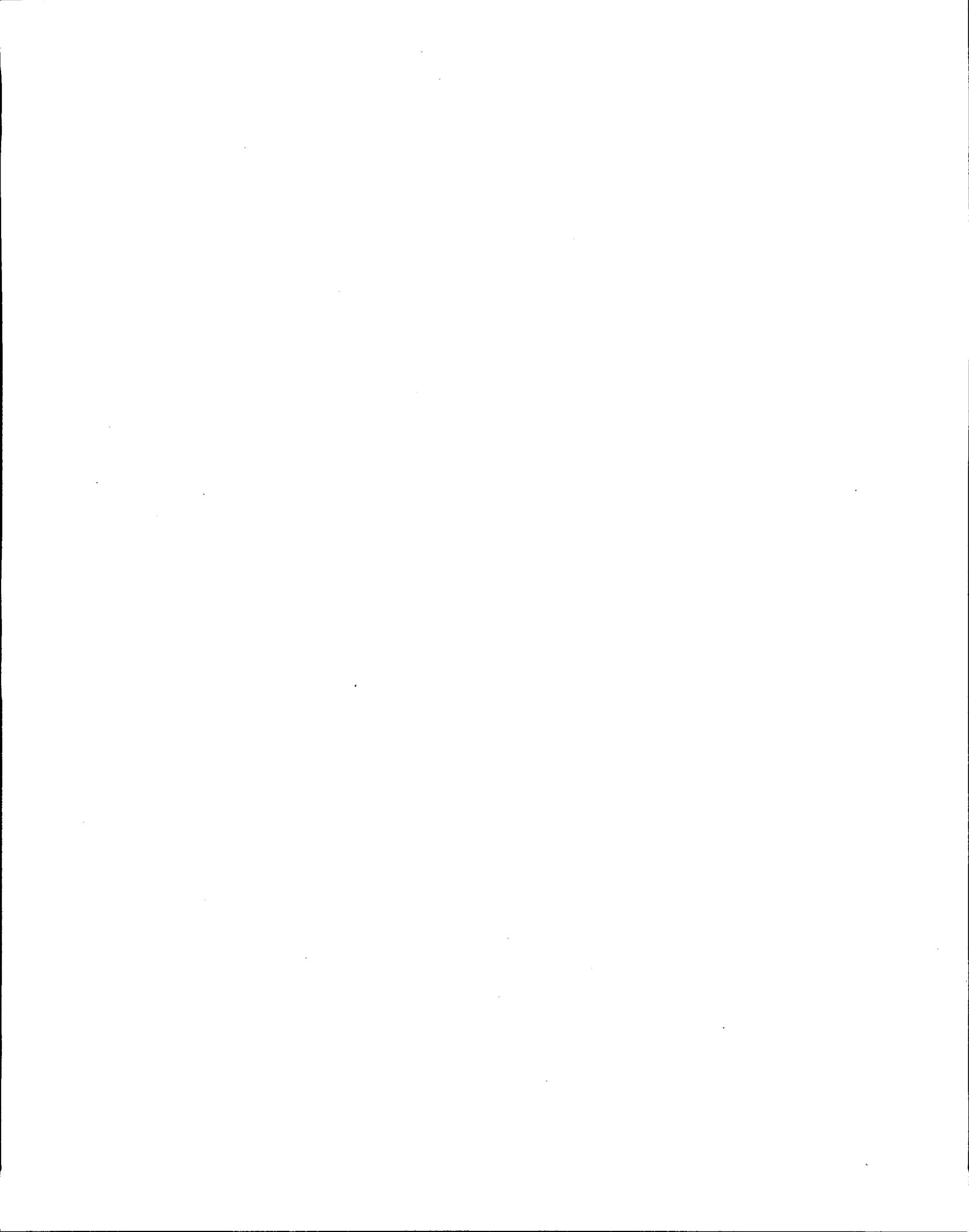
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R179	Continued From page 4  maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents.  This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure staff received at least 12 hours of in-service training per year. Findings include:  1. Per record review, the inservice folder had several pamphlets and flyers with information such as tick bites, flu symptoms and general health issues. The loose papers had signatures and dates. Not all of the staff signed the pamphlets nor were the dates consistently current. Per interview on 05/21/10 at 1:00 PM the Administrator stated that "I have to get a better system" and confirmed there was no evidence that direct care staff received the 12 hours of yearly inservice.	R179	
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.  This REQUIREMENT is not met as evidenced by:	R189	<i>See attached</i>



Division of Licensing and Protection

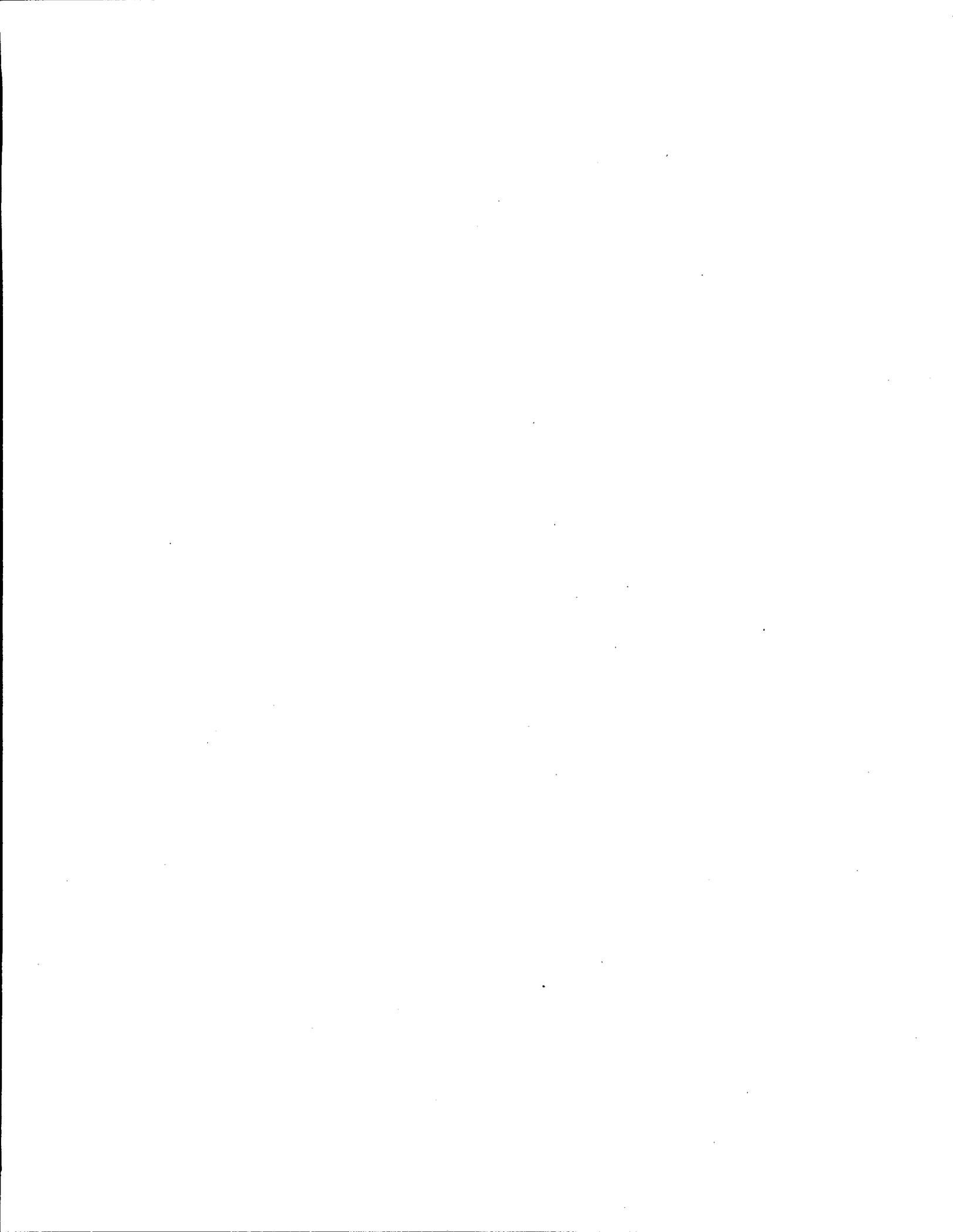
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R189	Continued From page 5  Based on record review and interview the facility failed to have in Resident #1's record, progress notes for changes and assessments. Findings include:  1. Per record review Resident #1, who received medication management, had a progress note dated February 2010 with no further entries. Per physician order dated 03/10/10, staff were to monitor weekly B/P and administer Vit. B12 as well as eye medication for recent eye surgery. There was no documentation regarding any changes to the resident's B/P status or refusals. Per interview on 5/27/10 at 11:30 AM the Administrator stated that the B/P and the changes to the resident's medication regime was not documented and "should've been in progress notes".	R189		
R191 SS=D	V. RESIDENT CARE AND HOME SERVICES  5.12 Records/Reports  5.12.c A home must file the following reports with the licensing agency:  5.12.c.(1) When a fire occurs in the home, regardless of size or damage, the licensing agency and the Department of Labor and Industry must be notified within twenty-four (24) hours. A written report must be submitted to both departments within seventy-two (72) hours. A copy of the report shall be kept on file.  5.12.c.(2) A written report of any accident or illness shall be placed in the resident's record. Any untimely deaths shall be reported and a record kept on file.	R191	<i>See attached</i>	



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R191	Continued From page 6  5.12.c. (3) A report of any unexplained absence of a resident from a home for more than 12 hours shall be reported to the police, legal representative and family, if any. The incident shall be reported to the licensing agency within twenty-four (24) hours of disappearance followed by a written report within seventy-two (72) hours, a copy of which shall be maintained.  5.12.c.(4) A written report of any breakdown or cessation to the home's physical plant's major services (plumbing, heat, water supply, etc.) or supplied service, which disrupts the normal course of operation. The licensee shall notify the licensing agency immediately whenever such an incident occurs. A copy of the report shall be sent to the licensing agency within seventy-two (72) hours.  5.12.c. (5) A written report of any reports or incidents of abuse, neglect or exploitation reported to the licensing agency.  5.12.c. (6) A written report of resident injury or death following the use of mechanical or chemical restraint.  This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to document an accident in 1 applicable resident's chart. (Resident#1) Findings include:  1. Per review of the Resident #1's chart on 5/21/10 there was no documentation of a fall that resulted in injury requiring hospitalization. Resident # 1 fell during the morning hours, in the bedroom, on 05/06/10. Per interview on 5/21/10 at 1:00 PM the Administrator confirmed that the resident's chart did not have a written report of	R191			

*See attached*



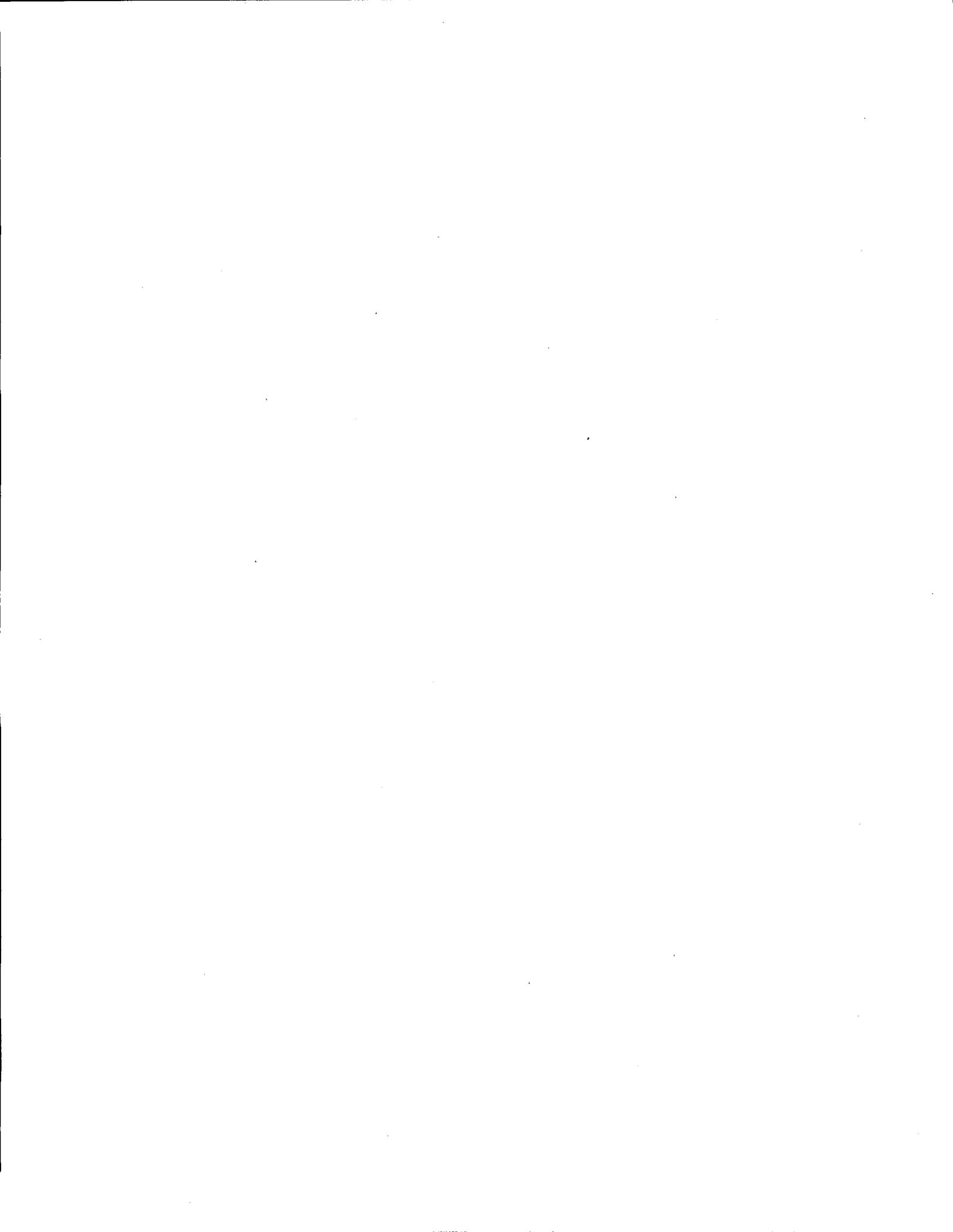
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R191	Continued From page 7 the fall with injury.	R191		
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## Atkinson Residence Plan of Correction

R-128

### 5.5 General Care

5.5c Each Resident's medication, treatment, and dietary services shall be consistent with the physician's orders.

This will be accomplished through review of orders by those responsible for delivery of services both at the time of admission and at the time of any changes. Documentation of review will be evidenced by signature of staff responsible prior to delivery of services.

All staff will receive inservice regarding review of orders to include title of inservice, instructor, time involved in the inservice, and brief outline of course content. This data will be included in staff member's personnel file.

Director/RN will complete periodic assessments of personnel records to assure staff review of information no less than annually. Director/RN will complete periodic record reviews to assure that physician's orders are reviewed by staff and effectively implemented.

*POC accepted 7/1/10 by S. Emmens, RN - S. Lewis, RN*

R139

### 5.8 Physician Services

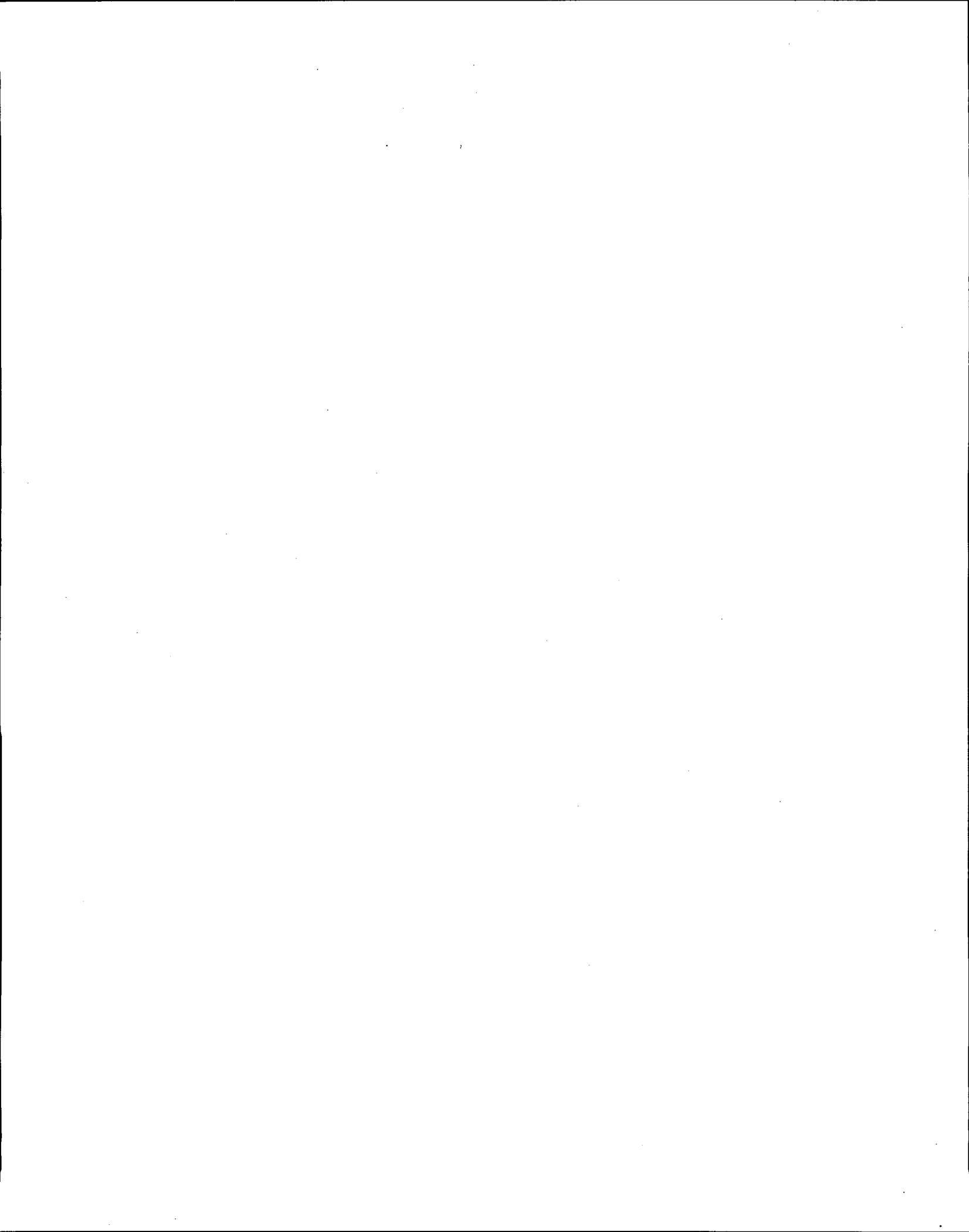
5.8c Each Resident refusing medical care or services shall have the refusal documented along with the reason for refusal in his record. If resident has an attending, the physician shall be notified.

This will be accomplished through reenforcing to the staff through inservice, the importance of documenting refusals in medical record and notifying provider to assure therapies and medications for resident are therapeutic and safe.

All staff will receive inservice to include title of inservice, instructor, time involved in the inservice, and brief outline of course content to include procedures for documentation of medication administration and procedures should resident refuse medications or treatments.

Director/RN will complete periodic reviews of personnel records to be sure staff have received up to date inservice materials and resident's MAR's and charts to assure that recommended procedures are followed to assure safety and improved health of individual residents.

*POC accepted 7/1/10 by S. Emmens, RN - S. Lewis, RN*



R171

#### 5.10 Medication Management

5.10g Atkinson Residence will establish procedures for documentation sufficient to indicate to physician, registered nurse, certified manager or representatives of the licensing agency that medication regimen as ordered is appropriate and effective to include: documentation that medications were administered as ordered; instances of refusal of medications include why and subsequent actions taken by the home, all PRN medications administered include the date, time, reason for giving the medication, and its effect; a current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; for residents receiving psychoactive medications, a record of monitoring for side effects; and incidents of medication errors.

This will be accomplished through thorough review of medication policy and procedures at Atkinson Residence required by any staff member employed to provide administration of medications at Atkinson Residence. Documentation of review shall be by signature of both staff member and person providing the inservice. Documentation of inservice to be kept in staff member's personnel file.

Director/RN to review personnel records to confirm that staff member has been properly instructed and understands materials prior to medication administration. Director/RN to check MAR's weekly to assure accuracy of documentation and F/U to refusals etc.

*POC accepted 7/1/10 by S. Emmens, RN, S. Perry, RD*

R179

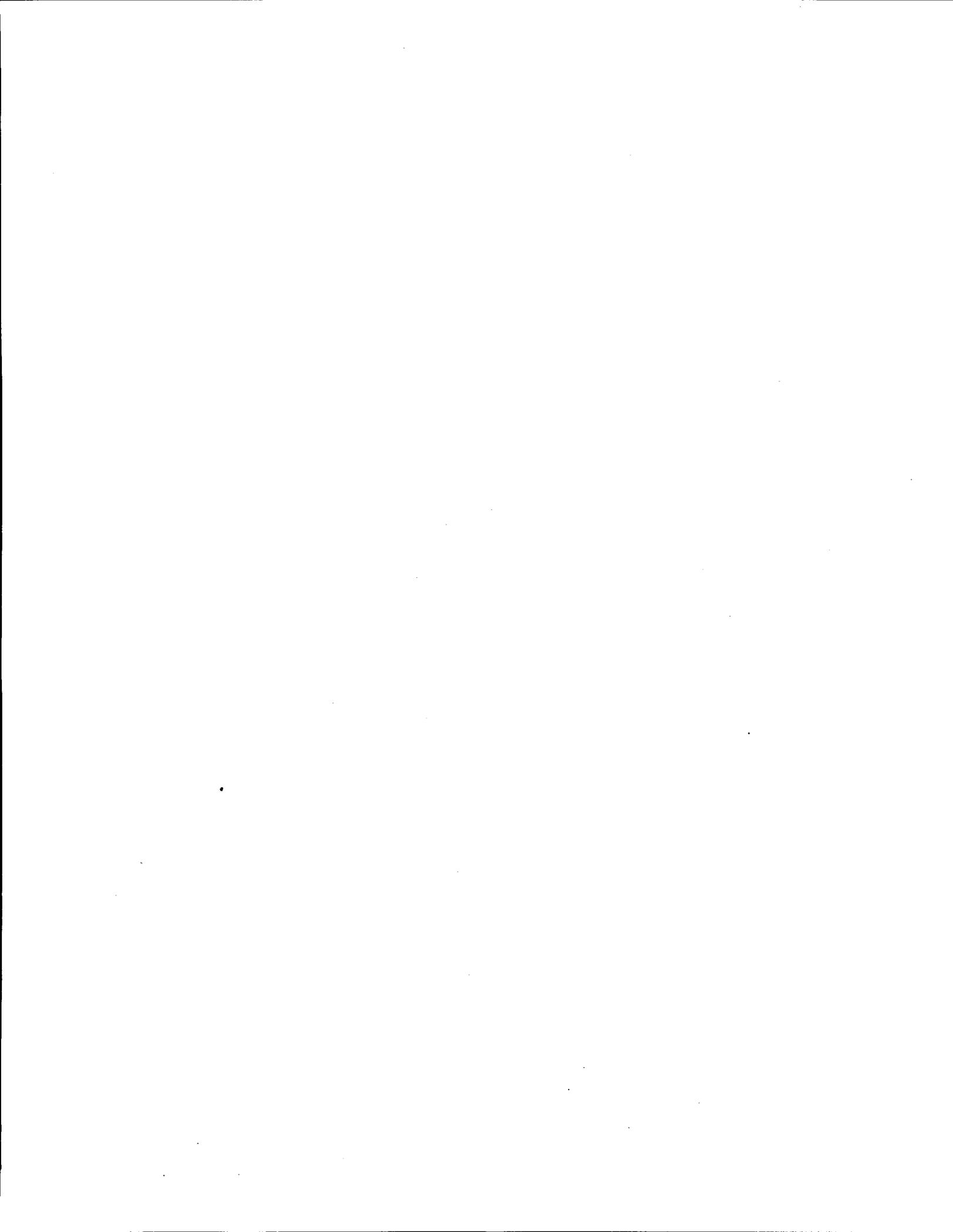
#### 5.11 Staff Services

5.11b Atkinson Residence will ensure that staff demonstrate competency in skills and techniques they are expected to perform prior to providing direct care to residents. 12 Hours of training each year shall be provided to each staff member providing direct care to residents. The training must include resident rights; fire and safety emergency evacuations; resident emergency response procedures such as the Heimlich maneuver, accidents, police and ambulance contact, and first aid; Policies and procedures regarding mandatory reports of abuse, neglect, and exploitation; respectful and effective interactions with residents; infection control measures, including but not limited to handwashing, handling of linen, maintaining clean environments, blood borne pathogens and universal precautions; and general supervision and care of residents.

This will be accomplished through orientation of new staff members to include 12 hours of training as outlined above before the staff member is permitted to provide direct resident care. The staff member must demonstrate a thorough understanding of the material either through written tests, by actual demonstration, or interrogation. Staff members will be required to complete 12 hours of mandatory inservice annually addressing the above. Documentation of these will be found in the staff member's personnel record.

Director/RN will assess competencies prior to staff providing direct resident care. Director/RN will track inservice for staff members to assure the competencies are reviewed in a timely manner.

*POC accepted 7/1/10 by S. Emmens, RN - S. Perry, RD*



R189

5.12 Resident Care and Home Services

5.12b Records for residents of Atkinson Residence who require nursing care, nursing overview, or medication management shall contain initial assessment; annual reassessment; assessments with significant change; physician's admission statement and current orders; staff progress notes including changes in the resident's condition and action taken; reports of physician visits; signed telephone orders and treatment documentation; and resident plan of care.

This will be accomplished by review of current residents' charts to assure records contain pertinent data needed to provide safe effective resident care.

Director/RN will review each resident's chart and assure current data is reflective of care being delivered and goals for resident's care.

*POC accepted 7/1/10 by S. Emmens, RN - S. Lemay, RD*

R191 Resident Care and Home Services

5.12 Records/Reports

5.12c Reports to the licensing agency shall be made according to the requirements of the licensing agency.

This will be accomplished by gathering data from those who were present and completing the written reports as required within the time frame outlined in each situation. Staff will be provided inservice outlining the state requirements and copies of the data supporting attendance will be kept in each personnel file. This will be part of annual review for staff.

Director/RN will be responsible for completing the written reports for submission to licensing agency within the time specified by that agency. Director/RN will keep a copy of the written report to track trends.

*POC accepted 7/1/10 by S. Emmens, RN - S. Lemay, RD*

