

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

May 22, 2013

Ms. Carrie Jewell, Administrator
Davis Home
45 State Street
Windsor, VT 05089

Provider #: 0021

Dear Ms. Jewell:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation that was initiated by the Division of Licensing and Protection on March 14, 2013 and completed on **April 4, 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



MAY - 3 2013

PRINTED: 04/17/2013
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/04/2013
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NAME OF PROVIDER OR SUPPLIER DAVIS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 45 STATE STREET WINDSOR, VT 05089
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R100	Initial Comments: An unannounced onsite complaint investigation was initiated by the Division of Licensing and Protection on 3/14/13 and completed on 4/4/13. There were regulatory findings.	R100	<i>R126, R167, R200 + R266 POC's accepted 5/9/13 K. Campos RN / PMC</i>	
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 adequate supervision to meet the nursing needs of one resident sampled (Resident #1). Findings include: Per closed record review on 3/14/13, Resident #1 had significant memory issues, a history of wandering and actual elopement from the home, and an unsteady gait when ambulating. Per review of the record and interviews with staff, it was determined that on the afternoon of 2/15/13, Resident #1 was brought to the dining room and sat at a table. According to the home's Administrator, the delivery person from the medical company was delivering a hospital bed, and propped the door open to bring in the bed. The alarm had been turned off to accommodate the delivery. The staff were out of the room, and Resident #1 got up and went out the side door off	R126	<i>Any resident with assessed 4/20/13 needs for wandering risk will be monitored when the alarm is turned off. Doors will not be left open and unalarmed when there are residents with wander/elopement risks.</i>	

Division of Licensing and Protection

Carmy Jewell administrator TITLE *5/1/13* (X6) DATE

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

PMC

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R126	<p>Continued From page 1</p> <p>the dining room and down the ramp, where s/he was found lying at the bottom of the ramp.</p> <p>Staff who responded to the incident asked the resident if they were alright, and the resident was able to get up from the ground and walk back into the home with assistance. Per interview with the home's Administrator, there was no nurse on duty at the time of the incident, and the staff did not call 911, the nurse, or the Administrator before moving the resident inside. Per interview on 3/14/13 at 3:30 PM, the home's Administrator confirmed that per their policy, unlicensed staff should not have moved the resident without first speaking to the nurse or the Administrator, and that Resident #1 was left unsupervised with an opened door in view.</p> <p>Also see R266.</p>	R126		
R167 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.10 Medication Management</p> <p>5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:</p> <p>(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.</p>	R167	<p>We have instituted a behavior intervention record flow sheet. Staff have been trained to use the tool. (copy enclosed)</p> <p>The nursing staff will monitor PRN medications and usage along with documentation on a weekly basis. (cont.)</p>	4/30/13

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R167	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to assure that all PRN (as needed) psychoactive medications had a complete and clear order for their use for one resident sampled (Resident #1). Findings include: Per record review on 3/14/13, Resident #1 had an order for "Lorazepam 0.5 mg. [milligrams] One tablet by mouth every 8 hrs PRN [as needed] for anxiety". The order is present on the MARs (Medication Administration Records) reviewed from April 2012 to January 2013. The medication was documented as given anywhere from 3 to 9 times in a month by staff. The reverse side of the MAR was filled out as to the time given, and the reason, however follow up notes as to the effect of the medication were not recorded, and no guidelines for specific behaviors or non-pharmacological interventions to be tried first available in the resident's record. The Lorazepam order was discontinued on 12/14/12, however on January 23, 2013, the discontinued medication was recorded as being given to the resident. Also per review of the MAR for Resident #1, there was an order started on 12/14/12 for "Trazadone 25 mg. (half of a 50 mg. tablet) PRN for agitation. If no improvement in 1 hour, may give 25 mg. more. You may use 100 mg. in 24 hours. Notify MD if not working or resident is sleepy". On 1/23/13, the order was changed to "Trazadone 50 mg. four times daily PRN agitation". The back of the MAR had the times given and the reason, however lacked the follow up documentation as to the effectiveness of the medication. Also the	R167	Staff will be educated on prescribed PRN medications for specific behaviors the med is intended to address and documentation required. <i>4/20/13</i>		
			All PRN meds administered will have a documented result. This will be monitored by the nursing staff and/or manager on a weekly basis. <i>4/20/13</i>		

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R167	Continued From page 3 1/23/13 order did not give any time spacing parameters between doses of the medication. Also per review at that time, no behavior sheets or documentation was available to guide staff as to the specific behaviors that would warrant the use of this psychoactive medication and the side effects to be watchful for, or any non-pharmacological interventions to try first. Per interview on 3/14/13 at 3:35 PM, the home's Administrator confirmed that there were no behavior plans in place for the use of these psychoactive medications to guide staff in the correct use of them, that the Trazadone order did not have timing parameters for administration, and that the Lorazepam was documented as being given on 1/23/13, over a month after it was discontinued by the physician.	R167		
R200 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on review of facility policies, the home failed to assure there was a written policy for medical emergencies. Findings include: Per review of the home's Policy and Procedures and staff training logs on 3/14/13, there was no written policy available for handling medical emergencies. Per review of staff training, the content was included in the orientation and yearly	R200	<i>A policy and procedure was written to address medical emergencies. All staff have been trained on the policy. (copy enclosed)</i> <i>The manager will ensure all new staff have the above training and</i>	<i>4/8/13</i>

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R200	Continued From page 4 trainings, however there was no written policy to guide staff in handling a medical crisis. Per interview on 3/14/13 at 3:05 PM, the home's manager confirmed that staff were verbally trained to properly handle an emergency, however the home did not have a written policy in place for handling medical crises.	R200	That it is renewed at bi-monthly staff mtgs.	
R266 SS=D	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to provide a safe environment for one resident sampled (Resident #1). Findings include: Per closed record review on 3/14/13, Resident #1 had significant memory issues, a history of wandering and actual elopement from the home, and an unsteady gait when ambulating. Per review of the record and interviews with staff, it was determined that on the afternoon of 2/15/13, Resident #1 was brought to the dining room and sat at a table. According to the home's Administrator, the delivery person from the medical company was delivering a hospital bed, and propped the door open to bring in the bed. The alarm had been turned off to accommodate the delivery. The staff were out of the room, and Resident #1 got up and went out the side door off the dining room and down the ramp, where s/he was found lying at the bottom of the ramp.	R266	Doors will not be left open and unalarmed when there is are residents with wander/ elopement risk. Supervision and one-on-one attention will be given to such resident when a door is opened or when the alarms are turned off.	4/17/13

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R266	Continued From page 5 Staff who responded to the incident asked the resident if they were alright, and the resident was able to get up from the ground and walk back into the home with assistance. Per interview with the home's Administrator, there was no nurse on duty at the time of the incident, and the staff did not call 911, the nurse, or the Administrator before moving the resident inside. Per interview on 3/14/13 at 3:30 PM, the home's Administrator confirmed that per their policy, unlicensed staff should not have moved the resident without first speaking to the nurse or the Administrator, and that Resident #1 was left unsupervised with an opened door in view. Also see R126.	R266			