



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

August 26, 2010

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

Dear Ms. Jewell:

Enclosed is a copy of your acceptable plans of correction for the annual survey conducted on **July 27, 2010**. 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,

A handwritten signature in black ink that reads "Pamela M. Cota RN". The signature is written in a cursive style.

Pamela M. Cota, RN
Licensing Chief



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 07/27/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DAVIS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 45 STATE STREET WINDSOR, VT 05089
---	---

(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 onsite recertification survey was conducted by the Division of Licensing and Protection on July 27, 2010.

R100

R147
SS=D

V. RESIDENT CARE AND HOME SERVICES

5.9.c (4)

Maintain a current list for review by staff and physician of all residents' medications. The list shall include: resident's name; medications; date medication ordered; dosage and frequency of administration; and likely side effects to monitor;

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the nurse failed to maintain a current list of medications for 1 of 3 applicable residents (Resident #2). Findings include:

1. Per record review, Resident #2's current list of medications failed to accurately reflect physician orders. Resident #2's current list of medications included an anti-depressant drug indicated as prescribed by the resident's physician on 4/2/09 and recorded on the MAR (Medication Administration Record) as "Celexa 20 mg (milligram) po (orally) QD (daily) 1/2 tab as needed for increased depression." A second order on 4/2/09 was recorded on the same MAR as "Celexa 10 mg po QD." Per record review, there was an order for the daily Celexa but no order for the "as needed" dose. During an interview at 11:57 AM on 7/27/10, the Manager confirmed that no physician order had been written for the "as needed" Celexa order recorded

R147

The nursing staff and administrator will review all MAR's for accuracy immediately.

The nursing staff will monitor the MAR's sent from the LTC Pharmacy each month and make any changes needed.

8/31/10

RECEIVED
Division of
AUG 25 10
Licensing and
Protection

Handwritten signature/initials

Division of Licensing and Protection

Carm Jwell

Administrator

8/10/10
(X6) DATE

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

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 07/27/2010
NAME OF PROVIDER OR SUPPLIER DAVIS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 45 STATE STREET WINDSOR, VT 05089		
(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
R147	Continued From page 1 on the MAR and stated that this order should be discontinued.	R147		
R179 SS=E	V. RESIDENT CARE AND HOME SERVICES 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, 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 home did not assure that each staff person providing direct care to residents received 12 hours of annual training. Findings include: Per record review on 7/27/10, 3 of 5 staff	R179	<p>all staff that are lacking in sufficient training hours will have them made up by 9/30/10.</p> <p>We will ensure that any staff deficient in mandatory topics will be made up by 9/30/10</p> <p>The administrator or manager will monitor the professional development log on a monthly basis to renew the status and needs of all staff training.</p> <p>8-25-10 R179 POE accepted C. Kennedy, R</p>	

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 07/27/2010
NAME OF PROVIDER OR SUPPLIER DAVIS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 45 STATE STREET WINDSOR, VT 05089		
(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
R179	Continued From page 2 members reviewed had less than 12 hours of annual training recorded. During an interview at 1:15 PM on 7/27/10, the Manager confirmed that the record did not reflect the required training hours for 3 of 5 direct care staff.	R179		
R190 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home did not have available the results of criminal record checks for 5 of 5 staff. Findings include: Per record review on 7/27/10, no record of criminal record checks was available for 5 of 5 direct care staff reviewed. During an interview at 1:15 PM on 7/27/10, the Manager confirmed that no criminal record checks were available for the 5 direct care staff reviewed.	R190	<i>The administrator will conduct criminal records checks on all staff that were missed by 7/31/10 7/31/10</i> <i>all new hired employees will have a criminal records check upon accepting a position at Davis Home.</i>	
R302 SS=D	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on	R302	<i>The administrator will monitor employee files for appropriate paper work.</i> <i>8-25-10 R 190 poc accepted, C. Lanning, R/L</i>	

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 07/27/2010
NAME OF PROVIDER OR SUPPLIER DAVIS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 45 STATE STREET WINDSOR, VT 05089		
(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
R302	Continued From page 3 at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home did not complete night-time fire drills during the prior year. Findings include: Per record review on 7/27/10, fire drills were completed on 8/29/09 at 9:00 AM, 9/29/09 at 1:28 PM, 10/28/09 at 6:45 PM, 1/29/10 at 8:00 AM, 6/16/10 at 3:00 PM, and 4/13/10 at 3:45 PM. During an interview at 1:15 PM on 7/27/10, the Manager confirmed that drills had not been performed during night time hours for the prior year.	R302	<i>A fire drill will be performed during night time hours by 8/31/10.</i> <i>2 Night time hours Fire drills will be done annually.</i> <i>The manager and/or administration will ensure that Fire drill standards are met.</i> <i>R 302 - be accepted - C. Leamy, et</i>	<i>8/31/10</i> <i>12/31/10</i>