

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

February 3, 2012

Ms. Roxanne Ladabouche, Administrator
Giordano Manor
34 Canada Street
Swanton, VT 05488

Provider #: 0038

Dear Ms. Ladabouche:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **January 5, 2012**. 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, MS
Licensing Chief

PC:ne

Enclosure



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	Licensing and Protection	(X3) DATE SURVEY COMPLETED C. 01/05/2012
NAME OF PROVIDER OR SUPPLIER GIORDANO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 34 CANADA STREET SWANTON, VT 05488		
(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 complaint investigation was conducted by the Division of Licensing and Protection on 12/13/11, and completed on 1/5/11. The following regulatory violations were identified as a result.	R100			
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 record review and staff interview, the home failed to assure that the plan of care contained all information necessary to describe care and services provided to a resident. (Resident #1) Findings include: Per record review on 12/13/11, Resident #1 was on anti-coagulant therapy daily, which included ongoing blood tests and a need for monitoring of signs/symptoms of bleeding. Per review of the plan of care, there was no mention of the anticoagulant therapy or the interventions appropriate to this therapy. Also per record review, and staff interview, Resident #1 was on continuous oxygen therapy, and this was also not written in the plan of care to designate amount of oxygen administered, when the tubing and other equipment was supposed to be replaced or maintained, and who was responsible for these	R145	Per a telephone call on 2/2/12 at 8:50 am, the home manager and nurse will be responsible for monitoring for compliance. R145, R149, + R179 POCs accepted. 2/2/12 K Campos RN / P McArthur		

Division of Licensing and Protection

Coranne Ladouceur TITLE *Manager*

(X6) DATE
1-30-12

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

PML

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R145	Continued From page 1 tasks. Per interview on 12/13/11 at 2:15 PM, the home manager confirmed that the resident's plan of care did not contain information regarding oxygen therapy or anticoagulant medication use.	R145		
R149 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (6) Maintain a current list of all treatments for each resident that shall include: the name, date treatment ordered, treatment and frequency prescribed and documentation to reflect that treatment was carried out; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to assure that the current medication and treatment list contained the prescribed use of oxygen for one resident (Resident #1). Findings include: Per record review on 12/13/11, the medical record of Resident #1 did not list oxygen use on the medication or treatment record. Per interview on 12/13/11 at 2:10 PM, the home manager confirmed that the resident did require oxygen therapy daily, and that this was not on the list of current medications or treatments provided.	R149	<i>We will have a Tx Sheet for residents on O2 Therapy. Will also list on mar.</i> <i>1. Weekly Tubing & Humidification Bottles if needed - Clean Soap + water wkly</i> <i>3 Filter - washed c soap + water + towel dried - weekly.</i> <i>Also included new care plan.</i> <i>Will tested yearly on Dx + Tx inservices.</i>	
R179 SS=G	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	R179		

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R179	<p>Continued From page 2</p> <p>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:</p> <ol style="list-style-type: none"> (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. <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to ensure that staff demonstrated competency in following established emergency response procedures following an accident for one resident (Resident #1). Findings include:</p> <p>Based on record review, Resident #1 had a history of falls and was on anticoagulant medication therapy. The resident would get up during the night independently to use the commode nearby. The aide on duty overnight on 8/18/11 heard a loud noise at 2:00 AM, and went to the resident's room where they found the resident lying face down with his/her pants halfway down. The staff person asked if s/he was hurt, and the resident answered no. The staff</p>	R179		

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R179	Continued From page 3 member assisted the resident up to the recliner, and noticed a red mark above the left eye and on the lip. The aide asked the resident again if they were OK, and stated that the resident should be evaluated by the hospital. The resident refused transport to the Emergency room, and stated again that they were not hurt. The aide took vital signs, applied ice to the bump, and checked on the resident frequently, however did not contact the home manager or the nurse at the time of the fall per the home's written protocol. The resident appeared to be fine until a few hours later at 6 AM, when the forehead swelling increased, and the resident started vomiting. At this time, emergency transport was arranged, and the aide called the home manager. The resident passed away later that day at the hospital. The medical examiner listed the cause of death as a subdural hematoma from blunt trauma due to the fall. Per telephone interview on 1/5/11 at 1:50 PM, the aide involved confirmed that s/he had received training on procedures to follow after an accident, the protocol was to call the home manager and the nurse, and that the procedure was not followed. Per telephone interview on 1/5/11 at 10:25 AM the nurse stated that the aide involved is usually quick to call with any questions/concerns, and that the resident appeared to be alright, and was refusing transport to the hospital. Despite the circumstances, the expectation is that the aide would call the nurse or home manager (also a nurse), so they could further assess the resident for injuries. The nurse stated that staff has been re-educated on the importance of calling the home manager or the nurse if there is an injury, and on the side effects and problems associated with anticoagulant therapy.	R179	<i>Staff will be Tested yearly on Emergency procedures for anticoagulant Therapy, as Staff had previously trained in emergency protocol, but did not call either nurse. Staff has had 2 in services on The importance of calling the nurses & following protocol no matter what. A new care plan has been drawn up. enclosed is a copy.</i>	