

## 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) 871-3317  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 871-3318

November 12, 2013

Ms. Judith Chick, Administrator  
Historic Homes Of Runnemedede-Stoughton House  
40 Maxwell Perkins Lane  
Windsor, VT 05089

Provider #: 0161

Dear Ms. Chick:

Enclosed is a copy of your acceptable plans of correction for the unannounced onsite re-licensing survey and complaint investigation conducted from September 23, 2013 and completed on **September 25, 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

NOV 04 2013

PRINTED: 10/14/2013  
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0161	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/25/2013
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  HISTORIC HOMES OF RUNNEMEDE-STOUGH1	STREET ADDRESS, CITY, STATE, ZIP CODE 40 MAXWELL PERKINS LANE 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 on-site re-licensing survey, in conjunction with complaint investigation, was conducted by the Division of Licensing and Protection on 09/23/13 - 09/25/13. The following are Residential Care Home regulatory violations.	R100		
R101 SS=D	V. RESIDENT CARE AND HOME SERVICES  5.1. Eligibility  5.1.a The licensee shall not accept or retain as a resident any individual who meets level of care eligibility for nursing home admission, or who otherwise has care needs which exceed what the home is able to safely and appropriately provide.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home retained 1 applicable resident in the survey sample (Resident #3) who meets level of care for nursing home admission. Findings include:  1. Per interview on 09/23/13 at 10:30 AM the Administrator presented to the nurse surveyor the Level of Care (LOC) variance for 5 residents at the RCH (Residential Care Home) of which Resident #3 was not listed. Per record review on 09/24/13 Resident #3 had lived in a nursing home until its closure recently. The Administrator at that time confirmed that no variance to retain Resident #3 had been requested from the Licensing Agency.	R101	<i>R101 Resident #3 variance issued on 8/23/13 by Fran Keeler (see attached)</i>	
R145 SS=E	V. RESIDENT CARE AND HOME SERVICES	R145		

Division of Licensing and Protection LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 11/1/13
---	------------------------	----------------------

R101, R145, R149, R167, R175, R178, R179, R181, R192, R213, R234, R266, R302 + R999

*pmc*

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0161	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  C 09/25/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  HISTORIC HOMES OF RUNNEMEDE-STOUGHT	STREET ADDRESS, CITY, STATE, ZIP CODE 40 MAXWELL PERKINS LANE 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
R145	<p>Continued From page 1</p> <p>5.9.c (2)</p> <p>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;</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews on 09/25/13, the facility failed to develop enhanced activity care plans for 2 residents and failed to revise the care plan of 1 resident of the targeted sample. (Residents #2, #3, #5) Findings include the following: *This is a repeat deficiency</p> <p>1. The care plan for Resident #2 had not been revised since 06/25/13 to address the the discontinuation of oxygen nor the use of Haldol ordered on 08/19/13. The care plan directs staff to place oxygen at 2 liters at night and as needed when upset. There are no interventions for the use of the psychotropic drug Haldol.</p> <p>2. Resident #3 who was admitted on 08/28/13 and identified as having ERC [enhanced residential care] bundled services, does not have a care plan for ERC services. In addition there was no activity assessment found in the chart.</p> <p>3. There was no activity care plan for Resident #5 who has is receiving ERC bundled services, admitted on 07/16/12. In addition, there was no activity assessment found in the chart.</p> <p>These findings were confirmed with the activity staff at 2:15 PM and the DNS at 2:45 PM .</p>	R145	<p><b>R145</b></p> <p>1. Resident #2 care plan revised on 9/26/13 indicating discontinuation of oxygen. MD visit on 9/26/13 to review Haldol use and clarification of order. RN responsible for including a list of non pharmacological interventions to try prior to administration of medication in the plan of care. Behavior sheets will be reviewed by charge nurse weekly and as needed to monitor compliance and effectiveness of treatment. Provider will be notified of any adverse effects RN Administrator to monitor for compliance monthly.</p> <p>2. Resident #3 Activities Assessment filed on 9/26/13, activities care plan completed on 10/3/13.</p> <p>3. Resident #5 activities care plan completed on 10/1/13 Activities staff responsible for activities assessment will collaborate with RN for completion of activities care plan. RN Administrator to monitor for compliance monthly.</p>	

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0161</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/25/2013</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>HISTORIC HOMES OF RUNNEMEDE-STOUGHT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>40 MAXWELL PERKINS LANE WINDSOR, VT 05089</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
--------------------	--	---------------	---	--------------------

R149	Continued From page 2	R149		
R149 SS=E	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.9.c (6)</p> <p>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;</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview the Registered Nurse (RN) failed to assure that care staff documented treatments for 2 applicable resident requiring oxygen (Residents #8 &amp; #9). Findings include:</p> <p>1. Per observations during the initial tour on 09/23/13 at 10:30 AM Resident #8's nasal cannula prongs were noted to be of brown coloring and draped over the concentrator touching the floor. This was applicable to Resident #9 as well. The Clinical Coordinator who accompanied the nurse surveyor during the tour started that the oxygen tubing is changed weekly. Per review at 11:15 AM of the MAR (medication administration record) for the month of September 2013, notes the O2 tubing was not changed on 18th for both residents as scheduled. Additionally the filters were to be washed, also due on the 18th, was not documented as being completed. The Clinical Coordinator at 11:45 AM confirmed the lack of documentation to reflect that treatment was carried as ordered.</p>	R149	<p style="text-align: center;"><i>R149</i></p> <p><i>1. Resident #8 and #9 cannulas replaced filters and tubes cleaned on 9/25/13.</i></p> <p><i>RN educated and counselled staff to assure scheduled compliance bi weekly audit of records to assure compliance.</i></p> <p><i>RN Administrator to monitor for compliance monthly.</i></p>	
R167 SS=D	V. RESIDENT CARE AND HOME SERVICES	R167		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0161	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/25/2013
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  HISTORIC HOMES OF RUNNEMEDE-STOUGHT	STREET ADDRESS, CITY, STATE, ZIP CODE 40 MAXWELL PERKINS LANE 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
--------------------	--	---------------	---	--------------------

R167	<p>Continued From page 3</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> <p>This REQUIREMENT is not met as evidenced by: Based on information gathered, the RCH failed to develop a written plan for 1 applicable resident in the sample for the administration of as needed (PRN) psychoactive medication by unlicensed staff. (Resident #2) Findings include;</p> <p>1. Per review on 09/24/13 of the Medication Administration record (MAR) for Resident #2, who has a diagnosis of Alzheimer's and life long anxiety/depression among other medical issues, states 'Haldol 0.5 mg 25 mg 1 tab by mouth every four hours as needed'. The medication was given three time in the month of August 2013 for anxiety and twice in September for anxiety and or pain. The resident also has Lorazepam 0.5 mg for anxiety/agitation ordered. However, there is no written plan for the use of the medications that describes the specific behaviors the medication is intended to correct or address;</p>	R167	<p><i>1. Resident #2 seen by PCP on 9/26/13 to evaluate Haldol order, order updated appropriate changes and information included on behavior sheet and care plan. RN responsible for including a list of non-pharmacological interventions to try prior to administration of medication in the plan of care. Behavior sheet will be reviewed by charge nurse weekly and as needed to monitor compliance and effectiveness of treatment. Provider will be notified of any adverse effects. RN Administrator to monitor for compliance monthly.</i></p>	
------	---	------	---	--

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0161</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/25/2013</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HISTORIC HOMES OF RUNNEMEDE-STOUGHT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>40 MAXWELL PERKINS LANE WINDSOR, VT 05089</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
R167	Continued From page 4  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. Per interview 2:20 PM PM the DNS confirmed that the care plan did not contain the specific behaviors, circumstances or monitoring for the use of a psychoactive medication.	R167		
R175 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.10 Medication Management</p> <p>5.10.h (3)</p> <p>Residents who are capable of self-administration may choose to store their own medications provided that the home is able to provide the resident with a secure storage space to prevent unauthorized access to the resident's medications. Whether or not the home is able to provide such a secured space must be explained to the resident on or before admission.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the home failed to assure that 1 applicable resident (Resident #3) in the survey sample retained medications for self administration in a secure storage space. Findings include:</p> <p>1. Per record review on 09/24/13 and confirmed by staff, Resident #3 self administers over-the-counter (OTC) medications i.e.; Refresh eye drops, Mizoral 2% cream, and Preparation</p>	R175	<p><i>R 175</i></p> <p><i>1. Facility purchased lock box for resident #3 on 9/27/13, medications locked in secure place. Licensed Nurse will assure locking receptacle in place prior to OTC medication in resident room. Licensed Nurse to check with resident weekly regarding compliance in use of lock box and to document as such. RN Administrator to monitor for compliance monthly.</i></p>	

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0161</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>09/25/2013</b>
--	---	---	--

NAME OF PROVIDER OR SUPPLIER  <b>HISTORIC HOMES OF RUNNEMEDE-STOUGH1</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>40 MAXWELL PERKINS LANE WINDSOR, VT 05089</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
--------------------	--	---------------	---	--------------------

R175 Continued From page 5  
H, independently. Per observation on 09/24/13 at 4:15 PM, Resident #3's OTC medications were noted to be on the bedside night table. Per interview at the time observation, the resident stated that s/he keeps 'the eye drops and creams handy' that the nightstand is the usual storage place for medications, that it does not lock, and that the door to the room is not locked when the resident is attending meals or functions out of the building. A resident who resides on the same floor is know to wander.  
This was confirmed by the DNS on 09/25/13 at 1:30 PM.

R175

R178  
SS=E V. RESIDENT CARE AND HOME SERVICES  
  
5.11 Staff Services  
  
5.11.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies.  
This REQUIREMENT is not met as evidenced by:  
Based on staff interview, the home failed to assure that there were sufficient staff on duty at all times to provide necessary care. Findings include:  
  
1. Per interview on 09/23/13 at 10:30 AM, the manager of the home supplied the staffing schedule for both the Stoughton Home (24 residents) and Evarts Home (11 residents) and stated that "the schedule had some changes because of a call out on Sunday night leaving one staff person to do a double shift". Per review,

R178

*R178  
1. Shower schedule for resident #16 reviewed schedule had been disrupted, shower given on next scheduled option 9/27/13 RN put in place if shower postponed, must be rescheduled documented in resident chart alternate scheduled or declination licenced Nurse to audit and monitor for compliance weekly. RN Administrator to monitor for compliance monthly. RN Administrator to evaluate staffing pattern / work flow*

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0161	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/25/2013
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  HISTORIC HOMES OF RUNNEMEDE-STOUGH1	STREET ADDRESS, CITY, STATE, ZIP CODE 40 MAXWELL PERKINS LANE 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
--------------------	--	---------------	---	--------------------

R178	<p>Continued From page 6</p> <p>one person is scheduled for 7 AM- 3 PM, 11 AM -7 PM, one for 3 PM - 11 PM and one from 11 PM - 7 AM. The 11 AM - 7 PM staff person however, was listed for both buildings. The Stoughton Home has several residents who need additional assistance with care and mobility, one who wanders and/or has behaviors.</p> <p>Per observation on 09/24/13 at 9:45 AM and subsequent interview, Resident #6 stated that s/he had not had a bath since last week even though "I get one every Monday and Friday". S/he further stated that "last week was because we could not wash because of the boil water notice and I didn't get one on Monday because my regular girl was out".</p> <p>Per observation at 11:30 AM, Resident #5 who is care planned to have a staff person one-on-one half hour prior to and after meals due to increase in wandering and aggression, was observed not having a staff person providing one-on-one. Per interview later in the day the staff person stated "I was aware where [resident#5] was", but confirmed s/he was not nearby in order to prevent the resident from striking out at others as this staff person "had to get people in the dining room".</p> <p>Per interview on 09/24/13 at 3:30 PM, a resident who wished to remain anonymous, stated "I think it is dangerous to have only one person in the house...even my friends at my table say this place is going to the dogs...they used to have two ...I think it is too much for one person".</p> <p>Additionally, several residents have had a decline in mobility and are requiring addition assistance. This was confirmed by the DNS on 09/25/13 at</p>	R178	<p><i>R178</i></p> <p><i>2. Resident #5 recovery scheduled 1:1 periods, must be kept in view at all times during 1:1 period. Memo to staff on 9/27/13 clarifying definition of 1:1.</i></p> <p><i>Licensed Nurse to monitor for compliance weekly</i></p> <p><i>RN Administrator to monitor for compliance weekly.</i></p> <p><i>RN Administrator to evaluate staffing patterns/work flow.</i></p>	
------	---	------	--	--

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0161	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/25/2013
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  HISTORIC HOMES OF RUNNEMEDE-STOUGH1	STREET ADDRESS, CITY, STATE, ZIP CODE 40 MAXWELL PERKINS LANE 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
--------------------	--	---------------	---	--------------------

R178	Continued From page 7 9:30 AM.	R178		
R179 SS=C	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.11 Staff Services</p> <p>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:</p> <ol style="list-style-type: none"> <li>(1) Resident rights;</li> <li>(2) Fire safety and emergency evacuation;</li> <li>(3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid;</li> <li>(4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation;</li> <li>(5) Respectful and effective interaction with residents;</li> <li>(6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and</li> <li>(7) General supervision and care of residents.</li> </ol> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to assure that the staff education met the regulatory requirements for 5 of 5 staff reviewed. Findings include:</p>	R179	<p><i>R179</i></p> <p><i>1. All non direct care staff were in compliance with mandatory training. Direct care staff will have all mandatory training completed no later than 12/31/13. Licensed Nurse to check competency for all direct care staff, signed documentation audit for compliance on all mandatory training quarterly.</i></p> <p><i>RN Administrator to monitor for compliance quarterly.</i></p>	

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0161	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/25/2013
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  HISTORIC HOMES OF RUNNEMEDE-STOUGH1	STREET ADDRESS, CITY, STATE, ZIP CODE 40 MAXWELL PERKINS LANE 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 8  Per record review on 09/25/13, the Administrative assistant was able to provide only a few hours of training material used for staff education for 5 of 5 staff. Based on the lack of documentation, the RCH not assure that staff education met the 12 hours per year, as well as the required subject matter as listed in the regulation. For staff having greater than 1 year services, 5 of 5 staff had from 6 1/2 hours up to 11 hours for the last year. Additionally, 2 of 5 new hired staff had no documentation of staff competency or skills they are expected to perform before providing any direct care to residents. Per interview on 09/25/13 at 2:25 PM, the DNS confirmed that the education provided to staff did not meet the requirements.	R179		
R181 SS=C	V. RESIDENT CARE AND HOME SERVICES  5.11 Staff Services  5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to	R181	<p style="text-align: center;"><i>R181</i></p> <p><i>1. Staffing solution registry check and all required background checks received on 9/26/13.</i></p> <p><i>HR to request from agency copies of background checks and any training education mandated prior to orientation at HHR. HR to monitor compliance quarterly.</i></p> <p><i>RN Administrator to monitor for compliance quarterly.</i></p>	

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0161</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/25/2013</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HISTORIC HOMES OF RUNNEMEDE-STOUGHT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>40 MAXWELL PERKINS LANE WINDSOR, VT 05089</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
--------------------	--	---------------	---	--------------------

R181 Continued From page 9

see if prospective employees are on the abuse registry or have a record of convictions.

This REQUIREMENT is not met as evidenced by:

Per staff interview and record review, the home failed to provide evidence the required State background checks were completed for two applicable employees reviewed. Findings include:

Per record review of employee files on 09/25/13 at 3:45 PM, the two newest staff members hired on 09/13/13 and 09/16/13 at the home were reviewed. There were no Vermont criminal background checks, adult abuse registry checks or child abuse registry checks. The Administrative Assistant stated that the two were employees of Staffing Solutions Agency and "I assume they do background checks". The Administrator confirmed on 09/25/13 at 4:00 PM that the RCH failed to assure all required background checks were obtained for all staff providing services to the residents.

R181

R192  
SS=C V. RESIDENT CARE AND HOME SERVICES

5.12 Records/Reports

5.12.d Reports and records shall be filed and stored in an orderly manner so that they are readily available for reference. Resident records shall be kept on file at least seven (7) years after the date of either the discharge or death of the resident.

This REQUIREMENT is not met as evidenced by:

R192

*R192*

*1. Senior management working to locate missing documentation by 12/31/13. Senior management to review current process of record keeping to identify barriers and determine solutions to ensure compliance. It is the current practice of HMR to maintain resident records a minimum of 7 years boxed and labeled on site. Senior management to monitor compliance quarterly.*

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0161</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/25/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HISTORIC HOMES OF RUNNEMEDE-STOUGHT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>40 MAXWELL PERKINS LANE WINDSOR, VT 05089</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
R192	Continued From page 10  Based on staff interview, the home did not assure that resident's records were readily accessible for reference.  Based on record review during the three days of survey, information regarding case management, medication records, progress notes, physician orders, as well as prior assessments and medication delegation records were not readily available. Per interview on 09/25/13 at 1:30 PM the Clinical Coordinator and the DNS stated that there had been recent personnel changes "so there are boxes of files" and confirmed missing paper work for residents, "we just don't know where they went". The Administrator confirmed later in the afternoon that "we have to have a better system".	R192		
R213 SS=D	VI. RESIDENTS' RIGHTS  6.1 Every resident shall be treated with consideration, respect and full recognition of the resident's dignity, individuality, and privacy. A home may not ask a resident to waive the resident's rights.  This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews with staff, the home failed to ensure that residents were treated with consideration, respect, and full recognition of the resident's dignity and individuality. Findings include:  1. Per review of a recent anonymous complaint regarding staff behaviors, incident reports and personnel file, there had been at least three occasions during the year where an employee	R213	<i>R 213</i>  <i>1. The staff person whom surveyor identified has tendered their resignation effective 11/8/13. All staff will receive inservice training by 11/29/13 regarding resident rights, dignity, and communication. RN Administrator to monitor for educational compliance quarterly.</i>	

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0161</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/25/2013</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HISTORIC HOMES OF RUNNEMEDE-STOUGHT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>40 MAXWELL PERKINS LANE WINDSOR, VT 05089</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
--------------------	--	---------------	---	--------------------

R213	Continued From page 11  had been given verbal as well as written warnings regarding the tone and manner to which residents were spoken to, subjected to second hand smoke or their dignity breached by talking loudly about a health matter in front of other residents. Per interview on 09/25/13 at 4:30 PM, the Administrator stated that the above incidents "were not viewed as abuse to me", and that "this employee has been counseled about the 'frank' way of talking to residents". The employee has also "apologized to the residents and families to their [resident/family]satisfaction". S/he confirmed that residents' dignity were not fully considered.	R213		
R234 SS=C	VII. NUTRITION AND FOOD SERVICES  7.1.a.(3) The current week's regular and therapeutic menu shall be posted in a public place for residents and other interested parties.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the current's week's regular menu was not posted in a public area. This could affect all residents in the home. Findings include:  1. Per observations on 09/23/13 at 11:30 AM there was no menu listed for the week. In the dining room, a black board listed the meal being served at noon for that day only. Per interview at this time, the Dietary Manager confirmed and stated that they "only write the main meal items which is lunch and at night staff will go and ask residents their choice of sandwiches, soup which is offered at night". S/he was able to show a planned menu for the week and stated "that will	R234	<p style="text-align: center;"><i>R234</i></p> <p><i>1. Effective 9/24/13 Dietary manager posted weekly menu in the public area of the Stoughton House for easy access and viewing. Dietary manager will be responsible for posting weekly menu RN Administrator to monitor for compliance. weekly.</i></p>	

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0161</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/25/2013</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HISTORIC HOMES OF RUNNEMEDE-STOUGHT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>40 MAXWELL PERKINS LANE WINDSOR, VT 05089</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
R234	Continued From page 12 be easier to have the menu posted".	R234		
R266 SS=E	<p>IX. PHYSICAL PLANT</p> <p>9.1 Environment</p> <p>9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the home failed to maintain a safe environment for ambulatory residents with cognitive impairment by failing to secure potentially hazardous chemicals in the laundry room on the first floor. Findings include:</p> <p>1. During the initial tour of the home at 11:25 AM on 09/23/13, the door to the laundry room was opened and unlocked. No staff were currently doing laundry. This room, which is located near resident rooms and the living room contained jugs of laundry detergent, bleach and cleaning products. The sign on the door stated "keep locked at all times". Per periodic observations throughout the day and also on the morning of 09/24/13, the room would be noted to be propped opened, closed slightly but never locked and no staff insight. Per interview the DNS confirmed on the afternoon of 09/24/13 that the door should be locked at all times as there is a resident with cognitive impairment who wanders in this area.</p>	R266	<p><i>R266</i></p> <p><i>1. Notification to all staff on 10/3/13 to reinforce existing policy on mandate that laundry room door must be secured at all times.</i></p> <p><i>All staff will monitor door is closed and secured at all times.</i></p> <p><i>(RN) Administrator to monitor for compliance as management will round weekly to make sure door is secured.</i></p>	
R302 SS=D	IX. PHYSICAL PLANT	R302		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0161	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/25/2013
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  HISTORIC HOMES OF RUNNEMEDE-STOUGH1	STREET ADDRESS, CITY, STATE, ZIP CODE 40 MAXWELL PERKINS LANE 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	<p>Continued From page 13</p> <p>9.11 Disaster and Emergency Preparedness</p> <p>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 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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of fire drill records and interview, the facility failed to ensure that fire drills were conducted at varying times of the day, including morning, afternoon, evening and nights and failed to document staff who were present. This affected all Residents in the current census. Findings include:</p> <p>Review of the fire drill records on 09/23/13 noted only day, afternoon and night fire drills for the last year. Although fire drills were held quarterly, no evening fire drills were conducted from January 2013 to present day. Per interview at 11:17 AM the Administrative Assistant confirmed that the fire drills were not rotated among all times of day.</p>	R302	<p>R 302</p> <p>Evening fire drill conducted on 10/28/13 @ 6 PM. More specific time frames for morning, afternoon, evening and night outlined in policy and procedure handbook HR to monitor compliance quarterly.</p>	
R999 SS=C	<p>MISCELLANEOUS</p> <p>4.14.f The home shall make written reports resulting from inspections readily available to residents and to the public in a place readily</p>	R999		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0161	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/25/2013
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  HISTORIC HOMES OF RUNNEMEDE-STOUGH1	STREET ADDRESS, CITY, STATE, ZIP CODE 40 MAXWELL PERKINS LANE 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
--------------------	--	---------------	---	--------------------

R999	<p>Continued From page 14</p> <p>accessible to resident where individuals wishing to examine the results do not have to ask to see them. The home must post a notice of the availability of such written reports. If a copy is requested and the home does not have a copy machine, the home must inform the resident or member of the public that they may request a copy from the licensing agency and provide the address and telephone number of the licensing agency.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the Residential Care Home (RCH) did not have the latest licensing agency inspection report readily accessible for residents or the public. Findings include:</p> <p>1. Per observation on 09/24/13 at 11:35 AM AM, a copy of the most recent survey was not found or posted in the building where residents or the public could readily access the results. Upon further observation, the latest survey was noted on a staff bulletin board behind the nursing desk. Per interview at 11:55 AM the Administrative Assistant confirmed that no surveys or written report were posted or available in an area readily assessable for residents or the public.</p>	R999	<p><i>R 999</i></p> <p><i>Recent survey moved to a readily accessible location on 9/24/13. Senior administration to monitor survey results to make sure they do not get relocated or inadvertently covered with posting weekly.</i></p>	
------	---	------	---	--