



AGENCY OF HUMAN SERVICES  
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING  
Division of Licensing and Protection

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September 20, 2010

Ms. Harriet Davis, Administrator  
Lincoln House  
120 Hill Street  
Barre, VT 05641

Dear Ms. Davis:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **June 15, 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 cursive script that reads "Pamela M. Cota RN".

Pamela M. Cota, RN  
Licensing Chief



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0175</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/15/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LINCOLN HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>120 HILL STREET BARRE, VT 05641</b>
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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 visit was conducted by the Division of Licensing and Protection on 6/15/10 to investigate a complaint. The following deficiencies were cited.	R100	<p>RECEIVED Division of  SEP 13 10  Licensing and Protection</p> <p><i>R126 attached POC accepted 9/20/10 Mary Batty RN</i></p>	
R126 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.5 General Care</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that the physician was notified of a change in medical condition for 2 of 4 residents in the sample. (Resident #4 &amp; 3) Findings include:</p> <p>1. Per closed record review on 6/15/10, a progress note dated 12/31/08 for Resident #4 stated that the resident was found sitting on the floor and "appeared to have had a seizure, probably during the night, early AM". The note stated that the resident had a scratch on the forehead and RT eye was very bloodshot. Per interview on 6/15/10 at 3:15 PM, the Registered Nurse (RN) confirmed that there was no evidence that the physician had been notified of this change in medical condition.</p> <p>2. Per closed record review on 6/15/10, Resident #3 was noted to have low protein levels after lab</p>	R126		

Division of Licensing and Protection	TITLE	(X6) DATE
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_

STATE FORM 6899 128T11 If continuation sheet 1 of 3

Division of Licensing and Protection

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R126	Continued From page 1  tests during October, 2008. A progress note dated 10/14/08 stated "protein low, needs to increase protein intake. There was no follow up documentation in the record concerning this issue until a note of 1/26/09 stating "weight loss of 14# since April, implementing mid morning and mid afternoon snack". There was no documentation to indicate the physician was made aware of this weight loss. During interview at 3:15 PM on 6/15/10, the RN confirmed the lack of follow up documentation in the record.	R126		
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 staff interview and record review, the facility failed to assure that each resident's care plan addressed the resident's identified needs to maintain/promote independence and well being for 2 of 4 residents in the applicable sample. (Residents #2 & 3) Findings include:  1. Per review of the record for Resident #2 on 6/15/10, the care plan did not address the resident's history of falls.  2. Per closed record review on 6/15/10, the care plan for Resident #3 did not address the following: risk/history of falls, the disrobing	R145		

*R145 attached POC accepted 9/20/10  
Muz Kottar/RW*

Division of Licensing and Protection

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R145	Continued From page 2  behaviors and actual weight loss.  These care plan omissions were confirmed with the RN at 3:15 PM on 6/15/10.	R145		
R162 SS=D	V. RESIDENT CARE AND HOME SERVICES  5.10 Medication Management  5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that all resident medications administered by staff had a current signed physician order and supporting diagnosis list for 2 of 4 residents reviewed. (Resident #1 & 3) Findings include:  1. Per record review on 6/15/10, Resident #1, who was admitted to the home during May 2010, had no signed physician orders in the medical record. The resident has been receiving several medications daily since admission without signed MD orders. This was confirmed during interview with the RN at 12:30 PM the same day.  2. Per closed record review on 6/15/10, Resident #3 was administered an antipsychotic medication daily (Seroquel) without a supporting physician diagnosis. This was confirmed with the RN at 3:05 PM the same day.	R162		

*R162 attached POC  
accepted 9/20/10  
Ming Kobayashi RN*

R126

5.5a

In reference to the resident # 4, the dept had already had follow up in reference to some of the issues with untimely death. On March 26<sup>th</sup>, 2009 the concerns were addressed with Sue Perry at the Vermont Dept of Aging & Disability. Please feel free to review that response.

Overall the care and care plans were in place for this respective resident, the delinquency with documentation has been found. The communication between the PCP (primary care physician) had been quite clear in reference to her baseline chronic problems including the seizure activity that was driven by psycho-social issues as well as physiological. There fore not all alleged episodes were reported to the physician.

The overall issue was the lack of written communication in the resident's chart and on her care plan. This clearly supports that the necessity for written documentation, *to prove* that the care is being provided.

Instituted since the site visit is a clear algorithm of steps for when to call the PCP (Primary Care Physician) or send the resident to the Emergency Department for consultation and/or medical evaluation.

Documentation of all events with each resident is being done in their respective charts with a copy of the alleged incident.

Monitoring will be done by the Administrative Team; Excutive Administrator and the Resident RN

~~R126~~ R126 continued

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, psychological, nursing and medical care needs.

In addition Resident # 3 , in reference to the "low protein" and weight loss that was confirmed by laboratory studies and PCP( primary care physician) consultation with Lincoln House RN. Care plan instituted with having specialty foods brought in more frequently (fresh fish, fruits and vegetables of her choice)

Again the lack of documentation by staff is the issue.

June 2010

Clearer guidelines with resident chart documentation and care plans. Including use of the Medication record sheets to promote and facilitate the need to increase frequency of snacks and specialty foods for respective residents.

Addendum instructions are shared with the dietary staff as well in a written format.

Monitoring will be over seen by the Administrative team; Excutive Administrator, Resident RN and the Designated Medication PCA's

*POC accepted 9/20/10  
May Balto, RN*

R126

*POC accepted 9/20/10  
May Balto, RN*

R 145

5.9. c 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 and services necessary to assist the resident to maintain independence and well-being.

In response to the failure to address the care plan of the respective residents in reference to maintaining their independence and well-being, the system was in place to promote the well-being and safety of each resident, but the supporting documentation was not. Each resident on admission to Lincoln House has been evaluative by CVHH& Hospice Physical Therapists services for an evaluation and care plan of mobility and fall risk.

In both incidents with resident # 2 and #3 there was no formal written care plan but as part of the daily care of the residents, every effort was in place to provide safety to prevent falls and assist the resident with mobility at Lincoln House.

June 2010

Instituted since the site visit is the following care plan which with weekly care plan meetings with all available staff, note that the following are addressed with each resident:

- Behavior
- Diet
- Food allergies
- Toileting
- Bathing
- Ambulation
- Pain
- Extra Devises

In addition the addendum form to address the multiple temporary changes that happen in the course of daily living.

See attached.

Monitoring of Care plans will be monitored by the Resident RN and all The PCAs (Personal Care Attendants) are responsible for updating and reviewing the care plans. Bi-monthly meets have been instituted to ensure review and implementation of revision of the respective resident's care plans.

*R 145 PC accepted 9/20/10  
May Butler, RN*

14 September 2010

James Greenleaf APRN

Thank you for your quick response to the request of 22 June 2010. In reference to the diagnosis for respective residents who have mental illness and/or are receiving mental health services, they have encouraged us to request further diagnosis to allow for the PRN medication interventions of Klonopin and Seroquel for episodes of increased agitation and anxiety that we implement the use of PRN medication for. Therefore the initial diagnosis of generalized anxiety disorder does not cover these issues. Could you please review and redefine the diagnosis with addressing the increasing anxiety/agitation.

Thank You



Diagnosis Generalized Anxiety Disorder with Panic Attacks

Differentiating diagnosis requiring PRN intervention When suffering episodes of acute anxiety & panic utilize Klonopin first - if agitation continues use Seroquel.

Thank you

Pam Heffernan RN

*addendum to PR accepted 9/20/10  
May Balth, RN*

~~1216~~ 12162

#### 5.10 Medication Management

5.10.c Staff will not assist with or administer any medication, prescription or over the counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record.

1. Again the required written orders of this respective resident had signed orders visit the Nurse Practitioner prior to her arrival to Lincoln House but those orders could not be located the day of the site visit. This was in reference to resident #1

June 2010

As many staff handle the paperwork for admissions there is now a check list to allow responsible staff to check off the necessary items to ensure a continuity of care for each resident moving to Lincoln House. This will ensure that there is appropriate documentation to support the care of each resident.

Monitoring of the overall process of admissions and completion of necessary documentation will be done by the Executive Administrator and the Resident RN

2. In reference to the issue of resident # 2 receiving Seroquel on a daily basis without supporting physician diagnosis. On the resident's problem list anxiety disorder was listed, her anxiety problem was addressed in the consultation by the Endocrinologist (Dr. Mural H Nathan) from 2006. Consultation by Dr. Singer who evaluated her for the level of dementia and diagnosis of mental illness; dated May 12, 2009

In addition a form has since been sent to each of the respective care providers requesting a specific diagnosis to support the use of medication for stabilization.

See Attached supporting documentation.

Overall the constant theme of failure to comply was in reference to the documentation that did not support the excellent care that each resident that lives here at Lincoln House receives on a daily basis.

The administrative team here at Lincoln House saw this review as an opportunity to improve the processes and here is a summation of the processes that have been instituted or refined with a quality management since June 15, 2010

- Collaborative Care plans meeting with Administrative team, PCA (personal care attendants), and Physical Therapist have been held on a weekly basis and just recently changed to bi-weekly. Staff's comfort level and insight has been remarkable in the individual care plans for the residents. Great growth process with increasing comfort levels of the hands on personal.
- Documentation of changes from Physician's visits, medication changes and generalized physical changes has been monitored for appropriate documentation and improving with staff.

- All of the resident's that have a mental illness diagnosis have a written diagnosis signed by the psychologist/psychiatrist that is overseeing the respective resident. Monitoring of the necessary diagnosis / differentiating diagnosis for residents with mental diagnosis with acute components that need PRN intervention by behavioral modification and/or medications, with collaborative focus by the PCP( primary care physician) Psychiatrist/Psychologist and or mental health provider.

*R162 POC accepted & addendum  
9/20/10 May B. B. PA*

Overall the opportunity to improve is the mantra of Lincoln House and that the exit interview was quite productive for our administrative team; however the issues that were address in the exit interview are slightly different than documented in the letter of September 2, 2010.

Over the years the focus of the unannounced review of the facility has fostered an atmosphere that did not promote an environment of collaboration and support from a regulatory agency. At the exit interview our administrative team felt that the review was productive and collaborative. However the letter sent was quite dismaying to the administrative team in the above mentioned terminology and some of the issues that had been discussed previously.

At Lincoln House we are committed to the quality care with the focus of each of our resident's safety and well-being the goal. It is truly unfortunate that even though there are needs for improvement that that is not the resounding message in the reviews.