

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

March 27, 2012

Ms. Devida Deluca, Administrator
Living Well A Community Care Home
71 Maple Street
Bristol, VT 05443

Provider #: 0543

Dear Ms. Deluca:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **February 21, 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: 0543	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/21/2012
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NAME OF PROVIDER OR SUPPLIER LIVING WELL A COMMUNITY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 71 MAPLE STREET BRISTOL, VT 05443
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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 complaint survey was completed by the Division of Licensing and Protection on 2/21/12. The following regulatory violation was found.	R100		
R151 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.9.c (8)</p> <p>Ensure that the resident's record documents any changes in a resident's condition;</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, staff failed to document the intrusive behavior of Resident #1 towards Resident #2 during the night time hours during June and early July in 2011. Findings include:</p> <p>Per interview on 2/21/12 at 3 PM, the Registered Nurse (RN) and the evening caregiver each confirmed that Resident #1 had intrusive behaviors towards his/her roommate and staff failed to document these episodes in the medical record for each resident involved. The staff stated that Resident #1, who had dementia, climbed into the bed of Resident #2 at night because he/she believed the roommate was distressed and wanted to comfort them. Per review of the progress notes for each resident for the months of June and July 2011, there was no documented evidence of these incidents in either record.</p>	R151	<p><u>Action:</u> Administrator reviewed details of this survey with Home Nurse (HN), Client Care Coordinator and floor staff. 2/27/12</p> <p><u>Changes:</u> Staff understand we must document and/or all new/different behaviors/changes with residents. Documentation addressed at March staff meeting. 3/15/12</p> <p><u>Monitoring:</u> Home nurse reviews resident charts weekly. Nurse also sees residents and checks shift communication book as part of weekly documentation review.</p>	

Division of Licensing and Protection

Alice De Luca, Administrator 3/21/12
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Administrator
(X6) DATE 3/21/12

R151 POC accepted 3/21/12 MBoltonRN/AmortaRN