



VERMONT

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

September 21, 2011

Becky McDonald, Administrator  
Loch Lomond  
700 Willson Road  
North Concord VT 05858

Dear Ms. McDonald:

Enclosed is a copy of your acceptable plans of correction for the unannounced onsite re-licensing survey and complaint investigation conducted on **July 25, 2011**. 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".

Pamela M. Cota, RN, BS  
Licensing Chief

Enclosure: As noted above.



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Division of

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0062</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____  AUG 2 11 Licensing and Protection	(X3) DATE SURVEY COMPLETED  C <b>07/25/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LOCH LOMOND</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 WILLSON ROAD NORTH CONCORD, VT 05858</b>
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R100	Initial Comments:  An unannounced onsite re-licensing survey and complaint investigation was conducted by the Division of Licensing and Protection on 7/25/11. The following regulatory violations were identified.	R100		
R104 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.1 Admission</p> <p>5.2.a Prior to or at the time of admission, each resident, and the resident's legal representative if any, shall be provided with a written admission agreement which describes the daily, weekly, or monthly rate to be charged, a description of the services that are covered in the rate, and all other applicable financial issues, including an explanation of the home's policy regarding discharge or transfer when a resident's financial status changes from privately paying to paying with SSI or ACCS benefits. This admission agreement shall specify at least how the following services will be provided, and what additional charges there will be, if any: all personal care services; nursing services; medication management; laundry; transportation; toiletries; and any additional services provided under ACCS or a Medicaid Waiver program. If applicable, the agreement must specify the amount and purpose of any deposit. This agreement must also specify the resident's transfer and discharge rights, including provisions for refunds, and must include a description of the home's personal needs allowance policy.</p> <p>(1) In addition to general resident agreement requirements, agreements for all ACCS participants shall include: the ACCS services, the specific room and board rate,</p>	R104	<p><i>As of 7/26/2011 I sat down with the resident and we filled out and reviewed the admission agreement for our facility. To ensure that this does not happen again I have made a list and a folder of all forms, papers to sign, things to review etc of each new admission upon admission to our facility. I have also talked with our RN who is aware of the new folder/list and she is prepared to review that after each admission to make sure it has been done accordingly.</i></p>	7/26/11

Division of Licensing and Protection  
*Becky L. MacDonald*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE *Care manager* (X6) DATE *8/11/11*

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R104	Continued From page 1  the amount of personal needs allowance and the provider's agreement to accept room and board and Medicaid as sole payment.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, one of three sampled residents (Resident #1) did not receive an admission agreement upon moving to the home. Findings include:  1. Per record review of Resident #1, there was no signed admission agreement present in the resident's medical record to describe the services provided, room and board rates, transfer and discharge rights, and other information pertinent to the ACCS program such as specific room and board rates, personal needs allowance, and provider's agreement to accept room and board and Medicaid as sole payment. Per interview on 7/25/11 at 4:45 PM, the home's manager confirmed that a signed admission agreement was not on record for this resident, and s/he did not think it was given to the resident upon admission.	R104	<i>R104 POC Accepted 8/25/11 K. Campos RN / M. Costarini</i>	
R110 SS=D	V. RESIDENT CARE AND HOME SERVICES  5.2 Admission  5.2.b. On admission, the home must also determine if the resident has any form of advance directive and explain the resident's right under state law to formulate, or not to formulate, an advance directive. Any change of rate or services shall be preceded by a thirty (30) day written notice to the resident and the resident's legal representative, if any.	R110		

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R110	Continued From page 2  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to determine the existence of, or provide information on how to formulate advanced directives for one of three sampled residents (Resident #1). Findings include:  Per record review on 7/25/11, there was no evidence in the resident record that they had advanced directives, nor received the information regarding the formulation of advanced directives. Per interview on 7/25/11 at 2:15 PM, the manager of the home stated that the existence of previously formulated advanced directives was not determined, nor was information given to the resident as to how to formulate them.	R110	<i>as of July 26, 2011 I sat down with the resident and we reviewed advanced directives, the resident was given information to read and to think about and I will check back w/ him at a later time as he didn't want to make a decision right then about it. I recorded in the resident record that info was provided and resident will let me know of a decision in the near future. To ensure this doesn't happen again I have created a list of things to cover, review, forms to sign etc upon admission of a new resident. I have also spoken with RN about the new lists &amp; folders and she too will review upon admission to make sure all is completed in a timely manner.</i>	7/26/11
R111 SS=D	V. RESIDENT CARE AND HOME SERVICES  5.2 Admission  5.2.c The home must provide each resident with information regarding how to contact the Long Term Care Ombudsman, Vermont Protection and Advocacy, Inc. or the Vermont Senior Citizen's Law Project.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility home failed to provide information on how to contact advocacy agencies for one of three residents (Resident #1). Findings include:  Per record review on 7/25/11, there was no evidence in the resident record that they received the contact information for the Long Term Care	R111	<i>R110 POC Accepted 8/15/11 K.Campos RN / P.McArthur RN</i>	

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R111	Continued From page 3  Ombudsman, Vermont Protection and Advocacy, Inc. or the Vermont Senior Citizen's Law Project. Per interview on 7/25/11 at 3:15 PM, the manager of the home stated that because the admission agreement contains the contact information for the Long Term Care Ombudsman, and the resident had not received an admission agreement packet, that the information was not given to the resident.	R111	on July 26, 2011 the resident was provided with an admission agreement, I reviewed the agreement with the resident and also reminded him that these numbers were posted on the two living room walls and on the wall by the office, the resident stated he knew that because when admitted I had shown him those numbers along with other info on the walls. - To ensure it doesn't happen again I have made a list & folder of things to provide to new admissions upon admission. I spoke to RN who will also review new admissions to ensure all is provided in a timely manner. R111 POC Accepted 8/25/11 K. Campos RN / P. Mosta RN	7/26/2011
R134 SS=D	V. RESIDENT CARE AND HOME SERVICES  5.7 Assessment  5.7.a An assessment shall be completed for each resident within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The resident's abilities regarding medication management shall be assessed within 24 hours and nursing delegation implemented, if necessary.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to complete an initial assessment for one of three residents sampled (Resident #1). Findings include:  Per record review on 7/25/11, Resident #1 was admitted on 12/31/10. There was no evidence that an assessment was completed including the resident's abilities regarding medication management. Per interview on 7/25/11 at 12:45 PM, the manager of the home stated that an assessment had not been completed for this resident since admission to the home.	R134	on July 26, 2011 an assessment was completed by myself and reviewed by our RN To ensure this doesn't happen again we have added resident assessment to our list of things to do upon admission of a new resident. I have spoken to the RN who will also review each admission to make sure this is done in a timely manner.	7/26/11

R134 POC Accepted 8/25/11  
K. Campos RN / P. Mosta RN

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R135	Continued From page 4	R135		
R135 SS=D	<p><b>V. RESIDENT CARE AND HOME SERVICES</b></p> <p><b>5.5 Assessment</b></p> <p>5.7.b If a resident requires nursing overview or nursing care, the resident shall be assessed by a licensed nurse within fourteen days of admission to the home or the commencement of nursing services, using an assessment instrument provided by the licensing agency.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to have a licensed nurse complete an assessment of the need for nursing oversight for one of three residents sampled (Resident #1). Findings include:</p> <p>Per record review, Resident #1 was admitted on 12/31/10 with significant medical conditions including Insulin Dependent Diabetes with a sliding scale insulin regime. There was no evidence of a nursing assessment of the resident to determine nursing oversight needs within the required 14 days. Per interview on 7/25/11 at 10:20 AM, the manager of the home confirmed that the assessment had not been completed by the licensed nurse on staff.</p>	R135	<p><i>The RN has reviewed the assessment and to ensure this doesn't happen again the Nurse and myself will meet after each new admission and go over the admission records and the needs of each new admission to provide the best possible care for that person. We will review all admission forms to ensure they are done in a timely manner upon admission of a new resident.</i></p> <p><i>R135 POC Accepted Blast III K. Campos RN/Amotard</i></p>	<i>7/26/11</i>
R136 SS=D	<p><b>V. RESIDENT CARE AND HOME SERVICES</b></p> <p><b>5.7. Assessment</b></p> <p>5.7.c Each resident shall also be reassessed annually and at any point in which there is a</p>	R136		

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R136	Continued From page 5  change in the resident's physical or mental condition.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to complete a timely annual reassessment for two of three residents sampled (Residents #2, #3). Findings include:  1. Per record review on 7/25/11, Resident #2 was admitted on 11/04/05. The last reassessment on record for this resident was completed on 1/10/09. Per interview on 7/25/11 at 5:50 PM, the manager of the home confirmed that an annual or change in condition assessment was not completed since 1/10/09.  2. Per record review on 7/25/11, Resident #3 was admitted on 2/11/02. The last annual reassessment for the resident was completed on 5/8/10. Per interview on 7/25/11 at 5:50 PM, the manager of the home confirmed that the annual reassessment was not completed in May 2011 as required.	R136	On July 26, 2011 an assessment was completed on both resident # 2 and # 3 and reviewed by both myself and the RN. To ensure this doesn't happen again the nurse will set aside time each month to review all assessments of our residents so they are up to date and done accurately. I will also set aside time each month to review that they have been done accordingly. I have constructed a list of things to check + review each month to ensure they are keep current.  R136 POC accepted 8/25/11 K. Campos RN / M. Turner	7/26/11
R144 SS=D	V. RESIDENT CARE AND HOME SERVICES  5.9.c.(1)  Complete an assessment of the resident in accordance with section 5.7;  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the registered nurse failed to complete an	R144		

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R144	Continued From page 6  assessment to determine the need for nursing overview, medication management, and nursing care for one of three residents sampled (Resident #1). Findings include:  Per record review on 7/25/11, Resident #1 did not have a nursing assessment in the medical record. The resident has insulin -dependent diabetes with sliding scale coverage, requires medication administration, and has other medical issues which would require oversight and care by the nurse. Per interview on 7/25/11 at 3:15 PM, the manager of the home confirmed that there was no assessment completed for Resident #1 upon admission on 12/31/10 or since that time.	R144	On July 26, 2011 an assessment was completed and in that was determined that Resident #1 does need medication administration and nursing oversight he is however able to self administer insulin as he has done for many years. To ensure this doesn't happen again I have spoken to RN who will meet with me after each new admission we will review needs of the resident and make sure all proper forms, assessments and documents are done, as well as reviewing any medical issues such as sliding scales, diet needs, medications etc.	7/26/11
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 interview, the home failed to assure RN (Registered Nurse) development/oversight of a written plan of care for 1 of 3 residents in the survey sample (Resident #1). Findings include:  Per record review on 7/25/11, Resident #1 did not have a written plan of care in the record. Per interview on 7/25/11 at 3:15 PM, the manager of the home confirmed that the plan of care was	R145	R144 POC Accepted 8/25/11 K. Campos RN / M. Motar A Plan of care was developed on 8/4/11 and reviewed by myself and all RN. To ensure this doesn't happen again this has been added to the list of things to do upon admission of a new resident the nurse and I will meet after each new admission to ensure all is completed in a timely manner.	8/4/11

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R145	Continued From page 7  never developed for this resident since their admission on 12/31/10.	R145	<p>We have also set a set time each month to review care plans so as to keep them more current and up to date. The RN and I will do this together to ensure timely &amp; orderly records.</p> <p>R145 POC Accepted 8/25/11 K. Campos RN / P. Mcota RN</p> <p>We sent the Doctor admission orders for the resident and they were returned signed by the MD. We were of the thought that the orders we had which were electronically signed from the MD, upon admission were sufficient, but we have changed our policy and will no longer accept electronic signatures as a signed Doctor's order. To ensure this is not overlooked we have <del>add</del> to our admission of a new resident list and it will be reviewed by both myself &amp; our RN.</p>	
R162 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.10 Medication Management</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to obtain signed written physician orders upon admission for the administration of medications for one of three residents sampled. (Resident #1). Findings include:</p> <p>Per record review of Resident #1, there was no current signed physician order to administer medications to the resident. Although the record contained progress notes from the doctor's office before the resident's admission to the home that included diagnoses, medications ordered, and history and physical information, the facility had not obtained admission orders for the resident that included signed MD orders for the care home, therefore staff were administering medications including sliding scale insulin without a current signed MD order. Per interview on 7/25/11 at 5:00 PM, the manager of the home confirmed that there were no current signed orders for the administration of medications for this resident.</p>	R162		7/29/11

R162 POC Accepted 8/25/11  
K. Campos RN / P. Mcota RN

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R163 R163 SS=D	Continued From page 8  V. RESIDENT CARE AND HOME SERVICES  5.5 Medication Management  5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:  (1) A registered nurse must conduct an assessment consistent with the physician's diagnosis and orders of the resident's care needs as required in section 5.7.c  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to assure that a licensed nurse conducted an assessment before unlicensed staff administered medications for one of three residents sampled (Resident #1). Findings include:  Per record review on 7/25/11, Resident #1 receives medication administration by unlicensed staff, including daily insulin injections. There was no evidence that a licensed nurse conducted an assessment of the resident to evaluate the care needs before unlicensed staff administered medication to the resident. Per interview on 7/25/11 at 5:10 PM, the manager of the home confirmed that an assessment was not documented in the record to indicate the registered nurse had conducted an assessment before unlicensed staff administered medications to the resident.	R163 R163	We have completed an assessment for Resident #1, on 7/26/11. The resident does need medication administration and nursing oversight, he is however able to self administer insulin as he has done this for many years on his own. To ensure this doesn't happen again I have spoken to RN who will meet with me after each new admission we will make sure before any staff administers any medication, insulin or anything else we have reviewed the assessment and educated the staff appropriately for that resident. This has been added to our list of things to do upon admission of a new resident.  R163 POC Accepted 8/5/11 K Campos RN Western	7/26/11
R171 SS=E	V. RESIDENT CARE AND HOME SERVICES	R171		

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R171	<p>Continued From page 9</p> <p>5.10 Medication Management</p> <p>5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include:</p> <p>(1) Documentation that medications were administered as ordered;</p> <p>(2) All instances of refusal of medications, including the reason why and the actions taken by the home;</p> <p>(3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect;</p> <p>(4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and</p> <p>(5) For residents receiving psychoactive medications, a record of monitoring for side effects.</p> <p>(6) All incidents of medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to assure that there was evidence of monitoring for side effects of psychoactive medications, and indication for use or clear dosaging of PRN medications for 3 of 3 residents sampled. (Residents #1, #2, #3). Findings include:</p> <p>Per record review on 7/25/11, Residents #1, 2, and 3 had PRN (as needed) medications listed on the MAR (Medication Administration Record) that had a dosage/time range, but no indication for use, and/or lack of evidence of monitoring for</p>	R171		

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R171	<p>Continued From page 10</p> <p>side effects of psychoactive medications.</p> <p>1. Per review, Resident #1's MAR had an order for a benzodiazepine reading "Diazepam 5 mg. [milligrams] one PO [by mouth] TID [three times daily] PRN" that had no indication for use, or parameters for how many hours to wait between doses. The order for "Ketostix DM one PRN" did not contain indication for use, or route of administration. "Metamucil PO QD PRN" had no indication for use or dosage amount listed. "Senekot 50 mg one PO BID" had no indication for use listed. "Milk of Magnesia as directed" did not have an indication for use, dosage amount, frequency, or route of administration.</p> <p>2. Resident #2 had medication orders on the MAR as follows: "Citrucel 1-2 tsp PO in water" that had no indication for use and a dosage range without parameters. "Ibuprofen 200 mg. PO BID PRN" did not indicate what it was for. "Tylenol Arthritis 1-2 tabs q 4-6 hrs PRN" had no indication for use, and a dosage and time range without clear parameters. The resident was also on "Seroquel 100 mg PO Q HS", an antipsychotic, and there was no evidence that the resident was being monitored for side effects.</p> <p>3. Resident #3 has medication orders for "Zyprexa 7.5 mg. PO Q HS", an antipsychotic, with no evidence of monitoring for side effects of the medication.</p> <p>Per interview on 7/25/11 at 5:10 PM, the manager of the home confirmed the above orders as listed were missing the elements to be a clear and complete order, and that the Mental Health Agency monitors the side effects of the psychoactive medications, but does not provide</p>	R171	<p>The RN and I have gone over the MAR and checked all orders written for each resident we have contacted doctors and changed all orders to be more clear and complete - we now indicate the Drug, the Dose, <sup>w/</sup> parameters the time for taking (BID or TID) we indicate it as a prn or a regular order (qd, BID etc) We also indicate the indications for taking such as for (Severe anxiety or no bowel movement x 3 days) etc. We also have talked over the best way to handle the monitoring for side effects of psychoactive medications which we used to do but were told we no longer had to do because the Mental Health agency was doing hours it is hard to get documentation from them to support that so our RN and</p> <p>8/10/11</p>	

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R171	Continued From page 11  documentation to the home that the assessments were completed.	R171	<p>I have decided to again start monitoring that our selfs. Our RN will conduct those on a <del>monthly</del> quarterly basis and we will now keep that as part of our documentation for these residents who take psychoactive medications.</p> <p>R171 POC Accepted 8/10/11 K.Campos RN / Amcota RN</p> <p>We now have placed a marker on Each Pen/Insulin with the residents Name and the date opened and the Date to discard. As I am the one who pick up all medication from the pharmacy I will be sure to do that upon picking up. Then each staff upon opening the pen will date it with the Date opened and the discard date. - the RN will oversee monthly</p>	8/10/11
R172 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.10 Medication Management</p> <p>5.10.h All medicines and chemicals used in the home must be labeled in accordance with currently accepted professional standards of practice. Medication shall be used only for the resident identified on the pharmacy label.</p> <p>This REQUIREMENT is not met as evidenced by: Per observation and staff interview, the home failed to properly label insulin/antidiabetic agents to assure they were discarded within the recommended time frame after opening for 2 of 2 residents sampled (Residents #1, #4 ).Findings include:</p> <p>Per observation on 7/25/11 at 12:30 PM, the medication cart contained three insulin/antidiabetic agent pens currently in use stored in the cart. Resident #1 had two pens, one with Lantus insulin for once daily use, and one Novolog insulin pen for use per sliding scale at meals. Resident #4 had a Byetta (exenatide) injectable antidiabetic agent for use twice daily. There was no labeling on the pens to indicate when they were first opened, and the manufacturer's recommended discard date is 28 days after opening for Lantus and Novolog Insulin, and 30 days after opening for the Byetta pen. Per interview on 7/25/11 at 12:40 PM, the manager of the home confirmed that the medication pens were not labeled with the date they were opened, and could not say how long</p>	R172		

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R172	Continued From page 12 they had been in use since they were first opened.	R172	To ensure that this is done properly and timely.	
R173 SS=D	V. RESIDENT CARE AND HOME SERVICES  5.10 Medication Management  5.10.h.  (1) Resident medications that the home manages must be stored in locked compartments under proper temperature controls. Only authorized personnel shall have access to the keys  This REQUIREMENT is not met as evidenced by: Per observation and staff interview, the home failed to assure that refrigerated medications were stored in locked compartments under proper temperature controls. Findings include:  Per inspection on 7/25/11 at 4:45 PM, the resident's food refrigerator in the kitchen contained a plastic sealed box with insulin/antidiabetic agent pens stored within it. Observed on the door of the refrigerator in the unsealed butter compartment were 3 unopened boxes containing Insulin/Antidiabetic agent pens for resident use. Per interview on 7/25/11 at 4:45 PM, the manager of the home confirmed that there was insulin stored on the door compartment, no thermometer present in the refrigerator, and no process in place to regularly check and record temperatures of the refrigerator to assure proper medication storage.	R173	R172 POC Accepted 8/15/11 K. Campos RN / Amcota RN  I have placed new thermometers <sup>8/10/11</sup> in all of our Refrigerators and Freezers I have also come up w/ a chart for keeping track of Refrigerator and Freezer temps on a <del>weekly</del> <sup>daily</sup> Basis, and I will be checking these temps on a weekly basis to ensure that it is being done by the staff. All refrigerated medications have been moved into one locked box and no more meds are being stored outside of this box. — To ensure I will monitor upon receipt of meds from the pharmacy and on a weekly basis	

R173 POC Accepted 8/15/11  
K. Campos RN / Amcota RN

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R174	Continued From page 13	R174		
R174 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.10 Medication Management</p> <p>5.10.h. (2)</p> <p>Medications requiring refrigeration shall be stored in a separate, locked container impervious to water and air if kept in the same refrigerator used for storage of food.</p> <p>This REQUIREMENT is not met as evidenced by: Per observation and staff interview, the home failed to assure that medications stored in the food refrigerator were kept in separate, locked containers impervious to water and air. Findings include:</p> <p>Per inspection on 7/25/11 at 4:45 PM, the resident's food refrigerator in the kitchen contained on the door of the refrigerator in the unsealed butter compartment three unopened boxes of Insulin/Antidiabetic agent pens for resident use. Per interview on 7/25/11 at 4:45 PM, the manager of the home confirmed that there was insulin stored on the door compartment, and not in a sealed container impervious to air and moisture.</p>	R174	<p>We have moved the Insulin that was previously in the butter compartment in to the sealed box to keep from water + air. At the time we received those from the pharmacy they did not fit in the Box we had already for that purpose so we stored them there - I have now gotten a bigger box so they all will fit in at the same time - This should prevent that from happening again.</p> <p>R174 POC Accepted 8/10/11 K. Campos RN/PharmD</p>	8/10/11
R179 SS=E	<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</p>	R179		

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R179	Continued From page 14  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: Per review of education files for resident care staff of the home, there was no evidence that there was adequate education to meet the required yearly training. Findings include:  Per review of the education files, there were inservices and education materials provided to staff that included some of the required elements. The manager of the home was unable to show this surveyor that the required 12 hours/year of education was provided to each staff member. Per interview on 7/25/11 at 4:50 PM, the manager of the home confirmed that although ongoing education was provided to staff, the documentation of this education was disorganized and did not show that the requirement was met for each of the areas listed as mandatory per the regulation.	R179	we have organized our staff education procedure a bit, the nurse and I are aware that all training needs to be documented in a more clear and understanding way. So monthly we have added to our list of things to review and do, different training material to provide during that month such as one month = Fire safety; the next month = Infection Control etc. Staff will be trained in various ways by both myself + the RN also w/ reading material and hands on training this will all be documented by myself and our RN and we will both review each month to ensure this is being done. —  R179 POC Accepted 8/10/11 K Campos RN / Amet RN	8/10/11

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R180 SS=E	V. RESIDENT CARE AND HOME SERVICES  5.11 Staff Services  5.11.c All training to meet the requirements of 5.11.b shall be documented. Training in direct care skills by a home's nurse may meet this requirement, provided the nurse documents the content and amount of training  This REQUIREMENT is not met as evidenced by: Per review of education files for resident care staff of the home, there was lack of documentation that adequate education was provided to meet the required yearly training. Findings include:  Per review of the education files on 7/25/11, there were inservices and education materials provided to staff that included some of the required elements. The manager of the home was unable to show this surveyor that the required 12 hours/year of education was provided to each staff member. Per interview on 7/25/11 at 4:50 PM, the manager of the home confirmed that although ongoing education was provided to staff, the education provided was not consistently documented.	R180	As stated above we have organized our staff education procedure and each month we will conduct a different training for our staff - after completion the RN and/or I will document the time spent for each staff either hands on or reading material or lecture or what have you. This will be monitored monthly by the RN and myself to ensure it is being done in a timely/efficient manner.  R180 POC Accepted 8/25/11 K. Campos RN / P. Nestor RN	8/10/11
R181 SS=E	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	R181		

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R181	<p>Continued From page 16</p> <p>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 see if prospective employees are on the abuse registry or have a record of convictions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on employee file record review and staff interview, the home failed to conduct child abuse registry screening for staff. Findings include:</p> <p>Per review of five direct care staff employee files on 7/25/11, there was no evidence that child abuse registry checks were completed. Per interview on 7/25/11 at 3:10 PM, the manager of the home confirmed that they completed adult abuse registry and Vermont criminal checks on employees, but was unaware they had to check the child abuse registry, and this was not done for any of the staff.</p>	R181	<p><i>We were unaware of Child abuse registry checks that needed to be performed on our staff I will plan on making sure to get these done on all my staff currently and any in the future also for any volunteers we may have in the future I will make sure to have this done by August 30th 2011. To ensure it doesn't happen again I have a list of things to complete with each new hire and</i></p>	
R189 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.12.b. (3)</p> <p>For residents requiring nursing care, including nursing overview or medication management, the record shall also contain: initial assessment;</p>	R189		

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R189	Continued From page 17  annual reassessment; significant change assessment; physician's admission statement and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of physician visits, signed telephone orders and treatment documentation; and resident plan of care.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to assure that a resident who requires nursing care had a complete medical record with current orders and assessments for one of three residents sampled (Resident #1). Findings include:  Per record review on 7/25/11 of Resident #1, there was no physician's admission statement, no current signed orders for medications and treatments, no nursing assessment, and no plan of care present in the medical record. Per interview on 7/25/11 at 5:10 PM, the manager of the home confirmed that the resident has no signed MD orders, no admission statement from the physician, no initial assessment completed, and no plan of care as required per regulation.	R189	<i>have added that to that list of things to complete. R181 POC Accepted 8/25/11 K. Campos RN / Pmeto RN</i>  <i>As stated before I have completed along with my RN the signed MD orders, the admission agreement, the assessment, and the plan of care for the Resident #1 most of which was completed on 7/26/11 the MD orders took a bit longer as we had to wait for their return from the MD. But all are complete and to ensure it doesn't happen again the RN + I will review each new admission along with a list of things to do upon admission to make sure it is all completed in a timely, orderly fashion. R189 POC Accepted 8/25/11 K. Campos RN / Pmeto RN</i>	7/26/11
R302 SS=F	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		

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R302	Continued From page 18  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 interview, the home failed to meet the fire drill requirement for a residential care home. Findings include:  Per interview on 7/25/11, the manager of the home stated that the Fire Safety inspector cited the home in April 2010 for not meeting the required number of fire drills. On 7/25/11 at 3:15 PM, when asked for a record of drills conducted, the manager confirmed they had completed no fire drills in 2011, with the exception of one undocumented unplanned drill when the alarm went off due to smoking food on the stove where they evacuated residents from the building.	R302	We have now completed 2 Fire drills since 7/25/11 one of them on 8/4/11 and the other on 8/9/11  We have added to our Calendar duty list a Fire drill for each employee to complete at different times on a quarterly basis. So each employee will get a chance to perform a fire drill at least once if not several times per year. The Staff has been instructed on procedure and evacuation of all residents they are also responsible for documenting the drill w/ Date, time, location, etc. I will review this on a monthly basis to ensure it has been done accurately, timely and appropriately -	

R302 POC Accepted 8/25/11  
K. Campos RN/ PmtARN