

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

December 12, 2013

Ms. Becky MacDonald, Administrator
Loch Lomond
700 Willson Road
North Concord, VT 05858-7007

Provider # 0062

Dear Ms. MacDonald:

Enclosed is a copy of your acceptable plans of correction for the unannounced onsite re-licensing survey conducted on **October 1, 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

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0062	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DEC - 5 13 Licensing and Protection	(X3) DATE SURVEY COMPLETED 10/01/2013
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NAME OF PROVIDER OR SUPPLIER LOCH LOMOND	STREET ADDRESS, CITY, STATE, ZIP CODE 700 WILLSON ROAD NORTH CONCORD, VT 05858
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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
R100	Initial Comments: An unannounced onsite re-licensing survey was completed by the Division of Licensing and Protection on 10/1/13. Based on information gathered, regulatory violations were cited as follows.	R100		
R167 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to assure that staff other than a nurse administered psychoactive medications only when specific behaviors and undesired effects were monitored and specific results of medication use were documented for 1 of 5 residents in the sample (Resident #1). Findings include: 1. During record review on 10/1/13, it was	R167		

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Betsy L MacFarlane

TITLE

owner/manager

(X6) DATE

11/28/2013

STATE FORM

6899

YQ8111

If continuation sheet 1 of 7

R167, R171, R179 + R181 POC accepted 12/11/13 JHosmer RN/PMC

PMC

Division of Licensing and Protection

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R167 Continued From page 1

revealed that on 6/1/13 Resident #1 had been administered 1/2 of a 0.5 mg (0.25 mg) tab of lorazepam (an anti-anxiety medication) by an unlicensed staff person who was delegated (by the Registered Nurse/RN) to administer medications. It is not permissible for any staff, licensed or delegated, to change the dose of a medication without consultation and direction from the physician. The physician's written order prescribed a 0.5 mg lorazepam dose to be administered for episodes of anxiety which could not be resolved with non-pharmacological interventions. Additionally, there was no written evidence that the staff had later monitored the results or effects of the as needed medication after use. During an interview at noon on 10/1/13, the Administrator confirmed that documentation indicated that the unlicensed staff person had administered 1/2 tab of 0.5 mg (0.25 mg) to Resident #1 on 6/1/13 and that there was no documentation of monitoring for behaviors or side effects after the medication use.

R167 10/2/13
When this error happened on 6/1/13 I had spoken to the staff who had done it. And explained that ~~it~~ was not OK to give a medication in a different way than prescribed without a Doctors order. I also had spoken with the other staff to make sure they were aware this was not OK to do without a Doctors order. However I neglected to document that I had educated them on this matter so in the future I ~~will~~ have already set up a policy in the event this or other incidents where staff need to be educated of such errors to be documented by myself or the nurse that we had educated them. This policy should ensure that errors like this do not occur again. We have also added into the staff mandatory education more detailed instruction on medication management and handling by all staff. The nurse and myself will review these policies annually to ensure we are as up to date as possible. This was put into effect on 10/2/13. Also staff has all been instructed on monitoring for results and effects of residents who have been given PRN medications and documentation has been covered again in service with all staff.

R171
SS=D

V. RESIDENT CARE AND HOME SERVICES

5.10 Medication Management

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:

(1) Documentation that medications were administered as ordered;

(2) All instances of refusal of medications, including the reason why and the actions taken by

DJM

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R171	<p>Continued From page 2</p> <p>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 observation, record review, and staff interview, the home failed to document medication administration sufficiently to indicate to the Registered Nurse (RN) a record of monitoring for side effects and all incidents of medication errors for 2 of 7 residents in the medication administration sample (Resident #1 and Resident #6). Findings include: *This is a repeat deficiency</p> <p>1. During record review on 10/1/13, it was revealed that on 6/1/13 Resident #1 had been administered 1/2 of a 0.5 mg (0.25 mg) tab of lorazepam (an antianxiety medication) by an unlicensed staff person who was delegated (by the Registered Nurse/RN) to administer medications. It is not permissible for any staff, licensed or delegated, to change the dose of a medication without consultation and direction from the physician. The physician's written order prescribed a 0.5 mg lorazepam dose to be administered for episodes of anxiety which could not be resolved with non-pharmacological interventions. Additionally, there was no written evidence that the staff had later monitored the results or effects of the as needed medication</p>	R171	<p>10/2/13 As of this date staff has been educated about medication management, The dangers of administering medications or changing doses of medication without the consult of an MD. Also staff was educated on the documentation process, monitoring for results, side effects etc. with prn medications and has to properly document those in accordance to state regulations. This will also be added as a regular education topic for our staff to ensure that it stays fresh in and up to date on this topic. To ensure the safety of our residents.</p> <p>Bjm</p>	
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R171 Continued From page 3

after use. During an interview at noon on 10/1/13, the Administrator confirmed that documentation indicated that the unlicensed staff person had administered 1/2 tab of 0.5 mg (0.25 mg) to Resident #1 on 6/1/13 and that there was no documentation of monitoring for behaviors or side effects after the medication use.

2. During surveyor observation of medication administration at noon on 10/1/13, Resident #6 was administered by mouth (2) 500 mg tablets of Tylenol (1,000 mg). Upon review of the physician's written order, the order indicated a dose of 500 mg Tylenol to be administered by mouth three times per day. At noon on 10/1/13 the Administrator confirmed that the physician's written order was for 500 mg Tylenol by mouth three times per day.

R171

In reviewing the situation for Resident #6 again After the surveyor left I realized that he had two Tylenol orders written by his M.D. one of which stated "Tylenol 500mg TID PRN for pain or temp" the other order stated "Acetaminophen 650mg QID PRN P.O"

The RN was alerted to each of these medication incidents during a telephone conversation on 10/1/13 at 1:00 PM.

R179
SS=E

V. RESIDENT CARE AND HOME SERVICES

5.11 Staff Services

5.11.b The home must ensure that staff demonstrate competency in the skills and 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:

(1) Resident rights;
(2) Fire safety and emergency evacuation;

R179

The resident was actually getting his tylenol/Acetaminophen from the VA Clinic in White River and it was dosed as "Acetaminophen 325mg tab"

This is what he was receiving the "two tabs" of at noon; Not the two "500mg" tabs. At the time the inspector was there, there was a lot going on and I did make the mistake of stating they were "500mg each" but really they were "325mg" each. I did however contact the VA clinic and asked them to change the order to what he was actually getting which was "Acetaminophen 650mg TID" each day Not "PRN" as the order stated. I had gotten verbal permission from the VA Doctor prior to giving to him daily

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R179	<p>Continued From page 4</p> <p>(3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid;</p> <p>(4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation;</p> <p>(5) Respectful and effective interaction with residents;</p> <p>(6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and</p> <p>(7) General supervision and care of residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to assure that 5 of 5 staff in the sample who provide direct care to residents received all mandatory elements of training equalling at least 12 hours annually. Findings include: *This is a repeat deficiency</p> <p>1. During record review on 10/1/13, 5 of 5 direct care staff records indicated a lack of annual training for Resident Rights, Respectful Effective Communication, and Infection Control. Additionally, 5 of 5 staff in the sample had not received at least 12 hours of annual training. The Administrator confirmed during an interview at 1:30 PM on 10/1/13 that 5 of 5 direct care staff in-service records lacked documentation of at least 12 hours of annual training which included the mandatory elements of Resident Rights, Respectful Effective Communication, and Infection Control.</p>	R179	<p>however Not gotten a signed order changing it from a pm to a straight order. so on 10/17/13 I received a corrected/signed order from the VA Doctor stating (Acetaminophen 650mg tid p.o.)</p> <p>I have come up with a plan to ensure that when a doctor verbally gives us an order we at that moment write a telephone order or get the MD to sign an order right then and there so these orders are not confused like that again in the future. This was completed by 10/17/13 <i>pjm</i></p>	
R181 SS=D	V. RESIDENT CARE AND HOME SERVICES	R181	<p>10/2/13 I have Added a list of Topics including the mandatory topics listed above to be covered annually in our staff education manual and the RN and my self will make sure that these topics get covered each year along with other pertinent topics for the staff to be able to complete the "at least 12 hrs. of annual training" of their training. These topics have since been covered with all staff complete by 10/30/13 <i>pjm</i></p>	

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R181	<p>Continued From page 5</p> <p>5.11 Staff Services</p> <p>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 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 record review and staff interview, the home failed to assure that 1 of 3 potential staff in the sample had not been charged with adult abuse or crimes inimical to the public welfare prior to working with vulnerable residents. Findings include: *This is a repeat deficiency</p> <p>1. During record review on 10/1/13, no pre-hire screening information regarding adult abuse or criminal record was located for 1 of 3 employees in the sample. The Administrator confirmed on 10/1/13 at 10:35 AM that no pre-hire screening documentation for adult abuse registry or Vermont Criminal Information Center could be provided for 1 of 3 employees in the sample.</p>	R181	<p>No pre-hire screening info was available for one of my employees, I had tried to do his criminal check several times but was unsuccessful in getting the upto date info on it, in searching the website I came up with nothing as well. This employee was a close friend of the family and there fore I was slack in not pursuing harder/quicker than I did. However I know and understand the regulations are in place for a reason and will not let this happen again. Next time I will make a call to the state to get the proper info that I need in order to comply with the regulation for new hires regardless of family friend or stranger, summer help or full time staff. This employee was with us just for the summer as she had college in the fall but if she returns to us again I will make sure that her prehire screening is done per state regulations.</p> <p><i>(How to do it)</i></p> <p><i>BPM</i></p>	
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VERMONT DEPARTMENT OF PUBLIC SAFETY
DIVISION OF FIRE SAFETY
 Office of the State Fire Marshal, State Fire Academy and State Haz-Mat Team



CERTIFICATE OF BOILER & PRESSURE VESSEL INSPECTION

VERMONT FIRE & BUILDING
 SAFETY CODE
 BOILER/PV PROOF OF INSPECTION
 INSP. NO. **99767**
 11/25/13 11/25/15
 INSPECTION DATE EXP. DATE
 VIOLATIONS
 YES NO CORRECTED DATE INITIALS
 DIVISION OF FIRE SAFETY
 VERMONT DEPT. OF PUBLIC SAFETY

Boiler Pressure Vessel External Internal

Structure Name:	Loch Lomond		
911 Address:	700 WILLSON RD. NORTH CONCORD VT		
VT State ID #:	33438	NB #:	
Manufacturer:	BIASI	Year:	2010
		Object Type:	CAST IRON
MAWP:	30	S/V- R/V Set Pressure:	30
Insurance Co.:	HARTFORS STEAM BOILER	Inspector Name (Print):	ROBERT BABLER
VT Comm. #:	429	Inspector Signature:	

REINSPECTIONS

INSPECTION TYPE: INT/EXT/OPERATING	DATE Mo/Day/Year	INSPECTOR NAME	VERMONT COMM. #	VIOLATIONS FOUND

 THIS OBJECT MAY NOT BE OPERATED LEGALLY UNLESS THIS CERTIFICATE
 IS POSTED UNDER GLASS IN A CONSPICUOUS PLACE IN ENGINE OR BOILER ROOM

***Report any accident, incident or explosion to 802-479-4434 ***
 (1-888-870-7888 outside of normal business hours)

11/28/13

I am extremely sorry for the delay in returning my corrections. I did not receive them until the first part of November, I'm not sure why exactly but then it took me a while to find time to sit down and get them written out.

I have also included a copy of our boiler stickers which the ^(state) inspector had been looking for while she was out for a visit. We were finally able to get someone to come out on 11/25/13 to inspect it.

Thankyou for your patience.

Deely J MacNeill