

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

August 22, 2013

Mr. Steven Doe, Administrator
Our Lady Of The Meadows
1 Pinnacle Meadows
Richford, VT 05476

Provider #: 0197

Dear Mr. Doe:

Enclosed is a copy of your acceptable plans of correction for the unannounced on-site investigation of two self-reported incidents conducted on **July 8, 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: 0197	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	AUG 9 - 13 Licensing and Protection	(X3) DATE SURVEY COMPLETED C 07/08/2013
NAME OF PROVIDER OR SUPPLIER OUR LADY OF THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 1 PINNACLE MEADOWS RICHFORD, VT 05476		
(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 investigation of two self-reported incidents was conducted by the Division of Licensing and Protection on 7/8/13. The following regulatory findings were identified as a result.	R100			
R162 SS=E	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 record review and staff interview, the home failed to assure that all medications were administered according to the physicians' orders for five of five residents reviewed (Residents #1, 2, 3, 4, and 5). Findings include: 1. Per record review on 7/8/13, Resident #1 had a physician's order that read "Ativan 0.5 mg tabs (Lorazepam) take one by mouth three times daily as needed for agitation." Per review of the Medication Administration Record (MAR) the medication was written as above, however instead of being as needed, the Lorazepam was given as a scheduled dose at 7 AM and 5 PM, with the third dose available for staff to give "as needed". Per interview on 7/8/13 at 3:45 PM, the nurse manager confirmed that the order was written by the physician to be given "as needed". 2. Per record review on 7/18/13, Resident #2 had	R162	PLEASE SEE ATTACHED		

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

1LIC11

TITLE

ADMINISTRATOR

(X6) DATE

8/7/13

If continuation sheet 1 of 8

PML

Division of Licensing and Protection

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R162	<p>Continued From page 1</p> <p>an order for "Acetaminophen 325 mg. tab. Take 1-2 tablets by mouth 3 times a day as needed". On the MAR it was written as a scheduled dose to be given at 7 AM and 5 PM, with a third dose to be given PRN (as needed) for pain.</p> <p>3. Per record review on 7/8/13, Resident #3 had an order for "Oxycodone w/APAP 5/325 mg. Take one tablet by mouth every 8 hours as needed for breakthrough pain." The resident also had a Fentanyl patch as a scheduled medication order to manage pain. The Oxycodone/APAP was written on the MAR as a scheduled medication to be given at 6 AM and at IHS. Resident #3 also had an order for a stool softener that read "Doc-Q-Lace 100 mg capsule. Take 1-2 capsules by mouth daily as needed for constipation." This medication was also written as a scheduled dose for 7 AM daily.</p> <p>4. Per record review on 7/8/13, Resident #4 had an order for Alprazolam 0.5 mg tablet. Take one tablet by mouth twice a day. Morning and afternoon for anxiety." On the MAR, the medication was written to be given once daily at 4 PM, and the morning dose had not been administered to the resident. Also there was an order for this resident that read "Hydrocodone/APAP 5/325 mg. tab. Take one tablet by mouth 3 times a day as needed for hip and abdominal pain." This medication was also written on the MAR as a scheduled dose to be given at 10 PM and PRN. There was also an order for this resident that read "Senna-Ducosate 50/8.6. Take 2 tablets by mouth 2 times a day as needed." This medication was also scheduled to be given daily at 7 AM and 7:30 PM, and not as an "as needed" medication.</p> <p>5. Per record review on 7/8/13, Resident #5 had</p>	R162		
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R162	Continued From page 2 an order for "Lorazepam 0.5 mg. Take one tab PO twice daily as needed." Although written this way on the MAR, the medication was scheduled to be given at noon and at HS on a daily basis. Per interview on 7/8/13 at 3:45 PM, the Nurse Manager confirmed that they were the person who wrote in the scheduled times for these "as needed" medications as listed above for the 5 residents. S/he also confirmed that the physician's orders for these medications was written specifically with "as needed" on them and not as scheduled.	R162		
R167 SS=E	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 psychoactive	R167		

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R167	<p>Continued From page 3</p> <p>medications ordered to be given "as needed" were only given if the target behaviors/symptoms were present for two of five residents sampled (Residents #1 and 5). Findings include:</p> <p>1. Per record review on 7/8/13, Resident #1 had a physician's order that read "Ativan 0.5 mg tabs (Lorazepam) take one by mouth three times daily as needed for agitation." Per review of the Medication Administration Record (MAR) the medication was written as above, however instead of being given as needed, the Lorazepam was given as a scheduled dose at 7 AM and 5 PM, with the third dose available for staff to give "as needed". Per interview on 7/8/13 at 3:45 PM, the Nurse Manager confirmed that the order was written by the physician to be given "as needed", that s/he had written scheduled times on the MAR, and although there was a clear behavior plan that included PRN Ativan, the staff were giving the medication as a scheduled dose twice daily whether there were behaviors present or not.</p> <p>5. Per record review on 7/8/13, Resident #5 had an order for "Lorazepam 0.5 mg. Take one tab PO twice daily as needed." Although written this way on the MAR, the medication was scheduled to be given at noon and at HS on a daily basis. Per interview on 7/8/13 at 3:45 PM, the nurse manager confirmed that the order was written by the physician to be given "as needed", that s/he had written it on the MAR to be given at scheduled times, and the staff were giving the medication as a scheduled dose twice daily whether there were behaviors present or not.</p>	R167		
R224 SS=D	VI. RESIDENTS' RIGHTS	R224		

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R224	<p>Continued From page 4</p> <p>6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to assure that residents were free from abuse/neglect/exploitation for 3 residents sampled (Residents #2, 3, and 4)</p> <p>1. Per record review on 7/8/13, Resident # 2 sustained a fall with injury after being pushed over by Resident #1 on 6/4/13. Resident #2 suffered a fractured hip, was transferred to the hospital, where he later passed away due to the injury. Another earlier incident on 5/13/13 was documented as a similar situation where Resident #2 entered the room of Resident #1, and was pushed down sustaining minor injuries. Per interview on 7/8/13 at 2:20 PM, the home's owner confirmed that these two resident to resident altercations had occurred.</p> <p>2. Per record review, Resident #3 and Resident #4 were the victims of an employee's drug diversion of narcotic pain medications prescribed to them. On 5/28/13, the home discovered that Resident #3 had 15 tablets of Oxycodone/APAP 5/325 mg. taken and replaced with an unknown tablet. On 6/9/13, it was found that Resident #4 had 45 tablets of Hydrocodone/APAP 5/325mg. taken and replaced with an unknown tablet. The result of the home's and law enforcement's investigation was that a nurse working at the home confessed to diverting pain medication from these two residents. Per interview on 7/8/13</p>	R224		

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R224	Continued From page 5 at 2:40 PM, the home's owner confirmed that these two instances of exploitation had occurred.	R224		

Our Lady Of The Meadows
Plan of Correction
Residential Care Home State Survey
July 8, 2013

R162

5.10

Action: The Nurse Manager has obtained a new physician's medication order that corresponds to how the medication is being administered.

Resident #1: Ativan order now reads: "Ativan 0.5 MG Tabs (Lorazepam) Take 2 tabs by mouth daily" (Please see Attachment A-1)

Resident #2: An order was not obtained as RC has passed away on 06/07/13

Resident #3: Oxycodone is now being given as a PRN as ordered.
Doc-Q-Lace order now reads: "Colace 100 MG Caps (Docusate Sodium) 1 tab by mouth daily" (Please see Attachment A-3)

Resident #4: Alprazolam order now reads: "Alprazolam 0.5 MG Tabs (Apprazolam) Take 1 tab daily" (Please see Attachment A-4)
Hydrocodone order now reads: "Hydrocodone-Acetaminophen 5-325 MG Tabs (Hydrocodone-Acetaminophen) Take 1 tab by mouth daily at bedtime" (Please see Attachment A-4)
Senna-Ducosate order now reads: "Peri-Colace 8.6-50MG Tabs (Sennosides-Docusate Sodium) Take 2 tab by mouth twice a day" (Please see Attachment A-4.1)

Resident #5: Lorazepam order now reads: "Lorazepam 0.5 MG Tabs (Lorazepam) take 1 tab by mouth twice a day" (Please see Attachment A-5)

Measures: The Nurse Manager will insure all medications will be administered according to the physician's orders.

Monitors: The Nurse Manager and Nursing Team will monitor this practice to insure that this deficiency will not reoccur.

Date Completed: July 31, 2013

R162 POC accepted 8/8/13 K Campos RN/PMU

R167

5.10

Please see Plan of Correction for R162 and attached copies of the Written Plan for use of the PRN Psychotropic Medication which were in place for Resident #1 and #5.

Resident #1: Attachment B-1

Resident #5: Attachment B-5

R167 POL accepted 8/8/13 K Campos RN/PMU

R224

6.12

Incident 1:

Action: Administrator and Nurse Manager directed all staff working with Resident #1; to monitor Resident #1 at all times and insure that other residents are safe and not abused by Resident #1. Additionally, Resident #1's Care Plan was modified and includes a behavior flow sheet component. (Please see Attachment D-1 and Attachment D-2)

Measures: Administrator and Nurse Manager will provide on-going education for all staff working with Resident #1 to quickly assess Resident #1's behavior and work collectively to maintain an environment free from abuse.

Monitors: Administrator and Nurse Manager will monitor this practice to insure that this deficiency does not reoccur.

Date Completed: June 5, 2013

Incident 2:

Actions: Administrator and Nurse Manager introduced new Medication Administration Policy and Procedures to prevent future opportunities of drug diversion. These new procedures have been reviewed and are being followed by all staff responsible for medication administration. (*Please see Attachment E*)

Measures: Nurse Manager will provide on-going education for all staff responsible for medication administration in an effort to thwart any attempts to divert medication that is prescribed to the residents.

Monitors: The Administrator and Nurse Manager will monitor the new procedures to insure that this deficiency does not reoccur.

Date Completed: June 6, 2013

R224 POC accepted 8/8/13 KComposRN/PMU