

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/10/2010
NAME OF PROVIDER OR SUPPLIER RINGER'S HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 195 GREEN STREET VERGENNES, VT 05491		
(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 complaint investigation and licensing survey was conducted on 2/10/2010.	R100	APR 15 2010	2/10/10
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 interview, the facility nurse did not complete a medication management assessment for 1 of 2 applicable Residents (Resident #2) as required. Findings include: Per record review on 2/10/2010, Resident #2 was admitted to the facility on 2/1/2010 but was not assessed for medication management ability by the facility nurse within the required 24-hour period. During interview on the afternoon of 2/10/2010, the assistant manager confirmed that the resident was not assessed by the nurse within 24 hours to determine the Resident's ability to self-administer medication and / or to delegate medication administration to appropriate facility staff if necessary.	R134	<p>P.O.C. RN came in on 2/10/10 @ 7AM & assessed was found to need medication management by RN & staff. The assessment was signed by RN Michael Korkuc.</p> <p>Way corrective action for this issue will be as follows, within 24hrs when new Resident arrives the RN on staff will be here to fill out L.1 in the assessment package. Assessments will be monitored more closely from now on by Manager & Asst. Manager.</p> <p>Doc unnto 4-15-10 C Lunny 18</p>	2/10/10

Division of Licensing and Protection

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

STATE FORM

6899

F9SK11

If continuation sheet 1 of 7

Tullam Poooska 4/14/10
TITLE Assistant Manager (X6) DATE

Monica B. Ringer 4/14/10
Manager/administrator

Division of Licensing and Protection

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R136 Continued From page 1 R136 V. RESIDENT CARE AND HOME SERVICES SS=D 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility did not complete a significant change in status assessment for 1 applicable resident (Resident #1). Findings include: 1) Per record review on 2/10/2010, the most recent resident assessment instrument (RAI) was completed on 8/5/2009. During January 2010, the record indicated that Resident #1's condition had deteriorated and that the resident was admitted to the Visiting Nurse Hospice Program. During interview that afternoon, the Assistant Manager confirmed that the resident's condition had worsened in January and that an updated RAI had not been completed following this significant change in health status.	R136 R136	<p>• P.O.C. AT Time of review The Hospice RN had updated Hospice Certification dated 2/3/10 we did call the Hospice RN & on 2/10/10 @ 1:30pm she brought us the Plan of Care. we did also fill out a updated reassessment for Resident #1 due to change in status & this was signed by our R.N. Michael Kackuc 2/16/10</p> <p>• ways the corrective action will be followed is when a change in status occurs with a resident a reassessment & plan of care will be done.</p>	
R162 V. RESIDENT CARE AND HOME SERVICES SS=D 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.	R162	<p>• Medication Management plan of correction order was signed for Resident #1 for Risperidone BID and then was also signed to increase risperidone 5mg q 30mins. PRN</p>	

see unit 4-15-10
C Henry / [Signature]

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R162	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, an order for an antipsychotic medication was not transcribed and followed as written for 1 of 2 residents (Resident #1). Findings include:</p> <p>1) Per record review on 2/10/2010, Resident #1 had an order for liquid Risperdone 0.5 mg (milligram) BID (twice daily) P.O. (orally) or S.L. (under the tongue) as a scheduled medication. Review of the MAR (Medication Administration Record) indicated that the order for scheduled Risperdone had been transcribed TID (three times daily) and that the medication had been administered TID from 2/6/2010 through 2/10/2010 at noon. On the afternoon of 2/10/2010, the Administrator confirmed that the written order was for scheduled Risperdone 0.5 mg BID and that the MAR indicated a TID schedule of administration had been followed by staff.</p> <p>R164 V. RESIDENT CARE AND HOME SERVICES SS=F</p> <p>5.10 Medication Management</p> <p>5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:</p> <p>(2) A registered nurse must delegate the responsibility for the administration of specific medications to designated staff for designated residents</p> <p>This REQUIREMENT is not met as evidenced by:</p>	R162	<p>we had misunderstood orders the way they were signed so we contacted Hospice RN & on 2/10/10 she clarified the error & faxed a new order allowing us to administer Risperdone TID instead of BID. Problem was resolved 2/10/10 2/10/10. TID was exactly what Physician had wanted from the beginning</p> <p>(R162) corrective action will be monitored by having Hospice RN & Physicians clarify what they are writing on orders.</p> <p>Medication Management on 2/10/10 2/10/10 our RN came in & trained ALL of our staff on policies & procedures on proper</p>

(X5) COMPLETE DATE: 

Per ampt 4-15-10
C. Terry 182

Division of Licensing and Protection

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R164 Continued From page 3
Based on interview, the facility Nurse failed to properly delegate medication administration to all individual staff members. Findings include:

1) Per interview with the Assistant Manager on 2/10/2010 at noon, s/he had received training by the Nurse and was then authorized to train other unlicensed staff in medication administration. The Nurse confirmed, during an afternoon telephone interview, that training and delegation of staff regarding medication administration is initially performed by the Assistant Manager and that s/he performs a later observation of each designated staff members' skills.

R165 V. RESIDENT CARE AND HOME SERVICES
SS=F

5.10 Medication Management

5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:

- (3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for:
- i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects;
 - ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications;
 - iii. Assessing the resident's condition and the need for any changes in medications; and Monitoring and evaluating the designated staff performance in carrying out the nurse's

R164
Way to administer medications. Staff was given a written test by RN to make sure that they understood the way of administering medications.

The way this will be followed is that when a new employee is hired the RN will come and train the employee on how to administer meds & if a new techniques are changed by state the RN will come and retrain all staff. RN comes in once a week & if staff has questions or issues about administering meds they meet w/ RN & he answers questions. & IS always available to use staff 24/7 by phone

(R164)
see next page

(R165 cont)

the way we are going to monitor this is by having frequent training on medication administration by RN.
Per memo 4-15-10. C Long/R

Division of Licensing and Protection

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R165 Continued From page 4

instructions.
This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the Nurse did not assure that staff administer medications following proper technique. Findings include:

- 1) Per observation on 2/10/2010 at 12:39 PM, the Assistant Manager prepared medications for Resident #3 by removing the medications from the container and physically aligning each medication with it's order along the MAR (Medication Administration Record) with bare hands. The medications were verified (in this manner), picked up with bare hands, placed in a medication cup and delivered to Resident #3. The Assistant Manager confirmed during interview that afternoon that the medications had been touched with bare hands, that no training contraindicating this method has been taught, and that this is the method all staff use to assure proper medication is delivered.

R181 V. RESIDENT CARE AND HOME SERVICES
SS=D

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 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

R165

on 2/10/10 Before the Licensing Surveyor left the Building we purchased a pill count tray with a plastic Knife style separator from our pharmacy to check the meds so that none of the staff touches meds with bare hands or gloved hands any of the medications. Once checked they are poured into a cup & handed to Resident who then takes them! The meds are now coming precarded so when preparing the meds they are also not touched. they have been coming precarded since mid March 2010

R181

(R181) Employee #1 whose criminal background check revealed a misdemeanor, Administrator requested & Rec'd a variance from state 2/10/10 see attached VLP.

Poc airt 4-15-10
e h m 18

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

(R181)

February 16, 2010

Monica Ringer, Administrator
Ringer's Home Care
195 Green Street
Vergennes, VT 05491

Dear Ms. Ringer:

I am writing in response to your letter of February 12, 2010 requesting a variance from Section 5. 11. d of the State of Vermont Residential Care Home Licensing Regulations in order to retain a staff member, [REDACTED], despite [REDACTED]. Based on the information provided with your request I will grant the variance for you to retain this individual. This variance is subject to review and termination at any time.

Please contact me at 802-241-2345 if you have any questions.

Sincerely,



Frances L. Keeler, RN, MSN, DBA
Director



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R181 Continued From page 5

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.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility retained an employee (employee #1) whose criminal background check revealed a misdemeanor conviction. A second employee (employee #2) had no evidence of a criminal background check on file. Findings include:

1) Per record review on 2/10/2010, 1 of 5 employees had a criminal record substantiation revealed to the home during initial pre-employment screening. Per interview on the afternoon of 2/10/2010, the Administrator confirmed that employee #1 is a current employee, that the criminal record report indicated a misdemeanor conviction and that no request for variance has been submitted to the DLP.

2) Per record review and confirmed during interview with the Administrator on the afternoon of 2/10/2010, 1 of 5 employees had no evidence available in the personnel file that a criminal background check had been completed.

R291 IX. PHYSICAL PLANT
SS=F

9.6 Plumbing

9.6.d Hot water temperatures shall not exceed

R181

Employee that was found to have no record on file for criminal background check was done immediately & submitted to surveyor. (2/10/10)

It was just an over site. All background checks are done on prospective employees!

(2/10/10) It is part of new employee packet that is always done on each employee seeking & hired.

Account 4-15-10
Ehman 18

R291

water temps were fixed immediately on 2/10/10 while surveyor was still here.
corrective action-

F9SK11 we now have a log on water temps they are checked twice a week by staff. If not under 100 they immediately contact Jim Ringer

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R291	Continued From page 6 120 degrees Fahrenheit in resident areas. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to assure that water temperatures did not exceed 120 degrees Fahrenheit in resident use areas of the home. Findings include: 1) Per assessment of facility water temperatures on 2/10/2010 at 10:55 AM, the water temperature at the sink in the resident shower room was 122 degrees Fahrenheit (DF) and the water temperature in Resident #1's bathroom sink was 124 DF @ 10:57 AM. This was confirmed by the Administrator immediately following this finding by repeating the temperature tests.	R291		