

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 26, 2013

Ms. Marlene Ringer, Administrator
Ringer's Home Care
195 Green Street
Vergennes, VT 05491

Provider #0350

Dear Ms. Ringer:

Enclosed is a copy of your acceptable plans of correction for the unannounced on-site complaint investigation conducted on November 20, 2013 and concluded on **November 27, 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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0350 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | RECEIVED Division of DEC 23 13 | (X3) DATE SURVEY COMPLETED C 11/27/2013 |
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| NAME OF PROVIDER OR SUPPLIER RINGER'S HOME CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 195 GREEN STREET VERGENNES, VT 05491 | Licensing and Protection |
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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 investigation was conducted on 11/20/13 by the Division of Licensing and Protection. The investigation concluded on 11/27/13 and resulted in the following regulatory violations. | R100 | <p><i>This plan of correction constitutes my written Allegations of Compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by the state and federal law.</i></p> <p><i>Ringer's Home Care Policy for Admissions orders (exhibit A) and policy for receiving verbal orders (exhibit B)</i></p> | |
| R162 SS=E | <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 confirmed through staff interview medication was administered to 1 resident without a written physician order. (Resident #1). Findings include:</p> <p>Per record review, conducted on 11/20/13 Resident #1 was admitted to the facility on 6/20/13 with physician orders that included the following medications: Lorazepam (anti-anxiety drug) 1.5 mg HS (bedtime) PRN (as needed) and Lorazepam 0.5 mg PO (by mouth), TID (three times per day) PRN. Per review of the Medication Administration Records (MAR) for the months of June, July, August and September, 2013, Resident #1 received the Lorazepam 0.5 mg on a routinely scheduled basis, at 8:00 AM, 12:00 Noon and 5:00 PM daily, as well as every evening at 8:00 PM, instead of the PRN basis per direction of the physician orders. In addition, although there was no written physician order to</p> | R162 | | 11/27/13 |

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| Division of Licensing and Protection LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Maureen J. Ringer</i> | TITLE <i>Administrator</i> | (X6) DATE 12/20/13 |
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R162, R165, + R167 POC's accepted BHWERN/AMC 12/26/13

AMC

Division of Licensing and Protection

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| R162 | <p>Continued From page 1</p> <p>increase the dosage, Resident #1 received Lorazepam 2 mg daily at 8 PM, beginning on July 1, 2013, instead of the 1.5 mg as directed in the physician orders. A written physician order to administer Lorazepam 2 mg PO at HS was not obtained until 7/22/13. Despite the lack of physician orders to administer the Lorazepam on a PRN basis the resident continued to receive the Lorazepam, on a routinely scheduled basis three times a day, as well every evening, through 9/4/13, at which point s/he was admitted to the hospital.</p> <p>During separate interviews, on the afternoons of 11/20/13 and 11/27/13, respectively, PCA #1 confirmed that Resident #1 had received Lorazepam 0.5 mg PO on a routine basis at 8:00 AM, 12:00 noon and 5:00 PM daily from the date of admission on 6/20/13 through the patient's hospitalization on 9/4/13. In addition the PCA confirmed that Resident #1 had received Lorazepam 1.5 mg PO daily at 8:00 PM from 6/20/13 through 6/30/13 and that the resident had received a increased dose of Lorazepam 2 mg PO daily at 8:00 PM beginning on 7/1/13 through 7/22/13, all without a written physician order.</p> <p>During telephone interview, on the morning of 11/27/13, the RN responsible for medication management, who was out of state at the time of interview and did not have access to the resident's medical record, confirmed that staff had informed him/her there were no written physician orders for the above stated medication administration schedule.</p> | R162 | <p>Were both updated/ Created to ensure that Ringers Home Care will receive a current, accurate signed and dated medication list prior to residents admission to the home. Further more the policy regarding "receiving orders" clarifies who may take orders. It also states all orders are reviewed and approved by the RN.</p> | 11/28/13 |
| R165 SS=E | V. RESIDENT CARE AND HOME SERVICES | R165 | | |

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| R165 | <p>Continued From page 2</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>(3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for:</p> <ul style="list-style-type: none"> 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 instructions. <p>This REQUIREMENT is not met as evidenced by: Based on record review and confirmed through staff interview the facility failed to ensure that unlicensed staff, the PCAs (Personal Care Attendants), who were designated, by the Registered Nurse (RN), would only administer medications under the following conditions: the RN was responsible and accountable for assuring proper administration of medications; timely assessment of the condition of a resident and the need for change in the resident's medications; providing designated staff with appropriate information about the resident's condition, relevant medications and potential side effects and establishment of a process for timely communication with designated staff regarding</p> | R165 | <p>The policy for administration of medications was updated and staff was re-educated (exhibit C + D) - regarding proper medication administration techniques, routine communication with the RN regarding changes in the residents condition. Staff also has access to medication manual for any questions regarding medication side effects, etc. Education was also provided regarding PRN medication usage, behavior</p> | <p>12/2/13</p> <p>12/19/13</p> |
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| R165 | <p>Continued From page 3</p> <p>the resident's condition and the need for any medication changes. (Resident #1). Findings include:</p> <p>1. Per record review, conducted on 11/20/13, the RN failed to assure the proper administration of medication to Resident #1, who was admitted to the facility on 6/20/13. Physician. Physician orders, dated 6/20/13, included the following medications: Lorazepam (anti-anxiety drug) 1.5 mg HS (bedtime) PRN (as needed) and Lorazepam 0.5 mg PO (by mouth), TID (three times per day) PRN. Per review of the Medication Administration Records (MAR) for the months of June, July and August, 2013, Resident #1 received the Lorazepam 0.5 mg on a routinely scheduled basis, daily at 8:00 AM, 12:00 Noon and 5:00 PM, as well as receiving Lorazepam 1.5 mg daily at 8:00 PM, instead of the PRN basis per direction of the physician orders. In addition, although there was no written physician order to change medication doses from the 1.5 mg at HS PRN, Resident #1 received Lorazepam 2 mg daily at 8 PM, beginning on July 1, 2013. A written physician order to administer Lorazepam 2 mg at HS was not obtained until 7/22/13. Despite the lack of physician orders to administer the Lorazepam on a PRN basis the resident continued to receive the Lorazepam, on a routinely scheduled basis daily, through 9/3/13 at which point s/he was admitted to the hospital.</p> <p>During interview, on the afternoon of 11/20/13, PCA (Personal Care Attendant) #1, an unlicensed staff member who had been designated by the RN to administer medications, and PCA #2, both confirmed the physician admission orders that directed administration of the Lorazepam on a PRN basis, and both confirmed Resident #1 had received the Lorazepam on a daily routinely</p> | R165 | <p><i>monitoring and use of care plans. Importance of documentation of residents symptoms. Please see other forms related to staff education regarding medication administration (Exhibits E, F, G, H, I)</i></p> | |
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| R165 | <p>Continued From page 4</p> <p>scheduled basis, rather than the PRN basis, from admission on 6/20/13 through 9/3/13.</p> <p>Resident #1 returned to the facility from the hospital on 9/8/13 with physician orders for scheduled daily administration of Lorazepam. A physician order, dated 9/11/13, directed staff to administer Lorazepam 0.5 mg at 8:00 AM, 12:00 noon and 5:00 PM on a PRN basis as well as Lorazepam 2 mg at HS PRN. On 9/13/13, PCA #1 requested and received a physician order to change the administration of Lorazepam from a PRN basis back to a daily, routinely scheduled basis without evidence that the RN had been made aware of this change. In addition, despite the 9/13/13 physician order to change the Lorazepam administration schedule to daily routinely scheduled basis, the medication was not administered at all until 9/16/13.</p> <p>A progress note, dated 9/27/13 at 10:00 PM indicated that Resident #1 had "complaints of abdominal pain/cramping....Dr [physician] notified by care attendant new order received to give additional dose of Ativan 0.5 mg now...". Per review of the MAR, PCA #3 administered Lorazepam 0.5 mg PO at 10:20 PM without evidence that communication had occurred between the PCA and the RN to inform the RN of the change in the resident's condition that required a change in medication.</p> <p>Per interview on the afternoon of 11/20/13, PCA #2 confirmed s/he had requested and received the 9/13/13 physician order to change the administration of Lorazepam for Resident #1 from a PRN to routinely scheduled basis because the resident had exhibited increased agitation between 9/11/13 and 9/13/13 and PCA #2 felt it was related to the reduction in administration of</p> | R165 | <p><i>Refer to exhibits A, B + C</i></p> <p><i>Refer to exhibit B</i></p> | |
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R165 Continued From page 5

the Lorazepam as a result of the PRN order. The PCA further stated that communication regarding the resident's condition and need for change in medication had not occurred until after the physician order had been obtained and the new schedule of medication administration had been initiated. S/he stated the RN reviews resident medications on a weekly basis and is made aware, at the time of the weekly reviews of any changes in medications that had been made in the week prior. The PCA also confirmed the medication had not been administered on the 3 days between 9/13/13 and 9/16/13, however was unable to explain why the medication had not been given during that period. PCA #1 confirmed, during interview at the same time, that an order for PRN Ativan had been requested and received by PCA #3, on the evening of 9/27/13. S/he confirmed the medication had been administered to Resident #1 without first communicating with the RN.

During a telephone interview, on the morning of 11/27/13, the RN responsible for medication management, confirmed that s/he reviewed any medication changes for residents, on a weekly basis. S/he further stated that there was no process currently in place for ongoing communication between unlicensed, delegated staff and the RN to discuss any change in a resident's condition requiring a need for change in medication.

R165

*Refer to exhibit B
Policy + Procedure
for receiving verbal
orders.*

R167
SS=D

V. RESIDENT CARE AND HOME SERVICES

5.10 Medication Management

5.10.d If a resident requires medication

R167

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| R167 | <p>Continued From page 6</p> <p>administration, unlicensed staff may administer medications under the following conditions:</p> <p>(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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and confirmed through staff interview the facility failed to assure a written plan had been developed that identified specific targeted behaviors that indicated use of PRN (as needed) psychoactive medications and specified circumstances that indicated the use of the medication. There was also a failure to assure staff documented effectiveness of the medication for 1 resident. (Resident #1). Findings include:</p> <p>Per record review, and despite the lack of a written plan for the use of PRN psychoactive medications, Resident #1 received Lorazepam 0.5 mg PO (by mouth) PRN on 4 separate occasions between 9/27/13 and 11/4/13 for the following reasons: on 9/27/13 at 10:20 PM for "anxiety/stomach pain"; at 2:50 AM on 10/17/13 for "anxiety"; 10/21/13 at 11:00 PM for "anxiety/worked up" and on 10/26/13 at 4:20 AM for "anxiety/worked up". Although there was documentation on 10/21/13 that indicated the result after 1 hour as being "stayed the same", there was no documentation</p> | R167 | <p><i>Ringer Home Care has a Psychoactive medication Plan in place for residents on PRN psychoactive meds. Staff has been educated on use of medications and forms have side-effect list attached for each ease of use (exhibit J)</i></p> <p><i>a care plan for psychoactive med use and mood was also added (exhibit K)</i></p> | <p><i>12/2/13</i></p> |
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| R167 | Continued From page 7 of the effectiveness of the medication given on the other 3 dates. During interview, on the afternoon of 11/20/13, PCA #1 confirmed the psychoactive medication had been administered by PCAs on each of the dates identified and confirmed the lack of a written plan for administration of psychoactive medications for Resident #1. | R167 | <i>Refer to exhibit J</i> | |
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Exhibit A

RINGER'S HOME CARE
195 Green Street
Vergennes, Vt. 05491
(802) 877-1363

Admission Orders Policy

Prior to admission into Ringer Home Care the following documents **MUST** be complete and with appropriate signatures in place where required.

1. Every clinical record should have a face sheet or admission record that provides demographic information, responsible party and contacts, financial and insurance information, and contact information for outside professionals involved in the resident's care (i.e. attending physician, alternate physician, etc.).
2. Ringers Home Care must have physician orders for the resident's immediate care. The orders should include at a minimum dietary, drugs (if necessary), all known allergies and routine care to maintain or improve the resident's functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan.
3. A current medication list signed and dated by resident's doctor. Medication lists created by the resident, a family member or by the prior facility will **NOT** be accepted.
4. A written history and physical must be completed either on Ringers Home Care form or on formal H&P form from physician's office.
5. A current list of immunizations (i.e. Flu and Pneumonia vacs)

Policy and Procedure for Receiving Verbal Orders

Purpose

To reduce errors associated with misinterpreted verbal or telephone communications of medication orders or test results. Faxes and electronic mail is reducing the need for verbal orders in non-emergent situations. Limiting the number of personnel who may receive telephone orders will help ensure familiarity with facility guidelines.

Policy

1. Verbal communication of prescription or medication orders and test results is limited to urgent situations in which immediate written or electronic communication is not feasible.
2. Verbal orders and test results are not allowed when the prescriber is present and the resident's chart is available, except during an emergency situation, in which case a repeat-back is acceptable.
3. Verbal orders and test results are not permitted via voice mail.
4. The following job categories are authorized to accept verbal orders: [LPN, RN]
5. ALL orders are reviewed and approved by RN prior to activating. This may be done in person, by phone or via email.

Procedures

1. Verbal orders and test results, when allowed, will be immediately written down by the recipient, read back by the recipient, and confirmed or corrected by the prescriber. The order must be written before it is read back.
2. Both parties will pronounce numerical digits separately—saying, for example, "one six" instead of "sixteen."
3. For medication orders, the prescriber will spell the name of any unfamiliar medication, if either party feels this is necessary.
4. For medication orders, prescribers will include the purpose of the drug to ensure that the order makes sense in the context of the resident's condition.
5. For medication orders, both parties will express doses of medications by unit of weight (e.g., mg, g, mEq).
6. The recipient will record each verbal order directly onto an order sheet in the patient's chart and will include phone or pager numbers in case it is necessary for follow-up questions.
7. Recipients of verbal orders will sign, date, time, and note the order at the time it is written on the order sheet.
8. Prescribers will verify, sign, and date orders within 72 hours.
9. Verbal medication orders will include the following information:
 - Date and time order is received
 - Resident name
 - Drug name (brand or generic)
 - Dosage form (e.g., tablets, capsules, inhalants, etc.)
 - Strength or concentration
 - Dose
 - Frequency
 - Route
 - Quantity and/or duration
 - Name of prescriber
 - Signature of order recipient

Medication Administration Policy**Administration of Medications and Insulin Policy**

Administration of medications and Insulin to the residents of Ringer's Home Care is part of the staff's day and training is done with the expectation that every staff member is trained in excess of what is required by the State of Vermont Regulations. Medication and Insulin administration is an ongoing process as resident's medications change and new medications are used. Medication administration and Insulin administration is delegated to the staff by the registered nurse contracted by Ringer's Home Care. The registered nurse is responsible for medication and insulin administration policy, procedures and training as well as a Diabetes over-view and understands of the condition. All training is documented as part of the staff's personnel files.

The staff is tested at the end of their initial training by use of a pass/fail test and direct observation session by the registered nurse. If a staff member does not pass either the written test or observation session they will be retrained until successful complete or they are deemed unable to administered medications.

Current staff members are required to participate in annual refresher training on medication and insulin administration and again must take and pass the recertification test. Also if a staff member makes 3 or more significant medication errors in a one year period, it is up to the Registered Nurse who delegates to the staff the corrective course of action. This could include anything from re-training to having their medication abilities revoked permanently. Although discussion may be had with management and owners of Ringer's Home Care, the decision is solely the responsibility of the nurse who is delegating medication and insulin administration to the staff.

Medication Administration Procedures

1. Scheduled medications **must** be given on time (**1 hr before to 1 hr after prescribed time**). If outside that window, notify management and the RN will be notified.
2. If a resident is planning to be absent during a regularly scheduled medication dose, the medications should be given to the resident or a responsible party in an enveloped marked with residents name and time medication should be administered. The resident or family member is required to initial the resident's medication flow sheet that they have taken responsibility for the medication's administration.
3. Give this task your **full attention** with the only exception being an emergency event with another resident.
4. Wash your hands or use antibacterial foam in dispensers prior to and after each residents medication administration.
5. Due to infection control requirements, medications **cannot** be touched by staff members. You must use the pill tray, a pan with a symmetrically arranged pouring spout, and a plastic scraper to move medications during the documenting process. If for some reason you need to touch the medications, you must be wearing gloves.

Oral Medications

When it is time to administer medications the staff person will get the key to the medication closet from the lock box located on the south wall next to outside door. In addition to medications that are swallowed, oral medications also include those that are put between the cheek and the gums (buccal) and those put under the tongue (sublingual).

Medication Administration Policy

1. Unlock medication closet in kitchen and take out a pre-filled medication container for **one resident at a time only**.
2. **All** containers are marked with the resident name, each day of the week, and the time to be administered. Double check the name on the pre-filled medication box against the flow sheet to make sure it's the right pills for the right resident.
3. Pour the pills for the correct day/time into the pill tray. Working from top to bottom of the residents medication list, systematically identify each pill from the description provided in each medication list, moving each identified pill to the trough on the side of the pan with the plastic scraper.
4. When all medications are identified and accounted for, pour the pills into a paper or plastic cup to bring to the resident.
 - a. If a medication is missing, contact management.
 - b. If a pill does not match the description on the medication sheet, **do not administer that pill**, and contact management.
5. Return the pre-filled medication container to the medication closet. **Do not leave medications unattended in the kitchen.**
6. Deliver the pills to the correct resident. Remember that you **cannot** touch the pills, pour from the medication cup into the residents hand. If the resident cannot take all the pills at once, pour them into their hand a few at a time. If medication needs to be crushed, use the crusher provided and pour into whatever the resident prefers to take it with.
7. **Do not leave the medication unattended near the residents. Stay** with that resident until you are positive they have swallowed the medication; **WATCH them actually take the medication!** Take as long as necessary to make sure they have taken and swallowed all medications.
8. When you have finished giving all medications to that resident, immediately go to their flow sheet and legibly document your initials in the appropriate box.
9. Repeat steps above for next resident until all medications for that time have been given to each resident.
10. If dispensing liquid medication, check the name and **expiration date**. Read and follow directions on the label (i.e. shake well).
11. **During medication administration times, all staff should be especially alert for adverse reactions in all residents.**
12. If a resident refuses to take their medications, do your best to convince the resident to take them. **All residents have the right to refuse.**
13. If resident refuses or is unable to take medications, **notify management immediately**, then initial in red ink in flow chart and circle your initials.
14. Put unused medications in white envelope with name of resident, the time, and the name of the medication then lock them up in medication closet for RN to dispose of. **Do not PUT pills back into containers.**
15. Document in flow chart why medications were not taken (i.e. refused, unable due to illness).
16. Acceptable abbreviations include: R = refused, NG= Not Given, NA= Not Available
17. Include date and reason in white area at the bottom of page for all reasons pills not given.

IF A MEDICATION IS NOT TAKEN FOR ANY REASON NEVER DOUBLE UP THE NEXT DOSE

PRN Medications

PRN means medications to be given when needed. **PRN medications may be prescription or over the counter but in all cases, the resident needs a signed order from their physician.** The order will state the dose of the medication, the frequency it can be given and the reason it may be given.

When a resident asks for a PRN medication:

1. Check for a written order.
2. Look at the frequency it can be given.
3. Check the chart to ensure that enough time has passed since a previous dose, if any (Date and Time).
4. Check the dose that is ordered.
5. Check for restrictions on why it can be given. Example medications ordered for one reason (i.e. headache) cannot be given for another reason (i.e. knee pain).

****No medication ordered for one resident can be given to any other resident****

Medication To The Eyes (Ophthalmic)

1. Wash hands.
2. **PUT ON GLOVES.**
3. Gently wash exudates from the eyelid.
4. Read and follow the directions on the label.
5. Gently pull the lower eyelid down to form a pocket.
6. Apply the proper dosage of medication into the pocket **being very careful not to touch the dropper to the eye or eyelid.** You may brace your hand lightly on the residents cheek or nose as necessary.
7. If applying ointment, apply from inner to outer eye.

Medication TO THE EAR (OTIC)

1. Wash hands
2. **PUT ON GLOVES.**
3. Read and follow the directions on the label.
4. Ask the resident to tip head sideways, or lie down with affected ear up.
5. Pull earlobe gently up and out for an adult.
6. Apply the proper dosage of medication into the ear **being very careful not to touch the dropper to the ear.**
7. Ask the resident to remain in the same position for a few minutes to assure the medication is dispersed in the ear canal.
8. You may put a cotton ball in the outer ear if needed.

Topical Medications

Topical medications are any ointments, salves, creams, powders, sprays or patches applied to the surface of the skin.

1. Wash hands.
2. **PUT ON GLOVES.**

3. Apply a **THIN coat** with a gloved hand or tongue depressor.
4. When applying a patch, read and follow the directions on the label. Do **not allow the medication to touch your skin**. Dispose of the old patch in a proper container.
5. Initial and date patch prior to applying to skin.

Nose Drops And Sprays

1. Wash hands.
2. PUT ON GLOVES.
3. For drops, ask the resident to lie down with their head back. Place a pillow under their shoulders as necessary.
4. Apply the proper dosage of medication into the nostril being very careful not to touch the dropper to the nose.
5. Ask the resident to remain in that position for a couple of minutes.
6. For nasal sprays, insert the nozzle about a half inch into the nostril and spray as directed. Ask the resident to breathe in through their nose as you spray.

Inhalers

Inhalant medication varies depending on the type of inhaler. The specific instructions must be read carefully. Below are general instructions.

1. Wash hands.
2. Put on gloves.
3. Be sure the canister is firmly inserted into the container.
4. Shake inhaler well and remove the cap.
5. Use of a spacer or holding chamber is preferable.
6. Have the resident exhale completely.
7. With a spacer, the resident should close their lips around the mouthpiece.
8. Without a spacer, have them open their mouth wide.
9. Hold the inhaler 3 fingers away from their mouth. Do not put into their mouth.
10. Have the resident take a slow, deep breath through their mouth, as you firmly press down on the canister to administer the dose.
11. Have Pt hold their breath for 5 - 10 seconds as able.
12. Replace cap on medication.
13. If using multiple inhalers, use the bronchodilator inhaler before using inhalers containing Intal or steroids.
14. Have resident rinse mouth after steroid inhaler.
15. If a second dose is to be given, wait 5 minutes.
16. Clean the spacer mouthpiece with warm water. Shake off excess moisture.
17. Allow to air dry completely before storing in a sealed plastic bag.
18. Monitor the resident for changes in respiration.

Nebulizers

1. Wash hands
2. Put on gloves
3. Get the medication from the closet.
4. Attach the long thin tube to the protruding base on the nebulizer where the air is released.

Medication Administration Policy

5. Unscrew the cylinder shaped container, holding on to the bottom half.
6. Pour the correct dosage of medication and any other solution into this half of the cylinder.
7. Screw the top back on, making sure not to spill any medication.
8. Attach the air line to the bottom and the mouthpiece to the top.
9. Turn the nebulizer on and wait for the fog/mist to come out of the mouthpiece.
10. Have the resident put the mouthpiece between their teeth and close their lips around it.
11. Ask them to breathe through their mouth as normally as possible, keeping the cylinder in an upright position.
12. Occasionally tap the sides of the cylinder to help the solution drop to the bottom so it can be misted.
13. Continue until medication is gone (sputtering).
14. Monitor the resident for changes in respirations.
15. Take apart the cylinder and mouthpiece and wash with soap and water. Rinse thoroughly and shake off excess water. Allow to dry thoroughly before storing.
16. If any questions contact management.

Insulin Injections

Storing: Unopened insulin can be stored in a refrigerator between 2° and 8°C (36° and 46°F) or stored at room temperature (59 to 86°F) however it should not be placed in a freezer. Insulin vials that are being used can be kept at room temperature for up to a month. If stored in a refrigerator, unopened bottles are good until the expiration date printed on the bottle. All vials should be protected from light and excessive heat. Unused insulin should be thrown away after the expiration date. With insulin pens and their cartridges, storage life ranges from seven days to one month. Check the instructions for shelf life details on popular brands. If the insulin has an unusual appearance, it's probably no longer effective. Here are some warning signs: insulin is cloudy when it is supposed to be clear, insulin is supposed to be cloudy but it has clumps, even after rolling it between your palms, insulin looks stringy, insulin has changed in color. If you think the insulin has gone bad, don't take any chances: throw the bottle away immediately and open a new one.

Drawing and administering:

1. If opening a **new bottle always date** it, if bottle is **already open check the date**.
2. Wash hands.
3. Put on gloves.
4. Ensure residents' blood sugar is appropriate to the insulin dose to be administered, (**Every Resident, Every Time!**)
5. Check the label of insulin vial, confirm dose and check expiration date.
6. Mix insulin by rolling vial between hands or gently inverting 80 times. **Do Not shake.** Shaking introduces air into the solution, and air bubbles make it difficult to draw up an accurate dose.
7. Scrub top of vial with alcohol prep pad, let dry.
8. Remove cap from syringe and draw up slightly more air than the amount of insulin to be administered.
9. Inject air into top of insulin vial.
10. Turn the bottle upside down making sure the tip of the needle is covered with insulin.
11. Draw up the insulin. Remove any air bubbles by tapping syringe and injecting air back into vial.
12. Make sure the syringe is refilled with the correct amount of insulin before withdrawing needle.

Medication Administration Policy

13. Remove needle being careful to avoid contamination of the needle. If the needle touches anything, it is contaminated and you must discard it and start over.
14. Our policy is to not recap an unused needle except in case of emergency. If you must recap an unused needle, recap one handed.
15. **Never recap a used needle.** If you accidentally stick yourself with a used needle, immediately wash the site thoroughly and immediately report it to management.
16. Do not inject cold insulin. If you have to draw up cold insulin, warm the syringe in your hand before injecting.
17. Bring the needle and alcohol swab to the resident.
18. The subcutaneous tissue of the abdomen is preferred for injection of insulin but the site must be changed daily and you must avoid the navel by 1 1/2 inches.
19. Clean the injection site with rubbing alcohol.
20. Wait until the alcohol from the swab has dried completely on skin before injecting.
21. Pinch up a small bulge.
22. Be sure you are not bending the needle when you remove the cap. Needle caps should be removed by first twisting and then pulling them straight off.
23. Insert the needle quickly at a 45 degree angle.
24. Inject the insulin at a moderate speed, and remove the needle.
25. Dispose of the needle in an approved RED sharps container.
26. Monitor the resident for adverse reactions. If an overdose is suspected, call 911 immediately.

General rules for medication dispensing.

- NEVER give a medication if something seems out of the ordinary. If something seems unusual, contact management.
- Do not change the medication flow sheets in any way except to document medication given or not taken. If you find what you believe to be an error, notify management.
- Never dispose of a medication. Medications not taken by a resident should be put in an envelope and marked with the residents name, the date and time, and the reason not taken. The envelope will be locked in the medication closet for disposal by management.
- Controlled drugs will be disposed of in the presence of **both** the RN and the manager.
- If you make an error in documentation, NEVER erase it or scratch it out. Draw a single line through the error, write "error" under or over it and sign your initials legibly. (ERROR)
- **Always be sure you have the Right Resident, the Right Medication, the Right Dose, the Right Time, and the Right Route.**
- Always IMMEDIATELY NOTIFY management if a medication error is made. Document the circumstances of the error on the appropriate form.
- Always monitor residents for signs and symptoms of an allergic reaction. These include but may not be limited to: Itching, with or without rash or hives anywhere on the body. Swelling of the tongue, lips, face, or extremities or a complaint of the tongue "feeling thick". Complaint of a sense of tightness in the throat, or abnormal hoarseness, wheezing, repetitive cough, hacking or shortness of breath. Rapid onset of nausea, abdominal cramps, vomiting, or diarrhea. Loss of consciousness.
- **FOR ANY SYMPTOMS OTHER THAN MINOR ITCHING OR RASH CALL 911 IMMEDIATELY**
- ALWAYS notify management anytime a resident refuses or is unable to take their medications, anytime there is a medication change, anytime you observe any unusual signs or symptoms, or anytime you have a concern that something is not right.

December 19, 2113

Training Topic:

- Hospice Care
- Doctor Orders
- Communication with RN
- Documentation and Charting

Duration: 1.5 hours

ACHH to discuss Hospice Care

New policy regarding Dr. Orders and communication with RN

Correct documentation of accident event forms, medication error forms, and prn medication behavior plans.

State Survey Plan of Correction

Staff Present Signatures

Angela Polcasser

Billy

Babini

Brand N Bear

Salvina Bell

Margaret Ruiger

Jan B

RINER'S HOME CARE
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Vergennes, Vt. 05491
(802) 877-1363

Exhibit E

MEDICATION TEST

NAME _____

DATE _____

- 1) T F YOU CAN GIVE MEDICATIONS ANYTIME WITHIN 1.5 HOURS OF THEIR SCHEDULED TIME AND STILL BE CONSIDERED ON TIME.
- 2) T F IT IS OKAY TO ANSWER THE PHONE WHILE YOU ARE GIVING MEDICATIONS AS LONG AS YOU ARE NOT ALREADY OUTSIDE THE KITCHEN.
- 3) T F IF YOU DROP A PILL ON THE FLOOR, YOU MUST THROW IT AWAY AND CALL MANAGEMENT TO GET ANOTHER ONE.
- 4) T F IT IS OKAY FOR A RESIDENT TO USE THEIR FINGERS TO PUT THEIR PILLS IN THEIR MOUTH IF THEY WANT TO.
- 5) T F ONCE YOU ARE COMFORTABLE GIVING MEDICATIONS, IT IS OKAY TO POUR 2 RESIDENTS AT ONCE TO SAVE TIME.
- 6) T F IT IS OKAY TO LEAVE MEDICATIONS ON THE KITCHEN COUNTER WHEN YOU LEAVE THE ROOM AS LONG AS THERE IS ANOTHER EMPLOYEE TO WATCH THEM.
- 7) T F YOU MAY STAY WITH A RESIDENT AS LONG AS NECESSARY TO ASSURE THEY HAVE SWALLOWED THEIR PILLS.
- 8) T F SINCE YOU NEED TO GIVE EACH RESIDENT YOUR ATTENTION WHILE ADMINISTERING MEDICATIONS, IT IS OKAY TO IGNORE ALL THE OTHER RESIDENTS DURING THAT TIME.
- 9) T F OUR RESIDENTS DO NOT HAVE TO TAKE THEIR PILLS IF THEY DON'T WANT TO.
- 10) T F IF A RESIDENT IS UNABLE TO TAKE THEIR MEDICATION DUE TO ILLNESS, PUT THE PILLS BACK IN THE PILLBOX AND LEAVE A NOTE FOR MANAGEMENT OR THE NEXT SHIFT PERSON.
- 11) T F IF THAT RESIDENT IN THE PREVIOUS QUESTION IS FEELING BETTER IN AN HOUR AND ASKS FOR THEIR MISSED MEDICATIONS, YOU CAN GIVE THEM BUT MUST ADD TO THE NOTE TO EXPLAIN WHAT HAPPENED.
- 12) T F SINCE "PRN" MEANS "AS NEEDED", YOU MAY GIVE A PRN PMEDICATION ANYTIME A RESIDENT SAYS THEY NEED IT.
- 13) T F WHEN APPLYING MEDICATION TO THE EYE, IT'S IMPORTANT NOT TO TOUCH THE APPLICATOR TO ANYTHING SO AS TO AVOID CONTAMINATION.
- 14) T F WHEN APPLYING MEDICATION TO THE EAR, YOU DO NOT HAVE TO BE AS CAREFUL ABOUT TOUCHING IT BECAUSE IT ISN'T AS SENSITIVE AS THE EYE.
- 15) T F YOU SHOULD ALWAYS WEAR GLOVES WHEN DISPENSING OR APPLYING MEDICATIONS.
- 16) T F WHEN APPLYING TOPICAL MEDICATION, YOU SHOULD APPLY IT THICKLY TO BE SURE OF ADEQUATE COVERAGE
- 17) T F WHEN USING INHALERS, IT IS VERY IMPORTANT TO SHAKE THE INHALER VERY WELL
- 18) T F IF ADMINISTERING MORE THAN ONE INHALER, YOU CAN GIVE THEM IN ANY ORDER YOU WANT.
- 19) T F WHEN ADMINISTERING ANY MEDICATIONS, ESPECIALLY INHALERS, IT IS IMPORTANT TO MONITOR THE RESIDENT FOR A FEW SECONDS AFTERWARD FOR CHANGES IN RESPIRATIONS.
- 20) T F INSULIN CAN ONLY BE GIVEN ORALLY IF THE RESIDENT ABSOLUTELY REFUSES THE INJECTION.
- 21) T F IT IS OKAY TO SHAKE THE INSULIN TO MIX IT IF YOU ARE IN A HURRY, BUT NORMALLY YOU ROLL IT IN YOUR HANDS OR GENTLY INVERT IT 20 TIMES.

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- 22) T F IF THE INSULIN NEEDLE ACCIDENTALLY TOUCHES THE CLEAN KITCHEN COUNTER, YOU MUST WIPE IT WITH THE ALCOHOL SWAB AND LET IT DRY BEFORE INJECTING THE RESIDENT.
- 23) T F THERE IS NO REASON TO EVER RECAP A USED NEEDLE.
- 24) T F IF YOU SHOULD ACCIDENTALLY STICK YOURSELF WITH A USED NEEDLE, IMMEDIATELY WASH THE SITE THOROUGHLY AND IMMEDIATELY REPORT IT TO MANAGEMENT.
- 25) T F YOU SHOULD NOT INJECT COLD INSULIN.
- 26) T F IF AN OVERDOSE IS SUSPECTED, MONITOR THE RESIDENT CLOSELY FOR 5 MINUTES AND IF NO IMPROVEMENT, CALL 911.
- 27) T F NEVER GIVE A MEDICATION IF SOMETHING SEEMS OUT OF THE ORDINARY.
- 28) T F IT IS OKAY FOR A RESIDENT TO LIE DOWN FOR A NEBULIZER TREATMENT IF YOU HELP HOLD THE MOUTHPIECE IN PLACE.
- 29) T F WHEN GIVING A NEBULIZER TREATMENT, INTERMITTENT MISTING (SPUTTERING) MEANS THE TUBING IS BLOCKED.
- 30) T F NEVER THROW A MEDICATION AWAY FOR ANY REASON.
- 31) T F IF YOU ALMOST MAKE AN ERROR IN DOCUMENTATION (IE. NOT A WHOLE WORD) IT'S OKAY TO ERASE IT AND START OVER.
- 32) T F EVEN THOUGH I'M NOT FAMILIAR WITH THE SIGNS AND SYMPTOMS OF AN ALLERGIC REACTION, IT IS OKAY TO ADMINISTER MEDICATIONS IF ANOTHER STAFF MEMBER IS AROUND.
- 33) T F ALWAYS IMMEDIATELY ADVISE MANAGEMENT ANYTIME A RESIDENT REFUSES OR IS UNABLE TO TAKE THEIR MEDICATIONS, ANYTIME YOU OBSERVE UNUSUAL SIGNS OR SYMPTOMS, OR ANYTIME YOU ARE CONCERNED THAT SOMETHING IS NOT RIGHT.

Exhibit F1

Resident Medication Administration Delegation

I, Michael Korkuc, RN provide professional nursing delegation to Ringer Home Care. I have trained and delegated to Marlene Raymond, Jim Ringer, Angela Polacsek and Bobbie Lee Ryan to **pre-fill weekly medications** and/or use of weekly prefilled medication system provided by Marbleworks Pharmacy and delegate them to administer all medications including insulin. I have worked with all the above and have complete confidence in their ability to do the weekly pre fills.

If there are physician order changes I am to be contacted for approval prior to those changes. After approval I have trained and delegate the above employees to make those changes for the following residents:

I also have trained the following staff PCAs to **administer only** the pre filled container (in no way are these staff members to alter the pre filled containers) to the above residents and to obtain blood sugar reading and administer insulin to the above residents whom are diabetic. If there are any questions the staff listed below have been instructed to notify one of the above Prefill Certified Staff members listed above.

Staff:

| | |
|-------------------------------|-------|
| _____ | _____ |
| Michael Korkuc, RN | Date |
| _____ | _____ |
| Marlene Ringer, Administrator | Date |

Exhibit G

Ringer's Home Care, Inc.
195 Green Street
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**MEDICATION PRE-FILL, MEDICATION PROCUREMENT,
AND MEDICATION DOCUMENTATION
TRAINING CERTIFICATION**

I, _____ certify that I have received the medication pre-fill, medication procurement, and medication documentation training and that I am able to perform the tasks as delegated by the Registered Nurse employed by Ringer's Home Care, Inc, without supervision.

Employee

Date

I, _____ certify that I have delegated, trained and observed the above named employee in medication pre-fills, medication procurement, and medication documentation.

Registered Nurse

Date

Annual Recertification:

Dates: _____

RN: _____

Exhibit H

Ringer's Home Care, Inc.
195 Green Street
Vergennes, VT 05491

**MEDICATION ADMINISTRATION
TRAINING CERTIFICATION**

I, _____ certify that I have received the medication administration training and that I am able to perform the tasks as delegated by the Registered Nurse employed by Ringer's Home Care, Inc., without supervision in my position as a Personal Care Attendant (PCA).

Employee

Date

I, _____ certify that I have delegated, trained and observed the above named employee in medication administration and it has been completed with a 70% or better score on the written and observation testing.

Registered Nurse

Date

Annual Recertification:

Dates: _____

RN: _____

Exhibit I

**INSULIN ADMINISTRATION
TRAINING CERTIFICATION**

I, _____ certify that I have received the Insulin administration training which includes but is not limited to basic understanding of Diabetes, Blood sugar testing and charting, proper technique for drawing and administering Insulin. I am able to perform the tasks as delegated by the Registered Nurse employed by Ringer's Home Care, without supervision in my position as a Personal Care Attendant (PCA).

Employee

Date

I, _____ certify that I have delegated, trained and observed the above named employee in Insulin education and administration and it has been completed with a 70% or better score on the written and observation testing.

Registered Nurse

Date

Annual Recertification:

Dates: _____

RN: _____

What are the signs of anxiety:

A wide variety of symptoms may be signs of anxiety, some of which may be physical symptoms:

- Trembling, twitching, or shaking
- Feeling a fullness in the throat or chest
- Having difficulty catching your breath
- Feeling like your heart is pounding
- Feeling dizzy or lightheaded
- Sweating or cold, clammy hands
- Feeling jumpy
- Having aches, tense muscles, or soreness
- Feeling extremely tired
- Having trouble falling asleep or getting a good night's rest

You might also have symptoms that impact your emotions, thoughts, or behavior, like:

- Feeling restless
- Feeling on edge or keyed up
- Being angry or irritable
- Worrying about everyday decisions for several days in a row
- Fearing that something bad is going to happen
- Feeling doomed
- Becoming easily distracted
- Having difficulty concentrating
- Feeling like your mind goes blank
- Finding it hard to do your work or normal activities
- Focus on what isn't going well or what could go wrong
- Pull away from other people and become isolated
- Have an explosive temper when things go wrong

Seroquel Oral Side Effects

The following side effects are associated with Seroquel oral:

Common side effects of Seroquel oral:

| | |
|--|-------------|
| Blood Pressure Drop Upon Standing | Less Severe |
| Dry Mouth | Less Severe |
| Indigestion | Less Severe |
| Incomplete or Infrequent Bowel Movements | Less Severe |
| Drowsiness | Less Severe |
| Dizzy | Less Severe |
| Chronic Trouble Sleeping | Less Severe |
| Weight Gain | Less Severe |
| Head Pain | Less Severe |
| Sluggishness | Less Severe |
| Feeling Weak | Less Severe |

Infrequent side effects of Seroquel oral:

| | |
|--|-------------|
| Parkinson Symptoms | Severe |
| Abnormally Low Blood Pressure | Severe |
| A Feeling of Restlessness with Inability to Sit Still | Severe |
| Rash | Severe |
| Difficulty Speaking | Severe |
| Trouble Breathing | Severe |
| High Blood Sugar | Severe |
| Decreased White Blood Cells | Severe |
| Having Thoughts of Suicide | Severe |
| Feeling Restless | Less Severe |
| Problems with Eyesight | Less Severe |
| High Blood Pressure | Less Severe |
| Throat Irritation | Less Severe |
| Inflammation of the Nose | Less Severe |
| Stuffy Nose | Less Severe |
| Inflammation of the Lining of the Stomach and Intestines | Less Severe |
| Abnormal Increase in Muscle Tone | Less Severe |
| Flu-Like Symptoms | Less Severe |
| Excessive Sweating | Less Severe |
| Pain | Less Severe |
| Involuntary Quivering | Less Severe |
| Loss of Appetite | Less Severe |
| Increased Hunger | Less Severe |
| Fast Heartbeat | Less Severe |
| Heart Throbbing or Pounding | Less Severe |
| Cough | Less Severe |
| Throwing Up | Less Severe |
| Stomach Cramps | Less Severe |
| Increased Levels of Prolactin in the Blood | Less Severe |
| High Cholesterol | Less Severe |
| High Amount of Triglyceride in the Blood | Less Severe |

Rare side effects of Seroquel oral:

| | |
|---|--------|
| Depression | Severe |
| Abnormal Movements of Face Muscles and Tongue | Severe |

Seroquel Oral Side Effects

| | |
|--|-------------|
| Extrapyramidal Reaction | Severe |
| Neuroleptic Malignant Syndrome | Severe |
| Cataracts | Severe |
| Pancreatitis | Severe |
| Disease of the Muscle of the Heart with Enlargement | Severe |
| Prolonged Q-T Interval on EKG | Severe |
| Inflammation of the Middle Tissue Heart Muscle | Severe |
| Stroke | Severe |
| Lack of Blood Supply to the Brain | Severe |
| Continued Painful Erection | Severe |
| Discharge of Milk in Men or Women when Not Breastfeeding | Severe |
| Problem with Periods | Severe |
| Toxic Epidermal Necrolysis | Severe |
| Stevens-Johnson Syndrome | Severe |
| Serious Muscle Damage that may Lead to Kidney Failure | Severe |
| Muscle Pain | Severe |
| Seizures | Severe |
| Fluid Retention in the Legs, Feet, Arms or Hands | Severe |
| Low Body Temperature | Severe |
| Life Threatening Allergic Reaction | Severe |
| Problems with Food Passing Through the Esophagus | Severe |
| Underactive Thyroid | Severe |
| Diabetic Ketoacidosis | Severe |
| Diabetes | Severe |
| Syndrome of Inappropriate Antidiuretic Hormone Secretion | Severe |
| Low Amount of Sodium in the Blood | Severe |
| Decreased Blood Platelets | Severe |
| Deficiency of Granulocytes a Type of White Blood Cell | Severe |
| Decreased Neutrophils a Type of White Blood Cell | Severe |
| Muscle Problems that cause Abnormal Movement | Less Severe |
| Widening of Blood Vessels | Less Severe |
| Loss of Memory | Less Severe |
| Difficulty Swallowing | Less Severe |
| Bedwetting | Less Severe |

Exhibit K

| Resident: | | | | | |
|--|--|-------------|--------------------|--|--|
| Date: | | New | Revised/Re-written | | |
| Problem/Concern/Strength | Goal | Target Date | Start Date | INTERVENTIONS (check appropriate, add start date if added after above CP date) | |
| <input type="checkbox"/> Altered <input type="checkbox"/> At Risk for Altered <input type="checkbox"/> Coping <input type="checkbox"/> Mood <input type="checkbox"/> Behavior R/T: <input type="checkbox"/> Depression <input type="checkbox"/> Dementia <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Psychosis <input type="checkbox"/> OCD <input type="checkbox"/> Insomnia <input type="checkbox"/> Other: AEB: | <input type="checkbox"/> Will have improved mood, by target date aeb: <input type="checkbox"/> Will have improved behavior by target date aeb: <input type="checkbox"/> Will maintain comfort and dignity, qd, through target date, aeb: calm, relaxed manner, and neat clean, odor free appearance. <input type="checkbox"/> Other: <input type="checkbox"/> Other: | | | <ul style="list-style-type: none"> <input type="checkbox"/> Praise appropriate behavior and discourage negative / inappropriate behavior, qd/prn <input type="checkbox"/> Encourage resident to express needs, feelings and concerns to staff, prn <input type="checkbox"/> Provide support and encourage compliance with care, qd/prn <input type="checkbox"/> Monitor for changes in mood and/or behaviors, prn, report to MD/NP as warranted <input type="checkbox"/> Approach in a calm, relaxed manner, explain all care/procedures prior to starting, qd/prn <input type="checkbox"/> Attempt to re-direct when resistive to care, if unable to re-direct, leave resident for a short while and attempt to complete care at a later time, prn <input type="checkbox"/> Encourage daytime activity to promote night time sleep, prn <input type="checkbox"/> Provide support and reassurance when "R" is angry, anxious, or repetitive. Allow ample time to express self and encourage to do so, redirect as needed, prn <input type="checkbox"/> Allow resident to vent thoughts and feelings. Use re-orientation and/or validation as warranted, qd/prn <input type="checkbox"/> Set limits on behaviors; try to re-direct / re-focus resident when experiencing altered thoughts, moods, behaviors, prn <input type="checkbox"/> Redirect when resistive or verbally/physically abusive, prn <input type="checkbox"/> Psychiatric consult prn <input type="checkbox"/> Acknowledge resident's moods in 1:1 interactions, prn <input type="checkbox"/> Observe for signs of improvement or decline in adverse moods and/or behaviors & address as warranted, prn <input type="checkbox"/> Staff to explain all care in simple terms, talk with resident during care, allow resident time to express self, qd/prn <input type="checkbox"/> Provide care in an unhurried, gentle manner, qd <input type="checkbox"/> Encourage family visits and familiar belongings to be in room, prn <input type="checkbox"/> Provide medications as ordered and monitor for positive as well as adverse effects and notify MD/NP as warranted, qd/prn <input type="checkbox"/> Refer to activity POC, prn <input type="checkbox"/> Staff to listen carefully and provide positive conversation when appropriate or needed, qd/prn <input type="checkbox"/> Redirect when repetitive or restless to positive behaviors and provide emotional support, prn <input type="checkbox"/> Provide emotional support and realistic reassurances, prn <input type="checkbox"/> Monitor compulsive behaviors, set limits as warranted. Do not argue or debate. Provide reassurance and praise appropriate behavior, prn <input type="checkbox"/> Encourage to participate in diversional activity, prn | |

| Resident: | | | | |
|--|--|-------------|------------|---|
| Date: | | New | | Revised/Re-written |
| Problem/Concern/Strength | Goal | Target Date | Start Date | INTERVENTIONS (check appropriate, add start date if added after above CP date) |
| <p>is at risk for adverse effects from daily dose of Psychoactive Medications</p> <p>AEB:</p> <p>R/T:</p> | <p>will be free of adverse effects from psychoactive medication use through target date.</p> | | | <p>Administer medication as ordered by physician. NSG</p> <p>Assess for mood or behavior declines or improvements and document as necessary. NSG</p> <p>Encourage physician to evaluate medication dosage periodically and increase or reduce as necessary to treat conditions, illnesses, diseases or disorders. NSG, Pharm</p> <p>May use psychological evaluation to treat conditions, illnesses, diseases or disorders as necessary to reduce use of psychoactive medications or in conjunction with their use. Psycho, NSG</p> <p>Observe for any decline in _____ baseline for ADL tasks and report to physician and therapies for further evaluations as indicated. NSG</p> <p>Document effectiveness of medications as necessary. NSG</p> |