



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

February 3, 2012

Mr. Michael Moore, Administrator
Safe Choices Lowell House
419 Rickaby Road
Lowell, VT 05847-9667

Provider #: 0538

Dear Mr. Moore:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **December 9, 2011**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

A handwritten signature in cursive script that reads "Pamela M. Cota".

Pamela M. Cota, RN, MS
Licensing Chief

PC:ne

Enclosure



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0538	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ JAN 23 12 Licensing and Protection	(X3) DATE SURVEY COMPLETED C 12/09/2011
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NAME OF PROVIDER OR SUPPLIER SAFE CHOICES LOWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 419 RICKABY ROAD LOWELL, VT 05847
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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 unlicensed onsite re-licensing survey and complaint investigation was begun on 11/14/11 and concluded on 12/9/11 by the Division of Licensing and Protection to determine compliance with Vermont's Residential Care Home Licensing Regulations. There were no regulatory violations related to the complaint investigation. Survey findings include:	R100		
R104 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.1 Admission 5.2.a Prior to or at the time of admission, each resident, and the resident's legal representative if any, shall be provided with a written admission agreement which describes the daily, weekly, or monthly rate to be charged, a description of the services that are covered in the rate, and all other applicable financial issues, including an explanation of the home's policy regarding discharge or transfer when a resident's financial status changes from privately paying to paying with SSI or ACCS benefits. This admission agreement shall specify at least how the following services will be provided, and what additional charges there will be, if any: all personal care services; nursing services; medication management; laundry; transportation; toiletries; and any additional services provided under ACCS or a Medicaid Waiver program. If applicable, the agreement must specify the amount and purpose of any deposit. This agreement must also specify the resident's transfer and discharge rights, including provisions for refunds, and must include a description of the home's personal needs allowance policy.	R104	<p>2/1/12 1203 Der Peter Kostuba oversight of R104 R110 provided by NKHS residential mgr.</p> <p>See Attached POC.</p> <p>2/1/12 R104 POC acceptable [Signature]</p>	

Division of Licensing and Protection

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

STATE FORM 6899 OK2V11 If continuation sheet 1 of 12

Michael Moore [Signature] 1/18/12 [Signature]

AME

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R104	Continued From page 1 (1) In addition to general resident agreement requirements, agreements for all ACCS participants shall include: the ACCS services, the specific room and board rate, the amount of personal needs allowance and the provider's agreement to accept room and board and Medicaid as sole payment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to assure that 3 of 3 residents in the survey sample had received information regarding transfer and discharge rights prior to or at the time of admission. Findings include: 1. Per record reviews on 11/15/11, admission agreements for Residents #1, #2, and #3 did not contain required information regarding the resident's transfer and discharge rights. There were no additional supporting documents to indicate that these rights had been provided to the residents and/or legal guardians. During interview that morning, the Manager confirmed that the signed admission agreements of these residents did not contain required information about involuntary transfer and discharge rights and that no addendums to this agreement were available to indicate receipt of these specific rights by the resident and/or legal guardian.	R104		
R110 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.2 Admission 5.2.b. On admission, the home must also determine if the resident has any form of advance directive and explain the resident's right under	R110		

See Attached POC

*2/1/12
R110 POC accepted
[Signature]*

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R110	Continued From page 2 state law to formulate, or not to formulate, an advance directive. Any change of rate or services shall be preceded by a thirty (30) day written notice to the resident and the resident's legal representative, if any. This REQUIREMENT is not met as evidenced by: Based on interview and record review, 3 of 3 residents in the survey sample (Resident #1, Resident #2, and Resident #3) were not screened to determine whether or not they had an advance directive document. Findings include: 1. Per record reviews on 11/15/11, the records of Residents #1, #2, and #3 contained no indication that advance directives had been discussed or whether any resident had already formulated this type of document. During interview that morning, the Manager confirmed that the records did not contain this information.	R110		
R135 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 Assessment 5.7.b If a resident requires nursing overview or nursing care, the resident shall be assessed by a licensed nurse within fourteen days of admission to the home or the commencement of nursing services, using an assessment instrument provided by the licensing agency. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to assure that a timely nursing assessment was conducted for 2 of 3 residents in	R135	<i>See Attached POC.</i> <i>2.1.12</i> <i>R135 POC acceptable</i> <i>RW</i>	

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R135	Continued From page 3 the survey sample (Resident #2 and Resident #3). Findings include: 1. Per record reviews on 11/14/11 and 11/15/11, Residents #2 and #3 required medication administration by unlicensed staff and each had physical conditions requiring nursing overview and/or care. There was no RN signature/date indicating completion or review of the admission assessment instrument as required by regulation. During interview on 11/15/11, the Manager confirmed that there was no indication that the RN had reviewed and/or completed these initial assessments. *This is a repeat violation identified at the last full licensing survey.	R135		
R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 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 staff interview and record review, the home failed to assure that a timely nursing assessment was conducted for 1 of 3 residents in the survey sample (Resident #1). Findings include: 1. Per record review on 11/14/11 and 11/15/11, Resident #1 requires medication assistance and has conditions identified which require nursing	R136	<i>2/1/12 R136: POC acceptable RW</i>	

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R136	Continued From page 4 overview / supervision. There was a completed assessment in the record but there was no signature indicating who had completed the assessment. During interview on 11/15/11, the Manager confirmed that there was no indication that the RN had reviewed and/or completed this assessment as required. *This is a repeat violation identified at the last full licensing survey.	R136		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, 3 of 3 residents were without a nursing care plan (Resident #1, Resident #2, and Resident #3). Findings include: 1. Per record review on 11/14/11 and 11/15/11, there were no nursing care plans available to direct staff in the daily nursing care needs of Residents #1 to #3. During interview 11/15/11, the Manager confirmed that there are no nursing care plans available to staff in the home for these residents.	R145	<i>See Attached POC</i> <i>2.1.12</i> <i>R145 poc</i> <i>acceptable</i> <i>[Signature]</i>	

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R147 R147 SS=D	Continued From page 5 V. RESIDENT CARE AND HOME SERVICES 5.9.c (4) Maintain a current list for review by staff and physician of all residents' medications. The list shall include: resident's name; medications; date medication ordered; dosage and frequency of administration; and likely side effects to monitor; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the home did not maintain a current and accurate list of medications for 2 of 3 residents in the survey sample (Resident #1 and Resident #2). Findings include: 1. Per record review on 11/14/11, the MARs (Medication Administration Records), Emergency Fact Sheets (used for emergency and routine physician visits) and physician orders were not in agreement for Resident #1. Resident #1's Emergency Fact Sheet (dated 10/4/11) indicated that this resident should receive Lithium 300 mg (milligrams) at 8 PM daily. The current physician order sheet indicated that Resident should receive 900 mg Lithium daily. The physician orders indicated Dexiland DR 30 mg daily but the MAR and the Emergency Fact sheet did not reflect this order. During interview at 2:15 PM, the RN (Registered Nurse) confirmed that the Emergency Fact Sheet was incorrect regarding the Lithium dosing and stated that the Dexiland order had been discontinued but was unable to locate the actual order indicating this change. The RN confirmed that there was	R147 R147	<i>2/1/12</i> <i>R147</i> <i>POC</i> <i>acceptable</i> <i>[Signature]</i> <i>See Attached</i> <i>POC</i>	

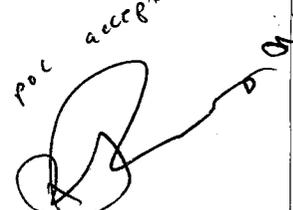
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R147	Continued From page 6 discrepancy between the orders, the MAR, and the Emergency Fact Sheet for Resident #1. 2. Per record review on 11/14/11, the MAR (Medication Administration Record), for Resident #2 indicated that the resident should take TUMS 1 tablet TID (three times daily) with meals and a Multivitamin daily. There was no reconciliation of these medications per review of the most recent orders of 3 authorized prescribers for this resident (psychiatrist, primary care physician and specialist). During interview that afternoon, the Manager confirmed that these medications were not on the most recent physician orders.	R147		
R179 SS=F	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; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens,	R179	<i>See Attached POC.</i> <i>2/1/12</i> <i>R179 POC acceptable</i> <i>[Signature]</i>	

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R179	Continued From page 7 maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the home failed to assure that staff received annual mandatory training per regulation*. Findings include: 1. Per record review on 11/14/11, 5 of 5 staff selected for review had received only Medication Delegation training during the prior year. No staff had completed either the annual hourly requirements nor the 7 required topics for training. During interview that afternoon, the Manager confirmed that education records were not complete. *This is a repeat violation identified at the last full licensing survey.	R179		
R187 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b. (1) A resident register including all discharges, transfers out of the home and admissions. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain a register of all discharges, transfers out of the home and admissions as required*. Findings include: 1. Per record review on 11/15/11, the home had a document to track admitted, transferred, and	R187	<i>See Attached POC</i> <i>2/1/12</i> <i>R187 POC acceptable</i> <i>[Signature]</i>	

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R187	Continued From page 8 discharged residents in a staff manual but had failed to maintain dates of transfer and readmission on a routine basis. During interview at 11:35 AM, the Manager confirmed that s/he was unaware of this document and that upon review it was incomplete. *This is a repeat violation identified at the last full licensing survey.	R187		
R277 SS=D	IX. PHYSICAL PLANT 9.3 Toilet, Bathing and Lavatory Facilities 9.3.a Toilet, lavatories and bathing areas shall be equipped with grab bars for the safety of the residents. There shall be at least one (1) full bathroom that meets the requirements of the Americans with Disabilities Act of 1990 and state building accessibility requirements as enforced by the Department of Labor and Industry. This REQUIREMENT is not met as evidenced by: Based on staff interview and observation, the home failed to assure that bathrooms are properly equipped. Findings include: Per observation and confirmed by staff during initial tour, there were no grab bars for tub/shower or toilets in either resident bathroom.	R277	2/1/12 R277 POC acceptable 	
R293 SS=F	IX. PHYSICAL PLANT 9.7 Water Supply 9.7.b If a home uses a private water supply, said	R293	2/1/12 R293 POC acceptable 	

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R293	Continued From page 9 supply shall conform to the construction, operation and sanitation standards published by the Department of Health. Private water supplies shall be tested annually for contamination, and copies of results shall be kept on premises. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home failed to assure that the residential water supply is free of contamination. Findings include: 1. Per record review on 11/14/11, there was no record of required water testing for bacterial contamination for licensed facilities with well or spring water. During interview that afternoon, the Manager confirmed that the residence is supplied with well water and that there was no record available that the water had been tested annually as required.	R293		
R302 SS=C	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced	R302	See Attached POC 2/1/12 R302 POC acceptable 	

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R302	Continued From page 10 by: Based on staff interview and record review, the home failed to conduct monthly fire drills per the home's policy or per regulatory requirements. Findings include: Per record review on 11/15/11, the home had conducted 5 fire drills in calendar year 2011. The home's policy and procedure manual at 5.5 (page 3) instructs staff to conduct monthly fire drills. Three of the five drills conducted did not indicate the time of day conducted and one of the five drills indicated an hour (5:20) but not time of day (AM or PM). During interview that morning, the Manager confirmed that fire drills had not been conducted per facility policy and that times were not noted on all drills.	R302		
R999 SS=D	MISCELLANEOUS u. "Licensed home" is a residential care home possessing a valid license to operate from the licensing agency. Based on observation, staff interview, and record review, the home provided service to an occupant of an unlicensed building on the property by the home's staff. Findings include: Per observation on 11/14/11 and 11/15/11, Resident #4 received medication administration, transportation, and consumed meals at the home by staff assigned to the home's residents. Per record review, staff performed records documentation daily for Resident #4 and routinely administered medications. During interview on 11/15/11, the Manager confirmed that Resident #4 does not live within the licensed home, that staff of the home provide the same care and	R999		

Facility: Safe Choices Lowell House
Survey Report Date: December 9th, 2011
Plan of Correction Date: January 13, 2012

R104 – V. RESIDENT CARE AND HOME SERVICES

5.1 Admission

5.2.a

Plan of Correction:

- The Lowell House Admission Agreement will be revised to include the required information regarding the resident's rights pertaining to involuntary transfer and discharge. Any new residents admitted to the home will be provided with the revised Admission Agreement.
- Existing Residents (#1 and #2; Resident #3 no longer resides in the home) and/or their legal guardians will be provided with an addendum detailing the resident's transfer and discharge rights as outlined in Regulation 5.2.a.

R110 – V. RESIDENT CARE AND HOME SERVICES

5.2 Admission

5.2.b

Plan of Correction:

- The Lowell House Admission Agreement will be revised to include the applicable regulatory language pertaining to Advanced Directives. The revisions will also include a component that will address whether the resident has any existing directives and will provide information regarding the resident's statutory rights pertaining to advanced directives.
- Existing Residents (#1 and #2; Resident #3 no longer resides in the home) and/or their legal guardians will be provided with an addendum, which will serve to identify any existing advanced directives and provide information regarding the resident's statutory rights pertaining to advanced directives.

R135 – V. RESIDENT CARE AND HOME SERVICES

5.5 Assessment

Plan of Correction:

- Resident Assessments will be completed and signed/reviewed by the agency RN for Resident #2. Resident #3 no longer resides within the facility.
- For any new residents admitted to the home, a Resident Assessment will be completed by the Residential Manager, LPN, or RN and signed/reviewed by the RN within 14 days of their admission date.
- The Residential Manager will notify nursing (RN and LPN) and the NKHS Director of Residential and Risk Management upon admission of a new resident. Nursing will complete an on-site visit within three business days to initiate the Resident Assessment.
- The Residential Manager will coordinate and monitor the timely completion of the assessment in accordance with Regulation 5.5. The Director of Residential and Risk Management will provide additional monitoring and oversight to ensure adherence with the regulatory timeframe.

R136 – V. RESIDENT CARE AND HOME SERVICES

5.7 Assessment

5.7.c

Plan of Correction:

- A new updated Resident Assessment will be completed and signed/reviewed by the agency RN for Resident #1.
- All residents will be reassessed annually and as needed in response to significant changes in the resident's physical or mental condition as mandated in Regulation 5.7.c.
- Given the repeat nature of this violation, a formal tracking tool will be developed to monitor annual reassessment dates. The Residential Manager will maintain this tracking system and, in conjunction with nursing, coordinate the annual completion of the reassessment. The Director of Residential and Risk Management will provide additional oversight, monitoring the tracking system to ensure completion on an annual basis.
- Reassessments will be completed in response to significant changes in the client's physical or mental condition. A discussion of each resident's status will be added to the agenda of each monthly staff meeting. In response to the information reported, the Residential Manager, in conjunction with nursing, will make a determination regarding whether an updated Resident Assessment is required.

R145 Resident Care and Home Services

5.9c 2,4

Plan of Correction:

- At the time of the review Residents 1,2,&3 lacked the necessary documentation required by state regulation 5.9c specifically outlining a plan of care consistent with clients' current residential assessment.
- Lowell house manager and NKHS nurse have already met to discuss this issue. The process of creating a plan of care for each of the afore mentioned clients has already been set in motion. Each plan of care will be the collaborative effort of the nursing staff (R.N. and L.P.N.). These documents will be available for your review shortly.
- The Lowell house residential staff will continue to serve our clients under the strong and strict oversight of NKHS nursing staff in accordance with State Licensing regulations.
- Compliance with these plans will be monitored daily as needed by NKHS Nursing staff and Lowell House Manager as well as quarterly oversight by the NKHS residential manager.

R147 Resident Care and Home Services

5.9 (4)

Plan of Correction:

- Medication Administration Records were found to be inconsistent with regards to discrepancies over a recent change in Client #1' Lithium Carbonate level as well as the discontinuation of the client's dexiland. These discrepancies have been addressed and reconciled by the NKHS nurse Judi Macpherson.
- Client #2's Medication Administration Records contained an inconsistency with regards to Tums being administered TID, and a multivitamin given daily. This issue is also being addressed as well by the nurse to reconcile the appropriate documentation where and

when necessary the NKHS coordinate their efforts through the client's primary care physician.

- Compliance in this regard will be monitored by regularly scheduled internal chart audits by both NKHS Nursing staff, Residential Manager, and Director of Residential and Risk Management at least quarterly and as needed.

R179 Staff Services

5.11b

Plan Of Correction

- NKHS Lowell House will institute corrective action to meet staff training compliance as put forth by the State Division of Licensing and Protection in article 5.11b.
- We have instituted regularly scheduled monthly staff meeting during which we dedicate a minimum of one hour to meet our training requirement as set forth in the licensing regulations. The topics covered during these meetings cover the range required by regulations including but not limited to:
 1. Resident Rights.
 2. Fire Safety and Emergency Evacuation procedures.
 3. Resident emergency response procedures, such as the Heimlich maneuver, accidents police or ambulance contact and first aid.
 4. Policies and procedures regarding mandatory reports of abuse, neglect and exploitation.
 5. Respectful and effective interaction with residents.
 6. Infection control measures, including but not limited to, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions.
 7. General Supervision and care of residents.
- Additionally, trainings on a variety of other topics have and will continue to be offered on an ongoing basis to further round out residential staff's ability to function effectively in the residential setting. Among topics slated to be covered are Critical Incident writing, Vital Document Identification & Client Chart Navigation and Management, Safety Plan Construction, Community Supervision CPR & First Aid Certification as well as ongoing Med Delegation. This training schedule has already been instituted as of October 2011. Attendance of all full time and relief staff is mandatory and is now tracked in appropriate log and stored on site at the main house. Staff will demonstrate necessary level of competence by completion of post training assessments. Assessment will help management identify weaknesses in staff training & development and address them in a timely manner to ensure that the residents receive a higher level of service and support.
- All training records and assessments will be reviewed quarterly by either the Residential Manager or the Director of Residential and Risk Management.

R187 Staff Services

Article: 5.12.b.

Plan of Correction:

- NKHS Lowell House will institute corrective action to remedy inadequate documentation of both residential Admissions & Discharges.

- We have assembled a new Admission & Discharge Log and will re-construct missing records. The log will be kept up to date and on site according to State Dept. of Licensing & Protection regulations.
- The Admission & Discharge Log will reviewed quarterly by the Residential Manager.

R277 Physical Plant

9.3, 9.3b

Plan of Correction:

- NKHS Lowell House will institute immediate corrective action to rectify situations in at least one lavatory with regards to grab bars in both toilet and shower area to maintain compliance with Americans with Disabilities Act of 1990 and State Building accessibility requirements as enforced by the Dept. of Labor and Industry.
- Compliance in this area will be monitored by an Environmental Safety and Compliance checklist reviewed quarterly by either the Residential Manager or the Director of Residential and Risk Management.

R293 Physical Plant

9.7, 9.7b Water Supply

Plan of Correction:

- Lowell uses a private artesian water supply on property that had not been tested in 2011 as annually required by State regulations. NKHS Lowell house has taken corrective action in this regard as of 12/15/2011 the water was tested and found contaminate free. These records are available for review at your request.
- Future compliance in this area will be monitored by an Environmental Safety and Compliance checklist reviewed quarterly by either the Residential Manager or the Director of Residential and Risk Management.

R302 Physical Plant

9.11 Disaster and Emergency Preparedness

Plan of Correction:

- At the time of the review only five of the 12 monthly fire drills had been conducted for the year of 2011. Documentation for fire drills were found to be lacking sufficient information as well.
- NKHS Lowell House immediately instituted corrective action by providing training and adequate oversight to house staff, and is in the process of revising checklist to make sure that information required is represented in the required fields of the document itself.
- Compliance in this matter will be monitored quarterly by either the Residential Manager or the Director of Residential and Risk Management on a Disaster and Emergency Preparedness checklist.

R999 – MISCELLANEOUS

Plan of Correction:

- The cottage located on the property houses a single NKHS Developmental Services client who lives semi-independently. Lowell House staff have been providing supervision, medication administration, transportation, and meals. At the time of the initial Lowell

House licensure, the cottage was utilized as a short term respite bed, which did not require services or support from the Lowell House staff. This change of use occurred gradually, over the course of several years, and was not an intentional misinterpretation of the licensing definitions or regulations.

- Following recent changes to the administrative structure of NKHS's residential program, the current use of the cottage on the Lowell House property was identified as an issue with potential regulatory implications just prior to the licensing survey. Efforts are underway to explore the feasibility of the various alternatives for continued use of the cottage. Current options include applying to incorporate the cottage into the Lowell House licensure, reverting to the buildings original intended use with no involvement by Lowell House staff, or discontinuing use of the cottage. NKHS will consult with DLP regarding the various options and determine a course of action within the next 30 days.

F9999 POC accepted 2/1/12 P. Mesturini

Michael Moore
Lowell House Manager



1/18/12