

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

May 23, 2011

Ms. Nanc Bourne, Administrator
Sterling House At Richmond
61 Farr Road
Richmond, VT 05477

Dear Ms. Bourne:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **March 23, 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,



Pamela M. Cota, RN
Licensing Chief



Division of Licensing and Protection

MAY 20 11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0591	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ Licensing and Protection	(X3) DATE SURVEY COMPLETED C 03/23/2011
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NAME OF PROVIDER OR SUPPLIER STERLING HOUSE AT RICHMOND	STREET ADDRESS, CITY, STATE, ZIP CODE 61 FARR ROAD RICHMOND, VT 05477
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site survey and complaint investigation was completed on 3/23/2011 by the Division of Licensing and Protection.	R100		
R128 SS=E	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.5 General Care</p> <p>5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, the home failed to assure that physician's orders were followed for 2 of 5 applicable residents (Resident #1 and Resident #5). Findings include:</p> <p>1) Documentation reviewed for Resident #5 showed evidence that the physician's orders were not followed for obtaining finger sticks QID [four times a day], or for the administration of sliding scale insulin. Documentation revealed that fingersticks were not obtained QID as ordered by physician on 5 days between 3-23-09 and 4-16-09. In addition, sliding scale insulin was not administered as ordered. On 4/21/09 when the resident's blood sugar was 290 there was no documentation that insulin was administered as ordered at HS. This was confirmed with the manager on 3-23-11.</p> <p>2) Documentation reviewed for Resident #1 showed evidence that the physician's orders were not followed for administering insulin. The physician order was for 3 units of Novolog insulin</p>	R128	<p>See addendum</p>	

Division of Licensing and Protection

My C Be 8/11

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

TITLE *Ex Director*

(X6) DATE
5/12/11

Division of Licensing and Protection

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R128	Continued From page 1 after each meal if Blood Sugar (BS) is greater than 90. Three times between the dates of 1/28/11 and 2/16/11 the Resident's BS was recorded as greater than 90, but documentation showed the insulin was held with no reason documented. In addition there was no documentation that insulin was administered as ordered on 1/17/11 for a BS of 170 and 1/28/11 for a BS of 105. This was confirmed with the manager on 3/22/11.	R128		
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 record review and interview, the home failed to maintain a current care plan for 1 of 5 applicable residents (Resident #2). Findings include: 1) Per record review on 3/23/11, Resident #2 had documented falls on 12/28/10 and 1/27/11. The care plan for Resident #2 did not address interventions to prevent or minimize the likelihood of falls. This was confirmed by the manager on 3/23/11.	R145		
R147 SS=D	V. RESIDENT CARE AND HOME SERVICES	R147		

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R147	Continued From page 2 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 record review and interview on 3/23/11, the nurse failed to maintain a current accurate list of medication dosage and frequency of administration for 1 of 5 applicable residents (Resident #1). Findings include: 1) Per record review on 3/22 and 3/23/11, Resident #1 had a physician order transcribed inaccurately on the Medication Administration Record (MAR). The physician order from 9/24/11 read, 'Hold Novolog Insulin 3 units 9/22/10 after supper meal. Return to 3 units after each meal if BS [blood sugar] is greater than 90.' The order transcribed on the MAR stated: Novolog 3 units after each meal, hold if FS [finger stick to test blood sugar] less than 90 or if she does not eat a good meal. This was confirmed with the manager and nurse on 3/23/11.	R147		
R171 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the	R171		

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R171	<p>Continued From page 3</p> <p>medication regimen as ordered is appropriate and effective. At a minimum, this shall include:</p> <ol style="list-style-type: none"> (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, including the reason why and the actions taken by the home; (3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect; (4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and (5) For residents receiving psychoactive medications, a record of monitoring for side effects. (6) All incidents of medication errors. <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the nurse failed to assure that documentation for PRN medication administration, including date, time, reason for giving the medication and effect was documented for 4 of 5 applicable residents (Resident # 1, Resident #2, Resident #3, Resident #4). Findings include:</p> <ol style="list-style-type: none"> 1) Per record review on 3/22/11, Resident #1 had an order for Mucinex 600 mg (milligrams) 1 tablet by mouth twice a day as needed for cough. The Medication Administration Record (MAR) demonstrated that Mucinex was administered to Resident #1 ten times between the dates of 3/11/11 and 3/22/11 and no effect was documented. This was confirmed by the manager on 3/22/11. 2) Per record review on 3/23/11, Resident #2 had 	R171		

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R171	Continued From page 4 an order for Oxycodone 1/2 tablet 2.5 mg every 6 hours and an additional 2.5 mg every 3 hours as needed for uncontrolled pain. The MAR demonstrated that Oxycodone was administered to Resident #2 on 3/8/11 and 3/14/11 and no effect was documented. This was confirmed by the manager on 3/23/11. 3) Per record review on 3/23/11, Resident #3 had an order for Lorazepam 0.5 mg 1 tablet by mouth every 4 hours as needed. The MAR demonstrated that Lorazepam was administered 45 times between the dates of 3/6/11 and 3/23/11 and the effect was not documented on 33 of the administrations. This was confirmed by the manager on 3/23/11. 4) Per record review on 3/22/11, Resident #4 had an order for Docusate Sodium 100 mg one by mouth twice a day as needed. The MAR demonstrated that Docusate was administered 27 times between the dates of 10/1/10 and 12/5/10 and the effect was not documented on 23 of the administrations. This was confirmed by the manager on 3/22/11. 5) Per record review on 3/22/11, Resident #4 had an order for Robitussin DS 1 teaspoon every 4 hours as needed for cough. The MAR demonstrated that Robitussin was administered on 3/2/11 at 2:45 AM, 11:20 AM and 8:00 PM and no reason for giving the medication or effect was not documented. Robitussin was also administered on 3/7, 3/9, 3/12, and 3/13 and no time given, reason or effect was documented. This was confirmed with the manager on 3/22/11.	R171		
R179 SS=E	V. RESIDENT CARE AND HOME SERVICES	R179		

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R179	Continued From page 5 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, 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 record review and interview, the home failed to assure that all employees providing direct care to residents completed the 7 required annual trainings. Findings include: Per record review on 3/22/11, 4 of 5 direct care providers did not have documentation of attending all of the 7 annual required trainings. This was confirmed with manager on 3/22/11.	R179		

Plans of Correction for deficiencies cited on 3/23/2011:

R128: Sterling House will ensure that each resident's medication, treatment and dietary services are administered in accordance with physician's orders.

Staff was re-inserviced **on 4/28** about sliding scale insulin, adhering to MD orders as transcribed in the medication administration record (MAR) and appropriate documentation of all medications and treatments administered, including the reason for with-holding or omitting a medication or treatment.

As of 3/24/11, the records of blood glucose test results and sliding scale insulin administered to Resident #1 are reviewed daily by staff nurses to ensure complete and accurate documentation by unlicensed staff administering medications/treatments.

Resident #5 has not resided at Sterling House since discharge to the resident's home in August, 2009.

Effective 5/2011, night staff will review all resident MARs each night to ensure that documentation is complete. Any lapses will be brought to the attention of the staff RN the following day and addressed within 24 hours.

The Nurse Manager is responsible for monitoring implementation and evaluation of the effectiveness of this plan.

5/23/11 POC accepted D. Cant RW
R145: Sterling House nurses will ensure that written plans of care are revised and reflect each a resident's current status.

Resident #2's care plan re: fall risk was revised on 3/24/11 to reflect staff interventions to prevent or minimize additional falls.

Resident care plans will be revised as needed to reflect changes in resident condition.

The Nurse Manager and staff RNs will monitor residents weekly for changes in condition and revise care plans as needed.

The Nurse Manager is responsible for monitoring implementation and evaluation of the effectiveness of this plan.

5/23/11 POC accepted D. Cant RW
R147: Sterling House will ensure that each resident's list of medications is complete and accurately reflects physician orders.

Resident #1's order for sliding scale insulin was clarified by the physician on 3/30/11 and is reflected, word for word, on the MAR.

Following the survey, each resident's MAR was reviewed against physicians' orders for accuracy. As of 3/24/11, all transcriptions of new orders are reviewed by 2 RN's to ensure transcription accurately reflects the physician's order.

The Nurse Manger is responsible for monitoring implementation and evaluation of the effectiveness of this plan.

5/23/11 poc receipt D. Carter MD

R171: Sterling House will ensure that the reason and effect of all PRN medications administered is documented as required and per standards of practice.

Care givers responsible for medication administration were provided training on appropriate documentation of PRN medications on **4/28**. Effective 5/2011, night staff will review all resident MARs each night to ensure that documentation is complete. Any lapses will be brought to the attention of the staff RN the following day and addressed within 24 hours.

The Nurse Manager and staff nurses are responsible for monitoring implementation and evaluation of the effectiveness of this plan.

R179: Sterling House will ensure that each direct care-giver is provided training in the 7 mandatory topics annually. Mandatory in-services will be taped allowing staff that is unable to attend the training to view the presentation. Staff nurses will follow-up with affected care-givers to ensure that any questions/concerns regarding the material are answered/clarified.

The Nurse Manager is responsible for monitoring implementation and evaluation of effectiveness of this plan.

5/23/11 poc receipt D. Carter MD