VERMONT

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

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

June 23, 2023

Ms. Kellie Decicco, Manager
Converse Home
272 Church Street
Burlington, VT 05401-4695

Dear Ms. Decicco:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 19, 2022**. 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

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1010	A. BUILDING: _____ B. WING _____	C 12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONVERSE HOME	272 CHURCH STREET BURLINGTON, VT 05401

(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: On 12/19/22 the Division of Licensing and Protection conducted an unannounced on-site investigation of two complaints and one facility reported incident. The following regulatory deficiencies were identified in the course of the investigation:: R126 V. RESIDENT CARE AND HOME SERVICES SS=G 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to provide the care and services necessary to meet the needs of one applicable resident (Resident #1) related to increased frequency of monitoring due to significant changes in presentation, reporting changes observed and medication refusals to the resident's physician, and scheduling a post hospitalization follow up appointment with the resident's physician. Findings include: Resident #1 was admitted to the facility in June of 2021 with diagnoses including Mild Cognitive Impairments, Asthma, and Chronic Obstructive Pulmonary Disease. During his/her residence at the home Resident #1 was diagnosed with Alzheimer's; and Progress Notes document	R100 R126	see attached KD R126-Accepted by Carolyn Scott 6-23-23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1010	A. BUILDING: _____ B. WING _____	C 12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONVERSE HOME	272 CHURCH STREET BURLINGTON, VT 05401

(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
R126	Continued From page 1 significant changes in his/her condition including increasingly aggressive and verbally abusive behaviors, resistance to care, wandering, cognitive decline, and episodes of chest pain and dizziness. Per record review Resident #1 tested positive for Covid -19 infection on 4/6/22. On 4/8/22 s/he was discharged emergently to the hospital due to inability to wear a mask and remain in quarantine, and risk for spread of Covid infection due to attempts to enter other resident's rooms. Resident #1 was readmitted to the home on 4/25/22 while awaiting placement at a nursing home. S/he was noted on return to be ambulating slowly and with difficulty including shortness of breath and inability to walk upstairs without sitting to rest. On 4/29/22 a Progress Note documented paranoid behaviors; and stated s/he appeared tired, unkempt, and had not showered or changed clothing for several days. Per staff interviews conducted during the course of the investigation on 12/19/22, Residential Care Staff stated they observed and reported significant changes in Resident #1's presentation after readmission including walking and talking very slowly, isolating, taking meals in his/her room when previously meals were primarily eaten in the dining room, reduced food intake, difficulty breathing and need to take rests during activities s/he previously engaged in with ease. On 5/1/22 s/he was noted to be unsteady on his/her feet. On 5/2/22 s/he repeatedly refused care including medication administration and incontinence care, and remained in soiled clothing s/he was noted to be wearing at 10:59 AM and at 1:11 PM. On the afternoon of 12/19/22 the Director of Nursing confirmed a post hospitalization follow up appointment with Resident #1's physician was not	R126		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1010	A. BUILDING: _____ B. WING _____	C 12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONVERSE HOME	272 CHURCH STREET BURLINGTON, VT 05401

(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
R126	Continued From page 2 scheduled by the facility nursing staff; and per record review there is no documentation indicating Resident #1's physician was notified regarding medication refusals and the significant change in presentation observed following readmission from the hospital. On the morning of 5/3/22 Resident #1 was found unresponsive on his/her floor at approximately 8:10 AM, and s/he was pronounced dead at 8:27 AM on 5/3/22. Resident #1's actual time of death is unknown, and it is unclear how long s/he was on the floor beside his/her bed. There was a failure to initiate and document frequent monitoring and checks in response to the significant changes observed and noted between readmission to the home on 4/25/22 and his/her death, which was confirmed by the Director of Nursing at 1:24 PM on 12/19/22. While Staff reported attempts were made to check on Resident #1 during the hours leading up to his/her death during interviews conducted on 12/19/22, there is no documentation of staff check-ins or interactions with Resident #1 between administration of evening medications at 7:00 PM on 5/2/22 and when s/he was found deceased approximately 13 hours later. Documentation of shift report notes and a record of direct care services provided after readmission were requested for review, however were unavailable due to the facility practice of destroying this documentation after 3 months, which was confirmed by the Director of Nursing at 1:27 PM on 12/19/22. The Co-Directors and Director of Nursing confirmed the findings listed above on the afternoon of 12/19/22.	R126		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1010	A. BUILDING: _____ B. WING _____	C 12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONVERSE HOME	272 CHURCH STREET BURLINGTON, VT 05401

(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
R128	Continued From page 3	R128		
R128 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Per record review and staff interview there was a failure to ensure administration of medications consistent with physician's orders for one applicable resident (Resident #1). Findings include: Per record review of Physician's Orders and the May 2022 Medication Administration Record (MAR) for Resident #1 provided by the Director of Nursing on request on the afternoon of 12/19/22: * Miralax Powder (Polyethylene Glycol) 17 grams daily as needed for constipation was ordered, however Resident #1's (MAR) included orders for Miralax 17 grams to be administered as a scheduled medication once daily. * Senna (for constipation) once daily as needed was ordered, however Resident #1's MAR included orders to administer Senna as a scheduled medication once daily for constipation. These findings were confirmed by the Director of Nursing on the afternoon of 12/19/22.	R128	see attached KD R128-Accepted by Carolyn Scott 6-23-23	
R136 SS=G	V. RESIDENT CARE AND HOME SERVICES	R136		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1010	A. BUILDING: _____ B. WING _____	C 12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONVERSE HOME	272 CHURCH STREET BURLINGTON, VT 05401

(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
R136	Continued From page 4 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the nurse failed to reassess one applicable resident when significant changes in physical and mental condition occurred, and on readmission after hospitalization. Findings include: Resident #1 was admitted to the facility in June of 2021 with diagnoses including Mild Cognitive Impairments, Asthma, Chronic Obstructive Pulmonary Disease, and Chronic Constipation. During his/her residence at the facility Progress Notes documented significant changes in Resident #1's mental condition including episodes of increasingly aggressive and verbally abusive behaviors, resistance to care, wandering, cognitive decline; and significant changes in his/her physical condition including episodes of chest pain and dizziness, onset of knee pain, shortness of breath, and activity intolerance. Progress Notes also indicate Resident #1 was diagnosed with Alzheimer's on 7/27/21, and Covid -19 infection on 4/6/22. On 4/8/22 Resident #1 was discharged emergently to the hospital due to inability to wear a mask and remain in quarantine, and risk for spread of Covid infection due to attempts to enter other resident's rooms.	R136	see attached KD R136-Accepted by Carolyn Scott 6-23-23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1010	A. BUILDING: _____ B. WING _____	C 12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONVERSE HOME	272 CHURCH STREET BURLINGTON, VT 05401

(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
R136	Continued From page 5 Resident #1 was readmitted to the home on 4/25/22 while awaiting placement at a nursing home, and noted on return to be ambulating slowly and with shortness of breath, and inability to walk upstairs without sitting to rest. On 4/29/22 a Progress Note documented paranoid behaviors; and stated s/he appeared tired, unkempt, and had not showered or changed his/her clothing for several days. Per staff interviews conducted during the course of the investigation on 12/19/22, Residential Care Staff stated they observed and reported significant changes in Resident #1's presentation on readmission including walking and talking very slowly, isolating, taking meals in his/her room when previously meals were primarily eaten in the dining room, reduced food intake, difficulty breathing and need to take rests during activities s/he previously engaged in with ease. On 5/1/22 s/he was noted to be unsteady on his/her feet; and on 5/2/22 s/he repeatedly refused care and remained in soiled clothing s/he was noted to be wearing at 10:59 AM and at 1:11 PM. On the morning of 5/3/22 Resident was pronounced dead after s/he was found unresponsive on his/her floor at approximately 8:10 AM. Per record review Resident Assessments on file included only an initial assessment completed on 6/28/21. At 1:20 PM on 12/19/22 the Director of Nursing confirmed Resident Assessments were not completed when Resident #1 demonstrated significant mental and physical changes; and on readmission to the home after an emergency discharge to a hospital when it was determined the facility was unable to meet Resident #1's needs.	R136		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1010	A. BUILDING: _____ B. WING _____	C 12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONVERSE HOME	272 CHURCH STREET BURLINGTON, VT 05401

(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
R145 SS=G	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 staff interview the nurse failed to ensure the plan of care for one applicable resident was updated to maintain a description of the care and services required to maintain independence and wellbeing for one applicant (Resident #1). Findings include: Per record review the Plan of Care on file for Resident #1 failed to address care and services required related to onset of knee pain attributed to bilateral Osteoarthritis; Covid-19 infection diagnosed on 4/6/22 with significant changes in his/her condition subsequent to infection including shortness of breath, activity intolerance, and changes in eating habits. Additionally there was no plan to provide increased observation and monitoring for Resident #1 on readmission to the facility following an emergency discharge to the hospital due to determination the facility was unable to meet his/her needs; and in response to a significant change in his/her presentation observed and documented on return from the hospital. This finding was confirmed by the Co-Directors and the Director of Nursing on the	R145	see attached KD R145-Accepted by Carolyn Scott 6-23-23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1010	A. BUILDING: _____ B. WING _____	C 12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONVERSE HOME	272 CHURCH STREET BURLINGTON, VT 05401

(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
R145	Continued From page 7 afternoon of 12/19/22. Refer to findings at R126 and R136.	R145		
R162 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the nurse failed to ensure all medication orders were signed by a physician for one applicable resident (Resident #1). Findings include: Per record review there were no signed orders on file for the following medications entered in Resident #1's May 2022 Medication Administration Record: * Risperidone (antipsychotic) 0.25 mg by mouth every 12 hours as needed for agitation * Melatonin 3 mg by mouth at 7 PM daily for sleep. The Director of Nursing confirmed the lack of signed orders for Melatonin and for PRN (as needed) administration of Risperidone on the afternoon of 12/19/22.	R162	see attached KD R162-Accepted by Carolyn Scott 6-23-23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1010	A. BUILDING: _____ B. WING _____	C 12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONVERSE HOME	272 CHURCH STREET BURLINGTON, VT 05401

(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
R167	Continued From page 8	R167		
R167 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Per record review and staff interview the Registered Nurse failed to implement a written plan for the use of one psychoactive PRN (as needed) medication to include instructions for unlicensed staff regarding monitoring of desired effects and undesired side effects for one applicable resident (Resident #1). Findings include: On the afternoon of 12/19/22 the Director of Nursing confirmed the Behavioral Management Plan for the administration of PRN Risperidone to Resident #1 by unlicensed staff did not include instructions for monitoring the desired effects and undesired side effects of the medication.	R167	See attached KD R167- Accepted by Carolyn Scott 6-23-23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1010	A. BUILDING: _____ B. WING _____	C 12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONVERSE HOME	272 CHURCH STREET BURLINGTON, VT 05401

(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
R200	Continued From page 9	R200		
R200 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to maintain a written policy and procedure for emergency response to finding a resident who wants to be resuscitated unresponsive. Finding include: Per record review of written policies and procedures provided on request during the course of the investigation on 12/19/22, it was noted there was no written policy and procedure for emergency response to finding a resident who has a"Full Code" status unresponsive. Full Code Status indicates the resident wants life sustaining interventions including but not always limited to CPR resuscitation to be provided if their heart has stopped breathing or they stop breathing. During separate interviews on 12/19/22 the Director of Nursing and the Nurse Educator both stated the expected staff response if a resident who has Full Code status is found unresponsive is to call 911, then initiate and maintain CPR until emergency responders have arrived. While a written policy and procedure for emergency response when a resident with a documented Do Not Resuscitate status was provided for review, at 1:21 PM on 12/19/22 the	R200	see allached HD R200- Accepted by Carolyn Scott 6-23-23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1010	A. BUILDING: _____ B. WING _____	C 12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONVERSE HOME	272 CHURCH STREET BURLINGTON, VT 05401

(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
R200	Continued From page 10 Director of Nursing confirmed a written policy for emergency response procedures if a resident with Full Code status is found unresponsive had not been developed.	R200		

Plan of Correction Response to Division of Licensing and Protection

Investigation 12/19/22

Plan of Correction Response 1/30/2023

Updated Plan of Correction Response 6/12/2023

R126

Action to correct deficiency:

1. If a resident has a new diagnosis following an office visit, hospitalization, change in condition, etc., the Nurse Shift Supervisor who receives the information will update the diagnosis in the residents Medical Record and update the Service Plan as indicated.
   - The DON & ADON will formalize a procedure for the process of updating a Service Plan.
   - The procedure will be reviewed with the nursing team.
2. Upon return to the home after a hospitalization, the day Shift Supervisor or the ADON will contact the primary care provider within 72 hours to arrange for a post hospitalization office or telehealth visit.
3. The handwritten Shift to Shift Reports remain in the respective nurses' offices for a set period of 3 months. At the end of each month, the Night Charge of Shift will take the oldest month of reports and place in the Co-Executive Directors internal mailbox to be archived for a period of one year, after which the records will be securely destroyed. Night Charge of Shift will be educated on this change immediately by the Co-Executive Director.

Measure/Systemic Change to ensure to recurrence:

1. The ADON will weekly review the electronic progress notes and/or the 24/72-hour shift reports to determine if any events or issues have arisen and assure that the Service Plan is updated to reflect the care and services required to maintain independence and wellbeing for any resident.
2. The ADON will review any resident paperwork after a hospital discharge to ensure contact has been made with the primary care provider.

Monitor:

1. The DON will review the 72 hour reports on Monday, the 24 hour reports on Wednesday, and discuss changes implemented with the ADON during weekly joint meeting.
2. The DON will discuss resident hospitalization discharges with the ADON during weekly joint meeting.
3. The Co-Executive Director of the Nursing Department will monitor receiving the monthly Shift to Shift Reports being archived.

Completion:

1. The implementation process for Service Plan updates will begin after the Nursing Department meeting/education on 2/1/23 and the anticipated POC will be fully implemented by 3/15/23.
2. The implementation process for assuring the primary care provider is contacted and appointment scheduled will begin 2/2/23 with the anticipated POC fully implemented by 3/15/23.
3. The POC for archiving Shift to Shift Reports will be fully implemented beginning 2/1/23.

R 128

Action to correct deficiency:

1. All residents' medication orders will be signed by their Primary Care Provider before entering the order into the residents Electronic Medical Record.
   - The nurse shift supervisor is responsible for ensuring all medication orders are signed by the resident's PCP and there are no duplicate medication orders placed in the Electronic Medical Record.
   - Director of Nursing/Assistant Director of Nursing will review with staff RN's and LPN's the standard procedures for placing medication orders in electronic medical record. (See attached Physician and Telephone Orders Policy)
   - DON/ADON will review with RN's and LPN's the need to check for duplicate medication orders, a medication order that has both a scheduled time and a prn and ensure all medications orders are signed by the resident's Primary Care Provider.

Measure/Systemic Change to ensure no reoccurrence:

1. The DON/ADON/Nursing will weekly review new orders and contact the resident's PCP for clarification of any medication order discrepancies that may be discovered.
2. DON/ADON/Nursing will check resident's record for a supporting diagnosis or problem statement to support a signed medication order.

Monitor:

1. The DON will be monitoring new medication orders by reviewing new orders weekly as mentioned above, as well as working with administrative staff to check on what orders faxed out have not returned signed timely.

Completion:

1. The implementation process for medication orders is effective immediately. This has been our standard of practice, the new additions of monitoring weekly by DON/ADON will also be effective immediately.

R136

Action to correct deficiency:

1. The Shift Supervisor will go into the residents Electronic Medical Record in PCC, using the Quick ADT access, and mark and resident who is sent to the hospital or emergently discharged as "Out of House" with a documenting Progress Note. This is our standard practice for a resident who leaves the home. Less typical practices such as Emergent Discharges documentation will be reviewed with the nursing department.
2. Administrative staff (Co-Executive Director(s) or DON will end date the resident in the Electronic Medical Record in PCC system in the event of an emergency discharge.
3. If an emergently discharged resident is able to come back to Converse Home, the resident record will be treated as a new admission.
4. A new Resident Assessment will be completed within 7-14 days of admission per regulations. (see attached procedure)

(continued) Measure/Systemic Change to ensure to recurrence:

1. A Resident Review occurs weekly at Converse Home during the Operations meeting. At this time we will discuss the individual and note review of the EMAR. The Co-Executive Director(s) will confirm in PCC that all appropriate discharge information can be found in the record and the record is closed.
2. Administrative department will bring a copy of the Resident Assessment to the nurses office and clip next to the computer with residents name on it and date due.

Monitor:

1. The Co-Director of Nursing department will continue a quarterly review of all resident EMARS.
2. The Administrative department tracks Resident Assessment due dates on a spreadsheet and will follow up if the assessment is due and not completed.

Completion:

1. The implementation process for accurate discharge dates is effective immediately and the review process began 1/1/23.

R145

Action to correct deficiency:

1. The ADON will weekly review the electronic progress notes and/or the 24/72-hour shift reports to determine if any events or issues have arisen and assure that the Service Plan is updated to reflect the care and services required to maintain independence and wellbeing for any resident.

Measure/Systemic Change to ensure to recurrence:

1. The DON will review the 72 hour reports on Monday, the 24 hour reports on Wednesday prior to Resident Review meeting.
2. During the weekly Resident Review meeting, any significant changes observed by multiple departments will be discussed. ADON and DON will assure the Service Plan is updated if applicable.

Monitor:

1. The DON and ADON will review print the recently updated Service Plans report monthly and review during a weekly joint meeting.

Completion:

1. The implementation process for Service Plan updates will begin after the Nursing Department meeting/education on 2/1/23 and the anticipated POC will be fully implemented by 3/15/23.

R 162

Action to correct deficiency:

1. Attached you will find a new policy Converse Home implemented effective week of 6/12/2023. The policy is titled **Readmission of Residents from Acute Care or Rehab Facilities**. (See Attached policy)

Measure/Monitor:

1. A Resident Review occurs weekly and at this time a review of all residents out of house in Acute Care or Rehab, residents with a discharge plan, and residents who have arrived in the home will be discussed.
2. The DON/ADON will review all documentation and orders for residents returning or discharged back to Converse Home.

Completion:

1. This policy will be reviewed with the nursing department week of 6/12/2023, it will be integrated into all policy and procedure manuals, and ongoing discussions will occur at the July nurse team meeting.

R167

Action to correct deficiency:

1. The Behavior Plan for the PRN administration of psychoactive medications has been revised to include the monitoring of desired effects and undesired side effects for unlicensed staff to monitor for. (please see attached revised form)

Measure/Monitor:

1. The DON and ADON review Behavior Plans monthly at the same time updated recent Service Plans during a weekly joint meeting.

Completion:

1. All current residents who have an order for PRN psychoactive medications had their plan updated to reflect the revisions above effective immediately.

R200

Action to correct deficiency:

1. A policy has been written to reflect the process for emergency response to finding a resident who has a "Full Code" status and is found unresponsive. (please see attached policy)
2. All RN/LPN's have reviewed the new policy and it has been added to the Policy & Procedure Manual for the Home's Nursing Department.

Measure/Monitor:

1. Discussion will occur again at the nursing meeting on 2/1/23 and is now part of nurse orientation/training.

Completion:

2. This is effective immediately.

The Converse Home

Department: Nursing
Procedure: Resident Assessment Procedure
Updated: 1/2/2023

Procedure:

Resident Assessments:

1. A **Resident Assessment** must be completed for each client upon **admission, annually, and with a significant change**. The Demographic Information Section (A.0, A.1.) and Medication Section (L.1) are the 2 sections that must be completed on the day of admission. You have up to **fourteen days** from the date of admission to complete the remainder of the assessment.

2. If the resident goes to the hospital, then returns, it is not necessary to complete a re-assessment **unless** the resident has experienced a status change. **Most if not all residents will have a change in status post hospitalization-even if temporarily, therefore a reassessment should be done within 7-14 days of return to the Home. The hospitalization should also be recorded in Section A.1 of the assessment.**

GUIDELINES FOR SIGNIFICANT CHANGE

- Deterioration in two or more activities of daily living (ADL). Ex: decreased ability to walk and toilet.
- Loss (or return of) ability to walk freely or use one's hands to grasp small objects (such as a spoon, toothbrush, or comb). Major and significant changes in these areas require close attention and follow up.
- Deterioration in behavior or mood to the point where daily problems arise, or a relationship has become problematic. If changes in psychological status are deemed by mental health professionals are likely to improve without any special intervention, or if the resident is responding to treatment, reassessment is not necessary.
- Unplanned weight loss (5% in 20 days, 10% in 180 days).
- Life threatening event (stroke, heart attack, metastatic cancer, etc.)
- Development of a pressure ulcer.
- Prolonged state of mental confusion or decline in mental alertness.
- A new diagnosis which is likely to effect the resident's well being.
- Improved behavior, mood, or functional status to the extent that the established assessment no longer matches the resident.

CONVERSE HOME

Department: Nursing
Procedure: Service Plan Updates
Effective Date: 2/1/2023

Procedure: How to update resident service plans

When there is any change to a resident's condition, be it a new infection, new diagnosis, fall, wound, etc. the service plan is to be updated to reflect this new status change.

How to document a change in the service plan section of the resident record

1. In PCC go to the "Service plan" tab and click on "edit" tab to go to the current service plan.
2. Click on 'New Focus' tab.
3. Click on the drop-down arrow in the Focus category section".
4. Choose the appropriate focus category and click on it to bring you to the focus list area.
5. Click on the 'add' tab on the appropriate description you wish to use.
6. Choose from the 'etiologies list' the related etiology you wish to use.
7. Hit 'next' tab.
8. In the description box, clarify the (specify) section on how it relates to the etiology.
9. Hit the 'next' tab.
10. Choose the appropriate goal(s).
11. Hit the 'next' tab.
12. Choose the appropriate interventions from the interventions list. Either remove the word (specify) or choose the appropriate item from the list given. Eliminate any portion of the chosen intervention that is not appropriate for this resident or situation.
13. Hit the 'save' tab.
14. You can change the dates of the focus and interventions sections if you are updating the service plan after the actual event/status change. All the dates must be the same.
15. If the issue/status change improves the service plan is updated to indicate that the change has been resolved. This is accomplished by clicking on the edit button next to the focus area and clicking the resolved 'button' and then saving the update. This focus area and ensuing interventions will be archived in the service plan.

WHEN DOES AN ASSESSMENT NEED TO BE DONE?

A resident assessment must be completed for each client upon **admission, annually,** and with a **significant change. The Demographic Information Section (A.0, A.1.) and Medication Section (L.1) are the two sections that must be completed on the day of admission.** You have up to fourteen days from the date of admission to complete the remainder of the assessment. Some facilities use the RA to see if potential admissions are appropriate. These facilities may require the assessment be as complete as possible. If a resident goes to the hospital and returns, **it is not** necessary to complete a re-assessment unless the client has experienced a status change. However, you should record the hospitalization in **Section A.1.**

WHAT IS A SIGNIFICANT CHANGE?

Clients will have good and bad days. Although conditions may fluctuate, these changes do not affect a client's status. For these clients, an assessment is required on an annual basis. Clients may experience what is called a significant change. A significant change may be a decline or an improvement in the resident's health status that is believed to be ongoing (see definition below). If a client experiences a significant change, a new assessment is required and must be completed in 14 days. It is the responsibility of the manager and nurse to monitor changes in client's condition. These changes must be documented in the client's record.

If a client is experiencing a short term illness that affects their physical abilities, behavior, or mood and the changes are expected to only last two or three weeks, then a significant change assessment is not required. A short term illness, or expected short term cognitive changes, should be documented. You should document what changes are being seen, who was consulted about them, any evaluations performed, and state that the changes are expected to be short in duration. Examples would be changes that may be seen with a UTI or cognitive changes seen after a new medication was started. If after three or four weeks the resident does not appear to be returning to baseline, then a significant change assessment should be completed.

GUIDELINES FOR SIGNIFICANT CHANGE

- Deterioration in two or more activities of daily living (ADL) For example, decreased ability to walk and toilet.
- Loss (or return of) ability to walk freely or use one's hands to grasp small objects (such as a spoon, toothbrush, or comb). Major and significant changes in these areas require close attention and follow up.
- Deterioration in behavior or mood to the point where daily problems arise, or a relationship has become problematic. If changes in psychological status are deemed by mental health professionals as likely to improve without any special intervention, or if the resident is responding to treatment, reassessment is not necessary.
- Unplanned weight loss (5% in 30 days, 10% in 180 days.)
- Life threatening event (stroke, heart attack, metastatic cancer, etc.)
- Development of a pressure ulcer.
- Prolonged state of mental confusion or decline in mental alertness.
- A new diagnosis which is likely to effect the resident's well-being.
- Improved behavior, mood, or functional status to the extent that the established assessment no longer matches the resident.

The Converse Home

Department: Nursing
Policy Title: Physician and Telephone Orders
Effective Date: 2/17/2021
Revision Date: 3/16/2023

Policy:

A Provider's Order shall be on file at the Converse Home for every medication and treatment for which staff will be providing assistance.

Physician Order Procedure:

1. Provider's Order's should be obtained from a resident's Providers before he/she moves into the Home.
2. There must be a written order for any new orders, either on a **Provider's Order Sheet, Provider's Visit Note, Prescription, E-Rx prescription** or **Telephone Order Slip**.
3. If the order is for a controlled drug, the proper protocol should be followed.

Telephone Order Procedure:

1. Provider Telephone Orders are used to document in writing provider orders taken over the telephone. Only a licensed nurse may take telephone orders.
2. Write the order as dictated to you and note from whom.
3. Read the order back to the provider, or their designee, to verify correctness.
4. Data enter the order into Point Click Care in the Orders section noting the order was a telephone order. Write a progress note indicating a new order was received.
5. Print the order and place original in the pink folder for reception to fax to MD office for signature. For Traditional put the duplicate copy in the Pending Provider Orders book. A copy of the order is faxed to the pharmacy to be filled. (GV faxes directly to provider office.
6. The original order should be signed and returned by the provider within 15 days.

Doctor Appointments:

1. Residents should take the Providers Visit Note to their provider appointments.
2. The provider will write any new orders on this form, which should then be given to the resident to return to the nursing office.
3. The nurse will review the Providers Visit Note after the resident returns to the Home.
4. The new orders will be faxed to the pharmacy to be filled and placed in the resident's chart. Prescription pad orders are faxed to the pharmacy. This order is placed in the resident's chart.

The Converse Home

Department: Nursing
Policy Title: Readmission of Residents from Acute Care or Rehab Facilities
Effective Date: 6/12/2023

Policy:
Residents will have safe transitions of care from acute care and rehabilitation facilities to The Converse Home. The nurses are responsible for ensuring updated orders are obtained from the resident's PCP and entered into PCC.

- DON will communicate weekly with Case Manager or Nursing Supervisor at Acute Care or Rehab Facility for updates on resident's condition and to inquire about anticipated discharge date.
- DON will assess resident for appropriateness of resident's condition for discharge and readmission to The Converse Home.
- DON/Nursing will obtain all discharge orders prior to accepting the resident for readmission.
- DON/Nursing will call primary care provider prior to resident's discharge to bring to their attention resident is being discharged from acute care or rehabilitation facilities and will be faxing discharge orders to them for review.
- Discharge orders will be faxed by nursing to the primary care provider for immediate review and request updated resident orders.
- Electronic Medical Record will be updated by the nurse per primary care provider's orders.
- If the resident returns to The Converse Home prior to receiving provider's updated orders, previous orders will be resumed. Charge Nurse will follow up with primary care provider to obtain updated orders as soon as possible.

Behavior Management Plan

Resident: _____ **Date of Plan:** _____

Medication Order:

Medication Effects/Side Effects for staff to watch for:

Behavior(s): Please be as detailed as possible.

Interventions:

NOTE: If PRN medication is administered, be specific when documenting the behavior and interventions/resident response. DOCUMENT THE EFFECT BEFORE LEAVING THE SHIFT. If the medication was administered close to shift change, the on-coming med passer is responsible for charting the resident's response to the medication.

CONVERSE HOME

Department: Nursing
Policy: Cardiopulmonary Resuscitation (CPR) and Medical Emergencies
Effective Date: 12/28/2022
Revision Date:

Policy:

It is the policy of The Converse Home to honor legally-executed COLST orders that have been enacted by a resident (or resident's agent).

Procedure:
CPR (cardiopulmonary resuscitation) is a medical order to provide resuscitation to individuals. An order to perform CPR in the event of cardiopulmonary arrest does not affect other therapeutic interventions that may be appropriate.

1. Once an order for CPR has been obtained on the VT State COLST Form it is filed in the back of the resident's health chart. A green dot is placed on the inside of resident's entry door at the top corner to the side of the door frame. A corresponding green dot is placed on the spine of the residents' charts in the nurses' station.
2. When a resident experiences a medical emergency, staff should do the following:
    a. Summon the person in charge of shift or shift supervisor via walkie-talkie
    b. Call 911 for assistance (if indicated)
    c. Verify the resident's code status by checking either the health record or whether there is a green or red dot in the designated spot.
    d. If the resident is a full code and CPR (cardiopulmonary resuscitation) will be performed, the charge of shift/shift supervisor should initiate CPR procedures after determining the resident is in cardiac arrest.
    e. If other staff is available, they should make a copy of the COLST order, give it to the emergency medical personnel and direct them to the resident.
3. Charge of shift/shift supervisor notifies the resident's legal representative and physician of the emergency.
4. Charge of shift/shift supervisor documents in the resident's health record details of the emergency and the actions taken.
5. If a resident is on Hospice services and goes into cardiac arrest, call the Hospice on-call staff if after hours or the main office during regular working hours and await instructions from the nurse.