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

November 29, 2017

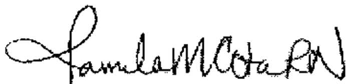
Ms. Kathrynn Titus, Manager
Cathedral Square Senior Living
3 Cathedral Square
Burlington, VT 05401-4429

Dear Ms. Titus:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on November 14, 2017. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1001	A. BUILDING: ______ B. WING ______ NOV 2 0 2017	C 10/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHEDRAL SQUARE SENIOR LIVING	3 CATHEDRAL SQUARE 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: An unannounced on-site survey was completed on 10/24/27 by the Vermont Division of Licensing and Protection. The purpose of the investigation was to review a facility mandated report of an untimely resident death. The following regulatory violations were found.	R100		
R139 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.8 Physician Services 5.8.c Any refusal of medical care and the reasons for the refusal must be documented in the resident's record. If the resident has an attending physician, the physician shall be notified. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that staff documented the reasons for a resident's refusal of care and treatment in the medical record and failed to notify the physician for 1 resident in the targeted sample. (Resident #1) Findings include: Based on interview on 10/24/17 at 11:45 AM, LPN #1 confirmed that s/he had not documented a progress note dated 10/16/17 at 2310 with complete and accurate information of the events of that night. She had received information from a Resident Assistant (RA) at 2250 regarding a change in symptoms for Resident #1. The LPN stated that s/he went to the resident's room and spoke with him/her. The resident explained why they did not wish to have treatment at another facility but the nurse failed to document the reasons and also failed to notify the physician of	R139	Please see attached page for Plan of Correction	12.1.17

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 11.17.17

R139 - R188 POC accepted 11/28/17 MBolton RN/PMC

Division of Licensing and Protection

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R139	Continued From page 1 the change in resident condition and his/her wishes related to treatment. The lack of accurate and complete medical record documentation and the failure to notify the physician of a change in condition was confirmed during interview with the Director of Nurses (DNS) on the afternoon of 10/24/17.	R139		
R170 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.f Residents who are capable of self-administration have the right to purchase and self administer over-the-counter medications. However, the home must make every reasonable effort to be aware of such medications in order to monitor for and educate the residents about possible adverse reactions or interactions with other medications without violating the resident's rights to direct the resident's own care. If a resident's over-the-counter medications use poses a significant threat to the resident's health, staff must notify the physician This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to have evidence of a written policy/procedure to monitor the resident's performance/compliance with self administration of their ordered medications for one applicable resident in the sample. (Resident #1). Findings include: Per record review, Resident #1 had physician orders for self-administration of medication. There was no evidence of a process for staff to	R170	Please see attached page for Plan of Correction	12.1.17

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R170	Continued From page 2 assure that the resident was self-administering their medications in accordance with provider orders and that the resident was educated about possible side effects or adverse reactions they may experience. Additionally, there was no evidence that the facility had a process to assure that the resident's medications were safely stored in a locked secure area of the resident's apartment. The failure to have a written policy/procedure to assure safe resident self-administration of medications was confirmed during interviews with the DNS and the Administrator (ADM) on the afternoon of 10/24/17.	R170		
R188 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(2) A record for each resident which includes: resident's name; emergency notification numbers; name, address and telephone number of any legal representative or, if there is none, the next of kin; physician's name, address and telephone number; instructions in case of resident's death; the resident's assessment(s); progress notes regarding any accident or incident and subsequent follow-up; list of allergies; a signed admission agreement; a recent photograph of the resident, unless the resident objects; a copy of the resident's advance directives, if any completed; and a copy of the document giving legal authority to another, if any. This REQUIREMENT is not met as evidenced by:	R188	Please see attached page for Plan of Correction	11.15.17

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R188	Continued From page 3	R188		

Based on staff interview and record review, the facility failed to assure that the record for one applicable resident in the sample included a copy of the advanced directives and any progress notes related to discussions by the Registered Nurse and /or physician provider of the resident's wishes related to advanced directives upon admission to the ALR (Assisted Living Residence). (Resident #1). Findings include:

Per record review and confirmed by staff interview, Resident #1 had a change in symptoms on 10/16/17 and stated that they did not wish to go to the hospital emergency department (ED) for an evaluation. The resident did have an advanced directive and also had a physician statement that they were a DNR (do not resuscitate) status upon admission to the facility. The copy of the advanced directive was not in the resident's medical record but was brought up to the ALR floor upon request of the surveyor on 10/24/27. Per review, the document, signed and dated 3/27/12, under "1. If my heart stops: I do want CPR to restart my heart." was checked. Although the LPN who was working on 10/16/17 confirmed that they asked the resident if they wanted to go the ED for an evaluation, and the resident stated "no", the LPN failed to record the reasons that the resident stated to h/her at the time of their discussions. The resident's wishes were respected and 911 was not called.

Regarding the advanced directives, there was no documentation in the progress notes from the facility RN or from the resident's provider of any discussions since admission to the facility related to any advance directives or final wishes at that time. These concerns were confirmed during interviews with the ADM and the RN DNS on 10/24/17 at 4 PM

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Plan of Correction for VT State Survey of
Cathedral Square Senior Living

ID Prefix Tag	Provider's Plan of Correction	Complete Date
R139	All nursing staff was educated at time of survey of proper documentation protocol per the AL and RCH Regulations. Any refusal of care will be documented in chart as well as notifying physician. Documentation education will be provided to LPNs on staff by RN monthly as well as auditing of nursing notes to ensure consistent documentation is occurring. LPN corrected and updated documentation from 10/16/17 with accurate information and submitted to surveyor on 10/30/17. Effective immediately, any cultural or religious beliefs that affect care will be documented in chart as well as care planned for. This will be monitored via RN chart/care plan auditing and re-assessment.	Nursing education effective immediately; RN chart auditing 12/1/17
R170	Administrator updated physician's statement to have MD signature on each page and physician's order to include self-administration of medication as suggested by the surveyor on 10/25/17. Medication administration policy has been updated to include direction for staff administering medications to check in with all self-administering residents daily to ensure that they are taking their medications safely and keeping medications secure appropriately. Pharmacy will be including direction in the December MAR for staff to sign off on. This will be monitored through monthly MAR audit by nursing staff.	12/1/17
R188	Effective immediately, all residents will be asked to provide copy of Advanced Directive prior to, or on, date of admission for inclusion in medical record. Administrator will make this part of admission process at time of signing Admission's Agreement and collecting documentation outlined in section V. 5.12.b (2) in the RCH Regulations. Cathedral Square Administrative Assistant has will include this in her monthly audit of resident charts. Effective immediately, all directives will be discussed with nursing staff during initial assessment to ensure that they are consistent with current wishes as indicated by the resident and the physician's statement and orders. If not, resident will be referred to ombudsmen's office to update and physician will be notified. In addition to the nursing note written on date of admission by a licensed nurse in the facility, RN will provide nursing note on all incoming residents within the first week of admission. In line with corrective action for R139, nursing staff will receive documentation education and all cultural or religious beliefs that affect care will be documented in chart as well as care planned for. Both will be monitored via RN chart/care plan auditing and re-assessment.	All actions have been addressed and made effective by 11/15/17.