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

April 19, 2019

Ms. Morgan Ouellette, Manager
Brownway Residence
328 School Street
Enosburg Falls, VT 05450-5500

Dear Ms. Ouellette:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 26, 2019.** 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0118	A. BUILDING: _____ B. WING _____	C 02/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNWAY RESIDENCE	328 SCHOOL STREET ENOSBURG FALLS, VT 05450

(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 OEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite investigation into a complaint and a related self-report was conducted by the Division of Licensing and Protection on 2/26/19. The following regulatory violation was identified.	R100		
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 staff interview, the home did not ensure the care plan was updated to reflect the current status for 1 of 2 residents (Resident #1). Findings include: Per record review, Resident #1 had long term use of an indwelling Foley catheter. The resident's plan of care indicated that the staff had been delegated and trained to complete catheter care of emptying the bag, switching to a leg bag, and washing out the bag with a vinegar solution. The resident was sent to the emergency room with hematuria (blood in urine) and a clogged catheter on 1/20/19, and back to the home with Urologist physician's orders to flush the catheter as needed (PRN) with 60 ML of sterile saline every 8 hours if it was clogged. This order was transcribed to the	R145	See Attached	

R145 - R146 POC accepted 4/17/19 KCampos RN/PME

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R145	Continued From page 1 resident's Medication and Treatment Administration record. There was no training conducted by the registered nurse to delegate to unlicensed staff regarding the PRN flushes of the catheter if it was clogged. The resident's care plan had the appropriate interventions listed for staff to complete catheter care, however was not updated to reflect the new order for flushes, including who was allowed to perform that task. On 2/26/19, the home manager confirmed that the care plan had not been updated to reflect the addition of flushes PRN as ordered, and that the home health nurse would be the only one responsible for flushing the catheter.	R145		
R146 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.9.c (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the home failed to ensure that the Registered Nurse provided instruction and supervision for delegated nursing tasks for 1 of 2 residents reviewed (Resident #1). Findings include: Per record review, Resident #1 has lived at the home since 2015. The resident has a history that includes prostate cancer, and has an indwelling Foley catheter that has been managed by the	R146		

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R146	Continued From page 2	R146		

local home health agency since Nov. 2017. The home health registered nurse is responsible for changing the catheter monthly, and responding to concerns related to the catheter. The resident has a history of pulling apart the catheter tubing and spilling urine on the bed, which according to staff is a behavior to get attention from the staff, who then need to spend time changing the bed and cleaning the resident. There were also multiple incidents of Resident #1 actually pulling out the catheter with the balloon still inflated, which sometimes caused bleeding. This was well documented by the Home Health nurse, and the resident was educated regarding the risk of infection by opening the closed system. The resident developed hematuria (blood in urine) as noted by the staff on the weekend of 1/19-1/20/19. The home health nurse recommended that the resident go to the emergency room, where they replaced the catheter, and diagnosed a urinary tract infection.

The resident was sent back to the home with Urologist physician's orders to flush the catheter as needed (PRN) with 60 ML of sterile saline every 8 hours if it was clogged. This order was transcribed to the resident's Medication and Treatment Administration record, which unlicensed med-delegated staff use to administer prescribed medications and treatments to residents. The staff had been delegated and trained to complete catheter care of emptying the bag, switching to a leg bag, and washing out the bag with a vinegar solution. There was no training conducted by the registered nurse to delegate to unlicensed staff the PRN flushes of the catheter if it was clogged. There was no evidence to indicate any of the staff had attempted to flush the catheter until the following incident.

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R146	Continued From page 3	R146		

Per interview on 2/26/19 at 1:10 PM, the resident care aide on the evening shift stated that on 2/15/19 at about 5:40 PM, Resident #1 came to him/her and said that they were bleeding "down there". The aide took the resident to the bathroom, and saw that there was frank blood in both the catheter bag as well as coming out around the tubing leading to the bag. They got the resident into bed and cleaned them up, as well as telephoning the on-call nurse, who is an LPN. The on-call LPN asked the aide if they were comfortable flushing the catheter with instruction over the phone, and the aide agreed. The LPN on call told the aide to call the home health nurse. The registered nurse from home health responded to the call, and arrived at the facility around 7:25 PM. When the RN deflated the catheter balloon with the syringe, they discovered the aide had inserted the saline into the port going to the balloon, instead of disconnecting the tubing to flush it, and determined there was more than 60 ML of saline in the balloon. As it was deflated, the resident had decreased pain and swelling to the area, and the catheter was removed. Due to the large amount of frank red blood and clots noted, the resident was sent to the emergency room by 8:00 PM.

According to another aide interviewed who worked the night shift, Resident #1 was sent back to the home shortly after midnight, with instructions to call the emergency room if bleeding continued. The aide called the emergency room nurse, who told the aide that there was trauma to the area and the blood needed to clot. The aide stated that the bleeding had slowed significantly and that they were keeping a close eye on the resident overnight. At 7:30 AM on 2/16, the registered nurse of the home came to the facility to perform med

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R146	Continued From page 4 delegation tasks, and saw the resident. The RN stated that the bleeding had stopped at that point, but told the aides to call the home health nurse to evaluate if they started bleeding again or had increased pain. The aide stated that the bleeding became active again, and they called the home health nurse who arrived at 10:30 AM. The home health RN was very concerned with the bleeding, as well as the pale skin color and weakness of the resident. The resident was transported to the emergency room, and later transferred to UVMMC hospital due to low blood pressure and needing a blood transfusion. The resident was treated and returned to the home with no further bleeding since that time. Per interview on 2/26/19 at 10:30 AM by telephone, the RN for the home confirmed that they had not delegated catheter flushes to the unlicensed staff, and they had only been trained to do routine catheter care of emptying the bags, switching to a leg bag, and cleaning the bags. The changing of the catheter was the responsibility of home health. Per interview on 2/26/19, the home manager confirmed that the delegation of catheter flushing by an LPN to an aide over the phone was not appropriate, and that home health is responsible for managing the catheter.	R146		

R145

5.9.c 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

1. Action to correct the deficiency

Intervention added to the plan of care that states "Franklin County Home Health are the only ones to irrigate foley catheter with 60cc normal saline every 8 hours as needed"

Expected completion date: 2/27/2019 with surveyor onsite

2. Measures to assure that it does not recur

Facility LPN is aware that Home Health is responsible for all aspects of foley catheters, wound care and other skilled services. Facility LPN understands that she is not to schedule, on the MAR or the care plan, tasks which should be deferred to Home Health.

During a meeting, following this incident, Home Health understands the need for greater supervision and oversight regarding the clients they serve. They have agreed to maintain their own file, here at the facility, which will include their care plan and interventions specific to their clients. Facility care plans will outline whether or not clients are receiving home health services and if so, the facility will defer to the treatment plan provided by home health.

Expected completion date: Ongoing

3. How corrective actions will be monitored

Home Health will be responsible for reporting any changes in their services and the facility will be responsible for reporting any difficulty accessing home health services. This will be done through more frequent communication between our two agencies as well as through the new Home Health treatment plan file for all clients receiving services.

Expected completed date: Ongoing

R146

5.9.c Provide instruction and supervision to all direct care personnel regarding each residents health care needs and nutritional needs and delegate nursing tasks as appropriate

1. Action to correct the deficiency

Facility LPN has received coaching about not delegating tasks to direct care staff over the telephone and understands that all interventions related to the service (i.e. catheter care, colostomy care, wound care or hospice care) that Home Health is providing should be deferred back to Home Health.

Expected completion date: 2/27/2019

4/11/19

2. Measure to assure that it does not recur

Facility LPN understands that she is not to schedule, on the MAR or the care plan, tasks which should be deferred to Home Health.

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Expected completion date: Ongoing

4/14/19