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

December 20, 2024

Amanda St. Cyr, Manager
Brownway Residence
328 School Street
Enosburg Falls, VT 05450-5500

Dear Ms. St. Cyr:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 6, 2024.** 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.

If you have any questions, please feel free to contact me at (802) 585-0995.

Sincerely,

Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

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 11/06/2024

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 DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: On 11/6/24 the Division of Licensing and Protection conducted an unannounced on-site investigation of one complaint. The following regulatory deficiencies were identified:	R100		
R128 SS=G	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: Based on staff interview and record review there was a failure to ensure treatments for diabetic foot ulcers were consistent with provider's orders for one applicable resident (Resident #1). Findings include: The home's Resident Care & Home Services Policy is consistent with this regulatory requirement. 1. Documentation of wound care provided as ordered was not on file and available for review in Resident #1's record. Resident #1 has a history of frequent diabetic foot ulcers and wound infections. His/her left leg is amputated below the knee, and the toes on his/her right foot are amputated. Per record review Resident #1 received treatment for multiple foot wounds between 6/4/24 and 11/6/24. During the investigation conducted on 11/6/24, the home's Nursing Team was requested to provide documentation of wound care provided as	R128	See attached	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amanda Stiles — TITLE: Executive Director — (X6) DATE: 12/20/24

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R128	Continued From page 1 ordered by the home's Registered Nurses (RNs), home health agencies, and his/her medical providers for Resident #1's wounds since 6/4/24. On the afternoon of 11/6/24, documentation wound care treatments provided as ordered for Resident #1 was not on file and available for review as follows: a. On 6/20/24 Resident #1's Primary Care Provider (PCP) ordered home health wound care for an open ulcer with signs of infection scheduled daily on weekdays, with a plan for wound care to be provided at the PCP's office until home health services began. On the afternoon of 11/6/24 documentation of wound care provided as ordered by Resident #1's PCP and /or a home health provider was not on file and available for review on request. Records obtained by the home's nursing staff on the afternoon of 11/6/24 indicated wound care was provided at the PCP's office on 6/21/24 and 6/25/24. Documentation of wound care provided by the home's nurses for this wound was also not on file and available for review on request. b. On 7/2/24 Resident #1's Podiatrist ordered daily bandage changes for a diabetic foot ulcer. Documentation of daily bandage changes or refusals as ordered were on file and available for review in Resident #1's record. c. On 10/10/24 Resident #1 saw his/her PCP for open wounds on the heel and side of his/her right foot. A Nursing Note documented a "Late Entry" at 8:57 AM on 10/11/24 indicated antibiotics were received from the pharmacy, however a signed order had not been received from the PCP. An order was requested from the PCP, however there is no documentation of a request for a copy of the PCP's electronically signed order from the	R128	See attached	

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R128	Continued From page 2 pharmacy which would allow the home to administer the antibiotics in the absence of a signed order directly from the PCP. A 4 day delay in Resident #1 receiving antibiotics resulted, during which there is no documentation of Nursing care provided including wound assessments and monitoring for signs of infection. d. On 10/14/24 the home received the requested antibiotic orders from the PCP along with a referral to a home health provider for wound care, and urgent referrals for an x-ray and a podiatry appointment. Resident #1's record does not include documentation of the ordered wound care provided by a home health agency, the PCP's office, or the home's nursing team. Documentation related to an x-ray of this wound or an appointment with the podiatrist in response to notification regarding the urgent referrals ordered was not on file and available for review in Resident #1's record. e. On the evening of 10/15/24 Resident #1's foot was evaluated at the Emergency Department. S/he returned to the home with a diagnosis of Cellulitis (infection caused by bacteria entering impaired skin) and an order for a different antibiotic. A Nursing Note entered at 6:29 AM on 10/17/24 states the PCP had ordered wound assessments on 10/16/24 and 10/18/24 with instructions to report any changes, measurements of the reddened area around the wound, and drainage or odor to the PCP. A Nursing Note at 10:02 AM on 10/17/24 states, "Wound Assessment: For 10/18/24 nurse visit at PCP scheduled" with no additional information; and a Plan of Care Note dated 10/18/24 includes only the wound description provided by the PCP and "antibiotics prescribed PCP prescribed	R128	Plans of Correction for R128 and R145 accepted by Jo A Evans RN on 12/20/24. Please see the attached document to review corrective actions for each individual tag. See attached	

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R128	Continued From page 3 following up with PCP [sic]". Resident #1's record does not include documentation of wound assessments completed and reported to the PCP as ordered. Notes obtained from the PCP by the home's Nursing Staff on the afternoon of 11/6/24 indicated wound care was provided at the PCP's office on 10/18/24 and 10/22/24. On 10/24/24 Resident #1 was transported via ambulance from the PCP's office to the Emergency Department. Resident #1 was diagnosed with Osteomyelitis and hospitalized until 11/1/24. f. Per hospital discharge documents, Resident #1's bone biopsy was positive for a rare Group B streptococcus and two additional bacteria. Hospital providers ordered outpatient wound care provided by skilled nursing at the home and the PCP on discharge. The hospital's discharge care plan also listed interventions including avoiding dorsiflexion of the foot, offloading heel at all times, and aggressive elevation. Resident #1's record did not include documentation of wound care provided between hospital discharge on 11/1/24 and the afternoon of 11/4/24. Resident #1's record does not contain documentation of care provided related to additional interventions ordered in the hospital discharge plan During an interview with the home's Nursing team commencing at 1:30 PM on 11/6/24, the home's RNs confirmed there were no specific written plans to monitor for skin integrity, wound care, and signs of infection in response to Resident #1's wounds; and stated these services were not provided by the home because Resident #1 was receiving this care from the PCP and home health. The home's Owner, who is an RN, stated the home does not provide wound care.	R128	See attached	

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R128	Continued From page 4 During an interview commencing at 4:55 PM on 11/6/24 a RN on duty stated the home health agency that provided wound care for Resident #1 was contacted by the home on the afternoon of 11/6/24; and it was confirmed Resident #1 had not received care from the home health agency since s/he was discharged from home health wound care services in April of 2024. The RN stated the home health agency confirmed receipt of a referral for home health wound care in June of 2024; however the home health agency indicated they did not provide this service. The RN stated Resident #1's wound care was provided by the PCP "a few times a week" in June, however documentation of this wound care provided by the PCP was not maintained on file in Resident #1's record. .	R128	See attached	
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 there was a failure to ensure development of a Care Plan which describes the care and services necessary to assist one applicable resident in	R145		

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R145	Continued From page 5 maintaining independence and well-being (Resident #1). Findings include: The home's policies and procedure indicate resident's care plans shall be updated, reviewed, and signed by a licensed nurse quarterly and updated as needed. Per record review Resident #1 is diagnosed with Diabetes Mellitus and multiple associated conditions including: * Diabetic Retinopathy (damage to the blood vessels of the eyes) * Diabetic Nephropathy (damage to the blood vessels in the kidneys) * Stage 5 Chronic Kidney Disease requiring hemodialysis three days a week * Diabetic Polyneuropathy (nerve damage in multiple areas) * Frequent wounds and infection. 1. Resident #1 has a history of Methicillin-resistant Staphylococcus aureus infection (MRSA, also known as Flesh Eating Disease) and Osteomyelitis which is a life threatening spread of infection to bone. Resident #1's left leg is amputated below the knee and the toes on his/her right foot are amputated. S/he primarily uses a wheelchair, although s/he has a prosthetic leg which is used infrequently. Resident #1 self-propels his/her wheelchair by planting the heel of his/her remaining foot and pulling forward, which causes significant mechanical friction and pressure to the heel. Resident #1 has been treated for multiple foot wounds requiring medical treatment and antibiotics during 2024, including a wound which required hospitalization and intravenous antibiotic treatment of Osteomyelitis from 10/24/24 - 11/1/24. Per Resident #1's Podiatrist's notes, this hospitalization resulted	R145	See attached	

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R145	Continued From page 6 from a wound infection that traveled to his/her heel bone and left his/her Achilles tendon exposed. Per record review, Resident #1's Care Plan on file on 11/6/24 lists general interventions including staff monitoring for any changes in skin and reporting to nursing, monitoring for skin integrity, and monitoring for pain. Specific instructions for completion of the routine monitoring identified are not included in the plan of care. Similarly, specific instructions to address tracking of wound progression, infection prevention, and infection control measures are not included in Resident #1's Care Plan. Interventions to address actual wounds and infections were also not identified in Resident #1's plan of care including instructions in the discharge summary following Resident's hospitalization from 11/24/24 - 11/1/24. Discharge instructions provided by the hospital included avoiding dorsiflexion of his/her foot, offloading the affected heel at all times (to prevent pressure and promote circulation), and utilizing "aggressive elevation" of the foot. Specific instructions for Staff regarding these interventions were not included in Resident #1's Care Plan. Nursing tasks including implementation of hospital instructions for twice daily dressing changes, along with implementation of standard nursing practices to monitor for wound healing and signs of infection, were also not included in a plan of care for Resident #1 following discharge from the hospital on 11/1/24. During an interview with the Nursing Team commencing at 1:30 PM on 11/6/24, the facility's Registered Nurses acknowledged the Care Plan of file for Resident #1 does not address care and services necessary to maintain the resident's independence and well-being.	R145	See attached	

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R145	Continued From page 7 2. Per interviews conducted with the home's nursing staff on the afternoon of 11/6/24, Resident #1 demonstrates significant resistance to care including refusing assistance with showering, medication refusals, and lack of communication regarding his/her needs. While Resident #1's Care Plan identifies Medication Management as an area of focus, interventions with specific instructions related to medication refusals and reporting of refusals to Resident #1's providers are not included in his/her plan of care. Similarly, Resident #1's care plan indicates s/he requires 1 assist with showering, however specific interventions related to resistance to care and refusal of staff assistance with showering are not included in his/her plan of care. During the interview commencing at 1:30 PM on 11/6/24, the home's Owner confirmed Resident #1 refuses any assistance with showers.	R145	See attached	

Plan of Corrections

R128
Plan of Correction
accepted by
Jo A Evans RN
on 12/20/24

R128. The Nursing department will develop and initiate record release forms, have sent to all providers to ensure orders, provider notes are sent to facility which will allow nursing staff to implement medication and treatment orders. Licensed nursing will have completed by 1/20/24. Records release will also be included in admission packets.

Audits of all residents will be conducted by licensed nurses for record release signatures and completed within the 30 days. The nursing department will call the provider's office upon residents return form visits to request visit notes be sent over if not readily available after return of appointments.

Skin Assessment Tool will be completed by Nursing staff in 1 week and completed by 12/27/24. Licensed Nurse will audit monthly for one month and then quarterly.

R145
Plan of Correction
accepted by
Jo A Evans RN
on 12/20/24

R145. Licensed Nursing will review and update care plans for wounds, infection control, related care needs and refusal of care. Care plans will be completed by licensed nursing staff by 12/27/24. Care plans reviewed by licensed nurses quarterly and as needed with changes. Providers will be updated with refusal of cares and any changes in skin/wounds.

Weekly skin meetings will be held by the nursing department for review of any resident with skin impairment or at risk for skin impairment, infection control or at risk for infections.

Skin Assessment Tool will be utilized and monitored by nursing department weekly and as needed to identify any changes in wounds. The provider will be updated with any changes in condition. Skin Assessment completed on residents with wounds by 12/27/24.