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 5, 2019

Ms. Jennifer Silva, Manager
Davis Home
45 State Street
Windsor, VT 05089-1213

Dear Ms. Silva:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 6, 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
	0021	A. BUILDING: ________ B. WING ________	C 03/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS HOME	45 STATE STREET WINDSOR, VT 05089

(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 complaint investigation was conducted by the Division of Licensing and Protection on 3/6/19. The following regulatory violations were identified:	R100		
R114 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.3 Discharge and Transfer Requirements 5.3.a Involuntary Discharge or Transfer of Residents (2) In the case of an involuntary discharge or transfer, the manager shall: i. Notify the resident, and if known, a family member and/or legal representative of the resident, of the discharge or transfer and the specific reasons for the move in writing and in a language and manner the resident understands at least 72 hours before a transfer within the home and thirty (30) days before discharge from the home. If the resident does not have a family member or legal representative and requests assistance, the notice shall be sent to the Long Term Care Ombudsman, Vermont Protection and Advocacy or Vermont Senior Citizens Law Project. ii. Use the form prescribed by the licensing agency for giving written notice of discharge or transfer and include a statement in large print that the resident has the right to appeal the home's decision to transfer or discharge with the appropriate information regarding how to do so. iii. Include a statement in the written notice that the resident may remain in the room or home	R114		

R114 - R226 POC accepted 4/4/19 MBertrandRN/PMC

Division of Licensing and Protection

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R114	Continued From page 1	R114		

during the appeal.

iv. Place a copy of the notice in the resident's clinical record.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to provide a written involuntary discharge/transfer notice to a resident and/or the legal representative for 1 applicable resident in a sample of 2, (Resident #1). The detailed findings include the following:

Per review of the progress notes dated 1/17/19 and signed by the RN Manager, identifies that Resident #1 had developed shortness of breath overnight and increased pedal edema (ankle swelling). The resident was unable to stand or walk in the AM. The hospice nurse was contacted by the facility manager to discuss transfer to another facility. Since Resident #1 resided on the second floor, the facility's concern was inability to manage the stairs in the case of an emergency, despite the presence of a stair glider. Resident and family notified by the facility manager on 1/17/19, of the facility's request to transfer. Family questioned how quickly a transfer would need to happen and the facility manager stated ["if they have a bed tomorrow that would be great because we can't evacuate him/her"]. Resident #1 was discharged on 1/18/19 via family vehicle to another residential care home.

Per facility Discharge Policy identifies that if the Davis Home implements an involuntary discharge the manager will, notify the resident, family member and/or legal representative of the

Provider's plan of correction (handwritten):

3/7/19
Policy for involuntary discharges in place.
have made discharge check list to make sure does not happen again. with all steps included.

date completed 3/7/19

RN Manager will follow requirement + do assessment

HAVE Policies in place.

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R114	Continued From page 2 discharge or transfer and the specific reasons for the move in writing and in a language and manner the resident understands at least 72 hours before a transfer within the home and thirty (30) days before discharge from the home. The notice to include a statement in large print that the resident has the right to appeal the home's decision to transfer/discharge with the appropriate information regarding how to so. The Registered Nurse (RN) Manager confirms on 3/6/19 at approximately 9:23 AM that the resident and/or family were not provided with the appropriate involuntary discharge/transfer notice prior to transfer/discharge, nor were they provided with the appropriate information related to the request of an appeal. The facility RN also confirms at this time, that the facility policy was not followed, that s/he did not conduct a significant change assessment identifying the resident's current status nor did the facility contact the licensing agency to request and emergency transfer.	R114	Give formal discharge notice - with all requirements will contact licensing agency for guidance due to inability for Resident to Evacuate Could not ambulate down a flight of Stairs in emergency. Staff unable to assist due to size (can't use stair glide in emergency size or power outage)	
R116 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.3 Discharge and Transfer Requirements 5.3.b Emergency Discharge or Transfer of Residents (1) An emergency discharge or transfer may be made with less than thirty (30) days notice under the following circumstances: i. The resident's attending physician documents in the resident's record that the discharge or transfer is an emergency measure necessary for the health and safety of the resident or other	R116	will call Physician discuss and get order for emergency Discharge will send paperwork to licensing agency.	

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R116	Continued From page 3	R116		

residents; or

ii. A natural disaster or emergency necessitates the evacuation of residents from the home; or

iii. The resident presents an immediate threat to the health or safety of self or others. In that case, the licensee shall request permission from the licensing agency to discharge or transfer the resident immediately. Permission from the licensing agency is not necessary when the immediate threat requires intervention of the police, mental health crisis personnel, or emergency medical services personnel who render the professional judgement that discharge or transfer must occur immediately. In such cases, the licensing agency shall be notified on the next business day; or

iv. When ordered or permitted by a court.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to request an emergency discharge/transfer to the licensing agency nor did the facility have physician documentation supporting the need for the emergency transfer, for 1 applicable resident in a sample of 2, (Resident #1). The detailed findings include the following:

Per review of the progress notes dated 1/17/19 and signed by the RN Manager, identifies that Resident #1 had developed shortness of breath overnight and increased pedal edema (ankle swelling). The resident was unable to stand or walk in the AM. The hospice nurse was contacted by the facility manager to discuss transfer to another facility. Since Resident #1 resided on the second floor, the facility's concern was inability to manage the stairs in the case of

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R116	Continued From page 4	R116		

an emergency, despite the presence of a stair glider. Resident and family notified by the facility manager on 1/17/19, of the facility's request to transfer. Family questioned how quickly a transfer would need to happen and the facility manager stated ["if they have a bed tomorrow that would be great because we can't evacuate him/her"]. Resident #1 was discharged on 1/18/19 via family vehicle to another residential care home.

Per review of the medical record, the physician assistance (PA) saw the resident on 12/18/18, 9/25/18, 9/18/18 and 7/13/18. There is no evidence in the medical record evidencing that the physician or the physician assistant were notified of the resident's current change in status (shortness of breath and/or inability to stand or walk).

The facility RN confirms on 3/6/19 at approximately 9:23 AM, that s/he did not contact the physician and/or the physician assistant to communicate the change in Resident #1's status and a request for a transfer.

Provider's plan of correction (handwritten): * will request emergency discharge. Can not use Stairglide if Fire or power outage.

R136 SS=D — V. RESIDENT CARE AND HOME SERVICES — R136

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.

Provider's plan of correction (handwritten): Will do Assessment
call provider
Request Emergency D/C
contact licensing agency

Division of Licensing and Protection

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R136	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to conduct an assessment at the time of a change in physical condition for 1 of 5 sampled residents, (Resident #1). The detailed findings include the following: Per review of the progress notes dated 1/17/19 and signed by the RN Manager, identifies that Resident #1 had developed shortness of breath overnight and increased pedal edema (ankle swelling). The resident was unable to stand or walk in the AM. Per review of the medical record, the physician assistant (PA) saw the resident on 12/18/18, 9/25/18, 9/18/18 and 7/13/18. There is no evidence in the medical record demonstrating that the physician or the physician assistant were notified of the resident's current change in status of shortness of breath and/or inability to stand or walk. The facility RN confirms on 3/6/19 at approximately 9:23 AM, that s/he did not conduct a significant change assessment identifying the resident's current status nor did the facility contact the physician to communicate the change in Resident #1's status.	R136	- RN will do assessment with any significant change in status. - and Then update MD with status change. - RN's will have weekly meeting to discuss + review Residents with condition changes. will be documented in resident record and update care plan as needed. Will Add to careplans section to prompt for significant change assessment. to be done. - This will be monitored by weekly review with condition changes	
R178 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.a There shall be sufficient number of qualified personnel available at all times to	R178	R178 Purchased Call bell System. Call bell can be at bedside or around Neck.	Will Add to care plan by 4/5/19. Nurses already review weekly so the prompt on care plan will be effective

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R178	Continued From page 6	R178		

provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview and confirmed by staff interview, the facility failed to provide a safe environment to assure prompt and appropriate action in cases of injury, illness, fire or other emergencies for 6 residents residing on the second floor, and 2 of the 6 residents are diabetics who could require emergency treatment,(Residents #2 and #3). The findings include the following:

1. Per observation during an investigation, it was discovered that six (6) residents who reside on the second floor of the facility, have no mechanism to notify staff, of any need during the over-night shift or at any time. One (1) of the six (6) residents who lives upstairs is designated as an Enhanced Residential Care (ERC) resident, (nursing home level of care), who require assistance managing the stairway and/or the stair glide. There is no elevator in the building. Two (2) of the residents are diabetic and one (1) of the two (2) receives insulin injections twice a day for the management of unstable blood sugars.

2. Per interview with Resident #2 and #3, who are both diabetics, were asked by the surveyor in the presence of the manager, what would they do if they were to have a problem with their Diabetes and needed assistance? Both residents confirm on 3/6/19 at approximately 10 AM that they do not have call lights or a way of contacting the nursing staff. Neither resident was able to communicate what they would do if they needed assistance. Random residents on both floors were asked if

Provider's plan of correction (handwritten):

Every bathroom has a call bell as well. There is a central monitor which indicates a number correlating with resident or bathroom, and portable pager.

CAll Bell system currently in place and operating in All Rooms + bathrooms.

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R178	Continued From page 7 they had a way of contacting the staff if they needed assistance and responded they would have to yell. The facility manager confirms during the interview on 3/6/19 at approximately 10 AM, that there is a plan to purchase a call light system that would enable all residents in the facility the ability to notify staff if they needed assistance. To date the facility manager has not ordered any system.	R178		
R226 SS=D	VI. RESIDENT'S RIGHTS 6.14 Residents subject to transfer or discharge from the home, under Section 5.3 of these regulations, shall: 6.14.a Be allowed to participate in the decision-making process of the home concerning the selection of an alternative placement; 6.14.b Receive adequate notice of a pending transfer; and 6.14.c Be allowed to contest their transfer or discharge by filing a request for a fair hearing before the Human Services Board in accordance with the procedures in 3 V.S.A. §3091. This REQUIREMENT is not met as evidenced by: Based staff interview and record review the facility failed to provide 1 applicable resident in a sample of 2, with adequate notice of an involuntary discharge/transfer, failed to adequately provide a notice of a pending transfer and failed to allow the resident the ability to	R226	Will use discharge Check list to ensure all requirements are met. - already in place.	

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R226	Continued From page 8 contest the transfer/discharge by filing a request for a fair hearing before the Human Services Board. Therefore, Resident Rights were violated for Resident #1. The detailed findings are as follows: Per review of the progress notes dated 1/17/19 and signed by the RN Manager, identifies that Resident #1 had developed shortness of breath overnight and increased pedal edema (ankle swelling). The resident was unable to stand or walk in the AM. The hospice nurse was contacted by the facility manager to discuss transfer to another facility. Since Resident #1 resided on the second floor, the facility's concern was inability to manage the stairs in the case of an emergency, despite the presence of a stair glider. Resident and family notified by the facility manager on 1/17/19, of the facility's request to transfer. Family questioned how quickly a transfer would need to happen and the facility manager stated ["if they have a bed tomorrow that would be great because we can't evacuate him/her"]. Resident #1 was discharged on 1/18/19 via family vehicle to another residential care home. Per facility Discharge Policy identifies that if the Davis Home implements an involuntary discharge the manager will, notify the resident, family member and/or legal representative of the discharge or transfer and the specific reasons for the move in writing and in a language and manner the resident understands at least 72 hours before a transfer within the home and thirty (30) days before discharge from the home. The notice to include a statement in large print that the resident has the right to appeal the home's decision to transfer/discharge with the appropriate information regarding how to so.	R226		

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R226	Continued From page 9 The Registered Nurse (RN) Manager confirms on 3/6/19 at approximately 9:23 AM that the resident and/or family were not provided with the appropriate involuntary discharge/transfer notice prior to transfer/discharge, nor were they provided with the appropriate information related to the request of an appeal. The facility RN also confirms at this time, that the facility policy was not followed, that s/he did not conduct a significant change assessment identifying the resident's current status nor did the facility contact the licensing agency to request and emergency transfer.	R226		