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

May 30, 2018

Ms. Ann Bouza, Administrator
Equinox Terrace
324 Equinox Terrace Road
Manchester Center, VT 05255-9253

Dear Ms. Bouza:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 8, 2018**. 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
	0127	A. BUILDING: _____ B. WING _____	C 05/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EQUINOX TERRACE	324 EQUINOX TERRACE ROAD MANCHESTER CENTER, VT 05255

(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 re-licensure survey was conducted on 5/7 and 5/8/18 by the Division of Licensing and Protection in conjunction with one entity reported incident and an anonymous complaint investigation. There were regulatory findings surrounding the entity reported incident and the re-licensure survey.	R100		
R134 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7 Assessment 5.7.a An assessment shall be completed for each resident within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The resident's abilities regarding medication management shall be assessed within 24 hours and nursing delegation implemented; if necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete facility required assessments for 2 of 10 residents reviewed, Residents #1 and 3. The findings include the following: 1. Per record review, Resident #1 had a facility required assessment conducted and signed as completed by the Registered Nurse (RN) on 3/7/17. The following sections were identified as unanswered: 20a, b, c, 20c, 21, 22, 23, L.1. items 2, 3, 5, and 10. The Director of Nurses confirms on 5/7/18 at approximately 2:45 PM that the assessment is incomplete.	R134	ALL SECTIONS ON RESIDENT #1 AND RESIDENT #3 WILL BE AMENDED ON EACH ASSESSMENT. THE ASSESSMENT TOOL USED WILL BE REVIEWED AND REVISED IN ORDER TO ENSURE EACH SECTION IS CAPTURED AND APPLIED TO ALL FUTURE ASSESSMENTS. CORRECTIVE ACTIONS WILL BE APPLIED ANNUALLY AND WITH ANY CHANGE IN CONDITION.	5/23/18

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: RN, Executive Director — (X6) DATE: 5/25/18

R134-R999 POC's accepted 5/30/18 BBordeleau RN/PMC

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R134	Continued From page 1 2. Per record review for Resident #3, the facility required assessment conducted and signed as completed by the Registered Nurse (RN) on 3/23/18. The following sections were identified as unanswered: 20a, b, c, 20c, 25a, F.4. items 2, 3, G.1. item 10b, H.1. item 1 and 2, H.2. item 1, H.3. item 1, I.1 item 3, 4, 5, section J.1. item 4a The Director of Nurses confirms on 5/8/18 at approximately 10 AM that the assessment is incomplete.	R134		
R145 SS=E	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, the facility failed to insure that the written plan of care for 6 of 10 residents reviewed, Resident #1, 2, 3, 4, 5 and 6, described the care and services necessary to assist and maintain independence and well-being. Findings include: 1.) Record review for Resident #5 presents that the resident had falls 2/25, 3/17 and 4/16/18. Per interview with the Licensed Practical Nurse (LPN), the resident loses his/her balance or slips from the bed. Per observation of the resident and	R145		

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R145	Continued From page 2 the room, there are wheelchair and bed alarms being utilized. The resident stated, during an interview on 5/8/18 that sometimes s/he loses his/her balance and falls. During a review of the medical record, there was no evidence that a care plan had been developed to address the falls. Interview with the LPN confirmed at 10:30 AM that the falls and interventions have not been addressed in the care plans. 2.) Resident #6 had been identified by the facility as self administering his/her medications. There is no evidence that the facility had a care plan to address the resident's ability to self administer the medications and there is no evidence of assessing of the process, what to monitor the resident for and a process for insuring that the medications ordered were taken correctly. The LPN, Director of Nursing Services, confirmed at 1:45 PM on 5/8/18 that there was no care plan developed to address self administration of medications. 3.) Per record review, Resident #1, has a facility required assessment completed by the Registered Nurse (RN) dated 3/7/17. The assessment identifies that the resident has an unsteady gait and uses a walker, has daily pain that disrupts activities and has a history of falls. Incident report dated 2/17/18 identifies that the resident was found on the floor at 2:40 AM, that resulted in an emergency room evaluation. Individualized Care Plan dated 8/1/16 signed by the RN, was not updated at the time of the 2017 assessment. The Kardex Care Plan dated 8/26/17 which is utilized by the care attendants does not identify pain or code status, nor does the plan identify if the plan was developed or approved by the RN. The plan does identify that the resident is at moderate risk for fall, but there	R145	① Falls & fall interventions will be addressed on assessments & care planned 5/24/18 ② Self administration will be assessed per Resident. This will be monitored quarterly going forward. 5/24/18 ③ The Individualized Care Plan will be updated to reflect incident of 2/17/18 5/25/18 The Kardex Care Plan will address pain and code status and have RN approval. Initiatives will be put in place to address falls.	

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R145	Continued From page 3 are no initiatives in place to prevent falls. Per discussion with the Director of Nurses on 5/7/18 at approximately 2:45 PM confirmation is made that the care plan was not updated at the time of the last assessment and the care plan does not reflect the current needs of the resident. 4.) Per record review, Resident #2 has an assessment summary completed and signed by the RN on 2/5/18. The summary identifies that the resident has had 3 or more falls in the past 3 months. Resident #2 has an Individualized Service Plan developed and signed by the RN, dated 2/5/18. The plan identifies that the resident needs assistance moving between locations. The Kardex Care Plan, which is utilized by the care attendants identifies that the resident is moderately impaired cognitively, requires 2 staff for physical assist and is at high risk for falls. The Kardex does not identify if the plan was developed or approved by the RN. Physician orders identify that the resident is to be weighed daily and monitored. Incident reports dated 1/23/18, 2/2/18 and 3/23/18 the resident was found on the floor on all three incidents. The reports identify that the chair alarm was sounding in all three occurrences. The medication administration record does identify bed/chair alarm for all three (3) shifts. Per discussion with the Director of Nurses on 5/7/18 at approximately 4:15 PM confirmation is made that the care plan was not reflect the current needs of the resident as it relates to falls, chair alarm and the monitoring of weights. 5.) Per record review, Resident #3 has a facility required assessment completed and signed by the RN dated 3/23/18. The assessment identifies that the resident has limited speech, has 1:1 care givers to manage behaviors, is physically assisted	R145	④ The Kardex Care Plan is in addition to the Service Plan which is signed by RN. In future the Kardex utilized by Care Attendants will have section for RN approval. Addressing needs for residents at Risk for falls will be kept current. 5/25/18 ⑤ The Plan of Care developed for all residents is triggered by the Assessment. The program devised 5/25/18	

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R145	Continued From page 4 by 1 care giver due to unsteady gait, is totally dependent of staff for eating and personal care and the continence section was not completed. The Individualized Care plan dated 4/10/18 and signed by the RN, identifies that the resident has difficulty speaking, that there are 1:1 care givers 24/7 for increased care needs and staff assistance to serve all snacks and meals. The Kardex Service Plan that is utilized by the care attendants does not address that the resident is on a regular diet and is a high risk for falls. The Kardex is not signed by the RN, so there is no identification as to who developed the plan as written. Per discussion with the Director of Nurses on 5/8/18 at approximately 10 AM, confirmation is made that the care plan has not been updated identifying that private care givers are only at the facility Monday through Friday and during the day hours, that the resident is fed all meals and that there are no initiatives on the plan to prevent falls. Therefore the care plan does not reflect the current needs of Resident #3. 6.) Per record review, Resident #4 has a facility required assessment completed and signed by the RN dated 4/20/18. The resident had spent approximately 16 days in a skilled nursing home as a result of a fractured hip sustained at this facility. On return to the Residential Care Home, the assessment identified balance problems, change in gait pattern, need to utilize a walker, pain monitoring and now is requiring Hospice services. The Kardex Service Plan that is utilized by the care attendants identifies Resident #4 as a high risk for falls. There is no notation to the care attendants that the resident has severe pain, requires medications and because of the falls that took place in March 2018 requires the need for a	R145	does not duplicate assessment onto Kardex Service Plan. This will be addressed to ensure all areas of care planning are streamlined in order for the information to match. Current needs of Resident will be amended and updated. ⑥ The Kardex Care Plan will address pain and post surgery care. It will reflect interventions for prevention of falls.	5/25/18

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R145	Continued From page 5 chair alarm. Per observation on 5/8/18 at 9:30 AM the resident does have a chair alarm in place. Per discussion with the Director of Nurses on 5/8/18 at approximately 10 AM, confirmation is made that the care plan does not reflect the resident's current needs as it pertains to post surgery care, interventions to prevent falls, the use of a chair alarm and the need to monitor for pain.	R145		
R161 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.b The manager of the home is responsible for ensuring that all medications are handled according to the home's policies and that designated staff are fully trained in the policies and procedures. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview and record review, the Manager of the home failed to ensure that all medications were handled according to the home's policy for self administration for 1 resident, Resident #6.. Findings include: Per review of the facility's Medication Management Policy for Self Administration of medications, a Registered Nurse (RN) will complete a quarterly assessment to assure continued safety and that the service plan will reflect the processes that include self-medication and monitoring. The policy continues to state that the medications will be properly stored in the	R161		

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R161	Continued From page 6 resident's room and the medications are kept in the original containers dispensed by the manufacturer or pharmacy. At 12:30 PM, the resident received two boxes from the medication technician which contained Alphagan 0.1% eye drops labeled to apply one drop to the left eye three times a day and one that had Latanaprost 0.005% eye drops that was labeled to instill one drop to the left eye at HS (hour of sleep). Upon going into his/her room, the resident placed the eye drops on a shelf next to her chair. When asked where s/he keeps the eye drops, the resident replied that they are kept on the shelf. The label for Latanaprost states to refrigerate, but the resident stated that s/he keeps them on the shelf because it is easier to get to them. The resident said that s/he uses the Alphagan eye drops twice a day instead of the ordered three times a day. Also on the shelf with the eye drops was a bottle of Fluticasone Propionate Nasal Spray that the resident stated is used once a day and it is kept on the shelf so she remembers to use it. Per observation of the process for self administration of medications for Resident #6, the resident produced a pill container for holding one week of medications with spaces for four times each day, s/he also had a smaller container that the resident said was for the Synthroid which has to be taken first thing in the morning. S/he stated that the pill boxes are filled on Thursdays by the nurse. In the room on the table next to his/her chair was a bottle of Metamucil, a bottle of Tums and a bottle of Vitamin B12 500 mcg capsules. The resident was not able to tell what the medications were, the doses or what they were for. S/he said that s/he takes the Vitamin B12	R161		

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R161	Continued From page 7 once in a while and the Tums whenever s/he has gas and the Metamucil every day and that s/he doesn't tell the staff when s/he takes the medicines and that no one checks on him/her to see if they are re taken. Per interview with the Licensed Practical nurse on 5/8/18 at 1:15 PM, s/he stated that his/her only responsibility is to fill the pill boxes every week and that s/he signs them out for the resident when they are poured. Review of the medical record presents that the physician wrote an order on 4/8/16 that the resident may self administer medications. There is no evidence of a facility assessment to insure the resident remains capable of self administering. Review of the medication orders includes Miralax powder 17 Grams every other day, the resident states that s/he doesn't take Miralax. S/he also said that s/he uses the Alphagan eye drops twice a day, instead of the ordered three times a day. The medication administration record also presents that the resident takes Brimonidine 0.15% eye drops and is documented as self administrating, but the Director of Health Services stated that the resident doesn't receive those eye drops anymore. During conversation with the registered nurse at 1:45 PM, s/he confirmed that the policy had not been followed regarding self administration and quarterly assessments.	R161	A facility policy R/T Self Administration will be completed. All quarterly assessments will reflect Facility Policy R/T Self administration going forward. Measures will be taken to Ensure Facility policies are followed and designated staff are fully trained. 5/24/18	
R179 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before	R179		

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R179	Continued From page 8 providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to insure that 4 of 5 reviewed direct care staff receive the required twelve hours of training per year. Findings include: During review of the in-service training records from April 1, 2017 to April 30, 2018, the facility failed to insure that two employees complete training in the area of Fire Safety and Respectful Effective Communication. It was also found that three did not have the First aid/Emergency Response, Infection Control and General Care and Supervision training. Confirmation was made on 5/7/18 at 2:30 PM by the Executive Director that the employees had not completed the	R179	All employees are expected to complete at least 12 hours of training each year and are given ample time for doing so. In future the Facility will ensure improved means of tracking and implementing all in-service training to every employee in order that requirements are met.	5/23/18

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R179	Continued From page 9 required training.	R179		
R181 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to insure that 2 of 5 direct caregivers had the required background references checked. Findings include: During review of employee records on 5/7/18, it was found that one employee was re-hired on 4/13/18, after an absence of greater than six months. The facility had not requested the Child	R181	All employees are required to undergo a background check on hire. In future any employee who has had a period of absence and is rehired will have a new background check completed in the future. 5/7/18	

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R181	Continued From page 10 or Adult Abuse registry checks nor had there been a request for the Vermont Criminal background checks. The director of Human Resources (HR) stated at 11:40 AM, that s/he was not aware that background checks needed to be done for re-hired employees. Further review of the employee records presented that a second employee had been employed 12/16/15, and left employment on 2/12/16. S/he returned to the facility 6/21/17 and had background checks performed but again left employment 8/15/17. In an interview with HR at 11:50 AM, s/he confirmed that the required background checks had not been performed when the employee again returned to the facility in October of 2017 after leaving to work in a different state.	R181		
R999 SS=A	MISCELLANEOUS The facility failed to make survey results readily available to residents and to the public in a place readily accessible. Findings include: During tour of the facility on 5/7/18, the surveyor observed the results of the last survey results in a glass covered case on the wall in the front hall. The case was locked and there was no key available. Per confirmation by the executive director at 9:45 AM on 5/7/18, the results are not accessible to the residents or the public.	R999	Survey results were posted for past 2 years in a prominent glass fronted cabinet. The key to this cabinet was available on top of the cabinet (kept there to prevent being lost). All visitors, residents and public are able to view RECORD survey is available at front DESK also. 5/7/18	