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 26, 2023

Ms. Wendy Beatty, Manager
Equinox Terrace
324 Equinox Terrace Road
Manchester Center, VT 05255-9253

Dear Ms. Beatty:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 4, 2023.** 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

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
	0127	A. BUILDING: _____ B. WING _____	C 04/04/2023

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EQUINOX TERRACE	324 EQUINOX TERRACE ROAD MANCHESTER CENTER, VT 05255

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R100	Initial Comments: An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on 3/21/23 and completed on 4/4/23. The following regulatory violations were identified: V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RCH failed to provide a expedient response and necessary emergency services for a resident who sustained 2nd degree burns on both thighs. (Resident #1) Findings include: Resident #1, with a history of dementia and mobility deficits after a stroke, is dependent on RCH staff for assistance with dressing, mobility, transfers, toileting and cueing and/or assistance with meals. The resident is presently enrolled in Hospice services due to physical decline and resides on the Memory Care Unit. The resident has been receiving treatment for a foot ulcer and was prescribed Oxycodone for pain. Per record review, Charting Notes dated 3/18/22 at 8:56 PM states "Resident screamed in pain when assisted to transfer from chair to	R100 R126	This plan of correction was written to follow state and federal guidelines. It is not an admission of noncompliance. However, it is the homes commitment to demonstrate and maintain compliance.	

tags R126 - R178 accepted on 4/26/2023 by M. McIntosh/C. Scott

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R126	Continued From page 1 wheelchair....Oxycodone 5 mg was given for pain at 16:20 hrs. Little effectiveness noted as resident continued to scream even after dinner when RS's (Resident Assistants) attempted to transfer her/him to toilet seat....PRN (as needed) Gabapentin 5 ML (prescribed for neuropathic pain) was administered. Positive effect noted". On the early morning of 3/19/23 Med Tech #1 (unlicensed staff trained to administer medications to residents) observes redness and blisters on both of Resident #1's thighs and applies a Calamine cream (used for minor skin irritation) to the affected areas on the thighs. Tech #1 reports concerns regarding observations made of Resident #1's thighs to Med Tech #2. Per Charting Note at 6:10 AM on 3/19/23 Med Tech #2 documents Resident #1 had "...open blisters to groin, PRN (as needed) Nystatin powder (used for fungal or yeast infection) applied. PRN Oxycodone given to resident at 1620 hrs to manage pain before AM care." When the day shift arrives, observation of Resident #1's groin is conducted by Med Tech #3. Charting Notes for 3/19/23 at 8:53 AM states "...Open blisters noted on both inner thighs,....". A decision was made by Med Tech #3 to again apply Nystatin Powder to the blistered sites. Despite the change in Resident #1's condition, the degree of blistering, redness and increased discomfort unlicensed staff assessed Resident #1 to have redness as a result of incontinence products and applied powder and creams to what was later diagnosed in an Emergency Department (ED) to be second degree burns to both upper thighs. It was not until 3/19/23 at 9:54 AM the Health Services Director was notified of Resident #1's condition. As a result, Resident #1's provider was notified and the "on-call"	R126	R126 Resident # 1 returned from the ED with orders to treat burn. Resident healing well. There have been no other burn incidents. All residents in the memory care unit who require cueing and or assistance with dining have the potential to be effected by this alleged deficient practice. Memory Care Staff have been educated on identifying burns and notifying the HSD. Education has also been provided about cooling hot liquids before serving. Signs have been posted in the kitchenette regarding hot liquids. Audits will be conducted weekly x4 then monthly x3 to ensure compliance. Results will be reported and discussed in QAPI. Resposible: HDS and ED Date of Compliance 4/19/23	

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R126	Continued From page 2 physician directed staff to send Resident #1 to Urgent Care or the Emergency Department at a local medical center. Upon arrival in the ED, the treating physician noted Resident #1 had sustained second degree burns bilaterally of the upper thighs and delay in treatment was determined to have occurred. Injuries assessed noted burns on right thigh extended 10 inches x 1 to 3 inches; and on the left thigh burns extended 6 inches x 1 inch. Both thigh injuries had blistering and sloughing of skin, requiring 25 minutes of painful debridement. Resident #1 was returned to the RCH with treatment orders for the management of the burns. The ED physician further determined the character of the burns was indicative of contact with hot liquids. In further review during the on-site investigation, Charting Notes dated 3/17/23 at 11:00 AM it is noted Resident #1 ".... continues to need to be fed by staff in order to eat anything at meals, otherwise s/he will just sit there with no attempt to eat on her/his own". On 3/18/23 at 10:17 AM again the resident required assistance with her/his breakfast. Although Resident #1 required total assistance with dressing and undressing, no staff acknowledged or reported that Resident #1 had spilled hot liquid on his/her lap, or noted upon undressing, the red and excoriated area on the resident's thighs. Per interview on 3/21/23 at 12 noon Dietary staff confirmed hot liquid drinks are only served at breakfast and due to the coffee temperatures staff are directed to add cold water to decrease the temperature. Per observation on 3/21/23 of the noon meal on the Memory Care Unit, Resident #1 was observed periodically napping at	R126		

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R126	Continued From page 3 the dinning room table and no effort was made by the resident to feed herself/himself, thus eventually receiving assistance from Memory Care staff. Per interview on 3/21/23 at 1:25 PM Med Tech #1 stated routine standing physician orders allows for the application of Calamine cream and/or Nystatin powder for skin irritation related to the use of incontinence products worn by residents. This was also confirmed by Med Tech #2 who had applied Nystatin powder to the blistered skin on Resident #1's thighs. Neither staff contacted the on-call Health Services Director/LPN to inform the supervisor of the change in Resident #1's condition and to seek direction regarding treatment and/or management for the redness and blisters. Per interview on 3/21/23 at 11:15 AM, the Health Services Director/LPN (Licensed Practical Nurse) stated "I should have been notified" after staff had identified a change in the resident's condition and prior to the application of powder and/or a cream. S/he further acknowledged Resident #1 has spilled coffee in the past, but refuses to use a safer/sippy cup. The Health Services Director stated staff are to add water to all the resident's morning coffee on the Memory Care Unit to make hot liquids tepid for safety purposes, however it can not be confirmed if staff performed this additional safety tasks on the morning of 3/17/23 or 3/18/23. The failure to report or acknowledge an accidental spill resulting in injury; the failure of unlicensed staff to seek direction prior to applying creams and/or powders to a sudden onset of redness and blisters and the failure to report to either the Health Services Director or RCH RN resulted in the failure to meet the immediate needs of Resident #1 causing a delay in	R126		

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R126	Continued From page 4 treatment of second degree burns experienced by a vulnerable elderly resident.	R126	R178 Resident # 1 returned from the ED with orders to treat burn. Resident healing well. There have been no other burn incidents. All residents in the memory care unit who require cueing and or assistance with dining have the potential to be effected by this alleged deficient practice. Memory Care Staff have been educated on identifying burns and notifying the HSD. Education has also been provided about cooling hot liquids before serving. Signs have been posted in the kitchenette regarding hot liquids. Audits will be conducted weekly x4 then monthly x3 to ensure compliance. Results will be reported and discussed in QAPI. Resposible: HDS and ED Date of Compliance 4/19/23	
R178 SS=G	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 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 staff interview and record review, there was a failure by staff to assure prompt and appropriate action was taken after a resident experienced an injury of unknown origin for 1 applicable resident. (Resident #1) Resident #1, with a history of dementia and mobility deficits after a stroke, was dependent on RCH staff for assistance with dressing, mobility, transfers, toileting and cueing and/or assistance with meals. The resident was presently enrolled in Hospice services due to physical decline. The resident has been receiving treatment for a foot ulcer and was prescribed Oxycodone for pain. Per record review, Charting Notes dated 3/18/22 at 8:56 PM states "Resident screamed in pain when assisted to transfer from chair to wheelchair PRN (as needed) Oxycodone 5 mg was given for pain at 16:20 hrs. Little effectiveness noted as resident continued to scream even after dinner when RA's (Resident Assistants) attempt to transfer her/him to toilet seat....PRN Gabapentin (used for neuropathic pain) 5 ml for pain. Positive	R178		

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R178	Continued From page 5	R178		

effect noted". On the early morning of 3/19/23 Med Tech #1 (unlicensed staff trained to administer medications to residents) observes redness and blisters on both of Resident #1's thighs and applies a Calamine cream (used for minor skin irritation) to the affected areas on the thighs. Tech #1 reports concerns regarding observations made of Resident #1's thighs to Med Tech #2. Per Charting Note at 6:10 AM on 3/19/23 Med Tech #2 documents Resident #1 had "...open blisters to groin, PRN (as needed) Nystatin powder (used for fungal or yeast infection) applied. PRN Oxycodone given to resident at 1620 hrs to manage pain before AM care."

When the day shift arrives, observation of Resident #1's groin is conducted by Med Tech #3. Charting Notes for 3/19/23 at 8:53 AM states "...Open blisters noted on both inner thighs,....". A decision was made by Med Tech #3 to again apply Nystatin Powder to the blistered sites.

Despite the change in Resident #1's condition, the degree of blistering, redness and increased discomfort unlicensed staff assessed Resident #1 to have redness as a result of incontinence products and applied powder and creams to what was later diagnosed in an Emergency Department (ED) to be second degree burns to both upper thighs. It was not until 3/19/23 at 9:54 AM the Health Services Director was notified of Resident #1's condition. As a result, Resident #1's provider was notified and the "on-call" physician directed staff to send Resident #1 to Urgent Care or the Emergency Department at a local medical center.

Upon arrival in the ED, the treating physician noted Resident #1 had sustained second degree

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R178	Continued From page 6 burns bilaterally of the upper thighs and delay in treatment was determined to have occurred. Injuries assessed noted burns on right thigh extended 10 inches x 1 to 3 inches; and on the left thigh burns extended 6 inches x 1 inch. Both thigh injuries had blistering and sloughing of skin, requiring 25 minutes of painful debridement. Resident #1 was returned to the RCH with treatment orders for the management of the burns. The ED physician further determined the character of the burns was indicative of contact with hot liquids. Per interview on 3/21/23 at 1:25 PM Med Tech #1 stated routine standing physician orders allows for the application of Calamine cream and/or Nystatin powder for skin irritation related to the use of incontinence products worn by residents. This was also confirmed by Med Tech #2 who had applied Nystatin powder to the blistered skin on Resident #1's blistered thighs. Neither staff contacted the on-call Health Services Director/LPN to inform this supervisor of the change in Resident #1's condition and to seek direction prior to the application of creams and powders. In addition, staff who provided assistance to Resident #1's during the breakfast meal when coffee is served on either 3/17/23 or 3/18/23 failed to acknowledge, respond or report the incident of hot liquids being spilled on Resident #1 resulting in significant injury. Per interview on 3/21/23 at 11:15 AM, the Health Services Director/LPN (Licensed Practical Nurse) stated "I should have been notified" after staff had identified a change in the resident's condition and prior to the application of powder and/or a cream. The provision of necessary care at the time of the exposure of hot liquids to Resident #1's thighs did not occur. Additional actions by unlicensed RCH	R178		

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R178	Continued From page 7 staff prevented prompt, appropriate action when observations noted significant skin changes on Resident #1's thighs. It was not until Resident #1 was transferred to the ED, emergent action and treatment was provided to the vulnerable elderly resident.	R178		