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

March 3, 2021

Ms. Barbara Spear, Manager
Historic Homes Of Runnemede-Stoughton House
40 Maxwell Perkins Lane
Windsor, VT 05089-1206

Dear Ms. Spear:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 9, 2021.** 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

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
	0161	A. BUILDING: _____ B. WING _____	C 02/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HISTORIC HOMES OF RUNNEMEDE-STOUGHTON HO	40 MAXWELL PERKINS LANE 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 onsite investigation into three complaints and one self-report was conducted by the Division of Licensing and Protection on 2/1/2021 and concluded on 2/9/2021. The following deficiencies were identified.	R100	R 128 A new form will be initiated for every narcotic to ensure a prescription does not run out. This form will be filled out by the PCAs to alert the charge nurse a medication/narcotic supply is low and needs a refill. The PCAs will be educated on the process of the new form & how to alert the charge nurse a narcotic needs a refill. This form will be co-signed by the charge nurse in confirmation she has followed up with the PCP for a refill. This will occur by day seven remaining of the narcotic. The charge nurse will follow up with the PCP until the order has been refilled. This form will also include indication of delivery has occurred and signed by the charge nurse in acknowledgement. The charge nurse will use the new audit tool to review the narcotic log on on Monday, Wednesday and Friday to ensure a supply is present for every narcotic and the PCAs are follwing the process by notifying the charge nurse appropriately. The Monday, Wednesday and Friday audit will occur for three months then weekly for three months. The charge nurse will check the MAR to review for circled narcotics and proper documentation. The PCAs will be educated to alert the charge nurse on day one of a circled medication. The charge nurse will sign the new form in acknowledgement of receipt of the form from the PCA. The circled medication audit will also be conducted Monday, Wednesday and Friday for three months, then weekly for three months by charge nurse.	
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 record review and staff interview, the home failed to ensure that a resident received medications as ordered by the medical provider. Findings include: Per record review, Resident #1 was admitted to the home in October 2017. The resident had a long-standing prescription for the antianxiety medication Lorazepam 1 mg., given as a scheduled medication, twice daily. Resident #1 also had a PRN (as needed) order for Lorazepam 0.5 mg for shortness of breath or anxiety. The resident had been taking the benzodiazepine Lorazepam daily for years, and sudden withdrawal from this class of drugs after extended daily use has the potential to cause serious side effects. Per the Medication Administration Record (MAR) for May 2020, there was a circled staff initials on the morning of May 23 that the medication was	R128		

R128-R171 POC accepted 3/1/21
K. Campos, RN/P.Cota, RN

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R128	Continued From page 1 not given, reason on the back of the sheet stated as " Med did not come in". The MAR had circled initials present on the 24th, 25th, 26th, and 27th also indicating that the medication had not been given. Only one other reason was written on the MAR, for May 26th, stating that the medication "did not come in still". The progress notes written by staff on 5/25/2020 stated that the resident "has not been feeling good at all today. Did not want to eat breakfast or lunch today. Complained about stomach pain and eye pain." The resident was sent to the ED on 5/25/20 "for complaints of chest/abdominal pain" and "appeared more confused than (his/her) norm." The Emergency Dept . evaluated the resident and sent them back to the home with a diagnosis of "Non-specific chest pain-adult" according to the progress note by the RN. On the following day, 5/26/2020, the resident had a high blood pressure reading of 223/117, was weak, shaky, and had near falls. The resident was sent back to the ED once again and this time admitted to the hospital. The information that the resident had not received their daily dose of Lorazepam for the last five days was noted in the hospital records, and they treated for benzodiazepine withdrawal as a suspected cause of the symptoms. The resident returned to the home on 6/3/2020 with some residual weakness noted. Physical and Occupational therapy evaluations were ordered to assist with strengthening. Per review of the home's medication policies, the medication administering staff are supposed to let the nurse know when a medication is low, below a week's supply, and needs to be reordered from the pharmacy. For controlled substances like	R128	The education will be completed by March 10 or sooner by the charge nurse.	

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R128	Continued From page 2 Lorazepam, the medical provider must write a prescription regularly to keep it active. The home's policy states that the registered nurse has the responsibility of checking three times per week for any narcotics that need more than a week's supply and follow up with the medical provider. Per interview on 2/1/2021 at 11:20 AM, the home's manager confirmed that the staff administering medications had alerted the registered nurse that the resident was low on Lorazepam, with a written memo as per their protocol. The registered nurse had not followed up on acquiring a new prescription for Lorazepam from the medical provider, or acquisition of an emergency delivery to ensure that the medication was available for administration. The manager stated that the nurse was terminated and reported to the Board of Nursing.	R128	R 171 A new form is in place to alert the charge nurse when a medication is circled on day one. The charge nurse will immediately review the circled medication for documentation of refusal/circled medication is on the back of the MAR with the date, time and effect (for PRN medications). The PRN medications administered will include the date and time of the refusal. The PRN medication administered will also include the effect after administerd. All psychoactive medications administered will have an indication for use as well as a record to monitor side effects. All medication errors will be documented in an incident report. The current list of staff delegated administer medications, will remain in the survey binder as well as in front of the MARs. The list of staff delegated by the RN will have the charge nurse signature. The audit tool and education will include documentation of the medication ordered, list all refusal on the back of the MAR, why the medication was refused, and any intervention or redirection used. The tool and education will include documention on the back of the MAR of effect when a PRN is administered. The audit and education will include review all psychoactive orders have	
R171 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include: (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, including the reason why and the actions taken by the home; (3) All PRN medications administered, including	R171		

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R171	Continued From page 3 the date, time, reason for giving the medication, and the effect; (4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and (5) For residents receiving psychoactive medications, a record of monitoring for side effects. (6) All incidents of medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to ensure there was sufficient documentation completed regarding medication administration. Findings include: Per record review, Resident #1's Medication Administration Record (MAR) had several examples in May 2020 of initials circled by staff that indicates that a medication was not given. The medication notes on the back of the MAR are supposed to explain why the medication was not given to the resident, whether unavailable, refused, or some other reason. Entries are missing for all of the instances of circled initials with the exception of two entries regarding the Lorazepam not being available. The medications circled on the MAR are as follows: 1. Latanoprost Sol. 0.005% One drop each eye at bedtime for Glaucoma. The circled initials are present on 5/25, 5/26, 5/28, 5/29, 5/30, and 5/31. There is a blank spot with no initials on 5/27/20. 2. Simvastatin 80 mg. One tablet at bedtime. There are circled initials on 5/25, 5/26, 5/28, 5/29, 5/30, and 5/31. There is also a blank spot for this medication on 5/27/20. 3. Trazadone 100 mg. One tab at bedtime. There	R171	an indication for use. The audit and education will include documenting and reporting all med errors. This education will be completed by March 10 or sooner by the charge nurse.	

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R171	Continued From page 4 are circled initials on 5/30 and 5/31/20, and blank spaces for the administration on 5/25, 5/26, 5/27-5/31/20. 4. Famotidine 40 mg. One tab at bedtime. The MAR entries were circled for 5/25, 5/26, 5/28-5/31/20, with 5/27 being blank as well. For these four medications, there was no explanation on the reverse side as to why they were not given, notably on the days before the resident was hospitalized. The resident was sent to the hospital on the afternoon of 5/26/20, and did not return until 6/3/2020, but this was not reflected in the MAR as the reason it was not administered. However for the entirety of the 25th and morning of the 26th of May, there was no explanation as to why the resident did not take the medications. For the Lorazepam 1 mg. scheduled twice daily at 0800 and 1700, there was a circled initial on the morning of 5/23/20, with an explanation on the back of the sheet that "Med did not come in". The evening dose on 5/23/20 was initialed by staff as having been given even though the staff earlier in the day had said there was none to give. The doses scheduled for 5/24 and 5/25/20 had circled initials with no explanation note on the reverse side. On 5/26/20, the doses were both circled, and there was an explanation on the reverse of the MAR for the 0800 dose saying that it "did not come in still", but no note on the evening circled initials. Again, 5/27/20 was blank for this medication, and the doses for 5/28- 5/31 have circled initials. Per interview on 2/1/21 at 10:45 AM, the home manager confirmed that the expectation for staff is that when a medication is not administered for any reason, they are to circle their initials and	R171		

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R171	Continued From page 5 then fill out the reverse side of the MAR to indicate why the resident did not receive the medication. The home's manager confirmed that the entries as listed above did not have the appropriate explanation written on the back of the MAR.	R171		