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

October 16, 2018

Ms. Brenda Schill, Manager
Our Lady Of Providence
47 West Spring Street
Winooski, VT 05404-1397

Dear Ms. Schill:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 14, 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
	0198	A. BUILDING: B WING	R-C 08/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PROVIDENCE	47 WEST SPRING STREET WINOOSKI, VT 05404

(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: {R100}

An unannounced onsite follow up and complaint investigation was initiated on 8/7/18 and concluded on 8/14/18. There are 5 violations that are uncorrected from the 4/11/18 survey, and 4 new citations as a result of concurrent investigations into reported incidents. A violation was identified that required immediate corrective action due to the potential of serious harm to residents regarding medication administration (see R128). Prior to the completion of the survey on 8/14/18, the facility had identified a plan to immediately correct the violation and had completed steps to ensure resident safety.

R128 V RESIDENT CARE AND HOME SERVICES SS=J R128

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 the facility failed to Assure that services were consistent with Physician's orders regarding administering Controlled medications. This citation represents a situation that required immediate corrective action due to the risk of serious harm or death of residents if remained un-noticed and uncorrected. The facility presented a plan for immediate corrective action prior to the exit on 8/14/18. Findings include:

Per record review, Resident #4 was admitted to the facility on 10/24/16. Resident #4 experienced

5.5.c

ACTION:

- Corrective action was created and given to the onsite surveyor (MH) who accepted and endorsed plan at time of presentation.
- Review of appropriate process, demonstration of correct process and remediation with each nurse was documented. All were successful in providing a return demonstration.

MEASURES:

- Ongoing monitoring nurse math and accurate documentation on the controlled substance sign out document. Once a month the overnight nurse will review the last 5 entries on each page to ensure the math is accurate. The nurse will review the logs for each cart (2) and document according to the audit form. **Completion date: 10/14/18**
- Any errors are to be brought to the Director of Nursing immediately for review, discussion and potential action. **Completion date: 10/14/18**
- Ongoing monthly meetings with nurse teams to review findings and provide appropriate remediation and training to correct any errors noted. **Completion date: 10/14/18**

R128 – R266 POC's accepted 10/11/18 mHigginsRN/PMC

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
	0198	A. BUILDING: B. WING	R-C 08/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PROVIDENCE	**47 WEST SPRING STREET** WINOOSKI, VT 05404

(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
R128	Continued From page 1	R128	**5.5.c** **MONITORING:** • Annually nursing staff will review the policies and processes around the administration of controlled medications, provide return demonstration and receive remediation as needed. • Monthly audits of the shift change narcotic count log and documentation in MAR will be conducted by the overnight nurse to determine compliance with policies and documentation practices. The audit results will be reviewed by the DHS with a plan for implementing further training, remediation or corrective action as needed for each nurse.	

a decline in condition beginning with an identified swallowing issue on 4/4/2018. The Resident's condition continued to deteriorate and on 4/12/18 the resident is documented as being Unresponsive and a referral was made to Hospice. On 4/13/18 the resident was placed on Hospice and liquid morphine was ordered. On the evening of 4/13/18 the resident fell and was found on the floor on top of a pillow. There was no apparent injury according to the nurse's notes.

On 4/14/18 beginning on the 4/13 to 4/14 (11 pm-7 am) overnight shift, the resident appeared to be restless and in the active dying stage. The order for morphine was updated to "Morphine Intense! 20 mg/ml [milligrams per milliliter]give 4 1 mg (0.2 ml) PO/SL 01H PRN [by mouth/sublingual every '1 hour as needed] for pain/dyspnea".

In a review of a document titled Controlled Medication Utilization Record (CMUR) Nurse *41* signed for the receipt of Morphine Sulfate 20 mg/dissolution in a 30 ml bottle on 4/12/18. Each time the medication is administered, the nurse administering the medication documents the date, time, dose given, signature, and amount remaining. In all a total 10 doses of medication are documented.

In reviewing the document, 3 doses were administered by the RN (Registered Nurse) working the 7 a-3 p shift on 4/14/18 (Nurse #3). The first recorded dose at 9:30 AM states that the dose given is 0.2 cc [cc's are equal to milliliters] however, documentation in subtracting the dose from the amount remaining it reflects that 2 cc (Totaling 40 mg of Morphine) were subtracted and used. In reviewing the documented dose given at 10:30 AM the issue is repeated in that the dose

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SURPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0198	A. BUILDING: B. WING	R-C 08/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PROVIDENCE	**47 WEST SPRING STREET WINOOSKI, VT 05404**

(X4) tad PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR [SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R128	Continued From page 2	R128		

given states 0.2 cc, however in subtracting the documented dose from the amount remaining in the bottle: it reflects that 2 cc were subtracted and used. The last dose prior to the Resident's death at 11:30 AM documentation states that the dose given was 0.2 cc and in subtracting the dose from the amount remaining it reflects that the correct 0.2 cc were subtracted and used.

It is noted that the amount remaining at the change of shift, between the 11-7 shift and the 7-3 shift on 4/14/18, is 28.9 ml (confirmed at the change of shift count). The amount remaining is documented as 26.9 nil after the 9:30 AM dose, 24.9 ml after the 10:30 AM dose and 24.7 ml's after the 11:30 AM dose. The final note on the CMUR states that on "4/14/18 at 1440 wasted 24.7 cc morphine sulfate as resident is deceased" and signed by the Director of Health Services (DHS) who was called in at the time of the resident's death. There is a difference of 3.6 ml's between the amount remaining (24.7 cc) and the amount that would remain (28.3 ml's) had the correct amount been used for each of the 3 doses.

This death was not referred to the Office of the Medical Examiner at the time, despite the fall that preceded the death or the medication errors. The facility was not aware of the medication errors until brought to their attention by the surveyor.

The documentation reflects that the resident received 40 mg of morphine at 9:30 AM and an additional 40 mg at 10:30 AM and 4 mg at 11:30 AM for a total of 84 mg in a 2 hour span. The resident was pronounced dead by the RN at 12:20 PM on 4/14/18. On the Medication Administration Record the RN initialed giving 2

5.5.C

I was not clear with the surveyor on site regarding this issue. I was not certain if I called the Medical Examiner's office to report the death. Consequently, I called the Medical Examiner's office and they confirmed that I did call to report resident death at 14:40 on 4/14/18.

As per 5.17.c when a resident dies unexpectantly or within 48 hours of a fall or injury, specific information must be reported to both the ME office and the Agency. This process was followed on 4/14/18 as per documentation in resident record and on file at ME and Agency offices.

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
	0198	• A BUILDING B. WING	R-C 08/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PROVIDENCE	47 WEST SPRING STREET WINOOSKI, VT 05404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(x5) COMPLETE DATE

R128 Continued From page 3

doses of PRN Morphine and on the reverse documented a dose at 9:30, 10:30 was listed but not completed and crossed out and the 11:30 dose was recorded. There is insufficient information in the nurse's note to determine the effect of the 3 recorded doses of morphine or that 3 doses were actually administered, nor what symptoms triggered the administration. The entire 7-3 note states "04-14-18 7-3 12:55 Resident restless restless RR 42, grimacing. Received Morphine 0.2 ml PO and Ativan 0.5 ml SL (with) good results. Resident pronounced at 1220. No pulse no RR for 1 minute. VNA (Visiting Nurses Association) notified of death. VNA provider will notify Dry Maclean. Minor Funeral Home notified. (Nurse's Signature)"

The DNS confirmed, in interviews on 8/9/18 and 8/15/18 that the amount of Morphine wasted was correct within a very small margin (due to bottle markings) at the dose remaining of 24.7 ml's. The RN involved made statements during interview on 8/9/18 stating that s/he did not recall the details of the medication administration on 4/14/18, there were various size syringes in the medication cart at the time, and that s/he may or may not have Used a 3 ml syringe by mistake. The same nurse submitted a written statement on 8/14/1, 8 recanting the statements made on 8/9/18 other than confirmation of insufficient and incorrect documentation confirmed in both statements.

The facility completed an Immediate Plan of Action on 8/9/2018 for remediation of all staff regarding administration of Morphine and Hydromorphone (being administered to another resident at the time) which would be conducted prior to each shift coming on until all nurses had been educated.

R128

The pharmacy vendor for this RCF is Health Direct. The pharmacist was contacted and a request for appropriate and accurate labeling of amounts in liquid narcotic bottles was made **(Completed 9/19/18)**. When the bottle of MORPHINE is sent to the facility it is typically an unopened bottle of 30 ml. When looking to bring the bottle into supply, the amount in the bottle is most frequently above the 30 ml line. Consequently, the amount in the bottle is never documented accurately. Per the pharmacist, the manufacture is granted a +/- 10% deviation from amount stated on the bottle. The pharmacist states there is no way to change this and there is no external measuring device that can be used to count more accurately.

ACTION:

- Review policy for counting and accepting liquid narcotic medication into facility.

MEASURE:

- Retraining and remediation with staff nurses accepting narcotic and other medications from the pharmacy to ensure accuracy and consistency in the process. **Completion date: 10/14/18**
- Update policies around the acceptance and documentation of narcotic medications from pharmacy vendor to ensure they reflect accurate amount of drug in bottle. **Completion date:10/14//18**

MONITORING:

- Ongoing review and update of pharmacy policies to ensure they are reflective of current changes in best practice (DHS, pharmacist and facility nursing team)
- Quarterly review with pharmacy vendor to ensure adherence to stated policy and procedures around the delivery and acceptance of controlled substances. (DHS, pharmacist and facility nursing team)

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
	0198	A. BUILDING: B. WING	R-C 08/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PROVIDENCE	47 WEST SPRING STREET WIN OOSKI, VT 05404

(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
{R146}1, Continued From page 4		(R146)		
(R146) SS-D	V. RESIDENT CARE AND HOME SERVICES 5.9. C (3) Provide instruction and supervision to all direct care personnel regarding each residents health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility has failed to correct this deficiency, as there is not delegation documentation of all nursing tasks completed for each staff member delegated, nor are there any nurses who are prepared to delegate nursing tasks to LNAs (Licensed Nursing Assistants) and PCAs (Personal Care Assistants). The current nursing staff were either new to the facility or were uncomfortable and unwilling to delegate. No new negative outcomes are identified.	(R146)	**5.9.C(3)** **ACTION:** • All nurses will participate in a training regarding appropriate delegation to others. • Ongoing education addressing nursing delegation including information from the Vermont State Nurses' website: o https://www.sec.state.vt.us/media/369178/PS-Role-of-the-Nurse-in-Delegating-Nursing-Interventions.pdf • Nursing staff will be competent in all skills required to meet the ongoing needs of the residents in the community. • Annual training and competency checks completed one on one or in group setting. **MEASURES:** • Ongoing training of care giver staff to ensure competence in the skills required to provide care to residents independently in the community. **Completion date: 10/14/18** • Research, develop and implement a stronger evidence-based policy addressing delegation by nursing staff. **Completion date 10/14/2018** • Sustainable and reliable documentation to determine the level of competence for each care giver so that the nurse may delegate accordingly. **Completion date 10/14/18** • Ongoing mentoring, training and support to ensure all nursing staff understand delegation and are doing so appropriately. **Completion date: 10/14/18**	
R150 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9. C (7) Assure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken; This REQUIREMENT is not met as evidenced by: Based on record review the facility failed to assure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken for four of five residents	R150		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0198	A. BUILDING: B. WING	R-C 08/1412018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE ZIP CODE
OUR LADY OF PROVIDENCE	47 WEST SPRING STREET WINOOSKI, VT 05404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) Completely DATE
R150	Continued From page 5	R150		

Reviewed. Findings include:

1). per record review on 7/10/18 at 8:30 PM Resident #1 presented with stridor [an abnormal finding when listening to lung sounds] noted in nurse's note to be a major change in breathing from earlier. Though the note does state that "EMS was called for immediate evaluation of respiratory status." there is no indication that the PCP (Primary Care Physician) was notified of this I Change in condition. There is no indication if the resident was transferred to the Emergency Room (ER) for evaluation and admitted to the hospital. The next nursing note is on 7/17/18 at 4 PM states that the resident returned to the community in a wheelchair van with no indication if the return was from the hospital or an MD appointment. On 7/17/18 at 8:30 PM the resident was found lying on the floor outside his/her room. There is no evidence of regular assessments and vital signs and the documentation appears to state that the PCP was notified by the Physical Therapist, who visited the resident, for an evaluation, at 10 AM the next morning. The resident was sent to the ER and admitted to the hospital, although the record does not state that s/he was admitted until re-admission from hospital on 7/24/18. The resident's condition continued to deteriorate and Hospice services were initiated on 7/27/18. The resident expired on 7/30/18.

2). Per record review Resident #4 is described in a nurses note on 4/4/18 during the 7 AM-3 PM shift as showing signs of swallowing less efficiently. The note states "Will monitor closely" and "follow-up with MD if necessary." The note also describes "gurgling (a few) sounds in throat". There are no further notes reflecting close monitoring, and the resident's condition until a note is written on 4/11/18. That note states that

5.9.C (3)

MONITORING:

- Annual training and competencies around nursing delegation of tasks and ensure appropriate remediation is in place to support less than optimal competency demonstration. (DHS)
- Annual review and updates to Delegation Policy once implemented. (DHS)

5.9.C (7)

ACTION:

- Education around appropriate documentation and follow up for identified resident issues.
- All nurses will be educated about how and what to communicate to the appropriate physician regarding resident health status and changes.
- The implementation of SBAR to support consistent and comprehensive communication between community nurses and physician offices.

MEASURE

- Nurses have been educated in the SBAR process of communication in an effort to strengthen communication between staff and shifts. **Completion date: 10/14/18**
- Nurses have received education and resources around best practice to build stronger documentation practices and skills. **Completion date: 10/14/18**
- Nurses have received education around facility policies and processes. **Completion date 10/14/18**

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
	0198	A. BUILDING. B. WING	R-C 08/1412018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY, STATE, ZIP CODE
OUR LADY OF PROVIDENCE	47 WEST SPRING STREET WINOOSKI, VT 05404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR [SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R150	Continued From page 6	R150		

The resident is "Throwing arms/legs, taking covers off, moaning and grimacing." On 4/12 the 7-3 shift the resident is described as "pocketing fluids. Difficulties getting her to drink choc milkshake". On the evening shift of 4/12/18 the resident is described as unresponsive, neck and tongue swelling, not able to swallow without difficulty x 8 days. The note states that the PCP office was notified and a referral made to Hospice. In a review the first notification of the PCP appears to have been done 8 days after the initial difficulty in swallowing was identified. The resident was admitted to Hospice on 4/13/18 and expired on 4/14/18 at 12:20 PM.

3). Per record review a note on 7/24/18 states that Resident *5 had "not eaten anything but 2 tsp ice cream. Res very lethargic, skin turgor poor." The next note was written on 7/30/18 (6 days later) and there were no notes to indicate that the resident was monitored for signs of Dehydration since the note 6 days earlier. In other notes the resident is described as having a Worsening pressure ulcer. There is not documentation found of regular assessments of the wound. The resident was on Hospice and his/her condition continued to fluctuate and move between unresponsive and awake and alert until his/her death on 8/13/18.

4). Per record review Resident *3 was readmitted to the facility on 6/21/18 after Short-term Acute Rehabilitation (SAR) after suffering a stroke. There are notes written for the day, evening, and night shifts. The resident's weight, height, and temperature are recorded on the evening shift, however a full set of vital signs are not recorded on any shift. There is not another note until the resident fell on 7/4/18 which shows continued assessment of the resident's condition/ abilities. A

5.9.C (7)

MONITORING:

- Ongoing audits of nursing notes and documentation in the resident medical record to ensure documentation meets expectations as outlined in the facility policies will be made available to nursing staff.
- Remediation will occur based on findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/Celia IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	0198	B WING	R-C 08/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY, STATE, ZIP CODE
OUR LADY OF PROVIDENCE	**47 WEST SPRING STREET WINOOSKI, VT 05404**

(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
R1501	Continued From page 7	R150		

note on 7/8/18 describes the resident able to eat toast but "unable to hold silverware or cup." On 7/13/18 a note states "encouraged to feed self with little success. Resident had a very hard time, especially c [with] utensil use. Was very embarrassed, ended up being fed and was unhappy everyone was watching." The notes Between 7/8/18 and 7/13/18 did not address the . Resident's functional status or any improvements.

(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 providing any direct care to residents. There shall be at least twelve (1.2) 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.

5.11.b

ACTION:

- All staff (direct care and others) who are involved in the day to day activities of the residents were assigned a minimum of 7 mandatory trainings as outlined in the regulations for residential care facilities.
- All care givers were assigned 5 trainings (beyond the 7 mandatory trainings) pertinent to identified knowledge gaps and the work being done.
- Ongoing mentoring and opportunities for training/learning with staff in the act of care giving whenever possible will be documented as training opportunities and will be included in the final tally of hours of training.

MEASURES:

- An internal staff member has been identified as the person responsible for assigning and monitoring RELIAS completion status. **Completion date 10/14/18**
- All completion reports will be ran and reviewed monthly with the DHS for progress to goal. **Completion date 10/14/18**

MONITORING

- Monthly reports ran and reviewed with the DHS to encourage and support completion of assignments.

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
	0198	B. WING	R-C 08/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY STATE, ZIP CODE
OUR LADY OF PROVIDENCE	47 WEST SPRING STREET WINOOSKI, VT 05404

(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

{R179} Continued From page 8 {R179}

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility has failed to correct this deficiency. The facility has not met the stated actions or timelines of their accepted Plan of Correction due to the in services not being conducted as stated in the plan of correction, the plans for the training of new employees and the completion of training by existing employees not being completed as stated, and the documentation of the in services not present for some of the trainings that have been provided.

{R188} V RESIDENT CARE AND HOME SERVICES {R188}
SSE

5.12. b. (2)

A record for each resident which includes: resident's name; emergency notification numbers; name, address and telephone number of any legal representative or, if there is none, the next of kin; physician's name, address and telephone number; instructions in case of resident's death; the resident's assessment(s); progress notes regarding any accident or incident and subsequent follow-up; list of allergies; a signed admission agreement; a recent photograph of the resident, unless the resident objects; a copy of the resident's advance directives, if any completed; and a copy of the document giving legal authority to another, if any.

This REQUIREMENT is not met as evidenced

5.12.b:

ACTION:

- Each incident report is forwarded to the DHS who in turn reviews the documentation on the incident report and completes any type of investigation as needed.
- The DHS then pulls resident chart and reviews nursing notes as pertains to the incident and should find documentation of: the incident and immediate findings, the one-hour post check findings and documentation of the 24-hour post check findings.
- Based on severity of incident resident may require closer follow up or transport to the emergency room of which clear documentation should be evident.

MEASURES:

- A statement has been added to the current version of the incident report that indicates the DHS has reviewed the reported incident and assessed nursing notes for complete documentation of incident with appropriate follow up notes and actions. **Completion date: 10/14/18.**

MONITORING:

- Ongoing review of each incident report by the DHS upon presentation and investigate as needed. The DHS signature will indicate the review was completed.
- All incident reports will be reviewed by the Administrator who will collaborate with the DHS to complete a root cause analysis as indicated.

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDEP/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0198	A. BUILDING: B. WING	R-C 08/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PROVIDENCE	47 WEST **SPRING STREET** Winooski, VT 05404

(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

{R188} Continued From page 9

By:
Based on interview and record review, the facility has failed to correct this deficiency. The facility has a new incident report which has just been put into use and there is no evidence of the concurrent monitoring of progress notes that describe the incident fully and contains Appropriate investigation or follow-up.

{R200} SS=F V. RESIDENT CARE AND HOME SERVICES

5.15 Policies and Procedures

Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request.

This REQUIREMENT is not met as evidenced by:
Per interview and record review, the facility has failed to correct this deficiency. Per interview with the DNS, and review of policies, the facility is missing policies regarding medication documentation, who is responsible for delegation, and other components of medication management as well as clinical policies for all care and services provided..

R203 SS=D V RESIDENT CARE AND HOME SERVICES

5.17 Death of a Resident

5.17.an In those deaths in which the law applies (such as an unexpected, untimely death), Pursuant to 18 V.S.A. §5205 (a), the manager shall be responsible for immediately notifying the

{R188}

5.15:

ACTION:

- The written policies and procedures that govern all services provided by the Health Services department will be reviewed and updated based on best practice measures identified.
- Health Services staff will be required to review and access updated policies and procedures to guide practice in the home.

MEASURES:

- Ongoing clinical team to complete policy review to update, remove and add policies as needed in support of the work being completed in the Health Services Department. **Completion date: 10/14/18**

MONITORING:

- New policies will be developed based on resident care needs.
- Policies will be reviewed by the team every 3 years or more frequently if needed to incorporate changes in best practice.
- All approved policies will contain date and signature by the Director of Health Services

5.17:

Follow-up telephone call to the ME office demonstrates the death was reported by this writer to the Medical Examiner's office on 4/14/18 at 1440.

{R200}

R203

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
	0198	A. BUILDING: B. WING	R-C 08/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PROVIDENCE	47 WEST SPRING STREET WINOOSKI, VT 05404

(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R203	Continued From page 10 Regional medical examiner This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to report a death to the Medical Examiner as required for Resident #4. Findings include: Per record review Resident #4, who was on Hospice, was found on the floor beside the bed on 4/12/18 and died on 4/14/18. Although the resident was on Hospice, the fact that the fall occurred within 48 hours of death should have triggered a report to the Office of the Medical Examiner. This was confirmed by the DNS on 8/14/18.	R203	There was no note written in the resident chart after she passed that indicated the proper authorities were notified. This writer takes responsibility for that as this writer is the one who made the calls. **ACTIONS:** • The policy in place will be reviewed with all staff and updated as needed to reflect expectations of State Regulations guiding RCH. to include when and how to report an untimely death. **MEASURES:** • Ongoing education for nursing staff to ensure all appropriate actions are completed upon the untimely death of a resident. **Completion date: 10/14/18** • Education to nursing staff to guide them through the steps required for identifying an untimely death and the activity that must follow. **Completion date: 10/14/18** **MONITORING:** • Documentation by nurse on duty at time of death (untimely and otherwise) will be reviewed and noted by the DHS or delegate within 24 hours of the time of death.	
R213 VI	RESIDENTS' RIGHTS 6.1 Every resident shall be treated with consideration, respect and full recognition of the resident's dignity, individuality, and privacy. A home may not ask a resident to waive the resident's rights. This REQUIREMENT is not met as evidenced by: Based on record review the facility failed to assure that residents were treated with consideration, respect and full recognition of the resident's dignity for 1 of 5 residents reviewed, Resident #3. Findings include: Per record review Resident #3 was readmitted to the facility on 6/21/18 from Short-term Acute Rehabilitation (SAR) after suffering a stroke. The	R213		

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
	0198	A. BUILDING B. WING	R-C 08/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PROVIDENCE	47 WEST SPRING STREET WINOOSKI, VT 05404

(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

R213 Continued From page 11
R213

Resident's Left Upper extremity was most affected by the stroke. The resident was found on the floor at the bedside on 7/4/18 with no apparent injury post fall. On 7/7/18 the resident was again found on the floor and was transported to the hospital where a Fracture of the Right Numerus (a bone in the upper arm) was found. The resident was readmitted to the facility on 7/7/18 with his/her right arm in a sling and limited function in that arm.

A note on 7/8/18 describes the resident able to eat toast but "unable to hold silverware or cup." On 7/13/18 a note states "encouraged to feed self with little success. Resident had a very hard time, especially c [with] utensil use. Was very embarrassed, ended up being fed and was unhappy everyone was watching." There is no evidence that the resident was offered the opportunity to move to a more secluded spot to eat or offered more manageable foods such as sandwiches, to reduce embarrassment.

A note on 7/16/18 stated resident needs to use two hands for the call light. On 7/20/18 the resident was placed on an antibiotic for a UTI (Urinary Tract Infection). There are notes describing the resident becoming increasingly anxious and agitated, using the call light frequently, and asking "what do I have to do about it if I need to urinate?" On 7/19/18 Nurse #3 documented as follows: "Resident asked not to scream/ holler out 'help'. (Res) understands how call light operates and to use that instead of yelling." On 7/22/18 Nurse #4 documented "resident on call bell/light every 2-3 minutes between 1600-1700. Asked resident if call light switch could be placed beside him/her instead of in his/her hand and s/he replied affirmatively". The note also states "anxiety over being left

6.1

ACTIONS:

- All staff have been assigned the 3 RELIAS module trainings to reinforce the intent of 6.1: "every resident shall be treated with consideration, respect and full
- recognition of the resident's dignity, individuality, and privacy. A home may not ask a resident to waive the resident's rights"
    - *AL Care of the Cognitively Impaired;*
    - *Communicating with People with Dementia;*
    - *Protecting Resident Rights in Assisted Living Facilities*

- Ongoing training on how to work with residents with a diagnosis of dementia by completing the RELIAS module titled: ***Dementia: Nursing Evaluation and Care***

MEASUREMENT:

- Ongoing assignments and competencies to support work. **Completion date 10/14/18**

MONITORING:

- Ongoing monitoring of completion reports to be reviewed with the DHS to ensure compliance with regulations and facility policies around mandatory education and training

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(Xi) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0198	A. BUILDING' B. VVING	R C 08/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PROVIDENCE	47 WEST SPRING STREET WINOOSKI, VT 05404

(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
R213	Continued From page 12	R213		

Alone." And "resident yelling out help me help me!". In notes also "resident would stare blankly and ask 'what do I do if I have to urinate?' and "Resident would be told it was OK to urinate in brief". Nurse #5 confirmed in interview on 8/14/18 that those things were said to the resident without consideration of dignity or safety.

On 8/14/18 the DNS confirmed that it was unacceptable to remove the call light from the resident's hands and to suggest urinating in a brief to a resident.

{R266} SS=D IX. PHYSICAL PLANT (R266)

9.1 Environment

9.1.at The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to provide a safe environment for one resident, Resident #3, by limiting his/her access to a call light. This is an uncorrected violation; however, it is cited due to different factors than the original 4/11/18 citation. Findings include:

Per record review Resident #3 was readmitted to the facility on 7/21/18 from Short-term Acute Rehabilitation (SAR) after suffering a stroke. The resident's Left Upper extremity was most affected by the stroke. The resident was found on the floor at the bedside on 7/4/18 with no apparent injury

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	0198	B. WING	R-C **08/14/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PROVIDENCE	**47 WEST SPRING STREET WINOOSKI, VT 05404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST DE 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 APPROPRIAT'E DEFICIENCY)	(X5) I COMPLETE DATE

(R266) Continued From page 13

Post fall. On 7/7/18 the resident was again found on the floor and was transported to the hospital where a Fracture of the Right Numerus (A bone in the upper arm) was found. The resident was readmitted to the facility on 7/7/18 with his/her right arm in a sling and limited function in that arm.

A note on 7/16/18 stated resident needs to use two hands for the call light. On 7/20/18 the resident was placed on an antibiotic for a UTI (Urinary Tract Infection). There are notes describing the resident becoming increasingly anxious and agitated, using the call light frequently, and asking "what do I have to do about it if **I** need to urinate?"

On 7/22/18 Nurse #4 documented "resident on call bell/light every 2-3 minutes between 1600-1700. Asked resident if call light switch could be placed beside him/her instead of in his/her hand and s/he replied affirmatively" The note also states "anxiety over being left alone" And "resident "yelling out help me help me!". The nurse confirmed in interview on 8/14/18 that the call light was removed from the resident's hands with the thought that the repeated use was unconscious but that it was not determined if the resident could access or use the call light.

On 8/14/18 the DNS confirmed that it was unacceptable for a call light to be moved from a resident's hand because of overuse.

(R260)

9.1:

ACTIONS:

- Have completed an initial training and will provide ongoing support. training that addresses the meaning of providing and maintaining a safe, functional, sanitary, homelike and comfortable environment.

MEASUREMENT:

- All Health Services staff will be mandated to attend at least one training as stated above. All attendees will sign in and take a pre-test and post-test to determine understanding and ascertain level of knowledge gained. **Completion date 10/14/18**

MONITORING:

- The training will be embedded in the annual training schedule and will be a mandated training for all Health Services staff.

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
	0198	A. BUILDING: B WING	R-C 08/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PROVIDENCE	47 WEST SPRING STREET WINOOSKI, VT 05404

(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: (R100)

An unannounced onsite follow up and complaint investigation was initiated on 8/7/18 and concluded on 8/14/18. There are 5 violations that are uncorrected from the 4/11/18 survey, and 4 new citations as a result of concurrent investigations into reported incidents. A violation was identified that required immediate corrective action due to the potential of serious harm to residents regarding medication administration (see R128). Prior to the completion of the survey on 8/14/18, the facility had identified a plan to immediately correct the violation and had completed steps to ensure resident safety.

R128 V RESIDENT CARE AND HOME SERVICES SS=J R128

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 the facility failed to Assure that services were consistent with Physician's orders regarding administering Controlled medications. This citation represents a situation that required immediate corrective action due to the risk of serious harm or death of residents if remained un-noticed and uncorrected. The facility presented a plan for immediate corrective action prior to the exit on 8/14/18. Findings include:

Per record review, Resident #4 was admitted to the facility on 10/24/16. Resident #4 experienced

5.5.c

ACTION:

- Corrective action was created and given to the onsite surveyor (MH) who accepted and endorsed plan at time of presentation.
- Review of appropriate process, demonstration of correct process and remediation with each nurse was documented. All were successful in providing a return demonstration.

MEASURES:

- Nurses will monitor each other at the change of each shift by: reviewing the last several (at least 5) entries to determine any mathematical errors, focus on process at hand (counting and reconciling controlled drugs) for each cart; documenting and reporting any errors or inconsistencies noted in the count. **Completion date: 8/13/18**
- Any errors are to be brought to the Director of Nursing immediately for review, discussion and potential action. **Completion date: 8/13/18**
- Schedule monthly meetings with nurse teams to review findings and provide appropriate remediation and training to correct any errors noted. **Completion date: 10/31/18**

OK Bschell 9/19/18 Our Lady of Providence Administrator

Note: This page only applicable to final packet due to signature of Manager.