

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

November 6, 2018

Ms. Rachael Parker, Manager Sterling House At Richmond 61 Farr Road Richmond, VT 05477-9301

Dear Ms. Parker:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 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

amlaMCotaRN

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		
		. 0591	B. WING		C 10/08/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	21
STERLIN	G HOUSE AT RICHM	OND 61 FARR I		7	
		RICHMON	ID, VT 0547	PROVIDER'S PLAN OF CORRECT	ION (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
R100	Initial Comments:		R100		
	An uannounced on was conducted by Protection on 10/8/following: V. RESIDENT CAF 5.7 Assessment 5.7.a An assessment each resident withing	-site complaint investigation the Division of Licensing and 18. The findings include the RE AND HOME SERVICES ent shall be completed for in 14 days of admission, physician's diagnosis and	R134	1. Resident As was comple Resident #1 2. Reviewed w Staff that Ri assess each within 14 de admission	ted for vith Licensed N's must resident ays of
	orders, using an as by the licensing ag regarding medicati assessed within 24 implemented, if ne This REQUIREME by:	ssessment instrument provided ency. The resident's abilities on management shall be hours and nursing delegation cessary. NT is not met as evidenced		4. 10/08/2018	by the rough audits
*	interview, the facili to ensure that 1 of admission assess	eview and confirmed by staff ty Registered Nurse(RN) failed 3 sampled residents, had the ment completed in the required ays (Resident #1). The e following:		R-134 POC acup m. Bertrand, EU	ted 11/5/18 15. leny. es
Division of L	admitted on 8/24/1 assessment was to of admission. For was due for compl signed the assess 5 days post due. confirmed on 10/8	d review for Resident #1, was 18. The State required of be completed within 14 days Resident #1, the assessment letion on 9/7/18. The RN ment as completed on 9/12/18, The Licensed Practical Nurse 1/18 at approximately 10 AM assessment was over due.			(XE) DATE

ABORATORY PIRECTOR'S OR PROVIDER/SUPPLIER/REPRESENTA

ages 10/20

(XO) MALE

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If continuation sheet 1 of

Division of Licensing and Pr	otection			T == == == 1			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
*		B. WING	· · · · · · · · · · · · · · · · · · ·	C 10/08/2018			
	0591	D. VVIIVO		10/00/2010			
NAME OF PROVIDER OR SUPPLIER	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
STERLING HOUSE AT RICHMOND 61 FARR ROAD RICHMOND, VT 05477							
PREFIX (EACH DEFICIENC	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND	JLD BE COMPLETE			
R150 Continued From p	age 1	R150					
	RE AND HOME SERVICES	R150	N.	No.			
SS=D	•		R150 Resident o	are and			
5.9.c (7)		***************************************	Home Services 1. Late Entry n	ote was			
	coms or signs of illness or	7	written to re				
accident are record	ded at the time of occurrence, aken;		symptoms/				
This REQUIREME	ENT is not met as evidenced		condition ar				
by:			taken by the Resident #1				
by the Registered	Based on medical record review and confirmed by the Registered Nurse (RN), the facility failed to assure that 1 of 3 sampled residents, had signs and symptoms of an illness recorded at the time of the condition change and included the actions		2. Education p				
assure that 1 of 3 and symptoms of			staff that ch	art in the			
of the condition ch			record to er				
	taken by the facility (Resident #1). The findings include the following:		documenta time of the				
Per record review	, Resident #1 was identified on		3. This will be				
9/20/18 as calling	facility staff for assistance. The not identify the time the			dom audits.			
resident was calling	ng loudly, but was found with	and a second	Weekly x 1r 4. Completed				
concentrator and	nnula disconnected from the improperly placed on the		4. Completed	10/20/2018			
resident. The RN anxious and upse	identified that the resident was t. The resident stated "that	indukati (ranthur ngalai)	0 150 000 0100	11/5/18			
[his/her] voice wa	s hoarse from yelling for help". ygen saturation level at that time		R-150 POCacupt M.Bertrand, Rr	c (15110			
was 70% (very lo	w). The RN reconnected the		M. Bertrand, Rx	s lengto			
reapplied on the r	entrator, the cannula was esident and within 15 minutes	and a department					
the resident's oxy	gen saturation elevated to 88%. monitored closely and remained	f					
between 87-88%	saturated. The RN documented		10 10 10 10 10 10 10 10 10 10 10 10 10 1				
and place. Both t	was mentally oriented to time the caregiver and medication						
technician were nobservations were	nade aware that frequent	No.	3				

	f Licensing and Pro	tection (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		Notes and an a	A. BUILDING:		COMPLETED		
					C	C 10/08/2018	
		0591	B. WING] 10/08	3/2018	
NAME OF PR	ROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE			
STERLING	HOUSE AT RICHM	OND 61 FARR	ROAD ND, VT 05477			<u> </u>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
R150	Continued From pa	ige 2	R150				
	conversation, that s the concentrator th that a lung assessr	n on 10/8/18 via a telephone s/he did check the flow rate of at was ordered to be at 4 L/M, nent was conducted, and that	And a second sec	.1 ,			
	resident, the Execu	communication with the utive Director (ED) and the ughout the shift and during the the progress of the resident.			* *,		
	telephone conversion physician on the eventhe possibility of a the RN and the ED communication that	ector confirms on 10/8/18 that ation had taken place with the vening on 9/20/18 to discuss Palliative Care consult. Both confirm that none of the at took place on 9/20/18 was lent #1's medical record.	a .				
	10/8/18, confirmati the resident was d oxygen saturation that this appeared and 911 was called transported to the this time that there Resident #1's med events or the action	with the Executive Director on on was made that on 9/21/18 ifficult to wake despite an of 92%. The ED determined to be a mental status change d. The resident was hospital. The ED confirms at is no documentation in lical record that identifies the lins taken on 9/21/18 that tance of Emergency Medical				The control of the co	
*	See also R151.	*	- 1989 - 1				
R151 SS=D	V. RESIDENT CA	RE AND HOME SERVICES	R151				
	5.9.c (8)						
	Ensure that the re changes in a resid	sident's record documents and dent's condition;	У	The state of the s			

	of Licensing and Pro	ptection		CONCEDUCTION	(X3) DATE SURVEY
STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		
					C
		0591	B. WING		10/08/2018
			DESC SITY S	TATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER			JATE, ZIP CODE	
OTEDLIA.	IG HOUSE AT RICHM	OND 61 FARR I			Į.
SICKLIN	IG HOUSE AT MOTHE	RICHMON	ID, VT 05477	The state of the s	1011
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL	ION (X5)
PREFIX				CROSS-REFERENCED TO THE APPRO	OPRIATE DATE
TAG	REGULATORY OR L	SCIDENTI TINO IN GIAMATICIA	TAG	DEFICIENCY)	
	***		D454		
R151	Continued From pa	age 3	R151		160
		*			
	This REQUIREME	NT is not met as evidenced			
	by:	v		5 ×	
	Based on medical	record review and confirmed			
14	by the Registered	Nurse (RN), the facility failed to			
	assure that 1 of 3	sampled residents medical			4
	record had docum	entation that identified a			
	change in the resid	dent's condition		R151	
	(Resident #1). The	e findings include the following:			
			***************************************	1 Lata Fata	anto was
	Per record review,	Resident #1 was identified on	and	1. Late Entry	
	9/20/18, as calling	facility staff for assistance.	Page State	written to r	ecord the
	The progress note	s do not identify the time the		symptoms/	change of
	resident was callin	g loudly, but was found with	g.orgoner	condition a	T
	his/her oxygen car	nnula disconnected from the			
	concentrator and t	mproperly placed on the identified that the resident was		taken by the	e facility for
*	resident. The KN	t. The resident stated ["that		Resident #1	
	his/hor vaice was	hoarse from yelling for help"].	-	2. Education p	rovided to
	The resident's avv	gen saturation level at that time	pt-transaction in the state of		
	was 70% The RN	I reconnected the tubing to the		staff that ch	iart in the
	concentrator the	cannula was reapplied on the	0.14	record to e	nsure
	resident and within	n 15 minutes the resident's		documenta	tion at the
	oxvoen saturation	elevated to 88%. The resident	Service of	time of the	incident
	was monitored clo	sely and remained between			
	87-88% saturated	. The RN documented that the	1,8000 200	3. This will be	
	resident was men	tally oriented to time and place.		through rar	idom audits.
	Bot the care giver	and medication technician	· ·	Weekly x 1	month.
		that frequent observations	1	4. Completed	
	were required.			4. Completed	10/20/2010
	TI DN 5	as 10/9/19 vis a talanhana			
	ine RN confirms	on on 10/8/18 via a telephone		R-15/POCaccepted M. Bentrand, RU	11/5/18
	conversation, that	s/he did check the flow rate of hat was ordered to be at 4 L/M,		R-15/100 accepted	-11/21/0
	that a lung access	sment was conducted, and that		m Berband (2)	(s. leny, R)
	there was onnoing	g communication with the		111.3211104101130	0
	resident the Ever	cutive Director (ED) and the	a March and		
	care providers thr	oughout the shift and during the	9		
	evening shift, as t	o the progress of the resident.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
AND FORM OF COMMECTION	an of correction identification to the correction is		A BUILDING.		c	
	0591	B, WING		4	08/2018	
NAME OF PROVIDER OR SUPPLIES	R STREET AD	DRESS, CITY, S	TATE, ZIP CODE	% .		
STERLING HOUSE AT RICH	MOND 61 FARR I	ROAD ID, VT 05477				
DREEN JEACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	TIVE ACTION SHOULD BE CED TO THE APPROPRIATE		
R151 Continued From p	page 4	R151	5	40.		
telephone conver physician on the extreme the possibility of a the RN and the Examination the documented Resident was oxygen saturation that this appeared and 911 was called transported to the this time that there is the events or the activation of the activation of the context of the conte	rector confirms on 10/8/18 that a sation had taken place with the evening on 9/20/18 to discuss a Palliative Care consult. Both D confirm that none of the last took place on 9/20/18 was ident #1's medical record. with the Executive Director on tion was made that on 9/21/18 difficult to wake despite an of 92%. The ED determined in the distribution of 92%. The ED confirms at the is no documentation in dical record that identifies the ons taken on 9/21/18 that stance of Emergency Medical					
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