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

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

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
	0591	A. BUILDING: ______ B. WING ______	C 10/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE AT RICHMOND	61 FARR ROAD RICHMOND, VT 05477

(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 uannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on 10/8/18. The findings include the following:	R100		
R134 SS=A	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 confirmed by staff interview, the facility Registered Nurse(RN) failed to ensure that 1 of 3 sampled residents, had the admission assessment completed in the required time frame of 14 days (Resident #1). The findings include the following: Per medical record review for Resident #1, was admitted on 8/24/18. The State required assessment was to be completed within 14 days of admission. For Resident #1, the assessment was due for completion on 9/7/18. The RN signed the assessment as completed on 9/12/18, 5 days post due. The Licensed Practical Nurse confirmed on 10/8/18 at approximately 10 AM that the admission assessment was over due.	R134	R134 1. Resident Assessment was completed for Resident #1 2. Reviewed with Licensed Staff that RN's must assess each resident within 14 days of admission 3. This process will be monitored by the manager through audits 4. 10/08/2018 R-134 POC accepted 11/5/18 M. Bertrand, RN / S. Perry, RN	

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Manager (X6) DATE 10/20/18

Division of Licensing and Protection

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R150	Continued From page 1	R150		
R150 SS=D	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 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 taken by the facility (Resident #1). The findings include the following: Per record review, Resident #1 was identified on 9/20/18 as calling facility staff for assistance. The progress notes do not identify the time the resident was calling loudly, but was found with his/her oxygen cannula disconnected from the concentrator and improperly placed on the resident. The RN identified that the resident was anxious and upset. The resident stated "that [his/her] voice was hoarse from yelling for help". The resident's oxygen saturation level at that time was 70% (very low). The RN reconnected the tubing to the concentrator, the cannula was reapplied on the resident and within 15 minutes the resident's oxygen saturation elevated to 88%. The resident was monitored closely and remained between 87-88% saturated. The RN documented that the resident was mentally oriented to time and place. Both the caregiver and medication technician were made aware that frequent observations were required.	R150	R150 Resident care and Home Services 1. Late Entry note was written to record the symptoms/ change of condition and actions taken by the facility for Resident #1. 2. Education provided to staff that chart in the record to ensure documentation at the time of the incident. 3. This will be monitored through random audits. Weekly x 1month. 4. Completed 10/26/2018 R-150 POC accepted 11/5/18 M. Bertrand, RN / S. Perry, RN	

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R150	Continued From page 2 The RN confirms on on 10/8/18 via a telephone conversation, that s/he did check the flow rate of the concentrator that was ordered to be at 4 L/M, that a lung assessment was conducted, and that there was ongoing communication with the resident, the Executive Director (ED) and the care providers throughout the shift and during the evening shift, as to the progress of the resident. The Executive Director confirms on 10/8/18 that a telephone conversation had taken place with the physician on the evening on 9/20/18 to discuss the possibility of a Palliative Care consult. Both the RN and the ED confirm that none of the communication that took place on 9/20/18 was documented Resident #1's medical record. Per conversation with the Executive Director on 10/8/18, confirmation was made that on 9/21/18 the resident was difficult to wake despite an oxygen saturation of 92%. The ED determined that this appeared to be a mental status change and 911 was called. The resident was transported to the hospital. The ED confirms at this time that there is no documentation in Resident #1's medical record that identifies the events or the actions taken on 9/21/18 that required the assistance of Emergency Medical Service. See also R151.	R150		
R151 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (8) Ensure that the resident's record documents any changes in a resident's condition;	R151		

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R151	Continued From page 3	R151		

This REQUIREMENT is not met as evidenced by:
Based on medical record review and confirmed by the Registered Nurse (RN), the facility failed to assure that 1 of 3 sampled residents medical record had documentation that identified a change in the resident's condition (Resident #1). The findings include the following:

Per record review, Resident #1 was identified on 9/20/18, as calling facility staff for assistance. The progress notes do not identify the time the resident was calling loudly, but was found with his/her oxygen cannula disconnected from the concentrator and improperly placed on the resident. The RN identified that the resident was anxious and upset. The resident stated ["that his/her voice was hoarse from yelling for help"]. The resident's oxygen saturation level at that time was 70%. The RN reconnected the tubing to the concentrator, the cannula was reapplied on the resident and within 15 minutes the resident's oxygen saturation elevated to 88%. The resident was monitored closely and remained between 87-88% saturated. The RN documented that the resident was mentally oriented to time and place. Bot the care giver and medication technician were made aware that frequent observations were required.

The RN confirms on on 10/8/18 via a telephone conversation, that s/he did check the flow rate of the concentrator that was ordered to be at 4 L/M, that a lung assessment was conducted, and that there was ongoing communication with the resident, the Executive Director (ED) and the care providers throughout the shift and during the evening shift, as to the progress of the resident.

Provider's Plan of Correction:

R151

1. Late Entry note was written to record the symptoms/ change of condition and actions taken by the facility for Resident #1.
2. Education provided to staff that chart in the record to ensure documentation at the time of the incident.
3. This will be monitored through random audits. Weekly x 1month.
4. Completed 10/26/2018

R-151 POC accepted 11/5/18
M. Bertrand, RN / S. Perry, RN

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R151	Continued From page 4	R151		

The Executive Director confirms on 10/8/18 that a telephone conversation had taken place with the physician on the evening on 9/20/18 to discuss the possibility of a Palliative Care consult. Both the RN and the ED confirm that none of the communication that took place on 9/20/18 was documented Resident #1's medical record.

Per conversation with the Executive Director on 10/8/18, confirmation was made that on 9/21/18 the resident was difficult to wake despite an oxygen saturation of 92%. The ED determined that this appeared to be a mental status change and 911 was called. The resident was transported to the hospital. The ED confirms at this time that there is no documentation in Resident #1's medical record that identifies the events or the actions taken on 9/21/18 that required the assistance of Emergency Medical Service.