



AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection

103 South Main Street, Ladd Hall

Waterbury VT 05671-2306

<http://www.dail.vermont.gov>

Voice/TTY (802) 241-2345

To Report Adult Abuse: (800) 564-1612

Fax (802) 241-2358

June 30, 2011

Ms. Laura Wilson, Administrator  
Cathedral Square Senior Living  
3 Cathedral Square  
Burlington, VT 05401

Dear Ms. Wilson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 11, 2011**. 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,

A handwritten signature in cursive script that reads "Pamela M. Cota".

Pamela M. Cota, RN  
Licensing Chief

PC:jl



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  1001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/11/2011
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NAME OF PROVIDER OR SUPPLIER  CATHEDRAL SQUARE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 3 CATHEDRAL SQUARE BURLINGTON, VT 05401
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R100	Initial Comments:  An unannounced onsite re-licensing survey was conducted from 5/9/11 through 5/11/11. Findings include:	R100		
R126 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.5 General Care</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assure that necessary services were arranged / provided for 1 applicable resident in the survey sample (Resident #2) Findings include:</p> <p>1. Per observation of medication administration on 5/9/11 at 12:01 PM, Resident #2 was administered Tramadol 50 mg (milligrams) (1 tablet). The Medication Administration Record (MAR) indicated that this order was 'Tramadol 50 mg 1-2 tabs TID (3 times daily)'. This was later confirmed by review of physician orders in the resident's record. During interview following administration of this medication, the Residential Assistant administering the medication stated that 1 tablet of 50 mg Tramadol is routinely administered. During interview at 12:10 PM, the RN (Registered Nurse) stated that no parameters exist for giving either 1 tablet or 2 tablets of this medication and that no clarification has been</p>	R126	<p>PCP re-wrote the order on 5/16/11 as two separate orders, one for Tramadol 50mg 3 times daily, and a second order was written for Tramadol 50mg – 1 tab PO prn – up to three additional doses daily.</p> <p>Physicians will be asked to avoid writing ranges for doses and or administration times. If a physician believes that s/he must give a dose range, specific parameters will be provided by the physician choosing the dose.</p> <p>R126 6-29-11 POC accepted. — C. Lanning, RN</p>	5/16/11

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Jana Welch*, Director TITLE *6.8.11* (X6) DATE

STATE FORM

6899

T9YT11

If continuation sheet 1 of 12

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R126	Continued From page 1 sought from the ordering physician.	R126		
R136 SS=B	V. RESIDENT CARE AND HOME SERVICES  5.7. Assessment  5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, Resident Assessment Instruments (RAIs) for 4 of 7 residents in the survey sample (Resident #1, Resident #3, Resident #4, and Resident #7) were unsigned by the RN (Registered Nurse) indicating completion and accuracy. Findings include:  1. Per record reviews from 5/9/11 through 5/11/11, the RAIs of Resident #1, #3, #4 and #7 were not signed by the RN as complete and accurate. During interview on 5/11/11 beginning at 4:05 PM, the RN confirmed that these assessments lacked his / her signature indicating completion and accuracy.	R136		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES  5.9.c (2)  Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services	R145	As of 5/11/11 the RAI's have been checked for the RN's signature and any not signed were signed and dated in real time.  RAI's will be double checked for accuracy and the nurse's signature prior to being filed in the individual resident charts. R136 - 6/29/11 POC accepted. C. Laraway, RN	5/11/11

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R145	Continued From page 2 necessary to assist the resident to maintain independence and well-being;  This REQUIREMENT is not met as evidenced by: Based on interview and record review, the written plan of care for Resident #1 and for Resident #3 did not include instruction to direct all staff in all areas of each resident's care needs. Findings include:  1. Per record review on 5/11/11, Resident #1 was identified through the RAI (Resident Assessment Instrument) by the RN (Registered Nurse) as requiring assistance with bowel and bladder management, as these had worsened since the prior annual assessment was completed. During interview at 4:11 PM, the RN confirmed that the resident's bowel and bladder function had declined and that the plan of care did not indicate this change.  2. Per record review on 5/9/11, Resident #3 takes a blood thinner (Warfarin 4mg [milligrams] daily). Per review of the plan of care, there was no indication that this resident is at increased for bleeding nor any instruction to staff to implement strategies to reduce the risk of accidental bleeding or bruising. During interview on 5/10/11 at 11:45 AM, the RN confirmed that this resident takes a daily blood thinner and that the plan of care did not instruct staff regarding this special care need.	R145	Resident #1's NCP and the Group Care Sheet were both updated on 5/26/11 to reflect the resident's increased bowel and bladder incontinence and increased need for assistance with personal hygiene and peri care after BM's.  On 05/26/11, Resident #3 had a text box added to her Group Care Sheet stating "On Warfarin - see NCP!"	5/26/11
R147 SS=D	V. RESIDENT CARE AND HOME SERVICES  5.9.c (4)  Maintain a current list for review by staff and	R147	<p style="text-align: center;"><b>Warfarin / Coumadin Therapy</b></p> <ul style="list-style-type: none"> <li>• Increased risk of bleeding (gums, nosebleeds, skin tears)</li> <li>• At risk for hematuria (blood in urine), bloody or tarry (black) stools</li> <li>• May bruise more easily</li> <li>• Check feet and toes for purple discoloration</li> <li>• Treat symptoms as they occur and notify the nurse on-call</li> <li>• <u>Excessive or uncontrolled bleeding - call 911, then notify the nurse</u></li> </ul> <p>All residents on anti-coagulant therapy have had both of these notices added to their Group Care Sheets and their NCPs. This will be done routinely when a resident is placed on anti-coagulant therapy.</p> <p>R145 - 6/29/11 POC accepted, C. Laramy, RN</p>	

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R147	<p>Continued From page 3</p> <p>physician of all residents' medications. The list shall include: resident's name; medications; date medication ordered; dosage and frequency of administration; and likely side effects to monitor;</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the RN (Registered Nurse) failed to assure that the current orders for 2 applicable residents (Resident #2 and Resident #3) were clear and accurate. Findings include:</p> <p>1. Per record review on 5/11/11, a current list of physician orders for Resident #3 was not available for review and comparison to the Medication Administration Record (MAR) for accuracy. During interview that afternoon, the RN confirmed that the current year's physician orders for Resident #3 were not in the record and later obtained a faxed copy of the orders from the facility pharmacy.</p> <p>2. Per record review on 5/10/11, orders on the MAR and physician orders following an office visit on 5/6/11 for Resident #2 were not consistent. An order originating 7/2/10 stated "Tramadol 50 mg 1-2 TID (3 times daily) alternating with Tylenol 1000 mg TID" and this was reflected in the current MAR. New orders dated 5/6/11 indicated "Tramadol 50 mg tablet '1' every 6 hours as needed for pain" and Acetaminophen 500 mg by mouth every 4 hours. Takes 2." Neither order dated 5/6/11 was transcribed to the MAR nor were clarifications sought from the physician to determine correct / desired dosing requirements. During interview on 5/11/11 at 2:30 PM, the RN confirmed that these orders should have been clarified and that the current medication list did</p>	R147	<p>On 5/11/11 the PCP for Resident #3 signed a complete med list which was placed in the resident chart .</p> <p>On 5/17/11 a current med list signed by the PCP for Resident #2 had been obtained and placed in the resident chart. All orders have been clarified and MAR is accurate.</p> <p>Only written, signed orders and signed prescriptions will be accepted as new orders following office visits. We will continue to clarify patient instructions written on the "After Visit Summaries" with the providers. We will fax the MARs to each PCP to sign and review at least yearly.</p> <p>Out of concern for non-residential patients who may follow inappropriate "Stop Taking" instructions, we have compiled a grid of residents, providers, dates of service, and the medications that they were instructed to stop when the PCP or specialist did not want the meds discontinued. This list will be sent to FAHC, to the Attention of Sue Goetschius, Director of Nursing Education.</p>	<p>5/11/11</p> <p>5/17/11</p>
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R147 - 6/29/11 POC accepted.  
C. Laramy, RN

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R147	Continued From page 4 not reflect all of the 5/6/11 physician orders.	R147		
R164 SS=E	V. RESIDENT CARE AND HOME SERVICES  5.10 Medication Management  5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:  (2) A registered nurse must delegate the responsibility for the administration of specific medications to designated staff for designated residents  This REQUIREMENT is not met as evidenced by: Based on record review and interview, there is no evidence of medication administration delegation for staff of the home. Findings include:  1. Per record review and confirmed by the RN (Registered Nurse) during interview on 5/9/11 at 3:00 PM, there was no list of trained unlicensed staff to whom the nurse had delegated authority to administer medications to residents.	R164	On 5/16/11, we created a "Medication Administration Delegation List" that identifies which unlicensed staff are certified to pass medications and lists any individual limitations that may apply (i.e. may not administer insulin without direct supervision by a nurse).  The Medication Administration Delegation List will be maintained and updated by the RN as personnel change and as new staff is certified.	5/16/11
R167 SS=D	V. RESIDENT CARE AND HOME SERVICES  5.10 Medication Management  5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:  (5) Staff other than a nurse may administer PRN psychoactive medications only when the home	R167	R164 - 6/29/11 POC accepted. C. Laraway, RN	

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R167	Continued From page 5  has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, the RN (Registered Nurse) failed to assure that a behavioral medication plan was available to direct non-licensed staff in the administration of a psychoactive medication for 1 applicable resident in the survey sample (Resident #1). Findings include:  1. Per record review on 5/10/11, Resident #1 receives Seroquel 12.5 mg (milligrams) daily PRN (as needed) from unlicensed staff. During interview on 5/11/11 at 3:50 PM, the RN confirmed that non-licensed staff administer PRN Seroquel to Resident #1 and that there is no behavior plan of care directing staff in this administration.	R167	On 6/6/11, Resident #1 had a specific Behavior Management Plan for the use of her PRN Seroquel placed with her MARs. This plan documents the behaviors that staff observed and the interventions that were attempted, including the use of the PRN medication.	6/6/11
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:	R171	<i>R167 - 6/29/11 POC accepted. C. Laraway, RN</i>	

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R171	Continued From page 6  (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 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 interview, the home failed to assure that 1 applicable resident in the survey sample (Resident #1) receiving psychoactive medication was being monitored for side effects. Findings include:  1. Per record review on 5/10/11, Resident #1 has an order for Seroquel 25 mg (milligrams) PO (orally) BID (2 times daily), Seroquel 75 mg Q (every) HS (at bedtime) and Seroquel 37.5 mg Q 12 noon. There is no indication in the record that this resident is being monitored for side effects of this psychoactive medication using an assessment such as the AIMS or DISCUS assessment tools. During interview on 5/11/11 at 3:27 PM, the RN confirmed that no assessment tool is being utilized to track and / or identify potentially irreversible side effects of this psychoactive medication.	R171	Resident #1 had two AIMS tests conducted by her psychiatrist on 2/16/11 and 4/1/11. Both tests were scored as "0". A request for Dr. Rebecca Dolgin was faxed for her signature. Resident #1 will have an AIMS test conducted from now on at 3 month intervals by our nursing staff, as part of the routine care. The frequency of the scheduled testing will be adjusted accordingly as medications change or abnormal movements develop.  All residents who receive psychotropic medications (list included) will have an AIMS test conducted at admission and at 6 month intervals thereafter. If a psychotropic medication is initiated as therapy, the AIMS will be done at monthly intervals x 3, then at 6 month intervals. This will be conducted by a staff nurse. Results will be filed in the resident's chart. If the dosage of the psychotropic drug is increased, the AIMS will be done monthly x 3 to assess any change. If the dosage is decreased, or the drug is discontinued, the AIMS will be done one month after the change.	6/6/11

R171-6/29/11 POC accepted.  
T9YT11 - C. Loring, RN



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R189 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.12.b. (3)</p> <p>For residents requiring nursing care, including nursing overview or medication management, the record shall also contain: initial assessment; annual reassessment; significant change assessment; physician's admission statement and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of physician visits, signed telephone orders and treatment documentation; and resident plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the records of 3 applicable residents in the survey sample (Resident #1, Resident #3, and Resident #4) did not contain progress notes indicating changes and / or follow up in resident condition. Findings include:</p> <p>1. Per record review on 5/10/11, the progress notes of Resident #1 indicated psychotic episodes on 8/10/11, 8/18/11, and 11/10/11. There were no further notes detailing resident status following each of these recorded incidents to indicate the resident's progression and / or treatment. During interview on 5/11/11 at 3:32 PM, the RN confirmed that there were no follow up notes following each of these incidents.</p> <p>2. Per record review on 5/10/11, Resident #3 had been hospitalized for 3 days. Upon return to the home on 4/10/11, there was no readmission note indicating the status of the resident nor care interventions potentially required as a result of the hospitalization. The next nursing progress note</p>	R189	<p>Day to day changes are noted on the in-house Daily Nurses Report. On 06/06/11, a retrospective note reflecting Resident #1's progression and response to treatment following the episodes of psychotic behavior noted on 08/10/10, 08/18/10, and 11/11/10 (corrected dates). Behavior Monitoring Logs were moved to the MAR binder for Resident #1.</p> <p>On 06/06/11, a retrospective note, as written on the Daily Nurses Report dated 04/10/11, was added to Resident #3's chart ("Returned from FAHC. New sliding scale and Lantus orders. FS now is qid. For PT/INR on 4/12 and q48h until INR is 2.0 – 3.0. O2 at 2L/m, continuous flow. Needs assist to stand and supervision to amb to BR w/4ww. Needs a raised toilet seat or commode over the toilet. Continue NCS diet. Code status: yes for CPR, no for intubation/ventilation (DNI).")</p> <p>A retrospective note, derived from notes on the Daily Nurses Report dated 05/3, 4, 5, 7, 9, 13, and 15/11, was added to Resident #3's chart on 06/06/11. This note reflected communication with the PCP, initiation of a second course of antibiotics, elevation of BLE, and the area's subsequent return to baseline.</p> <p>The note written on Resident #4 on 03/28/11 did indicate that this resident had had no ill effects from his fall of 3/11/11. It also indicated that he had been seen by his new PCP on 03/17/11.</p>	6/6/11  6/6/11  6/6/11  6/6/11

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R189	Continued From page 9 was dated 4/20/11 (10 days following readmission).  Additionally, a progress note dated 5/2/11 indicated that Resident #3 was experiencing an area of lower leg redness, swelling and heat at the site of a previously scabbed area that drained purulent exudate and required an ointment and dressing application. There were no further progress notes describing this resident's skin condition or staff actions until 5/5/11 when this was described as 'cellulitis' in a 5/5/11 progress note.  During interview on 5/11/11 at 3:20 PM, the RN confirmed that no information was documented regarding the resident's health status and needs following hospitalization and stated that a note should have been entered in the record. The RN also confirmed that there was a 3 day period between the identification of a potential problem with cellulitis on 5/2/11 and the next staff progress note regarding this issue on 5/5/11.  3. Per record review on 5/10/11, Resident #4 had an unwitnessed fall at 0630 on 3/11/11. There was no documentation that the resident was assessed following the fall or any interventions or care needs required related to the fall. The next documentation in the progress note was 17 days later on 3/28/11 that stated no further ill effect from his fall on 3/11/11. The RN confirmed on 5/10/11 that the progress notes did not document the resident's condition related to the fall or any action taken.	R189	Disruptive or aberrant behaviors, interventions, and responses will be recorded by the med passer on that resident's Behavior Monitoring Log. To facilitate this, Behavior Monitoring Logs for any resident who receives a PRN psychoactive medication will be re-located to the appropriate MARs binder.  Re-admission notes will be written on the day that the resident returns from another facility (FAHC or SNF). They will include the overall status of the resident and any new or changed interventions resulting from the out-of-facility stay.  Documentation of acute issues will be made in real-time, with follow-up notes indicating each resident's progress relative to the specific issue, until resolved. The issues will include, but are not limited to: falls, potential infections (local or systemic), mental status changes, acute behavioral changes, open areas / skin lesions, significant changes in bowel / bladder patterns, mobility, vision, or sleep, and response to new interventions. Charts requiring continued documentation will be identified by a list of the resident's initials, the onset date and a brief indication of the issue (i.e., 05/06/11, fall). Upon resolution, the resident's initials will be removed. Post-Its on the binder spines will provide a second visual cue that "alert charting" is in progress.  <i>R189 - 6/29/11 POC accepted.</i> <i>C. Haraway, RN</i>	6/6/11
R247 SS=F	VII. NUTRITION AND FOOD SERVICES  7.2 Food Safety and Sanitation	R247		

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NAME OF PROVIDER OR SUPPLIER  CATHEDRAL SQUARE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 3 CATHEDRAL SQUARE BURLINGTON, VT 05401		
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R247	Continued From page 10  7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the home failed to assure that all food in the refrigerator and freezer is dated and that a system to monitor refrigerator and freezer temperatures is in place. Findings include:  1. During observations of the kitchen area on 5/9/11, the opened clam chowder in the freezer and the opened Jello and Vanilla pudding in the refrigerator were not dated. Also, staff confirmed on 5/9/11 that they did not have a system in place to monitor if food and drink are held at proper temperatures.	R247	A log for the cooler, walk-in and the freezer has been created and all temps are being logged daily.  All food is being labeled and dated.  The food services manager will be reviewing compliance on a weekly basis during inventory.  <i>R247 - 6/29/11 POC accepted C. Haraway, RN</i>	5/11/11
R313 SS=E	XI. RESIDENT FUNDS AND PROPERTY  11.1 A resident's money and other valuables shall be in the control of the resident, except where there is a guardian, attorney in fact (power of attorney), or representative payee who requests otherwise. The home may manage the resident's finances only upon the written request of the resident. There shall be a written agreement stating the assistance requested, the terms of same, the funds or property and persons involved.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home	R313		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  1001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/11/2011
NAME OF PROVIDER OR SUPPLIER  CATHEDRAL SQUARE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 3 CATHEDRAL SQUARE BURLINGTON, VT 05401		
(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
R313	Continued From page 11  failed to obtain written requests for assistance with finances from 4 applicable residents (Resident #1, Resident #4, Resident #5, and Resident #6) nor were these residents provided with a facility agreement outlining the terms of the agreement. Findings include:  1. Per record and policy / procedure review on 5/11/11, the home managed petty cash funds for 4 residents in the survey sample. There was no formal request from any resident requesting facility management of funds. Per facility policy a written agreement is to be developed for each resident stating the type of assistance requested, the terms of the agreement, the amount of funds and the persons involved in managing those funds. During interview that afternoon, the Administrator confirmed that there were no formal contracts / requests to manage each of these resident's petty cash funds.	R313	On 6/6/11 a written agreement was developed for each resident who requested the facility hold funds. The request states the policy and clearly defines the terms and availability of funds being held.  R313 - 6/29/11 POC accepted. _____ C. Haraway, RN _____	6/6/11

# Cathedral Square Senior Living – Assisted Living

## Plan of Correction

Prepared by Mary Lynn, RN on 06/08/11

### **Page 1, R126, Resident #2:**

#### Action:

1. This resident's original order read "Tramadol 50 mg/tab 1 – 2 tabs (50 – 100 mg) PO tid". Ancillary staff was instructed to notify the nurse on-call if 1 tablet (50 mg) was not sufficient, AEB continued c/o knee pain. The number "1" was routinely circled on the MAR, but was not circled when surveyed.

The PCP was notified and asked to re-write the order without using a range. On 05/16/11, the order was re-written as two separate orders, one for the scheduled Tramadol 50 mg 3 times daily, and a second order was written for "Tramadol 50 mg/tab 1 tab (50 mg) PO prn – up to three additional doses daily."

#### Systemic Change:

Physicians will be asked to avoid writing ranges for doses and/or administration times. If a physician believes that s/he must give a dose range, specific parameters will be provided by the physician for choosing the dose. For analgesics, it might use a pain scale of 0 (no pain) to 10 (extreme pain). Example: "Tramadol 50 mg/tab 1 – 2 tabs (50 – 100 mg) PO tid prn for pain: pain rate 1 – 5, give 50 mg, pain rated 6 – 10, give 100 mg. If pain is unrelieved by 100 mg, notify the nurse on-call".

We hope to avoid using ranges since many of our residents are not able to rate their pain on a numerical scale or see the faces on the Wong Pain Scale. Additional criteria for evaluating non-verbal pain in the cognitively-impaired will be made available to med passers to aid them in describing the resident's pain (facial expressions, vocalizations, body actions or observed behaviors). If a resident's pain appears severe, and is unrelieved by prescribed medications and comfort measures, the med passer will notify the nurse on-call

### **Page 2, R136, Residents #1, #3, #4, #7:**

#### Action:

1. The RAIs for Residents #1, #3, #4, and #7 were signed and dated in real time during the survey (5/11 – 13).

#### Systemic Change:

RAIs will be double checked for accuracy and the nurse's signature prior to being filed in the individual charts.

### **Page 2 - 3, R145, Residents #1, #3:**

#### Action:

1. Resident #1's NCP and the appropriate Group Care Sheet were both updated on 05/26/11 to reflect the resident's increased bowel and bladder incontinence and increased need for assistance with personal hygiene and peri care after BMs.

2. On 05/26/11, Resident #3 had a text box added to her Group Care Sheet stating "*On Warfarin – see NCP!*" The following has been added to her NCP:

**Warfarin / Coumadin Therapy**

- Increased risk of bleeding (gums, nosebleeds, skin tears)
- At risk for hematuria (blood in urine), bloody or tarry (black) stools
- May bruise more easily
- Check feet and toes for purple discoloration
- Treat symptoms as they occur and notify the nurse on-call
- Excessive or uncontrolled bleeding - call 911, then notify the nurse

**Systemic Change:**

All residents on anti-coagulant therapy have had both of these notices added to their Group Care Sheets and their NCPs. This will be done routinely when a resident is placed on anti-coagulant therapy.

**Page 3 - 4, R147, Residents #2, #3:**

**Action:**

1. Resident #3's most current med list, signed by the physician had been obtained and faxed to our pharmacy. The original may have been misfiled. The copy was added to the chart on 05/11/11. We will audit all charts for any misfiled items.
2. An updated med list, signed by the PCP, for Resident #2 was obtained on 05/17/11 and placed in the resident's chart.

When FAHC switched to electronic charting (PRISM), many of the practices ceased using the "MD Visit" form which we send with each resident to an appointment. The resident's updated med list is also sent. In lieu of hand-written feedback and orders, we have been receiving the "After Visit Summary" that includes any new medications, but is not signed by the provider. Unfortunately, these summaries often come to us with instructions to "Stop Taking" various medicines that are not related to that visit. Additionally, the "Current Medications" are not always an accurate reflection of the medications and administration instructions currently in place for the resident. Up until the survey, we have accepted any new medications included in the summaries as new orders, and called or faxed the provider for clarification of and instructions to "Stop Taking". Resident #2's orders from 5/6/11 were from an "After Visit Summary". No new medications were ordered, but the nurse did not contact the provider regarding the inaccurate "Current Medications" on the report. We no longer accept these summaries as orders and on 05/16/11 added the following to our MD Visit form:

***New orders must be written and signed by the provider. We do not accept changes noted on the FAHC "After Visit Summary" as MD orders.***

**Systemic Change:**

Only written, signed orders and signed prescriptions will be accepted as new orders following office visits. We will continue to clarify patient instructions written on the "After Visit Summaries" with the providers.

Per the survey team's suggestion, we will fax the MARs to each PCP to sign and review at least yearly.

Out of concern for non-residential patients who may follow inappropriate "Stop Taking" instructions, we have compiled a grid of residents, providers, dates of service, and the medications that they were instructed to stop when the PCP or specialist did not want the meds

discontinued. This list will be sent to FAHC, to the Attention of Sue Goetschius, Director of Nursing Education.

**Page 5, R164**

Action:

1. On 05/16/11, we created a "Medication Administration Delegation List" that identifies which unlicensed staff are certified to pass medications and lists any individual limitations that may apply (i.e., may not administer insulin without direct supervision by a nurse).

Systemic Change:

The Medication Administration Delegation List will be maintained and updated as personnel change and as new staff is certified.

**Page 5, R167, Resident #1:**

Action:

1. On 06/06/11, Resident #1 had a specific Behavior Management Plan for the use of her PRN Seroquel placed with her MARs. This plan documents the behaviors that staff observed and the interventions that were attempted, including the use of the PRN medication.

Systemic Change:

All residents who have PRN psychoactive interventions will have a documented Behavior Management Plan and a Behavior Monitoring Log placed with their MARs. These plans will be adjusted and updated as behaviors and/or medication orders change.

**Page 6 - 7, R171, Resident #1:**

Action:

1. Resident #1 had two AIMS tests conducted by her psychiatrist on 02/16/11 and 04/01/11, as per a telephone call with Rebecca Dolgin, MD, on 06/06/11. Both tests were scored as "0". A signed statement from Dr. Dolgin stating this will be placed in the resident's chart when it is returned by fax. Resident #1 never exhibited any abnormal movements or signs of tardive dyskinesia. She will have an AIMS test conducted henceforth at 3 month intervals at CSAL, as part of her routine care. The frequency of the scheduled testing will be adjusted accordingly as medications change or abnormal movements develop.

Systemic Change:

All residents who receive psychotropic medications (list included) will have an AIMS test conducted at admission and at 6 month intervals thereafter. If a psychotropic medication is initiated as therapy, the AIMS will be done at monthly intervals x 3, then at 6 month intervals. This will be conducted by a staff nurse. Results will be filed in the resident's chart. If the dosage of the psychotropic drug is increased, the AIMS will be done monthly x 3 to assess any change. If the dosage is decreased, or the drug is discontinued, the AIMS will be done one month after the change.

**Page 8, R173, general, Resident #1:**

Action:

1. Keys to both med carts are kept on the physical person of the med passer(s). If there is only one med passer, the extra set of keys is locked in one of the med carts.

2. Resident #1 has been provided with a locked box for her OTC and homeopathic medications. An extra key is available to the med passer.

Systemic Change:

Keys to both med carts will be kept on the physical person of the med passer(s). If there is only one med passer, the extra set of keys will be locked in one of the med carts.

We will continue to discourage residents from self-medicating when they, or their physicians, have arranged for med administration to be done by the CSAL staff. If a resident insists on self-medication with OTC and/or prescription medications and the physician is aware and in agreement, CSAL will provide a locked box for the OTC medications. An extra key or the combination will be available to the med passer.

**Page 9, R189, Residents #1, #3, #4:**

Action:

1. Day to day changes are noted on the in-house Daily Nurses Report. On 06/06/11, a retrospective note reflecting Resident #1's progression and response to treatment following the episodes of psychotic behavior noted on 08/10/10, 08/18/10, and 11/11/10 (corrected dates). Behavior Monitoring Logs were moved to the MAR binder for Resident #1.
2. On 06/06/11, a retrospective note, as written on the Daily Nurses Report dated 04/10/11, was added to Resident #3's chart ("Returned from FAHC. New sliding scale and Lantus orders. FS now is qid. For PT/INR on 4/12 and q48h until INR is 2.0 – 3.0. O2 at 2L/m, continuous flow. Needs assist to stand and supervision to amb to BR w/4ww. Needs a raised toilet seat or commode over the toilet. Continue NCS diet. Code status: yes for CPR, no for intubation/ventilation (DNI).")

A retrospective note, derived from notes on the Daily Nurses Report dated 05/3, 4, 5, 7, 9, 13, and 15/11, was added to Resident #3's chart on 06/06/11. This note reflected communication with the PCP, initiation of a second course of antibiotics, elevation of BLE, and the area's subsequent return to baseline.

3. The note written on Resident #4 on 03/28/11 did indicate that this resident had had no ill effects from his fall of 3/11/11. It also indicated that he had been seen by his new PCP on 03/17/11.

Systemic Change:

Disruptive or aberrant behaviors, interventions, and responses will be recorded by the med passer on that resident's Behavior Monitoring Log. To facilitate this, Behavior Monitoring Logs for any resident who receives a PRN psychoactive medication will be re-located to the appropriate MARs binder and completed by the med passer.

Re-admission notes will be written on the day that the resident returns from another facility (FAHC or SNF). They will include the overall status of the resident and any new or changed interventions resulting from the out-of-facility stay.

Documentation of acute issues will be made in real-time, with follow-up notes indicating each resident's progress relative to the specific issue, until resolved. The issues will include, but are not limited to: falls, potential infections (local or systemic), mental status changes, acute behavioral changes, open areas / skin lesions, significant changes in bowel / bladder patterns, mobility, vision, or sleep, and response to new interventions. Charts requiring continued documentation will be identified by a list of the resident's initials, the onset date and a brief indication of the issue (i.e., 05/06/11, fall). Upon resolution, the resident's initials will be removed. Post-Its on the binder spines will provide a second visual cue that "alert charting" is in progress.