

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

May 22, 2013

Mr. Eric Fritz, Administrator
Woodstock Terrace
456 Woodstock Road
Woodstock, VT 05091

Provider #: 1005

Dear Mr. Fritz:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **January 22, 2013**. 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

PC:ne

Enclosure



Division of Licensing and Protection

APR 29 13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	Licensing and Protection C 01/22/2013
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NAME OF PROVIDER OR SUPPLIER WOODSTOCK TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 456 WOODSTOCK ROAD WOODSTOCK, VT 05091
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R100	Initial Comments: An unannounced on site complaint investigation was conducted on 01/22/13 by the Division of Licensing and Protection. The following are regulatory violations.	R100		
R147 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (4) Maintain a current list for review by staff and 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; This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to maintain a current list of 1 of 4 applicable residents' medications that included frequency of administration and likely side effects to monitor. (Resident #2) Findings include: 1. Per review of Resident #2's MAR (medication administration record), a physician order dated 09/27/12 is noted for "Seroquel [an anti-psychotic medication] 25mg p.o. [by mouth] PRN [as needed] for agitation". There is no frequency on the order. Staff administered the medication on 09/27/12 at 11:40 PM due to the resident being "very agitated...didn't help", on 09/30/12 on the evening shift for "agitation w/ good effect", on 09/28/12 at 2:40 AM, however no reason given nor effects were documented, and again on the same day between the hours of 7:00 AM and 9:00 AM for "agitation". In addition, a physician	R147	R 147 Resident #2 has expired. All physician orders for medications are required to have the type, dose and frequency of administration which is reflected on the MAR. Staff are required to follow the orders exactly and according to regulation. They are also required to document on the MAR for the efficacy of the medication. In-service education sessions were conducted on 2/20/13; 2/21/13 and 3/1/13 to assure compliance with this standard. The Health Services Director and Vice President of Resident Services will conduct periodic audits and report the results to the Executive Director to assure compliance. R147 POC accepted 5/13/13 SEmmons Rm/ Pmc	3/7/13

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE EXECUTIVE DIRECTOR (X6) DATE 3/26/13

Pmc

Division of Licensing and Protection

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R147	Continued From page 1 order of 9/28/12 states "Zyprexa [an anti-psychotic medication] 10 mg 1 p.o. to start and then q4 [every 4 hours] PRN for agitation, severe aggressive behavior". Per review of the MAR staff administered Zyprexa on 09/29/12 at 9:00 PM for "agitated"; on 09/29/12 at 8:35 PM for "agitation"; on 09/30/12 at 4:00 PM for "agitation" and on 09/30/12 at 10:00 PM for "slight agitation", however there is no documentation as to the efficacy or monitoring the effects of the medication. Per interview on 01/22/13 at 2:28 PM the DNS confirmed that there was a failure to have a current list of medications that included frequency of administration and likely side effects to monitor. Also see R167	R147		
R167 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: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home 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.	R167	R 167 Resident #2 has expired. All residents receiving PRN psycho-active medications now have a written plan for the use of the PRN that describes the specific circumstances for the use of the medication, the desired effects and undesired side-effects that must be monitored for and documents the time of, reason for and specific results of the medication use.	

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R167	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assure, when staff other than a nurse administer PRN psychoactive medications, there was a written plan for the use of the PRN psychoactive medication which describes the specific behaviors the medication is intended to address, specifies the circumstances that indicate use, educates staff about the desired effects and/or undesired effects staff must monitor for, and failed to assure that non-nurse staff document time of, reason for and specific results of medication use. This effected 1 of 4 applicable residents (Resident #2) Findings include:</p> <p>1. Per review of Resident #2's MAR (medication administration record), a physician order dated 09/27/12 is noted for "Seroquel [an anti-psychotic medication] 25mg p.o. [by mouth] PRN [as needed] for agitation". There is no frequency on the order. Staff administered the medication on 09/27/12 at 11:40 PM due to the resident being "very agitated...didn't help", on 09/30/12 on the evening shift for "agitation w/ good effect", on 09/28/12 at 2:40 AM, however no reason given nor effects were documented, and again on the same day between the hours of 7:00 AM and 9:00 AM for "agitation". In addition, a physician order of 9/28/12 states "Zyprexa [an anti-psychotic medication] 10 mg 1 p.o. to start and then q4 [every 4 hours] PRN for agitation, severe aggressive behavior". Per review of the MAR staff administered Zyprexa on 09/29/12 at 9:00 PM for "agitated"; on 09/29/12 at 8:35 PM for "agitation"; on 09/30/12 at 4:00 PM for "agitation" and on 09/30/12 at 10:00 PM for "slight agitation", however there is no documentation as to the efficacy or monitoring the effects of the</p>	R167	<p>In-service education sessions were conducted on 2/20/13; 2/21/13 and 3/1/13 to educate staff on the use of PRN medication and appropriate documentation of behaviors for which a PRN may be administered. The Health Services Director and Vice President of Resident Services will conduct periodic audits and report the results to the Executive Director to assure compliance.</p> <p><i>R167 POC accepted 5/13/13 SEMUNONS RN / ANU</i></p>	<p><i>3/7/13</i></p>
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R167	<p>Continued From page 3</p> <p>medication.</p> <p>In addition, nursing notes of 09/28/12 state Resident #2 was "found in another res's room 6:00 AM - 2:30 PM shift with an electric chair flipped over and was attempting to cut the electric cord, PRN Seroquel 25 mg, then found a small pocketknife, another dose of Seroquel 25 mg given when able little to no effect, during breakfast [S/he] was agitated again PCP notified and Seroquel 50 mg po x 1 now and trazadone 50 mg x1 now both ordered, [resident] is refusing to take these at this time". A nursing note later that day during the 2:00 PM - 10:00 PM shift states "while doing rounds found resident on the floor very disoriented and speech was garbled vital signs done no apparent injuries no c/o pain PCP called and said just to monitor as [resident] had large doses of Seroquel and its just now catching up to [resident], try to get food/fluids into [him/her]".</p> <p>Per interview on 01/22/13 at 2:28 p.m. the DNS confirmed that staff failed to describe specific behaviors or circumstances for the PRN medication to be given, educate staff about the desired effects or undesired side effects the staff must monitor for (like falls), and staff failed to document the time of administration, reason for administration, and specific results of the medication use.</p> <p>Also see R147</p>	R167		
R178 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.11 Staff Services</p> <p>5.11.a There shall be sufficient number of</p>	R178		

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R178	Continued From page 4 qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies. This REQUIREMENT is not met as evidenced by: Based on staff interview, the home failed to assure that there were sufficient staff on duty at all times to provide necessary care for 1 applicable resident. (Resident #3) Findings include: 1. Per an anonymous complaint received at the Division of Licensing and Protection on 11/07/12 stated that Resident #3, who was bedridden, dying and was on Morphine, did not receive Morphine during the night shift before the resident died. The 12 hours before s/he died there was no med-tech (non-nurse staff member who has been delegated by the Registered Nurse to administer certain medications) on the overnight shift, when s/he was used to getting it every 1-2 hours for pain. Per record review on 01/22/13 Resident #3 was admitted to Hospice services on 03/22/12 with a diagnosis that included dementia with expressive dysphasia, hypertension, diabetes, kyphosis and cancer, and died on 10/29/12. Physician orders were for comfort care as well as medications such as Morphine 10 mg/ml every 1 hour for break though pain and shortness of breath and Tylenol 650 mg every 4 hours for pain /fever were ordered. Per review of the MAR (Medication Administration Record), Resident #3 received Morphine from 10/22/12 - 10/28/12 every 1 to 4 hours routinely and Tylenol up to 4 times in 24 hours. Nursing notes indicate Tylenol for "fever of 100 - 103.3" degrees and Morphine for "lots of	R178	R 178 Resident #3 expired on 10/29/12. Resident # 3 was monitored for pain and discomfort at least 3 times from 10 P.M. to 6 A.M on 10/28 and 10/29. No report of either symptom was made to the licensed nurse on-call. If a resident requires a medication between the hours of 10:00 P.M. to 6 A.M. a Medication Technician or Licensed Nurse will be scheduled in the building to administer the medication according to physician orders. The Health Services Director or staff nurse on duty will contact the Executive Director if additional staffing is needed on short notice and arrangements will be made. The Vice President of Resident Services will conduct periodic audits and report the results to the Executive Director and QA Committee to assure compliance. R178 Pol accepted 5/13/13 SEMMONS RN / Pmc	3/7/13
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R178	Continued From page 5 pain" or "comfort" during this time period. Morphine was given every 1 to 3 hours on 10/28/12 with the last dose given at 9:30 P.M. No medications were given during the night shift and no monitoring of pain/comfort was noted as evident by no progress note. Morphine was given on 10/29/12 at 10:10 AM and Tylenol suppository given at 10:45 AM. The resident died shortly after noon that day. Per interview the DNS on 01/22/13 at 2:28 PM verified there was no medication delegated staff person (med-tech) on duty in the home to administer any medications that may be needed during the night shift hours (10 PM to 6 AM). The DNS stated that "staff know that if someone needs medication to call the on-call nurse", however confirmed that the staff that evening are not delegated to assess resident's pain level and there was no documentation on how often the resident was checked that night.	R178		

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A 951 SS=E	<p>XI Physical Plant</p> <p>11.1 Resident Units. All resident units must be private occupancy unless a resident voluntarily chooses to share the unit.</p> <p>This Statute is not met as evidenced by: Based on record review, observation and interview, not all resident rooms were private. Two rooms are shared (double occupancy) by 4 applicable residents (resident #4, #5, #6 & #7). Findings include:</p> <p>1. Per review of the Resident 's census, 2 residents share a 1 bedroom apartment upstairs and 2 residents share a room in the Memory Care Unit. Per interview on 01/22/13 at 8:36 AM, Resident #4 who shares a room with Resident #5, stated "I was in a room downstairs when I came, but then was told because of the medicaid monies, about a year ago I would have to share...what could I do, can't be on the street?". Resident #5 stated "I was never asked, just told someone was going to share my room". Per observation of Resident #6 & #7's room in the Memory Care Unit, two beds were in the one bedroom space. The residents were not capable of interview.</p> <p>Per interview later that same day, the Administrator stated "that no waivers were requested from the Licensing Agency because the family wanted them to stay and it was cheaper with 2 to a bedroom". S/he confirmed not all resident rooms were private.</p>	A 951	<p>A 951</p> <p>Resident # 4 was admitted on 1/18/12 to an apartment with a roommate. She requested a transfer to her present apartment because she felt her new roommate would be more compatible. Resident # 5 was admitted on 3/16/11 with the understanding that the policy of the facility was to "apartment share" residents admitted under the Medicaid Waiver Enhanced Residential Care Program.</p> <p>Residents # 6 and # 7 are sharing their apartments at the request of their DPOAs.</p> <p>Requests has been sent to the Division of Licensing & Protection asking for a variance of the ALR regulations to allow residents # 4 and # 5 and residents # 6 and # 7 to share apartments together. A request for a Waiver will be made in the future whenever residents share an apartment unless they are voluntarily requesting to do so when moving into Woodstock Terrace. The Executive Director will be responsible for maintaining compliance to this standard.</p> <p><i>A951 POC accepted 5/13/13 SEMMONS RN / PMK</i></p>	4/17/13

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

EXECUTIVE DIRECTIVE

TITLE

(X6) DATE
4/17/13