

October 21, 2009

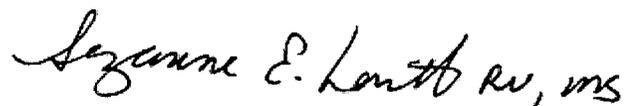
Mr. William Spalding, Administrator
Allenwood At Pillsbury Manor
90 Allen Road
South Burlington, VT 05403

Dear Mr. Spalding:

Enclosed is a copy of your acceptable plans of correction for the annual survey and complaint investigation conducted on **September 14, 2009**. 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,



Suzanne Leavitt, RN, MS
Licensing Chief



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0372	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/14/2009
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NAME OF PROVIDER OR SUPPLIER ALLENWOOD AT PILLSBURY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 90 ALLEN ROAD SOUTH BURLINGTON, VT 05403
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R100	Initial Comments: An annual licensing survey and a complaint investigation were conducted on-site on 9/9/09, 9/10/09 and 9/14/09.	R100	<i>Re: #1; R128 see attached documentation - Contesting #1</i>	
R128 SS=E	V. RESIDENT CARE AND HOME SERVICES 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, and staff interview, 1 of 7 residents in the total sample received medications which were not consistent with physician orders. (Resident #2) Findings include: 1. Per record review and confirmed by the Nurse manager on 9/10/09, Resident #2 had physician orders written on 7/10/09 to increase Atenolol to 25 mg BID (hold for pulse less than 60). The order on the MAR was for Atenolol 25 mg QD (hold if systolic <90). There was no current order found to support the change of Atenolol 25 mg BID back to Atenolol 25 mg QD. There was also no documentation that staff were obtaining a pulse or a BP prior to administering Atenolol as ordered. 2. Per record review and confirmed by the Nurse Manager on 9/10/09, Resident #2 had physician orders for Tramadol HCL 50 mg 2 tabs (100 mg) PO every 6 hours for Pain. Documentation on 9/5/09 shows that Tramadol was given at 12:45 AM and 6:00 AM (5:15 hours apart) and on 9/9/09	R128	<i>9-21-09 P.O.C accept D. involved</i> <i>see attached ORDER as included on (copy) 1/7/09 to Atenolol 25mg po daily. as to the BP prior to administering Atenolol it was documented on flow sheet - included - BP order on Renewals 6/09 plus BP on 9/15/09</i> <i>2. Staff involved LPN + RN counseled as to appropriate</i>	

Division of Licensing and Protection	TITLE	(X6) DATE
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Division of Licensing and Protection

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R128	Continued From page 1 documentation shows Tramadol was given at 6:25 PM and again at 11:30 PM (5:05 hours apart). Resident #2 also had an order for Darvocet N 100 1 tab to be taken orally every 4 hours for pain. It was documented on 9/9/09 that the Darvocet was given at 8:20 PM and again at 11:30 PM (3:10 hours apart).	R128	<i>times + how crucial this is. NOT Acceptable Nurses Totally aware not to let Resident dictate to have a plan +</i>
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 necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and interview the nurse failed to oversee the written plan of care reflected the current needs of 3 of 7 applicable residents (Resident #2, #3, and #5). Findings include the following: 1. Per review of progress notes Resident #2 has had several recent falls. The care plan did not address interventions to prevent or minimize the likelihood of falls. This was confirmed with the Nurse Manager on 9/9/09. 2. Per record review Resident #3 is on Coumadin therapy. Resident #3 is identified to self administer medications and has a documented fall history. The care plan did not address the signs/symptoms that the staff or resident should observe for and report that may	R145	<i>R145= Call M.D. #1 - A fall tracking system has been put in place to assure awareness of this important matter for our residents. (See attached documents) also all care plans have been updated to reflect the residents fall risk. Nurse manager responsible - reporting to RN. #2 - Care plan updated mid survey and all residents who are on Coumadin have had their care plan updated. We are implementing a procedure that all admissions on Res. care will be identified w a purple dot - Nurse manager reports to RN</i>

*Poc
9/21/09
Kendall*

Division of Licensing and Protection

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R145	<p>Continued From page 2</p> <p>indicate bleeding tendencies. This was confirmed with the Nurse manager on 9/10/09.</p> <p>3. Per record review Resident #5 required staff assistance to use bathroom during the night shift, was frequently incontinent at night and had some document skin integrity issues. The care plan did not include interventions to address the resident's need for assistance with toileting at night or the need for skin assessments. This was confirmed with Nurse Manager on 9/14/09.</p>	R145	<p><i>R145 #3 Care plan updated mid survey resident now on q2h toileting schedule while awake. Consistent Caregiver assignment updated to reflect need for daily incontinence skin care Nurse mgr. responsible reports to RN.</i></p>	<p><i>P.O.C. 9-21-09 D. [Signature]</i></p>
R155 SS=E	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.9.c. (12)</p> <p>Assume responsibility for staff performance in the administration of or assistance with resident medication in accordance with the home's policies.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, the home failed to assume responsibility for staff performance in the administration with resident medications for 1 of 7 applicable residents in survey (Resident #2). Findings include the following:</p> <p>1. Per review of of MAR it was documented that Resident #2 was administered on 9/9/09 Darvocet N 100 (1 Tab) at 4 PM and 11:30 PM and Tramadol HCL 50 MG (2 Tabs) at 6:25 PM. The nursing note on Resident #2 on 9/9/09 stated " Resident had Darvocet at 4 and 8:20 PRN for leg pain. Tramadol @ 6:00 PM for leg pain". Per review of the narcotic book the resident's Darvocet was signed out on 9/9/09 at 4 PM, 8:20 PM and 11:30</p>	R155	<p><i>R155 #1 Staff counseled on not documenting meds that they did not give.</i></p> <p><i>R155 #2 Staff counseled about documentation, & need for communications between shifts document need of improvement.</i></p> <p><i>(see pg. 4)</i></p>	<p><i>P.O.C. 9-21-09 D. [Signature]</i></p>

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R155	Continued From page 3 PM (no record in MAR of the 8:20 dose being given, noted to be given in nursing note). The Nurse Manger confirmed that the staff performance in the administration of the medication and documentation was not in accordance with the home's policies. 2. Resident #2 has an order for Lorazepam 0.5 MG (2 Tabs) PO at Bedtime. On 9/9/09 Lorazepam was signed out for resident in the Narcotic book and a nursing note stated that resident requested that the nurse leave it for her to take with her Tramadol and Darvocet. The note indicated that the Nurse left the medication at the bedside. There was no documentation stating whether the resident ever took the signed out Lorazepam, and the bedtime Lorazepam dose in the MAR was left blank and was not circled. The Nurse manager confirmed that the staff performance in the administration of the medication and documentation was not in accordance with the home's policies.	R155		
R162 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, 1 of 7 applicable residents in the survey was administered a medication without a physicians's signed order (Resident #2). Findings Include:	R162	<i>R162 - Resident's MD called in an Rx directly to pharmacy to continue this med. Nurse mgr. has contacted MD (AGAIN) to make MD aware of our need to receive signed order to be in regulatory compliance. NRSg. staff also aware to NOT accept an order from MD with # of pills attached, unless an end date is added by MD. Nrsq. manager responsible - Reports to RN. -</i>	

*POC Approved
9-21-09
D. W. W.*

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R162	Continued From page 4 1. Resident #2 was administered Darvocet N 100 PRN for pain on a regular basis by staff. Per record review and confirmed with Nurse Manager on 9/10/09, there was no signed physicians order for the medication.	R162		
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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to develop a written plan for the use of a PRN(as needed) psychoactive medication for 3 residents in the targeted sample (Resident #1, #2, and #4). Findings include the following: 1. Resident #1, #2, and #4 had a physician order for a PRN (as needed) anti-anxiety medication. The nurse manger confirmed that staff other than a nurse administer psychoactive medications. Per	R167	<i>R167 Resident #1 was within her 14 day of admission - see attached "working" care plan. Resident #2's plan has been updated & is posted in MAR Resident #4's plan is attached & was present @ survey. Nurse mgr. responsible reports to RN.</i>	

*All Nursing citations
Responsibility of
Elizabeth Rixon LPN (Nurse Manager)
Answering to
Deborah Benner
RW Administrator*

*P.C. Mispah
9-21-09
D. and W*

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R167	Continued From page 5 record review and staff interview there was no written plan describing the specific behaviors that the psychoactive medication was intended to address and circumstances that would indicate the use of the medication. This was confirmed with the Nurse Manger on 9/9/09 for Resident #1and #2, and on 9/10/09 for Resident #4.	R167		
R178 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.a There shall be sufficient number of 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: Per review of staffing pattern documentation, staff and resident interview and observation, the home failed to provide sufficient number of qualified personnel on the night shift. Finding include: 1. Staffing for night shift consist of 1 staff person on-site for 29 residents and 1 on-call person for emergencies . Staff and Resident's confirmed through interviews that there was not enough staff coverage on the night shift to assure prompt, appropriate action in case of injury, illness, fire or other emergencies. This was confirmed with the Administrator and Nurse Manager on 9/14/09. Staff interviewed during the 3 day survey process voiced concerns that if a resident with heavy care needs happen to fall on the night shift that one staff person would have a hard time assessing the resident's condition, lifting the	R178	<i>R178 We have hired a full time night caregiver, to work with our night nurse (one) _____ Will be 2 on- at all times</i>	

*P.O.C. reached
9-21-09
J. Campbell*

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R178	Continued From page 6 resident off the floor and calling for help if needed. Staff also identified that some of the residents had very high care needs and it was difficult for one person to be in many places at once. Residents interviewed voiced concerns that during the night it sometimes took a long time before someone could answer their bell.	R178		
R247 SS=E	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 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 record review the home failed to assure that all food was maintained at proper temperatures and failed to assure that all perishable food was labeled and dated. Findings include: 1. During facility tour on 9/9/09 Refrigerator temperature on thermometer registered 43 degrees. Upon review of the refrigerator temperature log on 9/10/09 demonstrated that the logged refrigerator temperature for the week of 9/7/09 ranged between 44 and 47 degrees. 2. In the Walk in freezer unit there was cooked french toast and vanilla pudding that was not dated or labeled. This was observed and confirmed by Director of Nursing on 9/9/09. 3. During facility tour on 9/9/09 there was no	R247	Staff educated regarding daily temperature logs, acceptable ranges for refrigerator food. Added a line to temperature records for employees to note who was notified if any temps not within range. Staff educated regarding dating & labeling of food. Commercial labels purchased (see attached) Daily cleaning schedule includes dating + labeling all food in refrigerator + freezers	

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R247	Continued From page 7 thermometer in the freezer in the dinning room refrigerator/freezer or in the chest freezer in dishwasher storage room. This was confirmed with the Director of Nursing.	R247	Staff educated regarding need to replace broke thermometers immediately. Staff educated to where spare thermometers are kept.
R251 SS=D	<p>VII. NUTRITION AND FOOD SERVICES</p> <p>7.3 Food Storage and Equipment</p> <p>7.3.a All food and drink shall be stored so as to protect from dust, insects, rodents, overhead leakage, unnecessary handling and all other sources of contamination.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations during the kitchen tour conducted with Director of Nursing, the home failed to assure that all foods were stored to protect from all sources of contamination. Findings include:</p> <p>1. During the kitchen tour on 9/9/09 and confirmed with the Director of Nursing the following foods were found not securely wrapped or stored to protect them from contamination.</p> <p>a. Walk-in freezer unit: loafs of frozen bread dough and frozen chicken were unwrapped and exposed.</p> <p>b. Kitchen shelf: Stored bag of sugar in original bag left wide open on shelf.</p>	R251	<p>Staff educated regarding requirement to rewrap frozen products, not in original containers, in clear plastic freezer bags, label: date. New labels ordered for frozen foods.</p> <p>Staff educated that all dry goods products must be stored in sealed containers, labeled & dated.</p> <p>Those responsible Daryl Holmes - Food Manager</p> <p>Responsible + answers to Shelly Gaige O'Brien - Dietician</p> <p>poc receipt 9-21-09 D.untw</p>

STATE SURVEY CORRECTIVE ACTIONS

R128 Resident #2

1. Contesting this matter

The telephone order sent out on 7-10-09 for Atenolol was a second request. The first request was from 1-6-09. (See the accompanying documentation) to support this. -

All counseled the importance of a signed medication order. -
Waiting till 1-6-09 not acceptable but we were giving the right medication - Dose + time