

## 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) 871-3317  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 871-3318

December 26, 2013

Ms. Wanda Waugh, Administrator  
Canterbury Inn  
46 Cherry Street  
Saint Johnsbury, VT 05819-2290

Provider # 0119

Dear Ms. Waugh:

Enclosed is a copy of your acceptable plans of correction for the unannounced onsite re-licensing survey conducted on **October 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0119</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/22/2013</b>
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DEC - 5 - 13  
Licensing and Protection

NAME OF PROVIDER OR SUPPLIER  <b>CANTERBURY INN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 CHERRY STREET SAINT JOHNSBURY, VT 05819</b>
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(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
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R100	Initial Comments:  An unannounced onsite re-licensing survey was conducted by the Division of Licensing and Protection from 10/21-10/22/13. The following regulatory deficiencies were identified.	R100	SEE ATTACHED POC.	
R128 SS=E	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.5 General Care</p> <p>5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interviews, the home failed to ensure that medication and treatment services were consistent with the physician orders for 2 of 6 residents sampled (Residents #3 and #5). *Repeat deficient practice as per previous survey dated 12/7/11. Findings include:</p> <p>1. Per medical record review on 10/21/13, Resident #3 was admitted on 6/11/12 with diagnosis to include Diabetes, Tachycardia, Depression and status post surgical removal of toes of both feet. Physician orders include fingerstick blood sugars three times a day (tid) with a sliding scale of insulin to be administered based on the fingerstick results. MD orders signed and dated 9/4/13 do not contain a physician order for Novolog 15 U at 0800, 20 U at noon and 1700, that has been administered to the resident. Medication Administration Record (MAR) documents an order for Novolog Insulin per sliding scale. Blood sugar record logs</p>	R128	<p>POC accepted with addendums per TC w/ Wanda Waugh on 12/12/13 @ 3:15 PM Karen Campos RN</p>	

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

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R128	<p>Continued From page 1</p> <p>reviewed for the past four months evidence that the resident has been receiving a scheduled dose of Novolog Insulin plus the sliding scale tid. Per interview with the Registered Nurse (RN) Administrator on 10/21/13 @ 12 noon s/he confirms that there is no physician order for the scheduled dose of Novolog Insulin, only for the sliding scale dosage.</p> <p>2. Per medical record review on 10/22/13, Resident #3 was admitted on 6/11/12 with diagnosis to include Diabetes, Tachycardia, Depression and status post surgical removal of toes of both feet. On 9/2/13 at 1400 Resident #3 complained of severe chest pain radiating down the left arm. The Nurse Aide/Med Tech administered 1 tab of Nitroglycerin at 14:10. Physician medication orders dated 6/11/12 and newly signed physician orders dated 9/14/13 do not contain a physician order to administer Nitroglycerin tabs for chest pain. Per interview on 10/22/13 at 1:00 PM, the Registered Nurse/Administrator confirmed that there is no order for the administration of Nitroglycerin for Resident #3, but it was given to the resident by an unlicensed staff member.</p> <p>3. Per record review on 10/22/13, Resident #5 was admitted on 3/30/12 with diagnoses that included a Neurogenic Bladder and Dementia. The resident had a physician's order written and signed on 5/7/12 to be catheterized twice daily due to an inability to void. Per the current Medication Administration Record, the resident was being catheterized 5 times daily. Per interview on 10/22/13 at 10:05 AM, the RN Administrator of the home confirmed that the catheterization had been ordered 5 times daily since at least January of 2013, and that there was no physician's order on file to reflect the change</p>	R128		

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R128	Continued From page 2 from the twice daily order.	R128		
R145 SS=F	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.9.c (2)</p> <p>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;</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the home failed to update care plans based on the resident's current abilities and needs as identified in the resident assessment for 6 of 6 residents sampled (Residents #1, #2, #3, #4, #5, and #6). A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being. *Repeat deficient practice as per previous survey dated 12/7/11. Findings include:</p> <p>1. Per medical record review, Resident #1 was admitted on 4/22/13 with diagnosis to include Pancreatic Cancer, Chronic Anemia, Type II Diabetes, Arteriosclerotic Cardio-Vascular Disease, blind in right eye and repair of a fractured left femur on 4/29/13. Resident Assessment completed annually with last assessment dated 6/27/13 which was reviewed and signed by the Registered Nurse (RN) Administrator. Interdisciplinary Care Plan has identified two problems/needs dated 6/26/12. Interview with RN Administrator on 10/22/13 @ 3</p>	R145		

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R145

Continued From page 3

PM, confirms that the care plan has not been updated to reflect the residents current status/needs since last assessment dated 6/27/13.

2. Per medical record review, Resident #2 was admitted on 4/9/98 with diagnosis to include Schizophrenia, Diverticulosis, Anemia, Seizure disorder secondary to medications and Arteriosclerotic Heart Disease. Resident Assessment completed annually with last assessment dated 4/9/13 of which was reviewed and signed by the Registered Nurse (RN) Administrator. Physician orders dated and signed on 7/10/13 identifies Nystatin topical Powder to apply as directed to affected areas daily PRN. Treatment sheet identifies that the resident is to have perineal area washed with soap and water, pat dry and apply Nystatin Powder topically daily PRN. Interview with RN Administrator on 10/22/13 @ 3 PM, confirms that the care plan has not been updated to reflect the current status/needs of the resident since last assessment dated 4/19/13.

3. Per medical record review, Resident #3 admitted on 6/11/12 with diagnosis to include Diabetes, Tachycardia, Depression and status post surgical removal of toes of both feet. Resident Assessment completed on 6/20/13, reviewed and signed by the Registered Nurse (RN) Administrator. Assessment identifies the resident has been to the hospital for day surgeries returned from the hospital with a wound/surgical site to the left foot (requires a plastic bag over his foot for showering), MD ordered treatment to the incision site, required antibiotic therapy for a wound infection and has had surgical removal of toes on left foot. Interview with RN Administrator on 10/22/13 @ 3

R145

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R145	<p>Continued From page 4</p> <p>PM, confirms that the care plan has not been updated to reflect the current status/needs of the resident since last assessment dated 6/20/13.</p> <p>4. Per record review on 10/22/13, Resident #4 was admitted to the home on 1/21/09 with diagnoses that included COPD, Colon Cancer, Anemia, Osteoarthritis, Hypertension, Degenerative Joint Disease, and Anxiety. Per review of the Plan of Care for this resident, the last update was completed on 1/17/12. The resident had declined to the point of being put on Hospice services on 10/4/12, with the expectation of a terminal decline. Due to an improvement in the health status of Resident #4, Hospice services were discontinued on 3/19/13. The resident also had an order for Lorazepam as needed for anxiety. There was no behavior plan in place for the use of the antianxiety medication. Per interview on 10/22/13 at 10:30 AM, the RN/Administrator of the home confirmed that the resident's plan of care did not include the initiation and subsequent discontinuation of Hospice services, and had no plan for the use of PRN antianxiety medication.</p> <p>5. Per record review on 10/22/13, the Plan of Care for Resident #5 did not include all of the identified needs or complete information regarding care of the resident. Resident #5 was admitted to the home on 3/30/12 with the following diagnoses: Dementia, Neurogenic bladder, Hx of UTIs, Glaucoma, Impaired Renal Function, Anemia, and Hypertension. According to the medical record and staff statements, the resident required I&amp;O catheterization 5 times per day to empty the bladder. The resident also has an order for Haloperidol 1 mg. every 12 hours for severe agitation. The Plan of Care for this resident did not include any mention of</p>	R145		
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R145	<p>Continued From page 5</p> <p>psychoactive medication use, with interventions to try before administering, as well as what behaviors were being targeted with the use of the medication. The plan of care also stated that catheterization was to be done twice daily, and had not been updated to reflect the increase to 5 times daily as currently being done. Besides these issues, the plan of care had no information regarding the level of assistance needed to complete Activities of Daily Living, dietary information, activity tolerance and preferences, or mention of visual problems related to glaucoma. Per interview on 10/22/13 at 10:05 PM, the RN Administrator confirmed that the Plan of Care was not updated to reflect the frequency of catheterization, and also was not developed in the areas of psychoactive medication use, vision problems, or Activities of Daily Living assistance needed.</p> <p>6. Per record review on 10/21/13, Resident #6 was admitted to the home on 4/25/08, with diagnoses that included Arthritis, Hypertension, Spinal Stenosis, Compression Fracture, Depression, and Osteoprosis. This resident had a history of falls, due to weakness and pain issues, with actual falls recorded on 2/6/13, 3/7/13, 3/11/13, and 3/30/13. Due to declining health, Resident #6 was admitted to Hospice services on 9/20/13. The Plan of Care for this resident did not include any mention of the history of falls with interventions to help prevent them, and also did not include the addition of Hospice services for the resident. Per interview on 10/22/13 at 10:35 AM, the RN/Administrator confirmed that the Plan of Care was last updated on 2/4/11, and it did not state all of the identified needs of the resident, including fall preventions and admission to Hospice.</p>	R145		

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R160	Continued From page 6	R160		
R160 SS=E	<p><b>V. RESIDENT CARE AND HOME SERVICES</b></p> <p><b>5.10 Medication Management</b></p> <p><b>5.10.a Each residential care home must have written policies and procedures describing the home's medication management practices. The policies must cover at least the following:</b></p> <p>(1) Level III homes must provide medication management under the supervision of a licensed nurse. Level IV homes must determine whether the home is capable of and willing to provide assistance with medications and/or administration of medications as provided under these regulations. Residents must be fully informed of the home's policy prior to admission.</p> <p>(2) Who provides the professional nursing delegation if the home administers medications to residents unable to self-administer and how the process of delegation is to be carried out in the home.</p> <p>(3) Qualifications of the staff who will be managing medications or administering medications and the home's process for nursing supervision of the staff.</p> <p>(4) How medications shall be obtained for residents including choices of pharmacies.</p> <p>(5) Procedures for documentation of medication administration.</p> <p>(6) Procedures for disposing of outdated or unused medication, including designation of a person or persons with responsibility for disposal.</p> <p>(7) Procedures for monitoring side effects of psychoactive medications.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	R160		

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STATE FORM

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If continuation sheet 7 of 20

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R160	<p>Continued From page 7</p> <p>Based on record review, observation, and staff interview, the home failed to assure that written policies and procedures were available describing medication management practices, and that all medication/treatment delegation was supervised by a Registered Nurse. Findings include:</p> <ol style="list-style-type: none"> <li>Per medical record review on 10/21/13, Resident #3 was admitted on 6/11/12 with diagnosis to include Diabetes, Tachycardia, Depression and status post surgical removal of bilateral toes of both feet. Per observation on 10/21/13 @ 11:30 AM Nurse Aid (NA), reviewed Resident #3's fingerstick blood sugar that registered 85. MAR identifies the resident is required to receive Novolog 12 units subcutaneous via insulin pen for blood sugar 80-120. NA prepared the resident's site with an alcohol wipe, with resident facing the NA s/he placed her/his gloved left hand on the resident's left upper arm, with the pen in her/his gloved right hand she/he then placed the capped needle (insulin pen) in her mouth, pulled the cap of the needle off and proceeded to administer the insulin dose to the resident. Per interview with the NA s/he confirms on 10/22/13 @ 9 AM, that s/he should not have put the needle in his/her mouth. Per interview with RN Administrator on 10/21/13 @ 3 PM, s/he confirms that the NA knows better and should not have removed the cap of the needle from the insulin pen by using her teeth. Also confirmed with the RN/Administrator at this time, the medication delegated staff had not been trained by the RN in the use of insulin pens.</li> </ol> <p>Per interview on 10/22/13 at 11:10 AM, the RN/Administrator stated that there were no current written policies and procedures describing the medication delegation training of the staff by</p>	R160		
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R160	Continued From page 8 the Registered Nurse.	R160		
R161 SS=E	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.10 Medication Management</p> <p>5.10.b The manager of the home is responsible for ensuring that all medications are handled according to the home's policies and that designated staff are fully trained in the policies and procedures.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the manager of the home failed to ensure that all medications are handled according to the home's policies and that designated staff are fully trained in the policies and procedures for 1 of 2 sampled residents (Resident #3). Finding include:</p> <p>1. Per medical record review on 10/21/13, Resident #3 was admitted on 6/11/12 with diagnoses to include Diabetes, Tachycardia, Depression and status post surgical removal of toes of both feet. Per observation on 10/21/13 @ 11:30 AM the Nurse Aid (NA) administering medications reviewed Resident #3's fingerstick blood glucometer reading registering 85. The Medication Administration Record (MAR) identifies the resident has a physicians order to receive Novolog 12 units subcutaneous via insulin pen for blood glucose reading of 80-120. The NA prepared the resident's injection site with an alcohol wipe, with resident facing the NA s/he placed a gloved left hand on the resident's left upper arm, with the pen in her/his gloved right</p>	R161		

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R161	Continued From page 9  hand, placed the capped needle (insulin pen) in her/his mouth, pulling the cap off the needle. Then proceeded to administer the insulin to the resident. On 10/22/13 @ 9 AM, the NA confirmed that s/he should not have removed the cap of the needle with their mouth. Per interview on 10/21/13 @ 3 PM, the RN Administrator confirmed that the home does not have a policy for insulin administration utilizing an insulin pen and that the insulin administration policy has not been revised since 11/17/10. The RN Administrator also confirmed that the cap should not have been removed from the needle by utilizing the employee's teeth. Also confirmed with the RN/Administrator at this time, the medication delegated staff had not been trained by the RN in the use of insulin pens.	R161		
R162 SS=E	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 observation, medial record review and staff interviews the home failed to ensure that staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician written order, signed order and supporting diagnosis or problem statement in the resident's record in 1 out of 6 sampled residents (Resident	R162		

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R162	<p>Continued From page 10</p> <p>#3) reviewed. *Repeat deficient practice as per previous survey dated 12/7/11. Findings include:</p> <p>1. Staff are administering medication to Resident #3 without a signed physician's order. Per medical record review on 10/21/13, Resident #3 was admitted on 6/11/12 with diagnosis to include Diabetes, Tachycardia, Depression and status post surgical removal of toes on both feet. Physician orders included fingersticks blood sugars three times a day (tid) with the a sliding scale to be administered via insulin pen subcutaneously. MD orders signed and dated 9/4/13 do not contain a physician order for Novolog 15 U at 0800 and 20 U at noon and 1700. Medication Administration Record (MAR) documents a scheduled dose of Novolog Insulin 15 U at 0800, and 20 U at 1200 and 1700, plus sliding scale insulin administration according to glucometer reading. Blood sugar logs reviewed for the past four months evidence that the resident has been receiving a scheduled dose of Novolog Insulin plus the sliding scale insulin three times per day. Per interview with the RN Administrator on 10/21/13 @ 12 noon s/he confirms that there is no physician order for the scheduled dose of Novolog Insulin.</p> <p>2. Per medical record review on 10/22/13, Resident #3 was admitted on 6/11/12 with diagnoses to include Diabetes, Tachycardia, Depression and status post surgical removal of toes on both feet.. On 9/2/13 at 1400 Resident #3 complained of severe chest pain radiating down the left arm. Nurse Aide (NA) administered 1 tab of Nitroglycerin at 1410. Physician medication orders dated 6/11/12 and newly signed physician orders dated 9/14/13 do not contain a physician order to administer</p>	R162		

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R162	Continued From page 11  Nitroglycerin tabs for chest pain. Per interview with RN Administrator on 10/22/13 @ 1 PM s/he confirms that there is no order for the administration of Nitroglycerin, and it was given by an unlicensed staff member.	R162		
R168 SS=E	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.10 Medication Management</p> <p>5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:</p> <p>(6) Insulin. Staff other than a nurse may administer insulin injections only when:</p> <p>i. The diabetic resident's condition and medication regimen is considered stable by the registered nurse who is responsible for delegating the administration; and</p> <p>ii. The designated staff to administer insulin to the resident have received additional training in the administration of insulin, including return demonstration, and the registered nurse has deemed them competent and documented that assessment; and</p> <p>iii. The registered nurse monitors the resident's condition regularly and is available when changes in condition or medication might occur.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to meet the following conditions for 1 of 6 sampled residents (Resident</p>	R168		

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R168	<p>Continued From page 12</p> <p>#3), for unlicensed staff to be permitted to administer insulin. The findings include:</p> <p>i. The diabetic resident's condition and medication regimen is considered stable by the registered nurse who is responsible for delegating the administration; and</p> <p>ii. The designated staff to administer insulin to the resident have received additional training in the administration of insulin, including return demonstration, and the registered nurse has deemed them competent and documented that assessment; Findings include:</p> <p>1. Resident #3 is receiving a scheduled dose of insulin by unlicensed staff for which there is no physician's order. Per medical record review on 10/21/13, Resident #3 was admitted on 6/11/12 with diagnoses to include Diabetes, Tachycardia, Depression and status post surgical removal of bilateral toes of both feet. Physician orders include fingerstick blood sugars three times a day (tid) with a sliding scale of insulin to be given based on the fingerstick result. MD orders signed and dated 9/4/13 do not contain a physician order for Novolog 15 U at 0800 and 20 U at noon and 1700. Medication Administration Record (MAR) documents an order for Novolog Insulin per sliding scale. Blood sugar logs reviewed for the past four months evidence that the resident has been receiving a standing order Novolog Insulin plus the sliding scale three times per day. Per interview with the Registered Nurse (RN) Administrator on 10/21/13 @ 12 noon s/he confirms that there is no physician order for the scheduled dose of Novolog Insulin.</p> <p>2. Per medical record review on 10/21/13, Resident #3 was admitted on 6/11/12 with</p>	R168		
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R168	Continued From page 13  diagnoses to include Diabetes, Tachycardia, Depression and status post surgical removal of bilateral toes of both feet. Per observation on 10/21/13 @ 11:30 AM Nurse Aid (NA), reviewed Resident #3's fingerstick blood sugar that registered 85. MAR identifies the resident is required to receive Novolog 12 units subcutaneous via insulin pen for blood sugar 80-120. NA prepared the resident's site with an alcohol wipe, with resident facing the NA s/he placed her/him gloved left hand on the resident's left upper arm, with the pen in her/his gloved right hand she/he then placed the capped needle (insulin pen) in her mouth, pulled the cap of the needle off and proceeded to administer the insulin dose to the resident. Per interview with the NA s/he confirms on 10/22/13 @ 9 AM, that s/he should not have put the needle in his/her mouth. Per interview with RN Administrator on 10/21/13 @ 3 PM, s/he confirms that the NA knows better and should not have removed the cap of the needle from the insulin pen by using her teeth. Also confirmed with the RN/Administrator at this time, the medication delegated staff had not been trained by the RN in the use of insulin pens.	R168		
R173 SS=E	V. RESIDENT CARE AND HOME SERVICES  5.10 Medication Management  5.10.h.  (1) Resident medications that the home manages must be stored in locked compartments under proper temperature controls. Only authorized personnel shall have access to the keys	R173		

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R173	Continued From page 14  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the home failed to ensure that temperatures were being monitored for a refrigerator that stored medications. Findings include:  Per observation on 10/22/13 at 9:45 AM, the refrigerator in the nurse's station contained medications for the residents, and some individual food items. There was no thermometer available in the refrigerator, and no log kept to monitor the temperatures of the unit. Per interview on 10/22/13 at 9:50 AM, the RN/Administrator confirmed the absence of a thermometer in the refrigerator, and stated there was no procedure to regularly monitor the adequate temperature control of the refrigerator.	R173		
R174 SS=E	V. RESIDENT CARE AND HOME SERVICES  5.10 Medication Management  5.10.h. (2)  Medications requiring refrigeration shall be stored in a separate, locked container impervious to water and air if kept in the same refrigerator used for storage of food.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the home failed to assure that refrigerated medications were stored properly. Findings	R174		

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R174	Continued From page 15  include:  Based on observation on 10/22/13 at 9:35 AM, the refrigerator in the nurse's station contained a locked box with medications inside, including insulin pens. Beside the box on the shelf, there was a box of Insulin pens, and other medications sitting on the shelf that were not stored in a locked box impervious to moisture. Per interview on 10/22/13, the RN/Administrator confirmed that there were medications sitting on the shelf of the refrigerator that were not stored in a locked, moisture proof container.	R174		
R179 SS=D	V. RESIDENT CARE AND HOME SERVICES  5.11 Staff Services  5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following:  (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens,	R179		

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R179	<p>Continued From page 16</p> <p>maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to ensure that 1 of 5 employees demonstrate competency in the skills and techniques that they are expected to perform before providing any direct care to residents. * Repeat deficient practice as per previous survey dated 12/7/11. Findings include:</p> <p>1. Per record review on 10/21/13 at 3 PM 1 of 5 direct care staff records indicated a lack of training. Employee record documented date of hire June 2013, to date the employee has not received training or demonstrated competency in the areas of emergency response 1st aid, abuse/neglect/exploitation, respectful communication, infection control and general care &amp; supervision. Per interview with the Administrator on 10/21/13 @ 3 PM s/he confirmed that the training has not been completed.</p>	R179		
R247 SS=F	<p>VII. NUTRITION AND FOOD SERVICES</p> <p>7.2 Food Safety and Sanitation</p> <p>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.</p>	R247		

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R247	<p>Continued From page 17</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the home failed to assure that refrigeration was monitored for proper ranges for food storage. Findings include:</p> <p>On 10/21/13 at 9:05 AM, the kitchen tour was conducted. Per observation of the refrigerated milk cooler, the thermometer inside the unit read 47 degrees F., and there was no temperature log observed near the unit. Per interview with the Kitchen Manager at the time of the observation, the refrigerator was over the 41 degree F. required for safe food storage, and upon replacing the thermometer with a new one, it was determined to be a faulty thermometer. Also at this time, the Kitchen Manager confirmed that there was no log kept for monitoring the main walk-in food refrigerator, or the milk cooler refrigerator, to ensure safe food temperatures.</p>	R247		
R251 SS=F	<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 observation and staff interview, the home failed to ensure that food was stored to protect from contamination. Findings include:</p> <p>Per observation during the initial tour of the</p>	R251		

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R251	Continued From page 18  kitchen on 10/21/13 at 9:05 AM, two bags of potatoes were observed to be stored directly on the floor of the kitchen. Per interview at the time of the observation, the Kitchen Manager confirmed that the two bags of potatoes were stored directly on the floor. Per observation on 10/21/13 at 10:35 AM, another large bag of potatoes was observed to be stored on the floor of the dry storage room downstairs. Per interview on 10/21/13, the RN/Administrator of the home confirmed that the potato bag was sitting directly on the floor, and that the Kitchen Manager knew that food must be stored up off the floor.	R251		
R266 SS=D	IX. PHYSICAL PLANT  9.1 Environment  9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the home failed to ensure that potentially hazardous chemicals were stored properly. * Repeat deficient practice as per previous survey dated 12/7/11. Findings include:  Per observation on 10/21/13 at 10:45 AM, there was a gallon jug of bleach observed sitting out in the unlocked laundry room, used by some residents. The RN/Administrator confirmed that some of the residents who walk by the room had cognitive problems, and would have access to the bleach sitting in the open. Also at this time, during the tour of the downstairs locked storage closet, a	R266		

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R266	Continued From page 19  full plastic gas container was observed sitting in the closet. The RN Manager confirmed that the gasoline was put in the closet by a staff person, that this was not a safe storage practice, and that it belonged outside in a shed.	R266		

Ms. Pamela Cota, RN  
Licensing Chief  
Division of Licensing & Protection  
103 South Main St.  
Ladd Hall  
Waterbury, VT 05671-2306

December 4, 2013

Dear Ms. Cota,

Please accept this letter as my plan of corrections for the deficiencies that we incurred during our survey on October 22, 2013. I have written the plans of correction according to the corresponding Regulation number that is cited on the survey.

**R128**

1. Resident #3 originally had an order for his Novolog to be given three times daily. The order was written upon his admission on 6/11/2012. The order was for Novolog 15 units @0800, Novolog 20 units @ 1200 and Novolog 20 units @ 1700. He was also to receive additional insulin per his sliding scale blood sugars at those same times. The total amount was to be documented on the flow sheet in his MAR. Looking back through the MARs it was found that the pharmacy had inadvertently crossed off that particular order and unfortunately it was not caught by any of us who work with the MARs. The order had never actually been D/C'd by the physician. When Resident #3 had a short stay at the hospital, the discharging physician had not included the order in his discharge as it was not on his MARs and somehow again we missed it! On October 21, 2013 I telephoned Resident #3's physician to let them know what had happened. They faxed me a copy of the order that they sent down to the pharmacy for a renewal order on August 15, 2013. So while Resident #3 has actually been getting the prescribed medication all along, the order was missing. The correct order is currently on his chart again. While there is no way that I can personally guarantee that a mistake will never happen again, we have currently set up a double check system to increase our likelihood of finding mistakes in the future. All new MARs from the pharmacy are reviewed by the LPN and the RN. We have asked the pharmacy not to cross off anything on our sheets starting 01/01/14, that the nurses would review all sheets themselves.

12/17/13 @ 3

Per TC w/Wanda Waugh - Home Administrator will be responsible for compliance. *monitoring for*

2. The staff member that gave Resident #3 a Nitro for chest pain has been reprimanded on 12/5/2013 for giving a med without checking for an order for that med.

*all addendum items agreed upon after discussion with Wanda Waugh RN on 12/17/13 at 3:15 PM.*

*Karen Campo*

The nursing staff met on 11/26/2013 to discuss the importance of always checking the MAR for current orders before giving a PRN medication.

3. We will not perform treatments on any resident in the future without a current order for such treatment. On 10/24/2013 I obtained a new order for Resident #5 to be straight cathed five (5) times daily.

*Add: The Home manager / RN will be responsible for monitoring for compliance through weekly audits x 1 mo, then monthly*

R145

#1-6. I received new care plan forms in the mail today (12/04/2013). I am hopeful that these new forms will be easier for me to use and keep up to date. I will have each of the residents records reviewed and a care plan done to include the care and services necessary to assist each resident in maintaining their independence and well being. This new system will be finished and implemented by 01/15/2014. The new plans will be reviewed and updated every month as we do the MARs or whenever a resident has a change in their physical or mental condition.

*Home manager will be responsible for compliance.*

*POC accepted w/ Add:*

160

1. This staff member was reprimanded for removing a needle cap with her teeth. On 10/24/2013 we reviewed insulin syringe use and discussion followed on 11/26/2013 for the rest of the nursing staff. Use of insulin pens was also reviewed on 11/26/2013. The use of insulin pens will become part our orientation program for new employees who are being delegated to do meds. Staff using the pens or syringes will need to repeat the protocol for use as well as perform a correct demonstration. New orientation to begin 01/01/2014.

*POC accepted w/ addendum*

*Home manager / RN will be responsible for auditing for compliance.*

161

1. I currently have medication policies on oral meds and insulin, but have not done a specific policy on the use of the insulin pens. There will be a policy and procedure written and placed in the Policy and Procedure book by 01/06/2013. All nursing staff will be mandated to read the new policy and to initial and date the document. It will be reviewed with new staff that is learning med administration starting 01/01/2014.

*Per TC addendum: Correction date changed to 12/23/13, policy will be written and in place by the 23rd of Dec.*

16

*K Compton*

1. Answered in R128.

*Home manager / RN will be responsible for compliance*

2. Answered in R128.

**R168**

//

1. Answered in R128.

2. Answered in R160.

**R173**

1. As of 10/28/2013 the refrigerator in the medication room has a new thermometer and is being monitored daily by the dietary staff and logged on a flow sheet. On 12/4/2013 I asked Maintenance to please check all refrigerators and milk cooler temps when doing monthly water temp checks in order to monitor dietary compliance with the daily log.

*Home manager will be responsible for monitoring for compliance w / new protocols.*

**R174**

*K. Campo*

1. The extra medication happens on occasions when the drug order is particularly large and there is not enough room in the refrigerator box to contain all of the boxes of insulin. On 10/28/2013 I purchased a new large moisture proof container which will fit in the crisper drawer of the refrigerator in the medication room. As of 10/28/2013 any medications that will not fit into the refrigerator box will now be stored in this second box. The 2<sup>nd</sup> box does not lock but the medication room door is always locked.

*POC :*

*Weekly checks by nurses, Home manager will be responsible for monitoring for compliance*

**R179**

*K. Campo*

1. The only staff member who did not meet the twelve hours of in-service requirement was just hired in June of 2013. She had successfully completed her LNA class at Lyndon Institute and passed her State exam. Although she did not have some of these things (yet) at Canterbury Inn, she had already done Resident Rights, First Aid, Infection Control and Abuse, Neglect and Exploitation as part of her training. She has done Fire Safety here and participated in our Evacuation drill last August. We are having Infection Control on 12/09/2013 and have a class scheduled with Alice Harter on 12/12/2013 on Resident Rights, Communication, Abuse, Neglect and Exploitation. The newest nursing staff member will have these as well. Starting on 01/01/2013 Resident Rights, Abuse, Neglect and Exploitation, First Aid and Fire Safety will be added and implemented into our orientation packet.

*add: Home manager will be responsible for monitoring for compliance in this matter*

*K. Campo*

**R247**

1. As of 10/28/2013 all refrigerators and the milk cooler have new thermometers and are monitored daily. Temperatures are documented on a flow sheet by the dietary staff. The refrigerator repairman came on 10/24/2013 to service the milk cooler. It is currently working and temp is stable. On 12/04/2013 the maintenance staff will check all refrigerators and the milk cooler for temperatures and review the dietary log for compliance.

per add: Home owner will be responsible for monitoring compliance w/ new protocols

**R251**

K Campin

1. On 11/18/2013 a new potato bin was ordered and it arrived on 11/25/2013. Potatoes will be placed in this bin as soon as they are delivered to us so that potato bags will not be stored on the dietary storage room floor anymore.

Add: Home manager will perform weekly walk-throughs of storage + kitchen to monitor for compliance. (K.C.)

**R266**

1. On 11/26/2013 the carpenter came in to build a new cupboard under the sink in the laundry room. It will be a locked cabinet so that laundry soap and bleach can be safely stored so that residents will no longer have potential access to them.

On 10/25/2013 the grounds keeper was advised **again** where to store the gasoline can. It is to be kept in the outside storage shed. The housekeeper was also advised that while she meant well, the gasoline can is never to be put in the indoor storage room. On 12/4/2013 a new sign was posted on the storage room door to prohibit storage of gasoline or hazardous materials in this area. It also advises that such materials are to be kept only in the outside storage area.

Spot checks will be performed by maintenance and home manager, and Home manager will be responsible for monitoring for compliance.

Respectfully,

Wanda Waugh RN

Wanda Waugh RN

POC accepted with the included addendums