



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. Ann Bouza, Administrator  
Equinox Terrace  
324 Equinox Terrace Road  
Manchester Center, VT 05255

Dear Ms. Bouza:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 8, 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 RN".

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:  0127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/08/2011
NAME OF PROVIDER OR SUPPLIER  EQUINOX TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 324 EQUINOX TERRACE ROAD MANCHESTER CENTER, VT 05255		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments:  An unannounced onsite complaint investigation was conducted from 6/6/11 to 6/8/11, in conjunction with a re-licensing survey. There were no regulatory violations related to the complaint investigation. Please refer to the Statement of Deficiencies dated 6/8/11 for the regulatory violations related to the re-licensing survey.	R100		

Division of Licensing and Protection

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

*[Signature]*  
TITLE

(X6) DATE

6/29/11

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R104	Continued From page 1  the amount of personal needs allowance and the provider's agreement to accept room and board and Medicaid as sole payment.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home failed to assure that the Admission Agreement for 1 of 12 residents (Resident #1) was available for review. Findings include:  1. Per record review on 6/6/11, there was no Admission Agreement available for Resident #1 indicating services, rates, resident rights / responsibilities. During interview on 6/8/11 at 8:55 AM, the Executive Director confirmed that the Agreement was not available.	R104	<b>RESIDENT # 1 NOW HAS A SIGNED &amp; DATED ADMISSION AGREEMENT ON FILE WITH DOCUMENTED SERVICES, RATES &amp; RESIDENT RIGHTS &amp; RESPONSIBILITIES. ALL FUTURE AGREEMENTS WILL BE SIGNED &amp; DATED TIMELY DURING ADMISSION PROCESS &amp; KEPT AVAILABLE ON FILE.</b>	6/14/11
R136 SS=E	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 record review and interview, the home failed to assure that 8 of 12 resident assessments (Resident #1, Resident #2, Resident #3, Resident #5, Resident #6, Resident #7, Resident #8, and Resident #10) were complete and accurate as validated by the RN (Registered Nurse) for residents requiring medication management and / or nursing oversight. Findings include:	R136	<b>R104 6-30-11 POC accepted as written. — C. Laxway, RN —</b>	

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R136	Continued From page 2  1. Per record review concluding on 6/8/11, the resident assessment for Resident #7 (dated 11/19/10) had a typed name with Licensed Practical Nurse (LPN) title, in the signature space. During an interview on 6/8/11 at 11:00 AM, the Health Services Director confirmed that the assessment document (dated 11/19/10) for Resident #7 had a typed LPN name in the signature section and lacked evidence of validation by an RN.  2. Per record review concluding on 6/8/11, the resident assessment for Resident #8 (dated 1/25/11) and the resident reassessment for Resident #10 (dated 2/22/11) were each signed by an LPN. During an interview on 6/8/11 at 11:00 AM, the Health Services Director confirmed that the assessment documents for Resident #8 (dated 1/25/11) and Resident #10 (dated 2/22/11) were each signed by an LPN and lacked evidence of validation by an RN.  3. Per record review on 6/7/11, RAIs (Resident Assessment Instrument) of Resident #1, Resident #2, and Resident #3 were not signed as complete and accurate by an RN. During interview on 6/7/11 at 9:55 AM, the Health Services Director confirmed that the RAIs for each of these residents were not signed and dated by an RN.  4. Per record review on 6/8/11, RAIs for Resident #5 and Resident #6 were not signed as complete and accurate by an RN. During interview on 6/8/11 at 8:50 AM and 11:00 AM, respectively, the Health Services Director confirmed that the RAIs for each of these residents were not signed and dated by an RN.	R136	RESIDENT #7 ASSESSMENT HAS VALIDATION OF RN SIGNATURE IN PLACE. ALL FUTURE ASSESSMENTS WILL BE SIGNED BY RN  RESIDENT #8 ASSESSMENT & RESIDENT #10 REASSESSMENT HAS VALIDATION OF RN SIGNATURE IN PLACE  RESIDENTS #1, 2 & 3 HAVE BEEN SIGNED AS COMPLETE & ACCURATE BY RN AND DATED.  RESIDENTS #5 & 6 ARE BOTH DECEASED  R136 6-30-11 POC accepted as written. — C. Laraway, RN	6/27/11  6/27/11  6/28/11



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R145	Continued From page 4  resident Kardex contained information to instruct staff regarding fall prevention measures and that the service plan was not signed by an RN indicating accuracy and completion.  3. Per record review on 6/7/11, Resident #2 (who experiences significant dementia) had no written service plan signed as complete and accurate by an RN. During interview on 6/7/11 at 10:05 AM, the HSD confirmed that neither the care plan (service plan) nor the resident Kardex contained information to instruct staff regarding fall prevention measures.  4. Per record review on 6/7/11 and 6/8/11, Resident #5, with a history of falls, had experienced multiple falls from 12/10 through 3/11. The service plan did not indicate specific fall risk reduction instruction measures for this resident and the service plan was not signed as complete and accurate by the RN. During interview on 6/8/11 at 11:10 AM, the HSD confirmed that Resident #5 was at high risk for falls, that the resident had experienced numerous falls throughout the resident's stay at the home, and that there was no RN signature indicating completion and accuracy of the service plan.  5. Per record review on 6/7/11, Resident #6 required a special footwear appliance and a cane for mobility and had an unsteady gait as a result of pedal neuropathies. There were no specific interventions identified in the service plan regarding this resident's fall risk factors to guide staff in daily care and monitoring. The service plan was not signed by an RN as complete and accurate. During interview on 6/8/11 at 11:00 AM, the HSD confirmed that Resident #6 had an unsteady gait, required specialized footwear appliance, and used a cane for mobility. S/he also	R145	RESIDENT #2 HAS A WRITTEN SERVICE PLAN SIGNED COMPLETE & ACCURATE BY RN. RESIDENT KARDEX & SERVICE PLAN RE: FALL PREVENTION IS NOW IN PLACE FALL RISK REDUCTION MEASURES WILL BE ADDRESSED FOR ALL FUTURE POC.  BOTH RESIDENT #5 & #6 ARE DECEASED  R145 6-30-11 POC accepted as written. — C. Lavery, RN —	6/28/11

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R145	Continued From page 5  confirmed that the service plan was not signed by an RN, indicating accuracy and completion.	R145		
R147 SS=E	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 record review and interview, the home failed to assure that medication orders for 5 of 12 residents in the survey sample (Resident #1, Resident #2, Resident #4, Resident #10 and Resident #12) contained dosage and / or frequency of administration. Findings include:  1. Per record review, a physician's order for PRN (as needed) administration of Lorazepam for Resident #10 lacked a timeframe to assure safe dosage and spacing. The order was written as follows: "Lorazepam 1 mg tab, take 2 tabs PO (by mouth) PRN (as needed) for breakthrough seizures". During an interview on 6/8/11 at 11:30 AM, the nurse confirmed that the written order for as needed administration of Lorazepam for Resident #10 lacked parameters to guide frequency of administration.  2. Per record review, a physician's order for PRN (as needed) administration of Lorazepam for Resident #12 lacked a timeframe to assure safe spacing of doses. The order was written as	R147	PARAMETERS FOR FREQUENCY OF ADMINISTRATION ARE NOW IN PLACE FOR USE OF LORAZEPAM FOR RESIDENT # 10 ALL FUTURE ORDERS WILL CONTAIN TIMEFRAMES FOR DOSAGE AND SPACING OF MEDICATIONS. NURSING STAFF IN SERVICE GIVEN TO INSTRUCT THEM TO REQUEST MD ORDERS TO REFLECT	6/9/11

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R147	Continued From page 6  follows: "Lorazepam 0.5 mg PO (by mouth) up to 3x/day PRN (as needed) for anxiety/agitation". During an interview on 6/8/11 at 11:30 AM, the nurse confirmed that the written order for as needed administration of Lorazepam for Resident #12 lacked parameters to guide frequency of administration.  3. Per record review on 6/6/11, Resident #1 was prescribed Ativan 1-2 mg (milligram) (0.25 ml [milliliter] to 0.5 ml) topical BID (twice daily). The Medication Administration Record (MAR) indicated that during the current and prior months, Resident #1 had received 0.25 ml (or 1 mg) of Ativan twice daily. The physician order did not indicate under what conditions to administer 1 mg or 2 mg of this scheduled medication.  An order for "Ativan 0.25 ml to 0.5 ml topical Q (every) 3-4 hours PRN (check scheduled dose first)" was also prescribed by the physician for Resident #1 (not administered during the current and prior month). The PRN Ativan order did not indicate whether to give at 3 or 4 hour intervals or whether to give 0.25 ml or 0.5 ml. During interview on 6/7/11 at 10:25 AM, the Health Services Director (HSD) confirmed that this resident's ordered Ativan lacked clear dosage and / or frequency instruction and that staff (both licensed and non-licensed) had administered 1 mg of Ativan twice daily during the current and prior month.  4. Per record review on 6/7/11, Resident #2 had an order for "Tylenol 325 mg 1-2 tabs Q 4 hours PRN for fever / mild - moderate pain". This medication was administered on 6/1/11 (1 tab), 6/2/11 (1 tab), 6/3/11 (2 tabs), 6/4/11 (2 tabs), 6/5/11 (1 tab) and 6/6/11 2 tabs X 2. During interview that afternoon, the HSD confirmed that	R147	PARAMETERS FOR FREQUENCY OF ADMINISTRATION IS IN PLACE FOR USE OF LORAZEPAM FOR RESIDENT # 12  DOSAGE AND FREQUENCY HAS BEEN CLARIFIED & ADDED TO MAR FOR RESIDENT #1. MD ORDER IS IN PLACE FOR USE OF ATIVAN DOSAGE & FREQUENCY ORDER WILL BE CLARIFIED BY NURSING STAFF ON ALL FUTURE MD ORDERS.  PARAMETERS ARE NOW IN MAR RECORD TO INDICATE SPECIFIC DOSAGE FOR TYLENOL FOR	6/9/11  6/28/11  6/28/11

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R147	Continued From page 7  the order did not contain specific dosage required and that staff had administered either 1 tab or 2 tabs on the dates indicated.  5. Per record review on 6/7/11, a physician's order dated 4/29/11 for PRN (as needed) administration of Ativan for Resident #4 lacked a timeframe to assure safe spacing of doses. The order stated "Ativan 0.5 mg PRN - Anxiety". During an interview on 6/8/11 at 11:35 AM, a staff nurse confirmed that the written order for as needed administration of Ativan for Resident #4 lacked parameters to guide frequency of administration.	R147	RESIDENT # 2 . STAFF HAVE BEEN INSTRUCTED TO HAVE ALL FUTURE MEDICATIONS CLARIFIED BY MD TO ENSURE CORRECT DOSAGE, TIMEFRAME & FREQUENCY .	
R179 SS=E	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	PARAMETERS ARE NOW IN PLACE FOR ADMINISTRATION OF ATIVAN TO RESIDENT # 4 TO GUIDE FREQUENCY . ALL FUTURE MD ORDERS WILL BE CHECKED AND CLARIFIED IF NEEDED BY MD . NURSING STAFF HAVE BEEN ORIENTED TO IMPORTANCE OF CORRECTION OF ORDERS AND TO APPLY THESE PARAMETERS TO ALL FUTURE MEDICATIONS	6/8/11

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R179	Continued From page 8  maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, staff failed to demonstrate competency in techniques they are expected to perform by failing to maintain proper infection control measures during meal assistance of multiple residents. Findings include:  1. Per observation of the breakfast meal on 6/7/11, infection control precautions were not maintained by a staff member. Following the completion of breakfast, clothing protectors were removed from residents and placed on top of the medication cart. Residents were cleansed and face cloths / towels were also placed on top of the medication cart. The caregiver did not change gloves between each residents care. A laundry bag was obtained and set on the floor beside the medication cart to dispose of the soiled items. Clean laundry was picked up from the kitchen sink area by the caregiver who had disposed of the soiled items without changing of his / her gloves. During interview at 9:05 AM immediately following the observation, the staff member confirmed that s/he had not followed infection control practices, that the medication cart was contaminated and that gloves should be changed between each resident's care provision.	R179	<b>TRAINING &amp; INSTRUCTION HAS BEEN GIVEN FOR INFECTION CONTROL PRECAUTIONS. CORRECTIVE ACTIONS WILL BE MONITORED TO PREVENT FURTHER OCCURRENCE. ALL STAFF WILL BE GIVEN ONGOING INSERVICES TO ADDRESS INFECTION CONTROL PRACTICES</b>	6/17/11
R200 SS=D	V. RESIDENT CARE AND HOME SERVICES  5.15 Policies and Procedures  Each home must have written policies and procedures that govern all services provided by	R200	R179 6-30-11 POC accepted as written. C. Haraway, RW	

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R200	Continued From page 9  the home. A copy shall be available at the home for review upon request.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home failed to develop policy and procedures to guide staff in the care of residents at risk of falls and / or for residents who experienced falls (with or without injury). Findings include:  1. Per record review on 6/8/11, the homes' 'Fall Risk Intervention' policy provided no staff instruction to direct care in the event of a fall (with or without injury). During interview on 6/8/11 at 9:35 AM, the Health Services Director confirmed that the 'Fall Risk Intervention' document did not instruct staff regarding this need nor was there written procedure instructing staff in the event of a fall with injury (or suspected injury) regarding monitoring and / or neurological assessments.	R200	POLICY AND PROCEDURE FOR FALL RISK INTERVENTION HAS BEEN ADDED TO OUR POLICIES AND IS NOW AVAILABLE. NURSING STAFF HAVE ACCESS TO AND ARE INSTRUCTED ON SEQUENCE OF EVENTS AND INTERVIEWS WILL BE HELD DURING THE YEAR TO ADDRESS FALL RISK INTERVENTION NEUROLOGICAL ASSESSMENT FLOW SHEETS ARE AVAILABLE.  R200 6-30-11 POC accepted as written. — C. Harvey, RN	6/27/11
R266 SS=E	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 interview, the home failed to assure a safe environment. Findings include:  1. Per observation and confirmed during initial tour on 6/6/11 with the Executive Director, cleansers including Ecolution liquid disinfectant	R266		

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R266	<p>Continued From page 10</p> <p>cleaner (2), a bottle of Shout stain remover, a bottle of Ammonia, Epsom salts, Green Earth Peroxide Cleaner and 5 bottles of nail polish remover were in an unlocked nursing / storage area. Also in this area was 1 unsecured oxygen container.</p> <p>On the Tan Wing, an electrical room door was unlocked / unattended. Chemical cleansers including toilet bowl cleaner and glass cleaner were in an unlocked laundry room on the Tan Wing.</p> <p>2. Per observation on 6/7/11, and confirmed by the Health Services Director at 2:55 PM, there were 5 unsecured oxygen cylinders placed in an unlocked, nursing station area.</p>	R266	<p>ALL CLEANSERS DISINFECTING AGENTS AND OTHER HAZARDOUS LIQUIDS ARE NOW HOUSED IN SECURED LOCKED STORAGE SPACE. OXYGEN CYLINDERS ARE CRATED IN HOLDERS AND STORED IN LOCKED SPACE.</p>	<p>6/8/11 6/10/11</p>
R291 SS=E	<p>IX. PHYSICAL PLANT</p> <p>9.6 Plumbing</p> <p>9.6.d Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and record review, the home failed to assure that hot water temperatures do no exceed 120 degrees Fahrenheit in resident use areas. Findings include:</p> <p>1. Per observation and record review on 6/6/11, the water temperatures in the resident accessible service area sink in the dining area currently exceeded 120 degrees Fahrenheit (DF) and had exceeded 120 DF for the prior 5 consecutive months. There was no evidence that adjustments</p>	R291	<p>ALL DOORS TO LAUNDRY AREAS MECHANICAL &amp; AREAS WITH HAZARDOUS LIQUIDS AND CHEMICALS ARE NOW WITH AUTOMATIC CLOSERS AND LOCKS. ALL STAFF ARE AWARE AND WILL BE PROVIDED WITH CONTINUING EDUCATION R266 6-30-11 POC accepted as written. — C. Laraway, RN — THE SERVICE AREA</p>	<p>6/10/11</p>

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R291	Continued From page 11  had been attempted / made following each reading over 120 DF. During interview on 6/6/11 at 3:05 PM, the Maintenance Director confirmed that the current temperature exceeded the maximum safe temperature of 120 DF, that the prior 5 months the temperature had exceeded 120 DF and that re-evaluation of those temperature findings had not been completed.	R291	(KITCHENETTE) FAUCETS / PLUMBING HAVE HAD TEMPERATURE ADJUSTMENT TO MAINTAIN SAFE TEMPERATURE OF 117° F. MAINTENANCE ARE AWARE OF NEED IN KEEPING SAFE TEMPERATURE AND CHECKS WILL BE MONITORED AND DOCUMENTED IN LOG EVERY MONTH  R291 6-30-11 POC accepted as written. — C. Lurway, RN	6/9/11

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # <b>0127</b>	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: <b>6/8/2011</b>
NAME OF PROVIDER OR SUPPLIER <b>EQUINOX TERRACE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>324 EQUINOX TERRACE ROAD MANCHESTER CENTER, VT</b>		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
<b>R104</b>	<p><b>V. RESIDENT CARE AND HOME SERVICES</b></p> <p>5.1 Admission</p> <p>5.2.a Prior to or at the time of admission, each resident, and the resident's legal representative if any, shall be provided with a written admission agreement which describes the daily, weekly, or monthly rate to be charged, a description of the services that are covered in the rate, and all other applicable financial issues, including an explanation of the home's policy regarding discharge or transfer when a resident's financial status changes from privately paying to paying with SSI or ACCS benefits. This admission agreement shall specify at least how the following services will be provided, and what additional charges there will be, if any: all personal care services; nursing services; medication management; laundry; transportation; toiletries; and any additional services provided under ACCS or a Medicaid Waiver program. If applicable, the agreement must specify the amount and purpose of any deposit. This agreement must also specify the resident's transfer and discharge rights, including provisions for refunds, and must include a description of the home's personal needs allowance policy.</p> <p>(1) In addition to general resident agreement requirements, agreements for all ACCS participants shall include: the ACCS services, the specific room and board rate, the amount of personal needs allowance and the provider's agreement to accept room and board and Medicaid as sole payment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home failed to assure that the Admission Agreement for 1 of 12 residents (Resident #1) was available for review. Findings include:</p> <p>1. Per record review on 6/6/11, there was no Admission Agreement available for Resident #1 indicating services, rates, resident rights / responsibilities. During interview on 6/8/11 at 8:55 AM, the Executive Director confirmed that the Agreement was not available.</p>		

The above isolated deficiencies pose no actual harm to the residents