

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 King, Administrator
Fairwinds Residential Care Home
108 Mechanic Street
North Bennington, VT 05257

Provider # 0031

Dear Ms. King:

Enclosed is a copy of your acceptable plans of correction for the unannounced onsite re-licensing survey conducted on **October 9, 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

DEC 16 13

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| NUMBER OF DEFICIENCIES AND NUMBER OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0031 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 10/09/2013 |
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| NAME OF PROVIDER OR SUPPLIER PARKLANDS RESIDENTIAL CARE HOME | STREET ADDRESS, CITY, STATE, ZIP CODE 108 MECHANIC STREET NORTH BENNINGTON, VT 05257 |
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| 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 re-licensing survey was conducted by the Division of Licensing and Protection on 10/9/13. There were regulatory deficiencies identified. The findings include; | R100 | <p>In response to the findings of the re-licensing survey conducted on 10/9/13, there was no supporting diagnosis for Resident #1 to be taking Zoloft 25mg daily as ordered by the physician. I contacted the physician on the afternoon of 10/9/13 and received the written orders with a diagnosis of chronic depression and an order to continue the Zoloft 25mg daily on that same afternoon 10/9/13. Orders were placed in Resident #1's chart. The RN promptly update her assessment and care plan on 10/10/13 to support the diagnosis and treatment ordered by the physician. To prevent this from reoccurring we also changed our physicians orders form which requires our residents to their appointments and keeps their records updated, adding an area for diagnosis along with the medications so we can be more diligent in making sure there is a diagnosis to support the medication. These will be placed in their charts after each physician visit. The RN and manager will review charts, assessments, care plans, medications, weekly, to assure that all orders coincide for each physicians orders and diagnosis for each resident.</p> | |
| R162 SS=D | <p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.10 Medication Management</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility administered medications to 1 of 3 residents reviewed (Resident #1) without supporting diagnosis or problem statement in the resident's record. The findings include;</p> <p>1. Resident #1 was admitted to the facility on 10/04/08 with diagnoses that include Hypertension, Hypercholesterol, forgetfulness and Congested Heart Failure. Per review of the medication administration record and the physicians signed orders, the records indicated that Resident #1 was taking Zoloft (medication used typically for a diagnosis of depression) 25 mg by mouth every day. Per review of the physician's notes and Administrator's notes there was no evidence as to why Resident #1 was taking Zoloft and there was no evidence of a medical diagnosis that corresponds to the use of the medication.</p> | R162 | | |

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| Division of Licensing and Protection LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Wanda J. King</i> | TITLE <i>owner - administrator</i> | (X6) DATE |
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R162, R165, R179 POCs accepted with attachments. McCullhan RN/PMC 12/18/13 pmc

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| NAME OF PROVIDER OR SUPPLIER FAIRWINDS RESIDENTIAL CARE HOME | STREET ADDRESS, CITY, STATE, ZIP CODE 108 MECHANIC STREET NORTH BENNINGTON, VT 05257 |
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| R162 | <p>Continued From page 1</p> <p>Per review of the assessment dated 1/4/2012 and completed by the Administrator and reviewed by the facility's Registered Nurse, the assessment indicated that Resident #1 had no indicators of depression or anxiety. The assessment did indicate that during the last 7 days during the assessment period the resident received antidepressant medication (Zoloft). Per review of the medication administration record there was evidence that the facility medication delegated staff administered Zoloft daily to Resident #1. Per review of the Administrator's charting and Physician's documentation there was no evidence that Resident #1 was displaying or verbalizing any issues or concerns with depression or depressive symptoms.</p> <p>Per interview with the facility Administrator and Registered Nurse on 10/9/13, they reviewed the medical record and plan of care for Resident #1, and confirmed that there was no diagnosis for the utilization of Zoloft. The Administrator indicated that when Resident #1 was admitted in 2008, he/she was placed on Zoloft to help him/her cope with the failing health and eventual expiration of Resident #1's spouse. Interview with the Administrator and the Registered Nurse on 10/9/13, after review of the medical record, they confirmed that the physician for Resident #1 was never approached and discussed whether Resident #1 was in continued need of an antidepressant medication. The Administrator also confirmed that facility medication delegated staff were administering Resident #1's Zoloft to the resident on a daily basis without a diagnosis or rationale for use by the physician.</p> | R162 | <p>R.N. will continue to monitor and delegate med training to staff for all newly prescribed meds, new diagnoses, as well as ongoing diagnosis and regularly prescribed medications.</p> | |
| R165 SS=D | V. RESIDENT CARE AND HOME SERVICES | R165 | | |

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| R165 | <p>Continued From page 2</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>(3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for:</p> <ul style="list-style-type: none"> i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects; ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications; iii. Assessing the resident's condition and the need for any changes in medications; and Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions. <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that the registered nurse accepted responsibility for the proper administration of medications, and ensured that the resident's condition is assessed and the need for any medication changes be identified. The findings include;</p> <p>1. Resident #1 was admitted to the facility on 10/04/08 with diagnoses that include Hypertension, Hypercholesterol, forgetfulness and Congested Heart Failure. Per review of the medication administration record and the physicians signed orders, the records indicated</p> | R165 | | |

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| R165 | <p>Continued From page 3</p> <p>that Resident #1 was taking Zoloft (medication typically used for a diagnosis of depression) 25 mg by mouth every day. Per review of the physicians notes and Administrators notes there was no evidence as to why Resident #1 was taking Zoloft and there was no evidence of a medical diagnosis that corresponds to the use of the medication.</p> <p>Per review of the assessment dated 1/4/2012, completed by the Administrator and reviewed by the facility's Registered Nurse indicated that Resident #1 had no indicators of depression or anxiety. The assessment indicated that during the last 8 days during the assessment period the resident received antidepressant medication (Zoloft). Per review of the medication administration record there was evidence that the facility medication delegated staff administered Zoloft daily to Resident #1. Per review of the Administrators charting there was no evidence that Resident #1 was displaying or verbalizing any issues or concerns with depression or depressive symptoms.</p> <p>Per interview with the facility Registered Nurse on 10/9/13, after he/she reviewed the medical record and plan of care for Resident #1, he/she confirmed that there was no diagnosis for the utilization of Zoloft. The Administrator indicated that when Resident #1 was admitted in 2008, he/she was placed on Zoloft to help him/her cope with the failing health and eventual expiration of Resident #1's spouse. Interview with the Administrator and the Registered Nurse on 10/9/13, after review of the medical record, they confirmed that the physician for Resident #1 was never approached and discussed whether Resident #1 was in continued need of an anti-depressant medication. The Registered</p> | R165 | | |

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| R165 | Continued From page 4 Nurse also confirmed that facility medication delegated staff were administering Resident #1's Zolof to the resident on a daily basis without an appropriate medical diagnosis. | R165 | | |
| R179 SS=C | <p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.11 Staff Services</p> <p>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:</p> <ol style="list-style-type: none"> (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, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure at least twelve (12) hours</p> | R179 | | |

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| R179 | <p>Continued From page 5</p> <p>of training each year for each staff person providing direct care to residents.</p> <p>1. Per review of the facilities in-servicing records, there was no evidence that the facility had completed the required 12 hours of yearly training for each of the facility's employees. Per interview with the Administrator on 10/9/13, he/she confirmed that the facility had not educated the facility staff with the required 12 hours of yearly education that included the following;</p> <ul style="list-style-type: none"> (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, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents <p>The Administrator and Registered Nurse indicated in interview on 10/9/13 that they were unaware of all the specific education required, and he/she indicated that he/she thought some of the education was to be provided by trainers other than facility staff.</p> | R179 | | |

RE:10/9/2013 Onsite re-licensing-Fairwinds Residential Care Home

5.10 Medication Management

R100

R162

In response to the findings of the re-licensing survey conducted on 10/9/13, there was no supporting diagnosis for resident #1 to be taking Zoloft 25mg qd. As ordered by the physician. I contacted the physician on the afternoon of 10/9/13 and received the physicians written orders with a diagnosis of chronic depression along with an order to continue the Zoloft 25mg qd. on that same afternoon of 10/9/13. Orders were placed resident 1's chart. The R.N. promptly updated the care plan and assessment on 10/10/13 to support the diagnosis and treatment. Per suggestion and follow-up of surveyor Fairwinds changed our physicians orders form, adding an area for diagnosis along with the medications. This form accompanies our residents to their appointments and will enable us to be sure there is a supporting diagnosis for each medication. These forms will be placed in their charts after each physician Visit and the care plan will be updated, documentation of visit provide by manager in the daily notes. The residents assessment will be done upon admission and yearly as usual or done if there is a change in diagnosis, condition or medications. This will be done by the manager and reviewed by the house R.N. The manager and R.N. will review charts assessments, care plans and medications weekly to assure that all orders coincide with the physicians orders and diagnosis for each resident. Care plans will be updated by R.N monthly if there are no changes in residents conditions. The R.N. will continue to delegate and train staff on newly prescribed medications, for new diagnosis as well as on going diagnosis and daily medications which will continue to be documented and signed by R.N and staff.

RE: Onsite re-licensing-Fairwinds Residential Care Home

5.10 Medication Management

R165

On 10/9/13 a physicians order was obtained with a supporting Diagnosis of chronic depression ,along with the order to continue the already existing order for Zoloft 25mg qd. orders were placed in residents chart .The R.N. updated care plan and assessment on10/10/13 adding the supporting diagnosis and existing zoloft 25mg qd. order to each.

.Education was provided to staff on both ,the diagnosis and again on the zoloft. Fairwinds changed our physicians order forms adding an area for supporting diagnosis, along with medications .This form accompanies our residents to their appointments and will enable us to be sure there is a supporting diagnosis for each medication.

The forms will be placed in the residents chart followed up by the managers documentation of the visit in the daily notes. The residents assessment will be done upon admission and yearly or resident will be reassessed if there is a change in condition diagnosis or medications. This will be done by the manager and reviewed by the R.N. The manager and R.N. will review charts, assessments , and care plans weekly to assure that all documentation coincide with the physicians orders and diagnosis for each resident .Care plans will be updated monthly by the R.N. if there are no changes in residents condition. The R.N. will continue to educate and delegate staff on all newly prescribed medications for new diagnosis as well as ongoing diagnosis and daily medications. This will continue to be documented and signed by the R.N. and staff and kept in the already existing medication delegation folder.

RE:licensing-Fairwinds Residential Care Home

5.11 staff services

R179

In response to the on site survey done on 10/9/13 staff services . It has always been our policy to educate our small staff with a minimum of 12 hours training per year and document accordingly . However, due to a miscommunication we thought we had to access some of these trainings from outside sources and this is difficult for a small home such as ours therefore we had missed some of the trainings but not all of them . Now that we have clarified that information we will add these trainings to our educational trainings and continue to do them yearly. We will continue to document as we always have except for the addition of a employee signature on the educational training documentation ,per suggestion of the surveyor. I do feel we have educated our staff on all of these topics almost on a daily basis with a home the size of ours you have too. We just did not document properly.