

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

March 12, 2012

Mr. Thomas Gaboriault, Jr., Administrator
Four Seasons Care Home
135 South Main Street
Northfield, VT 05663

Provider #: 0129

Dear Mr. Gaboriault, Jr.:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **January 25, 2012**. 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, MS
Licensing Chief

PC:ne

Enclosure



Division of Licensing and Protection

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|--|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0129 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | Licensing and Protection (X3) DATE SURVEY COMPLETED C 01/25/2012 |
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| NAME OF PROVIDER OR SUPPLIER FOUR SEASONS CARE HOME | STREET ADDRESS, CITY, STATE, ZIP CODE 135 SOUTH MAIN STREET NORTHFIELD, VT 05663 |
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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 |
|--------------------|--|---------------|---|--------------------|
| R100 | Initial Comments: An unannounced on-site complaint investigation was conducted on 01/25/12 by the Division of Licensing and Protection. The following are regulatory findings. | R100 | See attached Plan of Correction. | |
| R149 SS=D | V. RESIDENT CARE AND HOME SERVICES 5.9.c (6) Maintain a current list of all treatments for each resident that shall include: the name, date treatment ordered, treatment and frequency prescribed and documentation to reflect that treatment was carried out; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the nurse failed to assure consistent documentation of treatments for one applicable resident (Resident #1). Findings include the following: 1. Per the Nurse Practitioner's (NP) orders dated 12/23/11 for Resident #1, who became sick with shortness of breath, fever, cough, and weakness, was to receive an antibiotic (Levequin 500mg -starting 12/23/11) for 5 days and staff were to check vital signs every morning. Per review of the vital sign log for the month of December 2011, staff failed to monitor vital signs on 12/24/11 and 12/25/11. Although staff did take blood pressure and pulse on 12/26/11 & 12/27/11 they did not take respirations and temperatures. In addition, per review of the Medication Administration Record (MAR) the antibiotic was not signed off as being given. Per interview at 10:45 AM the Pharmacy confirmed that the medication was delivered on the | R149 | | |

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Annette Halasz RN CDE* TITLE *Nursing Manager/co-owner* (X6) DATE *2/14/12*

STATE FORM *[Signature]* 5899 HSZF11 If continuation sheet 1 of 5

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| R149 | Continued From page 1 afternoon of 12/23/11. Per telephone conversation at 11:00 AM, the medication staff confirmed that s/he did not sign off the medication but "remembers giving the meds in the dining room, which I normally don't do". Per interview at 2:00 PM the nurse manager confirmed that the expectation would be for "staff to take a full set of vital signs which includes respirations and temperature for someone with a respiratory infection" and to sign off all medications at the time it is being given, which staff failed to do. | R149 | | |
| R171 SS=D | V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include: (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, including the reason why and the actions taken by the home; (3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect; (4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and (5) For residents receiving psychoactive medications, a record of monitoring for side effects. (6) All incidents of medication errors. | R171 | | |

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| R171 | Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to assure that there was proper documentation for the administration of medications for 1 applicable resident (Resident #1) Findings include: 1. Per record review on 01/25/12, Resident #1 had NP orders dated 12/23/11 for an antibiotic (Levequin 500mg -starting 12/23/11). Per review of the Medication Administration Record (MAR) the antibiotic was not signed off as being given. Per interview at 10:45 AM the Pharmacy confirmed that the medication was delivered on the afternoon of 12/23/11. Per telephone conversation at 11:00 AM, the medication staff confirmed that s/he did not sign off the medication but "remembers giving the meds in the dining room, which I normally don't do". Per interview at 2:00 PM the nurse manager confirmed staff failed to document that medications were administered as ordered. | R171 | | |
| 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; | R179 | | |

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| R179 | Continued From page 3 (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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure that at least 12 hours of staff inservice were provided to all staff providing direct care to residents. Findings include: Per record review on 01/25/12 of the inservices for the calendar year of 2011, several staff did not complete 12 hours of education. Some staff had inservices that did not have the dates and/or times identified. In addition, one staff member did not demonstrate competency in the skill and techniques for nebulizer (breathing) treatments, however, was providing care and breathing treatments to Resident #1. Per interview at 1:02 PM, the nurse manager confirmed that the staff member administering the nebulizer treatment did not have inservice and/or demonstrated competency and the inservice records "are a big mess and we're working on getting this straightened out to make sure everyone gets the 12 hours of inservice". | R179 | | |
| R228 SS=A | VI. RESIDENTS' RIGHTS | R228 | | |

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| R228 | Continued From page 4 6.16 Residents have the right to formulate advance directives as provided by state law and to have the home follow the residents' wishes This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to assure that 1 applicable Advanced Directive Document was properly executed. (Resident #1) Findings include: Per interview on 01/25/12 at 9:00 AM, the Administrator stated that family members are contacted when residents have changes in care or treatments and would be contacted if it there was a concern. Per review of the closed record on 01/25/12, Resident #1's Advance Directive stated that a family member [daughter] was the person to notify. Resident #1 became ill on 12/22/11 with a fever of 101.7 and was started on an antibiotic on 12/23/11. The daughter was not contacted or made aware of the illness until a visit on 12/25/11. The resident died 2 days later. Per interview at 10:30 AM the staff nurse stated that "a son stopped in on the 24th and I assumed that the family knew". S/he confirmed that the family was not notified of this illness. | R228 | | |

Revised Plan of Correction 3/2/12

Page 1 of 5 R149

Refers to ensuring treatments, such as Vital Signs are documented.

Actions taken:

1/26/12 New Vital Sign Record update to include box tabs with all applicable Vital signs to ensure that there is space and visual cues to ensure complete documentation of Vital Signs. Copy enclosed.

Additionally on this date (1/26/12) an In-service was provided to staff to ensure that everyone understood how, where, when to document vital signs.

All Residents on Antibiotics as of 1/30/12 have a sign off, for taking daily or as ordered Vital signs, on their Treatment Administration Record Sheet.

As of 1/30/12 the lead/medication staff each day shift will review the MAR and Treatment Administration Record to ensure that all VS & Medications have been signed off. Any issues will be brought to the attention of the RN on duty. A review signature list has been created for this purpose. Additionally the RN will review these records weekly on Fridays to ensure all documentation is complete.

R149 POC accepted 3/9/12 SEMMONS/RN/DMCOTAR/N

Page 2 of 5 R171

Refers to ensuring that there will be proper documentation for administration of Medications.

Actions taken:

See above actions. As of 1/30/12 the lead/medication staff each day will review the MAR to ensure that all medications have been signed off properly. Any issues will be brought to the attention of the RN on duty. Additionally the RN will review these records weekly on Fridays to ensure all documentation is complete.

Additionally starting on 1/23/12 and completed for all medication staff on 2/13/12, the yearly Medication update In-service was performed.

R171 POC accepted 3/19/12 SEMMONS RN / PINEOTA RN

Page 3 of 5 R179

Staff In-service completion

Action taken:

In-service reports were reviewed and recompiled. It was found that all direct care staff in 2011 did have at least 12 hours (if full year employed; pro-rated if here only a few months) of In-service. All staff had completed all the state required In-services. Although staff did have Respiratory in service regarding the use of Nebulizers this was not specifically documented or specifically 'certified'.

On 1/3/12 the staff was provided with a full respiratory Care In-service by one of our RN's Patti Brandt RN. Completed prior to 12/11; for use starting 1/1/12, a revised updated 2012 In-service schedule notebook was placed in service. As of 1/1/12 all direct care staff have signed off in service sheets, with documentation of in service attendance. In-service attendance is recorded on these sheets immediately after each in service. In-service hours of completion are ahead of schedule at this time for 2012, with most staff having already completed a minimum of 4 hours.

After being asked by the reviewer for return competencies for Nebulizer Use, on 2/2/12-2/15/12 all assigned staff were provided with specific in service on Nebulizer use, written guides on nebulizer use, as well as hands on return demonstration of nebulizer use; constituting 'certification'.

In-service completion is the responsibility of the RN staff.

R179 POC accepted 3/19/12 SEMMONS RN / PINEOTA RN

Residents Rights

Just to clarify issues listed, this resident did not "die 2 days later" as stated in report. She died at Gifford Hospital on 1/ 2/12. This was 10 days later.

We spoke directly to her son Mark on 12/24/11 who told us that he would communicate to the rest of the family. Initially it did not appear that this resident was in any terminal condition, she had participated fully in facility activities on Thursday 12/22 and partially on 12/23 Friday am.

Action taken: As of 1/26/12 the Nurse, Nurse Manager, or Administrator/Owner will make the phone calls directly ourselves to indicated contact. RN staff has audited all advanced directives to ensure appropriateness, as of 2/14/12.

RN staff will conduct review of Advanced Directives with all Resident Assessments.

R228 POC accepted 3/1/12 SEMMONS RN/ PINESTAR