

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

November 5, 2013

Ms. Courtney Tabor, Administrator
Four Seasons Care Home
135 South Main Street
Northfield, VT 05663

Provider #: 0129

Dear Ms. Tabor:

Enclosed is a copy of your acceptable plans of correction for the unannounced onsite re-licensing survey conducted on **October 15, 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: 0129	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/15/2013
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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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R100	Initial Comments: An unannounced onsite re-licensing survey was conducted by the Division of Licensing and protection on 10/15/13. The following regulatory violations were cited as a result.	R100	<i>See attached.</i>	
R136 SS=D	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 staff interview and record review the facility failed to do an annual assessment for 1 of 6 sampled residents (Resident # 2). Findings include: Per record review on 10/15/13 at 12:55 PM, there was no current assessment for Resident #2. The last assessment was done on 8/20/12. This was confirmed by the Administrator on 10/15/13 at 1:15 PM.	R136		
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	R171		

Division of Licensing and Protection LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
<i>Courtney Habor, RN</i>	<i>Administrator</i>	

PMC

Division of Licensing and Protection

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R171	<p>Continued From page 1</p> <p>representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include:</p> <ol style="list-style-type: none"> (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. <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to maintain a record of monitoring for side effects for 2 of 6 residents receiving psychoactive medications (Residents #'s 4 and 6). Findings include:</p> <p>Per record review on 10/15/13 at 2:30 PM, Residents #4 and #6 were each receiving an antipsychotic medication (Clozapine). There was no evidence in the clinical record that staff were monitoring for side effects from the medication. The facility has a policy that all residents receiving psychoactive medications are to be monitored using the AIMS tool. This was confirmed by the Administrator on 10/15/13 at 2:40 PM.</p>	R171		

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R179	Continued From page 2	R179		
R179 SS=F	<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> <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>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that 6 of 6 sampled staff receive the required annual inservices. Findings include:</p> <p>Per record review on 10/15/13 at 11:05 AM, there is no evidence that 6 staff that had been employed for at least 1 year had received the 12</p>	R179		

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R179	Continued From page 3 hours, including the 7 mandatory topics, of educational inservices. This was confirmed by the Administrator on 10/15/13 at 12:07 PM.	R179		
R221 SS=A	<p>VI. RESIDENTS' RIGHTS</p> <p>6.7 Residents may manage their own personal finances. The home or licensee shall not manage a resident's finances unless requested in writing by the resident and then in accordance with the resident's wishes. The home or licensee shall keep a record of all transactions and make the record available, upon request, to the resident or legal representative, and shall provide the resident with an accounting of all transactions at least quarterly. Resident funds must be kept separate from other accounts or funds of the home.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to obtain a written request to manage finances for 1 of 6 sampled residents (Resident # 1). Findings include:</p> <p>Per record review on 10/15/13 at 12:55 PM, the facility was holding monies for Resident # 1. There is no evidence in facility records that the Resident had signed a request for the facility to manage his/her money. The Administrator confirmed this on 10/15/13 at 12:58 PM.</p>	R221		
R253 SS=F	<p>VII. NUTRITION AND FOOD SERVICES</p> <p>7.3 Food Storage and Equipment</p>	R253		

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R253	Continued From page 4 7.3.c All food service equipment shall be kept clean and maintained according to manufacturer's guidelines	R253		
R266 SS=E	<p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that food service equipment was kept clean and maintained. Findings include:</p> <p>Per observation during a kitchen tour on 10/15/13 at 10:15 AM, an operating fan in the walk-in cooler was heavily soiled with dust and debris. The fan was blowing over food products. Additionally, the walls in the walk-in cooler were soiled with dust. The facility chef confirmed the above at the time of the observations and stated that the fan and walls were not included on the current cleaning schedule.</p> <p>IX. PHYSICAL PLANT</p> <p>9.1 Environment</p> <p>9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a safe environment. Findings include:</p> <p>Per observation during a facility tour on 10/15/13 at 9:45 AM, an unlocked closet located near the</p>	R266		

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R266	Continued From page 5 main dining room contained germicidal bleach and other cleaning supplies, creating a potential accident hazard. Per interview with the administrator, there are residents in the facility that are confused and or demented and ambulate in the area. The administrator confirmed the observation at the time of the observation and stated that the closet should be locked.	R266		
R302 SS=F	<p>IX. PHYSICAL PLANT</p> <p>9.11 Disaster and Emergency Preparedness</p> <p>9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to conduct fire drills on at least a quarterly basis. Findings include:</p> <p>Per record review on 10/15/13 at 11:30 AM, the facility conducted only one valid fire drill since January 2012, on 6/20/13. The Administrator confirmed this on 10/15/13 at 12:05 PM.</p>	R302		

R136

We have in place already a yearly list of when assessments are due. This one was overlooked as we have been concentrating on reassessing 14 ERC clients who had previously been assessed inaccurately. Client number 2 is a high functioning client who holds a part time job as well as owns and drives his own vehicle. It is unfortunate that we missed him. In the future we will double check each month that each client due is completed. This assessment was completed as of October 16, 2013.

R171

Prior to my arrival at Four Seasons only months ago, the previous Administrator/RN & her nursing staff had a list of residents taking anti-psychotics. This list included 8 resident's names, as well as the AIMS monitoring documents for each of them.

We made the unfortunate mistake of continuing to monitor for potential side effects related to anti-psychotics drug use, based on this list alone. In hind sight, we should have reviewed each resident's specific medication record to ensure that all resident's taking anti-psychotics were included on this list.

Since the survey the Nurse Manager and I have gone through all 36 resident's MAR's and now have an accurate list of all residents on anti-psychotics. This review added 9 additional residents to be monitored, all but 1 of which should have been added to the list prior to the change in administration. Completed 10/21/2013

R179

Prior to survey I personally reviewed all staff in-services and determined that this would be a focal point and requirement needing to be addressed. This need was noted secondary to there being poor or no tangible documentation of previous in-services for the calendar year 2012.

Given we already knew this information either; did not exist or was not readily accessible in the unorganized mounds of paperwork, we could do nothing but continue to move forward.

Prior to survey, an in-service binder was created that has all staff members individually listed in alphabetical order. Each staff member has their own sheet that contains the 7 mandated topics, as well as an area to write in additional items to meet the required 12 hours per year. We have been working toward ensuring that all veteran staff meets their in-service requirements by years end.

Our staff who have worked for the Four Seasons for 6+ months, are well on their way of meeting the annual requirements currently averaging between 7-9 hours. We have many new staff members that we will make certain meet their 12 hour requirement by their 1 year anniversary of employment. Plan devised completed 10/25/2013.

R221

Client #1 in the presence of the nurse surveyor, shared he believed he had signed a statement/form, allowing the Four Seasons staff to assist him with check writing &/or holding petty cash. Unfortunately this statement was not readily on hand, at the time of survey. This was again secondary to the extreme disorganization of the resident's records. After the survey we were able to find several signed statements in thinned records in the basement, as well as in other resident's files. In an effort to streamline things and ensure that ALL residents had signed statements, we went resident to resident and had each of them sign a new form. This was completed in full on October 22nd, 2013.

R253

The walk in fan had been on our list of things to do. We had attempted to complete this task prior to survey, however, the switch to turn off the compressor was not where it had once been and no one knew where or how to turn it off. A call was placed to the walk in repair person 2 weeks prior to survey, but we never received a return call. The day after survey, the repair man was called for a second time. I was able to talk with him and he said that there was no longer a switch—that it was controlled by the fuse panel. Once that was determined, we were able to successfully shut down the compressor fan and clean it. Additionally we have now created a cleaning schedule for the kitchen and walk-in to ensure they stay neat, tidy and clean. This was completed as of October 18th, 2013.

R266

The mini supply closet off the living room was not locked. Within 15 minutes of the surveyor inspecting this, it was under lock and key. This was completed as of October 15th, 2013.

R302

We had on record 10 fire drills for our surveyor to look over. 9 of the 10 fire drills were considered inservices and otherwise inadequate due to the fact that there was no actual evacuation. The most recent Fire Drill on June 20th, we evacuated the entire building in 10 minutes. Our Nurse Manager has spoken to one of the captains of the Northfield Fire Department to help us formulate appropriate plans relating to fire drills (October 18, 2013). The fire department has shared that they are volunteers and could likely provide us some training re: fire safety (ie: RACE, PASS, demonstrations, etc.). Our Nurse Manager also placed a call to Division of Fire Safety on October 29, 2013 re: new regulations distributed on March 13, 2013. This call was placed for clarification of the memo distributed. Clarification of the need for evacuation was being sought. We plan to have this completed by the close of the year.
12/31/2013

Both Ashley Hudson, RN --Nurse Manager and Courtney Tabor, RN --Administrator will see to it that the Plan of Correction is followed as stated above.

Courtney Tabor, RN
Administrator