



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

February 2, 2010

Ms. Devida Deluca, Administrator
Living Well A Community Care Home
71 Maple Street
Bristol, VT 05443

Dear Ms. Deluca:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **January 4, 2010**. 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 "Suzanne E. Leavitt RN, MS".

Suzanne Leavitt, RN, MS
Licensing Chief



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0543	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/04/2010
NAME OF PROVIDER OR SUPPLIER LIVING WELL A COMMUNITY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 71 MAPLE STREET BRISTOL, VT 05443		
(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 complaint survey was conducted on 1/4/2010.	R100		JAN 28 2010
R150 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (7) Assure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the nurse did not assure that signs of illness for 1 of 3 applicable residents (Resident #1) received appropriate follow-up. Findings include: 1) Per record review on 1/4/2010, the record of Resident #1 indicated a staff member's concern recorded in the nursing progress notes (on 12/26/09) that the resident had a 'bladder infection' based on urine clarity and odor. No additional progress notes mentioned this issue. Per interview with the Manager and a Resident Assistant on the afternoon of 1/4/2010, this issue had not been forwarded to the nurse or the Manager for further action.	R150	<u>Action</u> → on 1/12/10 Administrator reviewed details of this survey with house nurse and specifically this deficiency. <u>Changes</u> → Nurse spoke with all staff this week and is going over details again at staff meeting on 1/20/10. Staff understand Nurse + Client care coordinator need to be notified thru nurses notes and verbally when there is a symptom or sign of illness or accident. R150 1-28-2010 POC accepted. — C. Lanning, RN	1/12/10 1/15/10
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	R171	<u>Monitoring</u> → Resident care Coordinator and nurse check weekly on patient status/changes. R150 1-28-2010 POC accepted. — C. Lanning, RN Administrator checks weekly to ensure compliance. R150 1-28-2010 POC accepted. — C. Lanning, RN	on 1/16/10

Division of Licensing and Protection

Debra Luca Administrator

1/16/10 TITLE

(X6) DATE

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

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R171	<p>Continued From page 1</p> <p>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: Per record review and interview, the home failed to assure documentation of the effectiveness of PRN (as needed) medications for 2 of 3 applicable residents (Resident #1 and Resident #2). Findings include:</p> <ol style="list-style-type: none"> 1) Per record review on 1/4/2010, there were 29 instances of PRN medications (including oxycodone, imodium and Milk of Magnesia) administered from 12/1/09 through 12/31/09, to Resident #1 without indication of effectiveness in either the progress notes or the MAR (Medication Administration Record). Per interview on the afternoon of 1/4/2010, the Manager confirmed that the records did not contain evidence of the effectiveness of these medications. 2) Per record review on 1/4/2010, there were 3 instances of PRN medications administered on 	R171	<p>1/12/10</p> <p><u>Action</u> → On 1/12/10 Administrator met with house nurse and client care coordinator + discussed in detail this specific deficiency.</p> <p><u>charges</u> → At staff meeting 1/20/10 nurse is receiving the charting requirements for PRN's. In addition we will write up any staff found out of compliance with 3 write ups requiring a one day suspension.</p> <p>R 171 1-28-2010 POC accepted. — C. Leman, RN</p> <p><u>Monitoring</u> → Nurse checks on PRN sign offs weekly. Administrator meets with nurse weekly and follows up to ensure compliance.</p> <p>R 171 1-28-2010 POC accepted. — C. Leman, RN</p>

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R171 Continued From page 2
12/10/09 (Lorazepam), 12/11/09 (Tylenol) and 12/18/09 (Lorazepam) to Resident #2 without indication of effectiveness in either the progress notes or the MAR. Per interview that afternoon, the Manager confirmed that the records did not contain evidence of the effectiveness of these medications.

R171

R189 V. RESIDENT CARE AND HOME SERVICES
SS=D
5.12.b. (3)

R189

For residents requiring nursing care, including nursing overview or medication management, the record shall also contain: initial assessment; annual reassessment; significant change assessment; physician's admission statement and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of physician visits, signed telephone orders and treatment documentation; and resident plan of care.

This REQUIREMENT is not met as evidenced by:
Per record review and interview, the nurse did not take action following a staff member's documented concern that 1 of 3 applicable residents (Resident #1) might have a bladder infection. Findings include:

1) Per record review on 1/4/2010, a nursing progress note dated 12/26/09, indicated concern that Resident #1 had a bladder infection based on urine clarity and odor. Per interview on the afternoon of the survey, the Residential Assistant on duty this date, stated that a verbal discussion with the writer of the progress note (a second Residential Assistant) had occurred but that no

Action → Administrator met with house nurse on 1/12/10 and discussed in detail the requirement to record take action and report outcomes when a resident presents symptoms or signs of illness.

Changes → Nurse has advised staff individually and is going over details again at staff meeting on 1/20/10. 1/20/10
R189 1-28-2010
POC accepted. — C. Lanning, RN on going

*Monitoring → Nurse and Resident Care Coordinator check in weekly regarding status changes.
Administrator coordinates with nurse and Resident Care Coordinator weekly and follows up to ensure compliance*

R189 1-28-2010
KIYP11
POC accepted. — C. Lanning, RN

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R189	Continued From page 3 further action was taken beyond monitoring of the urine by this Residential Assistant when on duty. S/he stated that the neither the Nurse nor Manager had been advised of this concern and that documentation of his / her observations following the initial report was not completed. The Manager confirmed that no additional information was recorded in the progress notes regarding this condition since 12/26/09, 9 days previously.	R189			