

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0138	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/26/2010
NAME OF PROVIDER OR SUPPLIER LORETTO HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 59 MEADOW STREET RUTLAND, VT 05701		
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R100	Initial Comments: An unannounced onsite licensing and complaint survey was conducted by the Division of Licensing and Protection from 3/29/2010 through 3/31/2010 and concluded on 4/26/2010.	R100		RECEIVED Division of OCT 04 10 Licensing and Protection
R101 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.1. Eligibility 5.1.a The licensee shall not accept or retain as a resident any individual who meets level of care eligibility for nursing home admission, or who otherwise has care needs which exceed what the home is able to safely and appropriately provide. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility retained a resident (Resident #4) who, through initial assessment, met nursing home level of care. Findings include: Per record review on 3/30/2010, Resident #4 was initially assessed by the facility Nurse on 4/7/2009 as a '4' (Total Caregiver Assistance) in the areas of Dressing, Toilet Use, Personal Hygiene, and Bathing. The assessment indicates that the Resident was incontinent of urine with multiple daily episodes and daily incontinence of bowel with some control present. An updated assessment dated 10/8/2009, indicated a deterioration of the Resident's mental status with increasing behavioral symptoms not easily altered and a decreased ability to understand / respond adequately to simple, direct communication. Per observation on 3/31/2010 at 10:00 AM,	R101	We will not accept or retain any individual who does not meet our level of care. The Administrator and DON have reviewed the process of variance requests for a resident who is not at our level of care, temporarily during the placement process. The error that was made and will not be repeated was in not reporting to the State that we had a resident who was not our level of care whom we were in the process of placing in a level II facility. <i>R101 - 10/18/2010 - POC accepted. C. Laramy, RN</i>	May 2010

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Deacon Gary Saffin
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Administrator

(X6) DATE 9/3/10

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R101	Continued From page 1 Resident #4 required the physical assistance of 2 LNAs (Licensed Nursing Assistants) to arise from the sofa to a standing position after an attempt by a single LNA to verbally and physically encourage the resident to stand was unsuccessful. Both LNAs assisted the resident to the bathroom for scheduled toileting. Per interview on 3/30/2010 at 5:00 PM, the Director of Nursing confirmed that the recorded assessments indicated total care for Resident #4 as noted above, that this level of care exceeds facility licensure, that no variance to retain this Resident had been sought from the Division of Licensing and Protection, and that Resident #4 has not been included among the facility's pre-approved variances for residents exceeding approved level of care.	R101			
R128 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assure that all physician orders were carried out for 1 of 8 residents (Resident #7). Findings include: 1) Per record review on 3/29/10, Resident #7 had a physician order dated 12/3/09 to check electrolytes with next PT/INR draw. The physician also included on the physician notes dated	R128	We will assure that the residents care will be consistant with the physician's orders. The DON has provided remedial training of all Charge Persons to assure the current process, which is in place, for double checking all orders and all documentation by the end of the shift is clearly understood. In addition all orders will be double signed by a nurse.	Sep 2010	

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R128	Continued From page 2 12/3/09, Electrolyte solution supplement TID. During interview on the afternoon of 3/31/10, the Director of Nursing confirmed that the Physician orders were not transcribed and Resident #7 did not have electrolytes drawn or receive an Electrolyte solution supplement as ordered. 2) Per record review on 3/29/10, Resident #7 did not have weights or blood pressure (BP) monitored as ordered. Resident #7 had a physician order dated 1/7/10 for Daily Weights. No weight was recorded for Resident #7 on 1/15/10. A Physician order on 1/13/10 was for BP to be done BID until further notice. There was only one recorded BP taken on 1/14/10. A new order on 1/15/10 was to take BP daily. Resident #7 did not have a BP recorded for 1/15/10, 1/16/10, and 1/17/10. This was confirmed by the Director of Nursing.	R128	The DON has provided remedial training of all Charge Persons and reviewed the requirement to validate that the doctors orders were transcribed correctly. <i>R128 - 10/18/2010 - POC accepted as written. — C. Lanning, RN</i>	Sep 2010
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home did not maintain a current care plan for 1 of 8 applicable residents (Resident #2). Findings include: Per record review on 3/30/2010, an order for	R145	The DON held training sessions with the Nursing Staff on the process in place for updating the Charge/DON of both change of condition and receipt of new orders. This insures that a timely update of the care plans takes place.	Sep 2010

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R145	Continued From page 3 sliding scale insulin was discontinued for Resident #2. The resident care plan stated "BS (blood sugar) QID (4 times daily) with SC (sliding scale). During interview on 3/30/2010 at 12:10 PM, a facility Nurse confirmed that this care plan had not been updated to reflect that the current diabetic treatment status of this resident no longer included the sliding scale insulin coverage.	R145	<i>R145 - 10/18/2010 - PO accepted as written. — C. Loranay, RN</i>	
R146 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to supervise and instruct direct care staff in obtaining timely medical care and assessing nutritional needs for 1 of 8 residents (#8). Findings include: 1) Per record review on 4/15/2010 and 4/16/2010, Resident # 8 was found on the floor on 11/16/2009 at 1:15 AM. The record indicated that Resident #8 had a "huge skin tear" to the right forearm and a hematoma (bump) on the back of the head. VS (vital signs) were taken at that time. The nursing note stated that there was no other injury and would continue to monitor. There was no further documentation of any monitoring of the resident's condition until 6:45 AM when the resident was sent to the hospital for a CAT scan to evaluate the bump on his/her head. During interview, the Director of Nursing confirmed that	R146	We will provide the proper instruction and supervision of all direct care personnel in all areas of resident care. Charge Personnel have been re-educated on the proper documentation required for all notifications by the DON.	May 2010

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R146	Continued From page 4 the evaluation of this resident injury was delayed. 2) Per record review and interview, Resident #8 started to refuse to go down to meals in October 2009 and refused to eat on a regular basis for the months of November and December 2009. There was no record indicating that Resident #8's Physician was notified of refusal to eat and a 20.6 pound weight loss (recorded on 12/1/09) until 12/29/2010. There was no evidence of a re-weight nor were additional weights ordered by nursing as a result of this significant weight loss over the period of 1 month (11/09 to 12/09). This was confirmed by the Director of Nursing.	R146	Nursing Procedure Nurs-006 "Weight Measurement Was created by the DON that states; "physician and POA/family members will be notified of any sudden weight gain or loss greater than 5 pounds or more" <i>R146 - 10/18/2010 - POC accepted as written. — C. Laraway, RN</i>	Sep 2010
R147 SS=D	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 facility did not maintain a current list of resident medications, side effects and / or parameters for 3 applicable residents (Resident #1, Resident #5, and Resident #7). Findings include: 1) Per record review on 3/30/2010, an order for Resident #1 stated "Acetaminophen 325mg (milligrams) 1-2 tabs Q (every) 6 hours PO (orally) PRN (as needed). A second order for this resident stated "Calcium Carbonate 650 mg PO	R147	We will maintain a current list of all resident's medications that will be available for review by staff and the physician. The list will be complete to include; resident's name; medications; date medication ordered; dosage and frequency of administration; and likely side effects to monitor. An In-service was conducted with all Charge Nursing Personnel on PRN pain and cardiovascular medications needing parameters. Also training will be given on all medications needing diagnosis before use. All current medication orders have been reviewed by the DON for all residents. This is coupled with the re-education of Charge Persons on our current process for checking documentation at end of shift.	Sep 2010 Sep 2010

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R147	Continued From page 5 PRN", with no reason for administration indicated. During interview on 3/30/2010 at 10:40 AM; a facility Nurse stated that the order for Acetaminophen should have been clarified according to usual facility practice to indicate under what circumstances to give 1 tablet or 2 tablets; and s/he confirmed that the order for Calcium Carbonate should have been clarified to indicate a reason for administration. 2) Per record review on 3/30/2010, Lanoxin (Digoxin) orders for Resident #5 and Resident #7 included no parameters under which the pulse-lowering medication would be / should be withheld. Additionally, the Medication Administration Records (MARs) were incomplete. There was no pulse recorded on the MAR on 3/3, 3/13, 3/15, 3/19, 3/20, and 3/26/2010 for Resident #5; and Resident #7 did not have a pulse recorded for 1/15/2010. During interview, the Director of Nursing confirmed that no parameters were present to indicate the lowest pulse rate allowable for this medication administration and that the MARs were incomplete.	R147	<i>R147 - 10/18/2010 - POE accepted as written. - C. Laraway, RN</i>	
R153 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (10) Monitor stability of each resident's weight; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home failed to monitor the stability of 1 of 8 applicable residents (Resident #8). Findings include: Per record review and staff interview, Resident #8 began refusing to go down to eat in 10/2009 and	R153	We will monitor the stability of each residents weight. A weight variance log is now in place to help with the evaluations of variances, and is overseen by the DON. In addition Policy Nurs-006 "Weight Measurement" is in place, and includes a notification requirement.	Sep 2010

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R153	Continued From page 6 continued to refuse to eat on a regular basis for the months of 11/2009 and 12/2009. Resident # 8 was on a monthly weight schedule and the weight documented on 12/1/2009 indicated a 20.6 pound weight loss from the previous month . There was no documentation to indicate that follow up weight checks related to the weight loss had occurred, nor was there documentation that the physician was notified of the weight loss. During interview, the Director of Nursing confirmed that there was no documentation to indicate that the resident's weight was re-checked for accuracy and / or that the physician was notified of this weight loss.	R153	<i>R153 - 10/18/2010 - POC accepted as written. — C. Laraway, RN</i>	
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	R171	We will establish the required documentation to assure all appropriate personnel or agency's can clearly see that the medication regimen is as ordered. A tracking book has been established to assure the follow through of resident assessments. All assessments are done/overseen by the DON. <i>R171 - 10/18/2010 - POC accepted as written. — C. Laraway, RN</i>	April 2010

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R171	Continued From page 7 effects. (6) All incidents of medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home did not assure that a record of monitoring for medication side effects was maintained for 1 applicable resident (Resident #4) per facility policy. Findings include: Per record review on 3/30/2010, Resident #4 had intermittently received PRN (as needed) Lorazepam 0.5 mg (milligrams) up to 3 times per day (TID) for increased anxiety and receives a daily dose of Risperidone 0.5 mg at HS (bedtime). During interview with a facility Nurse on 3/31/2010 at 9:36 AM, s/he confirmed that facility policy is to complete an AIMS (Abnormal Involuntary Movement Scale) assessment tool every 6 months to screen for the presence of adverse effects of psychotropic medications. S/he confirmed that the last AIMS assessment performed for Resident #4 was 4/8/2009 and that an assessment due 10/2009 had not been completed.	R171		
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:	R179	See Next Page	

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R179	Continued From page 8 (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. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assure that all employees providing direct care to residents completed the required 12 hours of annual training. Findings include: Per record review on 3/30/2010, 4 of 5 employee records did not contain evidence of all required annual training. During interview on 3/29/10, the Administrator confirmed that there was no evidence to indicate that all reviewed staff had completed required training.	R179	Actions Taken 1. Replaced the Excel worksheet used for tracking training with an Access Database that is easier to maintain and allows for custom reports. 2. The Training Record Form was changed to allow for a clear definition of the training that was given, the date and instructor. 3. A monthly training schedule has been posted and any direct care staff members who miss a State Mandated Class are required to do a make up. 4. Training status is reviewed monthly by the Administrator. <i>R179 - 10/18/2010 - POC accepted as written. - C. Laraway, RW</i>	May 2010
R208 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.c Incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse, or if an injury requiring physician intervention results, or if there is a pattern of abusive behavior. All	R208	An initial review by all mandatory reporters on staff was held in April 2010 by the DON. In addition a training session will be held for all staff to review mandatory reporting requirements. This training will be done on an annual basis as a minimum <i>R208 - 10/18/2010 - POC accepted as written. - C. Laraway, RW</i>	Nov 2010

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R208	Continued From page 9 resident-to-resident incidents, even minor ones, must be recorded in the resident's record. Families or legal representatives must be notified and a plan must be developed to deal with the behaviors This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility did not report an incident between two residents (Resident #1 and Resident #2) that resulted in an injury requiring physician intervention. Findings include: Per record review on 3/30/2010, a physical altercation between Resident #1 and Resident #2 occurred on 1/21/2010. As a result of the altercation, Resident #1 was hospitalized for treatment of injuries. During interview on 3/30/2010, the Administrator stated that s/he was unaware of the reporting requirement related to this incident and confirmed that a report had not been made to the licensing agency within the required 48 hour time frame.	R208		
R247 SS=D	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not assure that all perishable food and drink	R247	We will assure all perishable food and drink will be stored properly. Our Director of Food Service & Dietary held a training session with the special needs floor employees to review the policy for food storage. New charts were put in place and all items were marked as required. The refrigerator will be monitored daily. <i>R247 - 10/18/2010 - POC accepted as written - C. Loranay, RN</i>	Sep 2010

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R247	Continued From page 10 are labeled and held at the appropriate temperatures. Findings include: Per observation on 3/29/2010 during the initial environmental tour, the resident food storage refrigerator on the third floor contained 3 unlabeled sandwiches and 3 unlabeled / uncovered drinks. There were no temperature logs available, nor were there any thermometers in either the refrigerator or freezer sections of the appliance. During interview at the time of observation, the Director of Nursing confirmed that the sandwiches and drinks were unlabeled, that the drinks were uncovered and that temperature checks of the refrigerator / freezer were not performed, as s/he was unaware of this requirement.	R247		
R302 SS=F	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 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. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility did not conduct fire drills during morning,	R302	See next page	

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R302	Continued From page 11 afternoon, evening and night hours. Findings include: Per record review on 3/29/2010, facility conducted fire drills from 3/31/2009 through 3/29/2010 were performed between the hours of 9:00 AM and 6:45 PM. During interview on 3/29/2010 at 3:00 PM, the Maintenance Director confirmed that no drills had occurred during the 14-hour period from 6:45 PM to 9:00 AM.	R302	A monthly schedule of fire drills will be maintained by the Director of Maintenance that will include all shifts. The schedule will be kept in the Administrators Office and will be available for review by the State. <i>R302 - 10/18/2010 - POC accepted as written - C. Laraway, RN</i>	May 2010