



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

January 20, 2011

Ms. Holly Baker, Administrator
Manes House
127 Union Street
Bennington, VT 05201

Dear Ms. Baker:

Enclosed is a copy of your acceptable plans of correction for the unannounced onsite licensing survey conducted on **October 12, 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 black ink that reads "Pamela M. Cota". The signature is written in a cursive, flowing style.

Pamela M. Cota, RN
Licensing Chief

PC:jl



1/20/11 JL

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0193	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DEC 02 10 Licensing and Protection	(X3) DATE SURVEY COMPLETED 10/12/2010
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NAME OF PROVIDER OR SUPPLIER MANES HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 127 UNION STREET BENNINGTON, VT 05201
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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
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R100	Initial Comments: An unannounced onsite licensing survey was conducted on October 11 and October 12, 2010.	R100		
R134 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7 Assessment 5.7.a An assessment shall be completed for each resident within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The resident's abilities regarding medication management shall be assessed within 24 hours and nursing delegation implemented, if necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home did not assure that 2 of 3 applicable residents (Resident #1 and Resident #2) were assessed by the Registered Nurse (RN) within 24 hours for medication management. Findings include: Per record review on 10/11/2010, Residents #1 and #2 were not assessed by an RN prior to the initiation of medication administration. During interview on the afternoon of 10/11/2010, an LPN (Licensed Practical Nurse) confirmed that s/he completes/signs all resident assessments rather than the RN and that the assessments of each of these residents contained no indication that an RN had completed the medication administration assessment.	R134	5.7 a) THE CURRENT RN WILL ASSESS ALL MED ORDERS. THE ASSESSMENTS WITH THE EXCEPTION OF THE 2 MENTIONED WERE ALL REVIEWED AND SIGNED BY THE RN EMPLOYED AT THAT TIME. IT WILL BE CONSISTENTLY DONE IN THE FUTURE AND THE ADMINISTRATOR WILL FOLLOW THROUGH TO ASSURE SUCH. THE 2 IN CONCERN HAVE BEEN REVIEWED AND SIGNED BY THE R.N. PRESENTLY EMPLOYED ON 10-15-10	
R145 SS=E	V. RESIDENT CARE AND HOME SERVICES	R145	R134 12-21-2010 POC accepted. C. Lavery, RN	

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *[Signature]* (X6) DATE 11-30-10

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R145	<p>Continued From page 1</p> <p>5.9.c (2)</p> <p>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;</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the RN (Registered Nurse) failed to oversee the development and / or accuracy of the plan of care for 1 of 3 residents (Resident #1). Findings include:</p> <p>1. Per record review on 10/12/2010, the plan of care indicated that the catheter of Resident #1 should be changed Q (every) 2-3 weeks and PRN (as needed). A physician order, dated 8/10/2010, indicated that the catheter should be changed monthly. This resident's plan of care also indicated that a medication (Methenamine) was being administered prophylactically (as preventative medicine) to decrease the risk of UTI (urinary tract infection). There was no currently signed physician order for this medication nor was this medication listed on the resident's MAR (Medication Administration Record). Regarding the resident's ambulatory status, the plan of care indicated that the resident requires assist with ambulation and uses a walker. Through observation on 10/11/2010 and 10/12/2010, Resident #1 is non-ambulatory and requires a Hoyer lift for all transfers. During interview on 10/12/2010 at 4:50 PM, the LPN confirmed that the plan of care indicated catheter changes Q 2-3 weeks while the physician order is to change monthly, that Methenamine was on the</p>	R145 5.9 c)	<p>① THE ORDER DATED 3-29-07 STATES "CHANGE S/P TUBE monthly + prn." SEE enclosed copies. IT HAS BEEN NECESSARY TO DO THIS AT LEAST q 3 WEEKS AND OCC. WITHIN A 2WK. PERIOD. ALSO SEE UPDATED ORDER FOR 11-29-10. THIS IS INCORPORATED INTO THE CARE PLAN.</p> <p>ENCLOSED ALSO FIND THE SIGNED ORDER FOR METHENAMINE DATED 6-24-09 AND COPY OF OCTOBER '10 MAR CONFIRMING ADMINISTERING OF THIS MEDICATION. THIS IS ALSO INCORPORATED INTO THE CARE PLAN.</p> <p>ALSO PLEASE FIND REQUIREMENTS TO S/P CATH CHANGES THE STANDARD FOR S/P CATH CHANGES VIA MONUMENT UROLOGY - THE UROLOGIST WHO COVERS THIS NEED FOR THIS RESIDENT. A LIST OF SUPPLIES SUPPORTING THE ORDER IS ALSO INCLUDED ALTHOUGH THE RESIDENT IS USUALLY NON-AMBULATORY - OCC. SHE WILL WALK AND NEEDS ASST. AND WILL USE THE WALKER. HER CARE PLAN HAS BEEN CORRECTED TO INDICATE THIS IS A SPORADIC SITUATION AND WILL NEED ASST. @ THOSE X'S.</p>	

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R145	Continued From page 2 plan of care but is no longer used and that the resident is no longer ambulatory (although the plan of care indicates ambulatory assistance is required).	R145 5.9.2) cont.	<p><i>METHENAMINE HAS BEEN CONSISTENTLY USED AS SUPPORTING DOCUMENTATION INDICATES. R145 12-21-2010 POC accepted. — C. Lerman, RN</i></p> <p><i>ON 10-13-2010 THE HOYER LIFT DIRECTIONS WERE UPDATED TO INCLUDE SAFER USE OF THE LIFT AND PRESENTED TO STAFF AT THE STAFF MEETINGS THAT WEEK. A DEMO WAS DONE. — ON 11-29-10 THE POLICY WAS UPDATED TO INCLUDE PRECAUTIONS TO BE USED DURING TRANSFERS FOR THOSE RESIDENTS WITH INDWELLING CATHS. IT WAS PRESENTED TO STAFF & DEMO ON 11-30-10.</i></p> <p><i>THE RESIDENT IN QUESTION USUALLY USES A LEG BAG WITH THE EXCEPTION OF NIGHTTIME WHEN SHE IS ALREADY IN BED. SHE ALSO USES A URICED LEG BAG CATH POSITIONER ALONG THE STRAPS PROVIDED IN THE BAG TO PREVENT TRAUMA WHILE WEARING SUCH.</i></p> <p><i>PLEASE SEE DOCUMENTS ENCLOSED TO SUPPORT SUCH.</i></p> <p><i>R146 12-21-2010 POC accepted. — C. Lerman, RN</i></p>		
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 observation, record review and interview, the home did not assure that all nursing services required by Resident #1 were taught to unlicensed staff by the RN (Registered Nurse). Findings include: 1. Per observation, record review and confirmed during interview on 10/12/2010 by the home's LPN (Licensed Practical Nurse), Resident #1 has an indwelling catheter and is transferred via Hoyer lift. There was no evidence that unlicensed staff received instruction on how to perform catheter care or Hoyer transfers from the nurse responsible for nursing overview.	R146			
R163 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.5 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer	R163			

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R163	Continued From page 3 medications under the following conditions: (1) A registered nurse must conduct an assessment consistent with the physician's diagnosis and orders of the resident's care needs as required in section 5.7.c This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home did not assure that the Registered Nurse (RN) conducted admission and / or annual resident assessments for 2 of 3 applicable residents in the survey sample (Resident #1 and Resident #2) prior to the administration of medications by unlicensed staff. Findings include: 1. Per record reviews completed on 10/12/2010, an annual assessment for Resident #1 was completed on 9/11/2009 and was signed and dated by an LPN (Licensed Practical Nurse). Based upon this assessment, medication management was implemented through delegation to unlicensed staff by the LPN. There was no indication that the RN had conducted the assessment. During interview on 10/12/2010 at 4:52 PM, the LPN confirmed that s/he had independently completed the resident assessment. 2. Per record review completed on 10/12/10 an initial assessment for Resident #2 was completed on 1/30/10 and was signed and dated by an LPN. Based upon this assessment, medication management was implemented through delegation to unlicensed staff by the LPN. There was no evidence that the RN had conducted or reviewed the assessment. During interview on 10/12/10 at 4:52 PM, the LPN confirmed that s/he had independently completed the resident	R163		RECEIVED Division of JAN 04 11 Licensing and Protection

*R163
SSE*

Policy is being written to address the responsibilities of the RN for medication delegation according to the VT state regs - All assessments, medication orders and changes will be reviewed by the RN. The medication delegation policy was completed on 12-6-10 - see enclosed copy - It is also incorporated into her job description of which a copy is also included.

*R-163 1-19-11 POC accepted as written.
C. Laraway, RN*

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R163	Continued From page 4 assessment.	R163		
R164 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (2) A registered nurse must delegate the responsibility for the administration of specific medications to designated staff for designated residents This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home failed to assure that 3 of 6 staff members currently administering medication received delegation authority by a currently employed Registered Nurse (RN). Findings include: 1. Per record reviews completed on 10/11/2010, there was no evidence that medication delegation was approved by the current RN for 3 of 6 non-licensed staff members. During interview on 10/12/2010 at 12:45 PM, the LPN stated that s/he and / or the Manager performed the training and delegation tasks for all unlicensed caregivers, confirming that neither the current RN nor the most recent prior RN had signed the attestation of training statement for 3 of 6 staff members.	R164 SS=F	<i>A policy is being written to address medication delegation by the RN to include the reqs per vt. state. It will include observation, training and documentation of at least 3 med pours per unlicensed staff. A training statement will be provided on each unlicensed staff. It will be done annually and per. to address med errors and retraining per. See again completed policy dated 12-6-10 - enclosed also find completed training statements beginning 11/30/10 through 12-31-10.</i>	
R165 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management	R165	<i>R164 1-19-11 POC accepted as written. — C. Laraway, RN</i>	

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R165	Continued From page 5 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for: 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. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility RN (Registered Nurse) did not teach unlicensed staff regarding proper medication administration. Findings include: 1. Per record review on 10/12/2010, facility delegation records did not contain evidence that each unlicensed person currently administering medications had been directly observed by the RN to assure competency prior to independent medication administration. Per interview on 10/11/2010 at 12:45 PM, the facility LPN (Licensed Practical Nurse) stated that s/he and the Manager perform the medication delegation training and that the RN reviews the delegation training content. S/he confirmed that the RN does	R165 SS=F	ALL MEDICATION DELEGATION WILL BE DONE BY THE RN. AS MENTIONED ON PAGE 5. ALSO PLAN IS IN PLACE AS DESCRIBED TO OBSERVE STAFF DOING MED POWRS. - PLEASE SEE ENCLOSED MEDICATION DELEGATION DOCUMENTS COMPLETED ON 12-6-10 AND TRAINING STATEMENTS FROM 11-30-10 TO 12-31-10 R165 1-19-11 POL accepted as written. — C. L. Harvey, RN —	

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R165	Continued From page 6 not do direct skills observation of trained staff prior to the staff beginning medication administration. During interview on 10/11/2010 at 4:27 PM, an unlicensed staff member confirmed that s/he had not been observed during a medication pass by the RN prior to delegation to administer medications. 2. Based on observation, documentation review and staff interviews, the aid administering medications at the 5 PM medication pass on 10/11/10 failed to follow proper medication administration procedures as outlined in educational materials used in medication delegation training. During a medication pass at 5 PM the delegated aid poured medications from the bubble pack into his/her bare hand and then into the med cup. While preparing and administering medications s/he was also serving food and fluids to residents seated at the table. When s/he delivered the medication to the resident at their seating place s/he failed to remain and assure that the resident did in fact take the medication. During interview with the manager and LPN on 10/12/10 at 10:45 AM it was confirmed that the above practices were not within the accepted practices contain in the training materials used in medication delegation at this facility (In-The-Know Medication Administration). A review of the training materials confirmed this statement.	R165 SS=F	THE STAFF INVOLVED, AS WELL AS ALL STAFF WERE INSTRUCTED OF THE PROPER PROCEDURE TO BE IMPOSED DURING MED PASSES ON 10-13 AND 10-14. MED. CONTRACTS IN PLACE WERE REVIEWED THAT ADDRESS PROCEDURE THIS WILL BE ADDRESSED AND OVERVIEWED BY THE R.N. & MEDICATION DELEGATION RESPONSIBILITIES. ALSO ADDRESSED IN POLICY COMPLETED ON 12-6-10 AS ENCLOSED. ALSO WE HAVE SINCE UPDATED AND HAVE IN PLACE NEW MED DISTRIBUTION CONTRACTS AND STAFF AGREEMENTS. COPY ENCLOSED.	
R168 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:	R168	R165 1-19-11 POC accepted as written. — C. Laraway, RN	

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R168	Continued From page 7 (6) Insulin. Staff other than a nurse may administer insulin injections only when: i. The diabetic resident's condition and medication regimen is considered stable by the registered nurse who is responsible for delegating the administration; and ii. The designated staff to administer insulin to the resident have received additional training in the administration of insulin, including return demonstration, and the registered nurse has deemed them competent and documented that assessment; and iii. The registered nurse monitors the resident's condition regularly and is available when changes in condition or medication might occur. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the RN (Registered Nurse) did not provide specific training regarding the administration of insulin to each unlicensed person administering medications. Findings include: 1. Per record reviews on 10/11/2010 and 10/12/2010, there was no evidence to indicate that the RN completes teaching for all unlicensed staff regarding insulin administration. One NA (Nurse Assistant) confirmed, on 10/11/2010 at 4:27 PM, that s/he administers insulin but has had no RN training regarding this particular medication. During interview on 10/11/2010 at 12:45 PM, the LPN (Licensed Practical Nurse), confirmed that the RN did not perform insulin training for delegated staff.	R168 SS=E	<i>THIS WILL BE ADDRESSED BY THE R.N. WITHIN THE MED DELEGATION policy. TRAINING OF INSULIN ADMINISTRATION WILL BE DONE FOR ALL NEW STAFF AND REVIEWED ANNUALLY AND PRN. BY THE R.N. THIS IS ADDRESSED IN THE MEDICATION DELEGATION policy COMPLETED ON 12-16-10 AS ENCLOSED.</i> <i>R168 1-19-11 POC accepted as written. — C. Laraway, RN</i>	

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R171	Continued From page 9 There was no indication that monitoring for side effects is occurring, using an assessment tool such as the AIMS (Abnormal Involuntary Movement Scale) or the DISCUS (Dyskinesia Identification System--Condensed User Scale) tools. During interview on the afternoon of 10/12/2010, the facility LPN (Licensed Practical Nurse) confirmed that no assessment tool is being utilized to track and / or identify the potentially irreversible side effects of this psychotropic medication for Resident #1. 2. Per record review Resident #2 has an order for Seroquel 25 mg PO HS Daily. There is no indication in the record that this resident is being monitored for side effects using an assessment tool such as the AIMS or DISCUS tools. During interview on 10/12/10 the facility LPN confirmed that no assessment tool is being utilized to track and/or identify potentially irreversible side effects of a psychotropic medication.	R171 SS=E	AN AIMS ASSESSMENT HAS BEEN OBTAINED AND WILL BE UTILIZED FOR SUCH RESIDENTS WHO ARE BEING ADMINISTERED PSYCHOTROPIC MEDICATIONS. THIS MAY BE DONE BY THE RESIDENTS PHYSICIAN OR STAFF NURSE. ENCLOSED IS A COPY OF THE ASSESSMENT. ALL ASSESSMENTS ARE COMPLETED ON THE 7 RESIDENTS REQUIRING SUCH. THEY WERE COMPLETED BETWEEN 12-10-10 AND 12-16-10. THEY ARE SCHEDULED TO BE DONE 96 mos. AND WILL BE DONE BY 2011. THEY WILL BE DONE ON ALL NEW ADMISSIONS REQUIRING SUCH. R171 1-19-11 POC accepted as written. — C. Loney, RN	
R173 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h. (1) Resident medications that the home manages must be stored in locked compartments under proper temperature controls. Only authorized personnel shall have access to the keys This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not assure that all resident medications and	R173		

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R179	Continued From page 12 s/he washed his/her hands for 8 seconds and dried his/her hands on a communal cloth hand towel hanging in the kitchen area. During the second hand washing s/he washed his/her hands for 12 seconds drying his/her hands on the communal cloth towel hanging in the kitchen. During the medication pass on 10/12/10 at 8 AM a second staff member washed his/her hands twice. The first handwashing was for 10 seconds and s/he used the communal towel hanging in the kitchen. The second handwashing was for 14 seconds and s/he used paper towels hanging on a rack in the kitchen for hand drying. In interview the LPN (Licensed Practical Nurse) stated that the procedure for handwashing was contained in the "In-The-Know" for Infection Control and for Handwashing. Review of this documentation revealed a recommended time of 20-30 seconds for effective handwashing and the use of paper towels for hand drying. If a cloth towel is used it is recommended that the staff person use a clean towel that only s/he uses throughout the shift. In an interview at 11:00 AM the LPN confirmed that this was the facility policy.	R179	<i>5.11.6) THE HANDWASHING policy HAS BEEN UPDATED AND REVISITED 5 ALL STAFF. AS OF 10-27-10 - THE policy AND POSTERS ARE IN PLACE TO CALL TO ALL STAFF AND RESIDENTS ATTN. "THE DO THE KNOW" TRAINING HAS BEEN REPEATED AS WELL. IT WILL BE INCLUDED IN THE ANNUAL STANDARD PRECAUTION requirements. THE COMMUNITY TOWEL HAS BEEN REMOVED - PAPER TOWELS AND LIQUID PUMP SOAP ARE @ ALL STATIONS. PLEASE SEE ENCLOSED COPY of HANDWASHING policy/poster. ENCLOSED please FIND COPY of INSERVICE RECORD log PERTAINING to ABOVE. THE INSERVICE RECORD log HAS BEEN IN PLACE AS of 10-19-10</i>	
R200 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home	R200		

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R200	<p>Continued From page 13</p> <p>has not developed written policies to direct unlicensed staff regarding the care of a catheters and the use of a Hoyer transfer lift for 1 applicable resident (Resident #1). Findings include:</p> <p>1. Per record review on 10/12/2010, there was no written policy available for catheter care to direct staff in the care of an indwelling catheter for Resident #1. During interview on 10/12/2010, the LPN confirmed that there is no written policy regarding the care of this resident's catheter.</p> <p>2. Per record review on the morning of 10/12/2010, there was no written policy available to direct staff in the use of a Hoyer lift for Resident #1 who requires a Hoyer lift for all transfers. During interview that afternoon, the Manager and LPN confirmed that no policy directing staff in the use of this equipment is available.</p>	R200	<p><i>5.15 @ PLEASE SEE: COPY OF UPDATED POLICY FOR SUPRA PUBIC CATH CARE VIA RESIDENTS #1 urologist THIS HAS BEEN REVIEWED & STAFF ON 10-27-10.</i></p> <p><i>@ ALSO PLEASE SEE ENCLOSED COPY OF UPDATED HOYER LIFT DIRECTIONS</i></p> <p><i>WE ARE CURRENTLY COMPLETING A POLICY AND PROCEDURE MANUAL WHICH WILL BE AVAILABLE TO STAFF DAILY.</i></p> <p><i>ALL POLICIES AND PROCEDURES WILL BE ADDRESSED WITH NEW EMPLOYEES AND STAFF STAFF @ STAFF MEETINGS AND PRN.</i></p> <p><i>R200 12-21-2010 POC accepted</i> <i>C. Laraway, RN</i></p>	
R266 SS=F	<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, the home did not assure a safe, sanitary and homelike environment for all residents. Findings include:</p> <p>1. Per observation during initial tour on 10/11/2010, there was:</p> <p>a. storage of numerous chemicals and</p>	R266		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0193	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2010
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NAME OF PROVIDER OR SUPPLIER MANES HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 127 UNION STREET BENNINGTON, VT 05201
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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
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R266	<p>Continued From page 14</p> <p>cleansers unsecured in bathrooms throughout home, including a drain cleaner. In the large upstairs bathroom there were containers of Drano (next to a box of Polident tablets), Rust/ Lime and Calcium remover, Comet cleanser and disinfectant wipes found under the sink with personal care items.</p> <p>b. a sharps container (approximately 1/4 full of insulin syringes) with an opening approximately 1 and 3/4 inches to 2 inches in diameter, was open on a shelf above the commode in the common use 1st floor bathroom;</p> <p>c. a loosened handrail on the second floor next to the rear stairway;</p> <p>d. a commode bowl stored in the linen closet on the second floor with yellow spots on the outside and touching linens stored within;</p> <p>e. carpet spot and stain remover stored under the sink in a second floor bathroom accessible from the hallway.</p> <p>These observations were confirmed by the Manager on the afternoon of 10/11/2010.</p> <p>2. On the initial tour on 10-11-10 and again on 10-12-10 it is noted that in the back hallway, used by residents and near two resident rooms, there is a Fire alarm control box. The Fire alarm control panel box is found unlocked, slightly open with key in lock mechanism and screw driver inside panel near wiring inside. Per interview with the Manager on 10-12 at 11 AM she states that this panel would normally be kept locked.</p>	R266	<p>9.1) ALL CLEANING SUPPLIES HAVE BEEN REMOVED AND LOCATED IN A LOCKED CLOSET ONLY ACCESSIBLE BY STAFF. A TOTE HAS BEEN PROVIDED FOR STAFF TO TRANSPORT NEEDED SUPPLIES TO OTHER LOCATIONS AND TO BE RETURNED TO LOCKED CLOSET PER EACH USE. DONE 10-29-10</p> <p>b) THE SHARPS CONTAINERS HAVE BEEN REMOVED FROM THE LISTED LOCATION AND REPLACED WITH A SHARPS THAT HAS A ROLL TOP SLOT WHICH CLOSSES AFTER EACH USE. PREVENTING SPILLAGE OR INJURY. THIS WAS DONE ON 10-13-10</p> <p>c) THE RAZORS IN QUESTION WAS REPAIRED ON 10-15-10 - IT WILL BE CHECKED PERSONALLY TO ASSURE IT REMAINS SAFE FOR USE.</p> <p>d) THE COMMODE BOWL WAS DISCARDED ON 10-12-10 - THE LINENS WERE REMOVED AND UNLOCKED THAT SAME DAY.</p>	
R291 SS=F	<p>IX. PHYSICAL PLANT</p> <p>9.6 Plumbing</p> <p>9.6.d Hot water temperatures shall not exceed</p>	R291	<p>e) THESE ITEMS HAVE BEEN RELOCATED TO THE LOCKED STORAGE CLOSET LISTED IN #1a.</p> <p>2.) THIS IS LOCKED - HAS BEEN DONE 10-11-10 - USUALLY WAS LOCKED PRIOR TO THIS.</p>	

R266 12-21-2010 POC accepted. —
C. Laramy, RD

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0193	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2010
NAME OF PROVIDER OR SUPPLIER MANES HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 127 UNION STREET BENNINGTON, VT 05201		
(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
R291	Continued From page 15 120 degrees Fahrenheit in resident areas. This REQUIREMENT is not met as evidenced by: Based on observation and interview, hot water temperatures of the home exceeded 120 degrees Fahrenheit (F). Findings include: 1. Per observation on 10/11/2010, water temperatures throughout the facility exceeded 120 F. The water temperature in the community bathroom on the first floor was 129.0 F at 11:32 AM, followed by a second reading of 128.0 F at 11:40 AM and was 124.0 F in the second floor bathroom (hallway accessible) and 125.5 F in resident room #5 bathroom at 12:26 AM. The Manager confirmed, at the time of this finding, that a single water heating source was used for the entire residential care area and that the temperatures did exceed maximum safe levels.	R291	<i>9.6. On 10-12-10 the plumber was in and adjusted installed a mixer and the water temp. was 118° - the water temp. will be tested monthly. A log of such will be kept. It will be posted in the locker above the kitchen sink.</i> R291 12-21-2010 POC accepted. <i>C. Laraway, RN</i>	
R295 SS=F	IX. PHYSICAL PLANT 9.8 Heating 9.8.a Each home shall be equipped with a heating system which is of sufficient size and capability to maintain all areas of the home used by residents and which complies with applicable fire and safety regulations. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility did not follow the recommended maintenance schedule for furnace cleaning / inspection. Findings include: 1. Per observation during the environmental tour	R295		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0193	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2010
NAME OF PROVIDER OR SUPPLIER MANES HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 127 UNION STREET BENNINGTON, VT 05201		
(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
R295	Continued From page 16 on the morning of 10/11/2010, there was no evidence that required boiler unit safety inspections had been conducted for the home's heating unit. During interview on 10/11/2010 at 2:40 PM, the Manager confirmed that the current boiler has not been inspected by licensed, certified boiler inspector (placed in service 1 year ago per Manager).	R295	<p>980) THE BOILER WAS INSPECTED ON 11-29-10 BY MICHAEL SWIDORS. ENCLOSED IS A COPY OF VT. ST. DEPT. OF LABOR AND INDUSTRY CERTIFICATE OF BOILER AND PRESSURE VESSEL INSPECTION.</p> <p>ENCLOSED PLEASE FIND A COPY OF RECENT BOILER INSPECTION AND IT IS SCHEDULED THROUGH THE CIGNA LIFE INSURANCE COMPANY TO BE AUTOMATICALLY DONE EVERY 2 YRS. THIS CAN BE VERIFIED THROUGH MICHAEL SWIDORS @ 603-494-1963 OR DAVE NEWELL @ 802-442-5414 (WILLS INSURANCE AGENCY)</p> <p>R295 1-19-11 PSC accepted as written. — C. Laramy, RN</p>	