

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, 2013

Mr. Steven Doe, Administrator
Our Lady of the Meadows
1 Pinnacle Meadows
Richford, VT 05476

Provider #: 0197

Dear Mr. Doe:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **January 30, 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: 0197	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/30/2013
NAME OF PROVIDER OR SUPPLIER OUR LADY OF THE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 1 PINNACLE MEADOWS RICHFORD, VT 05476		
(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 1/30/13 by the Division of Licensing and Protection. The following regulatory violation was identified.	R100		
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 staff interviews and record review staff failed to provide care consistent with physician orders for 1 of 3 applicable residents. (Resident #1). Findings include: Per record review, conducted on 1/30/13, Resident #1, who was admitted on 10/25/10, with a diagnosis of dementia and a history of agitation and aggressive behavior towards others, did not receive a PRN (as needed) medication consistent with physician orders, in an effort to help alleviate symptoms for which the medication had been ordered. A physician order, dated 3/19/12, stated to administer Lorazepam (anti-anxiety medication) 0.6 mg PO (by mouth) every 8 hours as needed for agitation. The resident's behavior plan directed staff to only use the PRN Lorazepam when previously identified non-pharmacological approaches failed to alleviate behaviors that put Resident #1 and others at risk. The plan also	R128	(PLEASE SEE ATTACHED PLAN OF CORRECTION) 3/5/13	

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE - STEVEN A. JOE TITLE ADMINISTRATOR

(X6) DATE
2/1/13

STATE FORM

6899

ES1R11

If continuation sheet 1 of 3

PML

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0197	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/30/2013
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R128	Continued From page 1 directed staff to contact the nurse prior to giving the Lorazepam. A Nursing Progress note, dated 1/4/13, stated the resident had exhibited "extreme agitation last evening toward staff and other residents. Yelling incoherently and swearing at others. Shoving walker into people who got in [his/her] way....eventually settled into bed." A subsequent note, dated 1/7/13, stated "...Res 'pinched' female resident last evening, threw food x 2 at (another resident)"..."trying to push other res walkers into res. Difficult to redirect, distract." On 1/8/13 a Nursing Progress Note indicated there had been an incident, that day, with Resident #2, in which Resident #1 pushed Resident #2, who was passing by Resident #1's room, to the floor. Medical evaluation and treatment were subsequently sought for Resident #2 who had sustained an injury during his/her fall. Despite the fact that Resident #1 continued to intermittently exhibit agitated and aggressive behaviors towards other residents, that were evidently not able to be re-directed, there was no evidence that the nurse had been contacted in the evening to discuss the Resident's behavior and no evidence that the resident had received the PRN Lorazepam. A note on 1/11/13 stated that staff had reported the resident had been anxious and agitated during the previous evening and early am, showing aggression towards other residents and had been difficult to redirect. Although the resident continued to exhibit aggressive and agitated behaviors, and despite previous evidence that use of the PRN Lorazepam had been effective in reducing those behaviors, Resident #1 did not receive the PRN Lorazepam until a family member requested, on 1/11/13, "...some medication to calm [resident]"	R128		

Division of Licensing and Protection

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R128	Continued From page 2 down." A Nursing note, on that date, stated that Resident #1's provider had suggested use of scheduled Lorazepam and a daily 5 PM dose was then scheduled for administration. During interview, at 3:19 PM on 1/30/13, the RN providing oversight for care of Resident #1 confirmed the resident had exhibited agitated and aggressive behaviors towards other residents on 1/4/13, 1/7/13 and 1/8/13. S/he further stated that staff had not contacted him/her regarding the resident's behavior on 1/4/13 or 1/7/13, nor did the resident receive any PRN Lorazepam, consistent with physician orders, until 1/11/13, after a family member requested that medication be given to calm the resident.	R128		

Division of Licensing and Protection
STATE FORM

6899 E91R11

SAB
3/5/13

If continuation sheet 3 of 3

Our Lady Of The Meadows
Plan of Correction
Residential Care Home State Survey
January 30, 2013

R128

5.5

Action: The Nurse Manager has instructed all Direct Care Staff to attempt non-pharmacological approaches for residents who show evidence of anxiety and/or agitation that may put the resident and other residents at risk. The non-pharmacological approaches shall begin immediately upon evidence of mood or behavioral changes that result in the potential for unsafe behavior and continue for no more than twenty (20) minutes or until anxiety and/or agitation increases. At this point the nurse shall be notified.

All Nursing Care Plans shall be resident specific and include recommended non-pharmacological approaches that shall be utilized to address anxiety. Psychotropic Care Plans shall also be resident specific and include potential signs and symptoms of anxiety and/or agitation, recommended non-pharmacological approaches and pharmacological measures that are to be administered consistent with the physicians' orders.

Measures: The Nurse Manager will insure that appropriate staff members are instructed on the duration of non-pharmacological approaches prior to calling a nurse. The Nurse Manager will also closely monitor care plans to insure that they shall include non-pharmacological approaches that may help alleviate anxiety and/or agitation. The Nurse Manager will insure that the psychotropic Care Plan includes pharmacological measures that are to be administered consistent with the physicians' orders.

Monitors: The Nurse Manager and Nursing Team will monitor this practice to insure that this deficiency will not reoccur.

R128 POC accepted 3/6/13 BHowe RN/PMC