

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

June 17, 2013

Mr. William Spalding, Administrator
Pillsbury Manor - South
20 Harbor View Road
South Burlington, VT 05403

Provider #: 0149

Dear Mr. Spalding:

Enclosed is a copy of your acceptable plans of correction for the unannounced on-site complaint investigation conducted on March 18, 2013 and concluded on **March 25, 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



MAY - 8 2013,

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0149	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/25/2013
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NAME OF PROVIDER OR SUPPLIER PILLSBURY MANOR - SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 HARBOR VIEW ROAD SOUTH BURLINGTON, VT 05403
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R100	Initial Comments: An unannounced on-site complaint investigation was conducted on 03/18/13 and concluded on 03/25/13 by the Division of Licensing and Protection. The following are State of Vermont Residential Care Home regulatory violations.	R100 <u>R128</u>	<p><i>In this isolated situation with Resident #1 - clearly the RN. Charge did not go over the changes with Med.Tech. in regards to Morphine Sulfate Conc. That RN was spoken to - shown again our policies to go over and written up. Our policy states to go over any changes - going forward we are copying changes having nurse at MedTech sign they are aware + nurse has explained. All charge nurses have also been inservice'd best clinical practice - when MedTechs have to give prn - controlled liquid after Nurse assessment the amount has to be checked by nurse - charge nurse, Nurse Manager + RN Admin. Done but will be ongoing ✓</i></p>	
R128 SS=G	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.5 General Care</p> <p>5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the home failed to assure that 1 applicable resident (Resident #1) received medications consistent with the physician's orders. Findings include:</p> <p>1. Per record review on 03/18/13 for Resident #1, the physician's order dated 02/14/13 states, among others, Morphine Sulfate 100 mg/5 mL (100 milligrams per 5 milliliters) give: 2 mg/0.1 mL P.O. (by mouth) every 2 hours for mild to moderate pain or shortness of breath, PRN (as needed). The Medication Administration Record (MAR) indicated that staff administered 1.0 mL instead of 0.1 mL three times on the morning of 02/15/13, meaning that the resident received 60 milligrams of Morphine instead of 6 milligrams. There was a licensed nurse on site at the time, who directed the un-licensed staff member to retrieve the medication on 3 separate occasions instead of pouring and administering the medication his/herself. Per interview on</p>	R128		

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Deborah Fleming RN Admin TITLE _____ (X6) DATE 5/6/13

STATE FORM 6899 005Y11 If continuation sheet 1 of 10

R128, R147, R150, R164, R165, and R171 POC's accepted 6/10/13 SEMMONS/PJ/AME

PW

Division of Licensing and Protection

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R128	<p>Continued From page 1</p> <p>03/19/13 at 10:00 A.M. the unlicensed staff member who had been delegated to give the previous concentration of the liquid medication confirmed that the wrong dose was administered on 2/15/13. During that interview, s/he stated "there was no discussion about the concentration or the change in dose" for Resident #1, only the general state of resident's health.</p> <p>Per interview on 03/18/13 at 1:39 P.M. the Nurse manager confirmed that a recent change in medication for 1 applicable resident was not communicated thoroughly by the RN to on-coming un-licensed staff. The Nurse Administrator confirmed the home failed to assure that medications given were consistent with the physician's orders.</p> <p>See also R164.</p>	R128 <u>R147</u>	<p>All staff involved in this lack of proper documentation with change in orders as well as lack of proper documentation + side effects - Also the error of the Narcotic Count sheet without name of medication or correct directions have been spoken to + written up - Did not follow our protocol. From now on when meds come from Hospice - the Hospice Nurse will go over all to a licensed Nurse. - Side effects will be available if we hand write order on MAR - Coming from Pharmacy already on MAR. Responsible Charge Nurse, Nurse manager + RN Admin - To be Regularly checked</p>	
R147 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.9.c (4)</p> <p>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;</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to have a current list of medications that includes likely side effects to monitor for, for 1 applicable resident (Resident #1) Findings include:</p>	R147		

Division of Licensing and Protection

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R147	Continued From page 2 1. Per record review of Resident #1's medical record, the MAR did not contain the likely side effects that staff are to monitor for, for each medication. In addition, the 'Controlled Drug Record' record on 02/18/13 did not have the medication's name nor concentration and had the wrong frequency. Per review of the physician's order dated 02/14/13 and the medication administration record (MAR), both note "Morphine Sulfate 100 mg/5 mL (20 mg/ 1 mL) give: 2 mg/ 0.1 mL P.O. q 2* for mild to moderate pain or shortness of breath, PRN" {by mouth every 2 hours as needed}. Per interview with the Nurse Manager and Nurse Administer on 03/18/13 at 11:45 A.M. confirmed that the MAR did not have the likely side effects and the 'Controlled Drug Record' did not have the medication's name nor concentration and the wrong frequency.	R147 <i>Cont'd</i>	<i>The Narcotic Count sheet will always have name of Med Order as written by Hospice or M.D + Frequency - Responsible Charge nurse, Nurse Man. + RN Admin</i>
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 interview and record review, the nurse failed to assure sufficient documentation of the resident's symptoms and signs at the time of an incident, and failed to assure documentation reflected actions taken by staff for 1 applicable resident. (Resident #1) Findings include	R150	<i>R150 All parties involved in documentation of 2/15/13 have been spoken to the lack of documentation at the onset of occurrence was Amis - what we did and how we responded was not clearly documented our plan of action, our disclosure of error to family + how we failed to have a timeline to show, actually what occurred was thoroughly discussed with all observation, disclosure, documentation + plan of care to be accurate</i>

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R150	Continued From page 3 1. Based upon record review and staff interview on 03/18/13, Resident #1 had 3 occurrences of medication administration errors in a 4 hour period on 2/15/13. The nursing note dated 02/15/13 at 9:50 P.M., nearly seven hours after the discovery of the errors, stated "[resident] received the wrong dose of morphine this morning...reassured that resident was resting [comfortably] and that staff was observing and caring for resident frequently." There is no documentation of the assessment, vital signs or the follow up action as to how often staff observed the resident after receiving 3 significant medication errors. In addition, there is no RCH incident report nor a detailed follow up internal investigation noted to determine the causes of the errors. Per interview on 3/18/13 at 11:45 A.M., the nurse manager and Nurse Administrator confirmed the lack of sufficient documentation of the resident's symptoms and signs at the time of an incident and actions taken.	R150 <i>Cont'd</i>	<i>timely and clear in the future. Also we will in documentate + thoroughly investigate internally any error or mistake have it documented. - Responsible Nurse manager + RN Administrator ongoing monitoring + checking -</i>	
R164 SS=G	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	R164	<i>The RN involved is clearly aware of her error - she assessed but did not check the dosage with Med.Tech - but told her to give it. Education ongoing - emphasized importance + our policy + procedure - Licensed nurse will double check med. prior to administration</i>	

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R164	Continued From page 4 Registered Nurse failed to delegate the responsibility for the administration of specific medications to designated staff for designated residents for 1 applicable resident (Resident #1). Findings include: 1. Per record review on 03/18/13 for Resident #1, the physician's order (a new order with a change in the concentration of the medication) dated 02/14/13 states, Morphine Sulfate 100 mg/5 mL (100 milligrams per 5 milliliters) give: 2 mg/0.1 mL P.O. (by mouth) every 2 hours for mild to moderate pain or shortness of breath, PRN (as needed). The Medication Administration Record (MAR) indicated that un-licensed staff administered 1.0 mL instead of 0.1 mL three times on the morning of 02/15/13, meaning that the resident received 60 milligrams of liquid Morphine instead of 6 milligrams. There was a licensed nurse on site at the time, who directed the un-licensed staff member to retrieve the medication on 3 separate occasions instead of pouring and administering the medication his/herself. Per interview on 03/19/13 at 10:00 A.M. the unlicensed staff member who had been delegated to give the previous concentration of the liquid medication confirmed that the wrong dose was administered on 2/15/13. During that interview, s/he stated "there was no discussion about the concentration or the change in dose" for Resident #1, only the general state of resident's health. Per interview on 03/18/13 at 1:39 P.M. the Nurse manager confirmed that a recent change in medication for 1 applicable resident was not communicated thoroughly by the RN to on-coming un-licensed staff. Due to the regulation stating that unlicensed staff may administer medications only if a Registered Nurse	R164	+ clear documentation as to why. + of assessment + delegation to Med.Tech- needs to be consistent + clear. - Also see answer to R158- Responsible Charge Nurse, Nurse Manager RN Admin - Done Ongoing monitoring		

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R164	Continued From page 5 has delegated the specific medication, the RN was required to re-delegate the administration of the new, more concentrated form of liquid Morphine for Resident #1 to any unlicensed staff who would be responsible for administering that medication. See also R128	R164	<p><i>R165 → The RW Administrator of these Communities accepts responsibility for proper Medication Administration + Teaching of Unlicensed staff. Reviewing all assessments + delegate Med. Tech to give medication to residents - Also at time of training enlists + delegates licensed staff ONLY to assist in training with the RW doing the final OK to give medications to designated Residents - Responsible RW Administrator [Signature]</i></p>	
R165 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: (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 Registered Nurse (RN) failed to provide teaching to designated staff regarding: proper techniques	R165		

Division of Licensing and Protection

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R165	Continued From page 6 for medication administration; appropriate information about resident's relevant medications; and failed to establish a process for routine communication regarding changes in medications. This has the potential to effect all residents. Findings include: 1. Per interview on 03/18/13 at 10:00 A.M., the Administrator/RN stated that unlicensed staff pour and administer medications to residents prior to being delegated to do so by the RN. During the interview, the RN stated that other unlicensed staff, who have been delegated by the RN to give medications, supervise the unlicensed staff while they are administering medications prior to delegation, without the presence of a licensed nurse or RN. The Administrator/RN at 2:59 P.M. confirmed above findings that staff other than RNs are watching medication administration and teaching, although stated that " I thought it was ok to have staff start to watch and teach med techs and then I sign off that they are actually delegated". 2. Per record review on 03/18/13 for Resident #1, the physician's order dated 02/14/13 states, among others, Morphine Sulfate 100 mg/5 mL (100 milligrams per 5 milliliters) give: 2 mg/0.1 mL P.O. (by mouth) every 2 hours for mild to moderate pain or shortness of breath, PRN (as needed). The Medication Administration Record (MAR) indicated that staff administered 1.0 mL instead of 0.1 mL three times on the morning of 02/15/13, meaning that the resident received 60 milligrams of Morphine instead of 6 milligrams. Per interview on 03/19/13 at 10:00 A.M. the medication tech (non-nurse staff member who was delegated to give certain medications) confirmed that the wrong dose was administered. During that interview, s/he stated "there was no discussion about the concentration or the change	R165	Per policy the RN Admin Delegates Med Tech - to administer Meds - licensed staff only - Never Med Tech to Med Tech. Again AS ongoing training licensed nurses are to go over any changes in Med Tech. We will now be documenting that. Regular checks + monitoring Nurse Manager + RN Administrator		

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R165	Continued From page 7 in dose" for Resident #1, only the general state of resident's health. Per interview on 03/18/13 at 1:39 P.M. the Nurse manager confirmed that a recent change in medication for 1 applicable resident was not communicated thoroughly by the RN to on-coming un-licensed staff.	R165	<p><i>R171 Those involved were spoken to in regards to all said errors- Every PRN Medication needs to be documented on MAR- If it is a narcotic, also signed out on narcotic count sheet Reason for + effectiveness</i></p> <p><i>As per R147 Timely, Transparent + accurate information for a PRN Medication + effect to Resident is key + will never alter document. Also due to the nature of Resident's condition and error That occurred Timely documentation of action + plan</i></p>	
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 effects. (6) All incidents of medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the	R171		

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R171	<p>Continued From page 8</p> <p>facility failed to assure sufficient documentation of medication administration for 1 applicable resident. (Resident #1) Findings include:</p> <p>1. Per record review on 03/18/13, Resident #1 had a PRN (as needed) medication order for Morphine that was not administered as ordered, lacked documentation as to the reason for giving the medication and and lacked documentation of all incidents of medication errors. Per the physician order dated 02/14/13, it states "Morphine Sulfate 100 mg/5 mL (20 mg/ 1 mL) give: 2 mg/ 0.1 mL P.O. [by mouth] q 2 hr. [every 2 hours] for mild to moderate pain or shortness of breath, PRN." Per review of the Medication Administration Record (MAR) the morphine was not signed off as being given nor was there a documented reason for administration of three doses on the morning of 02/15/13 in the progress notes or on the MAR.</p> <p>There was also a lack of thorough and timely documentation regarding the medication errors in the nurse progress notes. Per interview, at 2:00 PM the Nurse Administrator confirmed staff failed to document that medications were administered as ordered, the reason being given, it's effect and confirmed the lack of the medication error documentation.</p> <p>In Addition, per review of the 'Controlled Drug Record', it did not have the drug name or concentration, nor the correct frequency written. Furthermore, the Controlled Drug Record had three incidents of the medication's quantity administered and amount remaining being altered and initialed by an un-identified person. Per staff interviews the Nurse manger and the medication technician denied altering and initialing the record. They confirmed at that time the record</p>	R171	<p><i>need to be documented a clear timeline of events is crucial All involved have been counseled. Responsible Charge Nurse, Nurse manager + RN Administrator Done but there will be ongoing monitoring</i></p>	
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R171	Continued From page 9 was not clear and accurate.	R171		
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*Faxed 5/7/13
Deborah Lemery*

Deborah Lemery RN Admin 5/6/13