



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  
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July 8, 2011

Ms. Nanc Bourne, Administrator  
Sterling House At Richmond  
61 Farr Road  
Richmond, VT 05477

Dear Ms. Bourne:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **June 6, 2011**. 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 "Pamela M. Cota RN".

Pamela M. Cota, RN  
Licensing Chief

PC:jl



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0591	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	Licensing and Protection	(X3) DATE SURVEY COMPLETED  C 06/06/2011
NAME OF PROVIDER OR SUPPLIER  STERLING HOUSE AT RICHMOND			STREET ADDRESS, CITY, STATE, ZIP CODE  61 FARR ROAD RICHMOND, VT 05477		
(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 by the Division of Licensing & Protection on 6/6/11. The following regulatory violation was identified.	R100			
R126 SS=D	V. RESIDENT CARE AND HOME SERVICES  5.5 General Care  5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to assure that the medical needs were met for one resident when nursing failed to assess the resident's condition following an unwitnessed fall. (Resident #1) Findings include:  Per record review Resident #1 had a nurse's note, dated 5/14/11, that stated the resident had fallen at 4:15 AM in the bathroom, had 2 skin tears and mild hip discomfort. The note further stated that staff had reported that the resident had increased hip pain and was transferred to the hospital by ambulance. Per telephone interview, at 1:48 PM on 6/6/11, LNA (Licensed Nursing Assistant) #1, who was responsible for providing oversight for the care of Resident #1, on the 11 PM - 7 AM shift of 5/14/11, stated that s/he had found the resident lying on the floor of the bathroom at approximately 4:15 AM on the morning of 5/14/11. The LNA stated that s/he had	R126	<i>See attached</i>		

Division of Licensing and Protection

*M. C. B...*

TITLE *Director*

(X6) DATE *7/7*

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

Division of Licensing and Protection

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R126	Continued From page 1 contacted Nurse #1 (the nurse on call), at home, at that time and requested that the nurse come to the facility to assess the resident, as the LNA was concerned the resident may have sustained a fractured hip because his/her knee was "turning in". The LNA stated that when asked about pain, the resident stated their hip was "a little sore". LNA #1 stated Nurse #1 was again contacted at approximately 7:00 AM to request an assessment of the resident. However, Nurse #1 still did not go to the facility to conduct an assessment. The resident was eventually transferred via ambulance to a local Emergency Department at approximately 8:20 AM and was subsequently diagnosed with a fractured hip. Nurse #1 confirmed, during a telephone interview at 1:16 PM on 6/6/11, that s/he did not do an assessment of Resident #1 after the resident's fall and confirmed the LNA's phone call at 4:30 AM. S/he further stated that s/he did not remember any subsequent phone call at 7:00 AM. During interview, at 10:33 AM on 6/8/11, the facility Manager confirmed that, despite 2 separate requests by caregivers at 4:30 AM and 7:00 AM, Nurse #1 did not do an assessment of the resident. The Manager stated that s/he "would have expected [the nurse] to come in" to assess the resident; and "we considered it inappropriate that [the nurse] didn't come".	R126		

POC:

Sterling House would like to highlight the stated sequence of events, as stated LNA #1 did not note a change in hip rotation until the 7am call, this was verified by multiple conversations with LNA #1. She did report "mild hip discomfort" to nurse earlier. The noted change "turning in" was seen and reported at the 7am call and ambulance was summoned as noted by surveyor at 8:20.

It is the goal of Sterling House to ensure that the nursing needs of each resident are addressed and that timely medical attention is provided as needed/warranted.

Re: the incident of 5/14/11, Nurse #1 was counseled re: on-call responsibilities at Sterling House of Richmond, including on-site assessment of residents as warranted or requested by caregiver staff.

Since 5/14/11, RN #1 works under the indirect supervision of an additional RN who is available to provide on-site support as needed.

Direct care giver staff were in-serviced in May re: the home's protocol to follow when an on-call staff person/nurse fails to respond to care giver observations or requests for on-site assessment of any resident's changing condition, i.e., contact the back-up RN and/or notify the RN owner/manager.

R126 POC Accepted 7/11/11 AMOturn