

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) 871-3317
To Report Adult Abuse: (800) 564-1612
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November 12, 2013

Ms. Sandy Peckner, Administrator
Hilltop House
65 Harris Avenue
Brattleboro, VT 05301

Provider #: 0047

Dear Ms. Peckner:

Enclosed is a copy of your acceptable plans of correction for the unannounced onsite re-licensing survey and complaint investigation conducted on October 7, 2013 and completed on **October 8, 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: 0047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/08/2013
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NAME OF PROVIDER OR SUPPLIER HILLTOP HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 65 HARRIS AVENUE BRATTLEBORO, VT 05301
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R100	Initial Comments: An unannounced onsite re-licensing survey and complaint investigation was conducted on 10/7/13 and 10/8/13 by the Division of Licensing and Protection. There were regulatory deficiencies identified. The findings include;	R100		
R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that resident assessments were completed when there was a change in the physical condition for 2 of 6 residents identified. (Resident #1 and #2) The findings include: 1. Per review of the medical record of Resident #1 on 10/7/13, the record indicated that Resident #1 was admitted to the facility on 10/11/10, with diagnoses that include dementia, atrial fibrillation, cerebral vascular accident, hypertension and diabetes. Per review of the medical record it indicated that Resident #1 fell on 8/28/13 and broke his/her right patella (knee cap). Per interview with staff Resident #1 physical mobility declined due to the broken patella and Resident #1 needed more assistance from staff and was receiving therapy	R136	Each resident is assessed annually. This nurse will create a new assessment whenever there is a change in the resident's physical or mental condition. An updated assessment addressing the fractured patella for Resident #1 was completed on 10/04/2013. It was not done at the exact time it should have been. In the future, the new assessment will be completed on the day the change in status occurred. This will be monitored by the nurse manager on a daily basis by reviewing the nurse's and resident aide notes.	10/17/2013

Division of Licensing and Protection LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sandra M. Peckner, RN</i>	TITLE <i>nurse mgr / Interim Administrator</i>	(X6) DATE <i>10/22/13</i>
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R136, R145, R179 POCs accepted 11/8/13 McCullinan RN/AMC

AMC

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R136	<p>Continued From page 1</p> <p>services. Per review of the assessments for Resident #1, there was no assessment done after Resident #1 fell to reflect Resident #1's change in physical status and need for more assistance from staff.</p> <p>Per interview with the facility Registered Nurse on 10/8/13, he/she confirmed after review of the medical record that no assessment had been completed after the fall on 8/28/13 to reflect Resident #1's change in physical status and need for more assistance from staff.</p> <p>2. Per review of the medical record of Resident #2 on 10/7/13, the record indicated that Resident #2 was admitted on 6/1/09 with diagnoses that include cerebral vascular accident and hypothyroidism.</p> <p>Per review of the medical record notes written on 6/24/13 indicate that Resident #2 was experiencing back pain nearly daily and it was difficult for Resident #2 to ambulate outside anymore related to the back pain. The note indicated that family was made aware and a conversation with the family was conducted discussing the potential need for therapy services. The medical record indicated that the physician for Resident #2 was treating Resident #2 for persistent back pain and had conducted x-rays to try to determine cause of the pain. The physician indicated that the pain was interfering with Resident #2 ability to ambulate outdoors.</p> <p>Per review of the assessments for Resident #2 there was no assessment done after Resident #2 complained of daily pain interfering with Resident #2's ability to ambulate outside of the facility as he/she had been accustomed to. Per interview with the facility Registered Nurse on 10/8/13,</p>	R136	<p>As for Resident #2's back pain issue, the care plan has been amended to include interventions for staff to follow when the back pain occurs.</p> <p>Resident #2's assessment was updated on 10/2/13 in the computer but a copy was not placed in the resident's chart. There is now a system in place with a check list for nurse's note, care plan review and evaluation for an updated assessment for each resident daily. If an assessment is needed, it will be done immediately. If a nurse's note and care plan update are appropriate, they will be written at the same time.</p> <p>If only a nurse's note is needed, it shall be done. All residents have notes done monthly and whenever there is an event that requires charting.</p> <p>The corrective action will be monitored on a daily basis using the check list system.</p>	10/17/13

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R136	Continued From page 2 he/she confirmed after review of the medical record that no assessment had been completed after the fall on 8/28/13 to reflect Resident #2 change in physical status and decline in ambulation related to pain.	R136		
R145 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</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 staff interview the facility failed to ensure that the plans of care were updated for 3 of 6 residents identified (Resident #1, 2, and 3) to reflect the residents current health status and interventions to assist resident in maintaining independence and well-being. The following include;</p> <p>1. Per review of the medical record of Resident #1 on 10/7/13, the record indicated that Resident #1 was admitted to the facility on 10/11/10, with diagnoses that include dementia, atrial fibrillation, cerebral vascular accident, hypertension and diabetes.</p> <p>Per review of the nurse's notes and direct caregivers, the notes indicate that Resident #1 had a history of verbal abuse toward staff and non compliance with care. Per review of Resident</p>	R145	All care plans have now been reviewed and will continue to be reviewed at the time nurse's notes are written. This action will be monitored via a checklist. Also, a new care plan book was created for staff to review.	10/17/2013

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R145	<p>Continued From page 3</p> <p>#1's physicians note dated 10/3/13, the note indicates that Resident #1's main issue is the ability to be an active participant in his/her own care. The note also indicated that the physician had identified specific interventions to use to help assist Resident #1 to cooperate with staff. The note indicated that staff members that addressed resident #1 in a more firm manner and were clear were able to get more cooperation from Resident #1. The note also indicated that the physician did not want staff to plead with Resident #1 or wait on him/her, that staff should give clear direction, calm direction and offer minimal assistance. The note also indicated that if Resident #1 resists, that staff should leave and come back later.</p> <p>Per review of Resident #1's plan of care, there was no careplan developed to indicate Resident #1's behaviors and resistance to care. There was no evidence that staff utilized any of the interventions indicated by the physician on the 10/3/13 note to maintain Resident #1's independence and well-being.</p> <p>Per interview with the Registered Nurse, he/she indicated that the Registered Nurse develops and updates the residents care plans to reflect the residents current status. The Registered Nurse confirmed that he/she was aware of the behavior issues of Resident #1 and the physicians note dated 10/3/13, that indicated specific interventions for staff to use to assist Resident #1 with behavior issues. The Registered Nurse confirmed that the care plan is the paper that the direct care staff utilize to know what care to provide to a resident and that the care plan should accurately reflect residents current status.</p> <p>2. Per review of the medical record of Resident #2 on 10/7/13, the record indicated that Resident</p>	R145	<p>There was a resident aid meeting that discussed the physician's plan on how to approach resident #1 when he/she was verbally abusive. It was written on both the care plan and the treatment record that is read every shift. They have both been updated to reflect Resident #1's physician's plan on them. The physician's plan for Resident #1 will be discussed at every Resident Aide's meeting until Resident #1 becomes compliant.</p>	10/17/2013
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R145	<p>Continued From page 4</p> <p>#2 was admitted on 6/1/09 with diagnoses that include cerebral vascular accident, dementia and hypothyroidism.</p> <p>Per review of the medical record, notes written on 6/24/13 indicate that Resident #2 was experiencing back pain nearly daily and it was difficult for Resident #2 to ambulate outside anymore related to the back pain. The note indicated that family was made aware and a conversation with the family was conducted discussing the potential need for therapy services. The medical record indicated that the physician for Resident #2 was treating Resident #2 for persistent back pain and had conducted x-rays to try to determine cause of the pain. The physician indicated that the pain was interfering with Resident #2 ability to ambulate outdoors.</p> <p>Per review of Resident #2's plan of care, there was no careplan developed to address Resident #2's pain issues and interventions created to assist Resident #2 in maintaining his/her independence and well-being. Per review of the medical record and facility investigation of Resident #2, on 4/9/13, Resident #2 was physically aggressive toward Resident #3 and hit Resident #3 in the face with a rolled newspaper. Per review of Resident #2's plan of care there was no revision to the residents care plan indicating that Resident #2 was aggressive toward Resident #3 and there were no interventions on how to prevent altercations between Resident #2 and other residents.</p> <p>Per interview with the Registered Nurse, he/she indicated that the Registered Nurse develops and updates the residents' care plans to reflect the residents' current status. The Registered Nurse confirmed that he/she was aware of the behavior</p>	R145	<p>As for Resident #2's back pain issue, the care plan has been amended to include interventions for staff to follow when the back pain occurs.</p> <p>Resident #2's assessment was updated on 10/2/13 in the computer but a copy was not placed in the resident's chart. There is now a system in place with a check list for nurse's note, care plan review and evaluation for an updated assessment for each resident daily. If an assessment is needed, it will be done immediately. If a nurse's note and care plan update are appropriate, they will be written at the same time.</p> <p>If only a nurse's note is needed, it shall be done. All residents have notes done monthly and whenever there is an event that requires charting.</p> <p>The corrective action will be monitored on a daily basis using the check list system.</p> <p>The altercation between Resident #2 and Resident #3 is now reflected in a care plan for both residents. The care plan includes interventions to assist with behavior issues and ways to prevent recurrence.</p> <p>An in- service is planned for 11/4/2013 with Nancy Hood, the VT Ombudsman to present a topic on Residents rights, abuse and neglect. In addition there will be an in-service on 11/13/2013 presented by Carol Lechthaler VNA/VNH on dementia.</p>	<p>10/17/2013</p> <p>10/17/2013</p>

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R145 Continued From page 5
issues of Resident #2 and the altercation between Resident #2 and Resident #3, where Resident #2 hit Resident #3 in the face with a rolled newspaper. The Registered Nurse confirmed that the care plan should accurately reflect residents current status and contain interventions to assist the resident with behavior issues and prevent reoccurrence.

R145

R179 V. RESIDENT CARE AND HOME SERVICES
SS=C

R179

As of November 13, 2013, Hilltop House will have completed 14 hours of training for each staff person providing direct care to residents. See attached copy of in-services.

10/17/2013

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:

- (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.

Efforts will be made to schedule required in-services well in advance of the middle of 2014.

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R179	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure at least twelve (12) hours of training each year for each staff person providing direct care to residents. Findings include:</p> <p>1. Per review of the facilities in-servicing records, there was no evidence that the facility had completed the required 12 hours of yearly training for each of the facility's employees. Per interview with the Registered Nurse on 10/8/13, he/she confirmed that the facility had not educated the facility staff with the required 12 hours of yearly education that included the following;</p> <ul style="list-style-type: none"> (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 <p>The Registered Nurse indicated in interview on 10/8/13 that s/he was unaware of all the specific education required.</p>	R179	<p>As of November 13, 2013, Hilltop House will have completed 14 hours of training for each staff person providing direct care to residents. See attached copy of in-services.</p> <p>Efforts will be made to schedule required in-services well in advance of the middle of 2014.</p>	10/17/2013