

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

December 20, 2011

Mr. Victor Martini, Administrator  
Battelle House  
348 Dewey Street  
Bennington, VT 05201

Provider #: 0531

Dear Mr. Martini:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 19, 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,



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:  0531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/19/2011
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NAME OF PROVIDER OR SUPPLIER  BATTELLE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 348 DEWEY 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
T 001	INITIAL COMMENTS  An unannounced onsite re-licensure survey was conducted by the Division of Licensing and Protection on 10/19/11 to determine compliance with the Vermont Therapeutic Community Residences Licensing Regulations.	T 001	<i>See Attached</i>	
T 002	IV.A.1 Resident Care and Supervision  General The Director shall provide every resident with the personal care and supervision appropriate to his/her individual needs.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Director failed to assure that 2 of 2 applicable residents in the survey sample received appropriate medical supervision. (Residents #1 and #2) Findings include:  1. Per record review on 10/19/11, Resident #1's medication administration record (MAR), Medication Reconciliation list, and most recent physician orders did not match. During interview, the Residence Nurse Manager confirmed that not all medications from the current physician orders were on the MAR as the resident was refusing to take them and stated that this fact had not been documented nor had the medications been discontinued.  2. Per record review on 01/19/11, Resident #2's physician orders, MAR and Medication Reconciliation were not identical. There were current orders for Constulose and for PolymyxinB-Trime eye drops that were not on the MAR. During interview that afternoon, the Nurse	T 002		

Division of Licensing and Protection  
*Victor A. Martini, LCSW*  
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE *Division Director* (X6) DATE *11/28/11*

- Division of Licensing and Protection

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T 002	Continued From page 1 Manager confirmed that these were current orders, stated that the resident was not taking them, and acknowledged that the orders should have been transferred to the MAR, marked as refused or discontinued.	T 002	<u>see Attached</u>	
T 003	IV.A.2 Resident Care and Supervision  Medication  The Director shall assure that all medications and drugs are: a. used only as prescribed by the resident's physician b. properly labeled and kept in a locked cabinet at all times or, when a program of self-medication is in effect, otherwise safely secured.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Director failed to assure that all medications are securely locked at all times. Findings include:  1. Per observation throughout the survey period, the medication cabinet keys were left in the cabinet lock. The medication room is accessible to non-delegated staff and potentially to residents. The office was not continually attended by the nurse. During interview that afternoon, the Nurse Manager confirmed that the keys were in the cabinet and that they should be secured.	T 003		

## Plan Of Corrections

Unannounced on-site re-licensing survey conducted at Battelle House on 10/19/2011 found two deficiencies. Each of these deficiencies involved licensing requirements. Here are our responses to them.

### T002: IV.A.1 Resident Care and Supervision

#### General:

The director shall provide every resident with the personal care and supervision appropriate to his/her individual needs:

- For all medications prescribed, both the MAR and the Medication Reconciliation list will match all physicians orders.
- When a resident refuses to take any medication listed on the MAR, refusal will be duly noted.
- In cases where the resident refuses to take medications for four consecutive days, the resident will be asked to sign a statement of voluntary discontinuation of prescribed medication.
- Statements of voluntary discontinuation will be sent to the prescribing physician with an attached request for doctor's orders to discontinue the medication.
- In cases where the prescriber is unwilling, unavailable or no longer providing care for the resident, the UCS psychiatrist will discontinue medications as appropriate.
- Monitoring will include two random checks quarterly by overnight shift nurses. The overnight nurse will compare the MAR, the Medication Reconciliation list, the physicians orders and ascertain that they match the actual medications kept onsite. Quarterly report will be prepared and sent to Division Director for review in Managers Meeting.

T002 POC accepted 12/18/11 Claraway RN / P. Mcota RN

### T003: IV.A.2 Resident Care and Supervision

#### Medication

The director shall assure that all medications and drugs are:

a) used only as prescribed by the resident's physician:

See T002 Above – including monitoring

b) properly labeled and kept in a locked cabinet at all times or, when a program of self-medication is in effect, otherwise safely secured otherwise safely secured:

- Diligence will be enforced to assure that keys will never be left in medicine cabinet locks.
- A sliding bolt exists on the lower section of the Dutch-doors that secure the nursing area. Diligence will be enforced to assure that the bolt is secured at all times.
- Use of door-stops to prop open medication-area doors will be prohibited.

T003 POC accepted 12/18/11 Claraway RN / P. Mcota RN