VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

April 3, 2024

Raeleen Bedard, Manager
22 Upper Welden
107 Fisher Pond Road
Saint Albans, VT 05478-1836

Dear Ms. Bedard:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 8, 2024.** 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.

If you have any questions, please feel free to contact me at (802) 585-0995.

Sincerely,

Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0528	A. BUILDING: _____ B. WING _____	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
22 UPPER WELDEN	107 FISHER POND ROAD SAINT ALBANS, VT 05478

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T 001	Initial Comments On 2/6/24 the Division of Licensing and Protection conducted an unannounced on-site relicensure survey, with additional information provided by the facility Manager on 2/8/24. The following regulatory deficiencies were identified:	T 001		
T 044 SS=D	V.5.8.g.1.2.3.4.5.6. Resident Care and Services 5.8 Medication Management 5.8.g Residences must establish procedures for documentation sufficient to indicate to the health care provider, 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 residence; (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; (5) For residents receiving psychoactive medications, a record of monitoring for side effects; and	T 044	T044 Resident #1's physician ordered "Albuterol Sulfate HFA 90 mcg Inhale 2 puffs by mouth every 8 hours as needed for short of breath or wheezing". Resident #1's Medication Administration Record (MAR) also listed "Albuterol Sulfate HFA 90 mcg Inhale 2 puffs by mouth every 8 hours as needed for short of breath or wheezing". Inhaler packaging with pharmacy label also read "Albuterol Sulfate HFA 90 mcg Inhale 2 puffs by mouth every 8 hours as needed for short of breath or wheezing". No medication error had occurred, no CIR needed. At time of survey Resident's physician had not signed paper copy of order to keep in binder. Order had been faxed; voicemails left for written copy to be sent for binder. On 2/19/2024 another request for signed paper copy sent to PCP via fax and voicemail left on triaging nursing line to have PCP sign and fax back updated order for binder. 2/27/2024-Signed PCP order received back, placed in Resident's binder. **Going forward starting March 11, 2024, weekly nursing check ins, and/or with any changes, nurse and house manager to confirm that binder orders, that they are updated to match MAR and the bubble pack (or vial) directions exactly, as evidence by the weekly checklist.** T044 Plan of Correction accepted by Jo A Evans on 3/18/24.	03/11/2024

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Raelee Bedard House Manager 3/15/24

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T 044	Continued From page 1 (6) All incidents of medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure a medication administered to one applicable resident (Resident #1 was administered as ordered. Findings include: On 2/6/24 the Manager confirmed policies and procedures related to Medication Administration were not on file and available for review. Per record review Resident #1's physician ordered "Albuterol Sulfate HFA 90 mcg Inhale 1 puff every 6 hours as needed"; however his/her Medication Administration Record listed "Albuterol Sul HFA 90 mcg Inhale 2 puffs by mouth every 8 hours as needed for short of breath or wheezing". On the afternoon of 2/6/23 the Registered Nurse confirmed an order to administer Albuterol Sulfate via inhaler every 8 hours was not on file, and the medication was not administered according to the signed medication orders on file dated 4/11/23. In conclusion this deficient practice is a risk for more than minimal harm to Residents because the physician's written, signed orders ensure the medication is administered as the prescriber intended.	T 044		
T 048 SS=D	V.5.8.h.3 Resident Care and Services 5.8 Medication Management 5.8.h.3 Residents who are capable of	T 048		

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T 048	Continued From page 2 self-administration may choose to store their own medications provided that the residence is able to provide the resident with a secure storage space to prevent unauthorized access to the resident's medications. Whether or not the residence is able to provide such a secured space must be explained to the resident on or before admission. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure medications belonging to residents capable of self administration are provided secure storage space to prevent unauthorized access. On 2/6/24 the Manager confirmed policies and procedures related to Medication Storagewere not on file and available for review. During the facility tour commencing at 9:30 AM on 2/6/24 medications were observed to be unsecured and accessible in two resident's rooms. A Combivent Respimat Inhaler was observed in Resident #2's room and Aspercream Pain Relieving Cream was observed in Resident #3's room. The Manager confirmed this finding on the morning of 2/6/23, and confirmed medications are not permitted to be stored in residentrooms. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents due to access to medications by residents with varying ability to of safely manage access to medications.	T 048	Residents are to keep/store all medications secured in the office. When and if residents purchase OTC medication in the community these are to be given to staff for safe keeping/storage. Medications are not to be stored in residents' rooms. Staff will perform routine room inspections to ensure OTC mediations were not purchased in the community and brought into the residence. **Going forward as of March 8, 2024, all residents and staff have been educated on current practices. By March 22, 2024 this practice will be reviewed at the house meeting with all residents as evidence by meeting minutes.** KOP medication will be stored securely in the office while residents are onsite. If a resident is leaving the property and wishes to bring their KOP PRN medications, they may do so if there is an order by the prescribing provider indicating PRN medication can be KOP. Residents must request medication when needed, and/or when leaving the premises. Staff will remind residents to return medication to office/staff when they return to the premises. **Going forward as of March 8, 2024, all residents and staff have been educated on current practices By March 22, 2024 this practice will be reviewed at the house meeting with all residents as evidence by meeting minutes.** **3/8/2024-Policy of safe medication storage, including OTC medication added to policy binder.** **3/8/2024-Policy on KOP medication added to policy binder.** T048 Plan of Correction accepted by Jo A Evans on 3/18/24.	03/22/2024
T 052 SS=D	V.5.9.b.1.2.3.4.5.6.7 Resident Care and Services	T 052		

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T 052	Continued From page 3 5.9 Staff Services 5.9.b. The residence 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, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure the documented completion of the required trainings for 1 out of 5 sampled staff.	T 052	T052 **The one staff flagged will be completing trainings by 3/15/24. Training will include the areas listed in T052. Going forward, as of March 4, 2024, the House Manager will review the training binder for compliance on a monthly basis.**	03/15/2024

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T 052	Continued From page 4 On 2/6/24 the Manager confirmed policies and procedures related to Staff Trainings were not on file and available for review. Per record review there were no documented trainings on file for 1 out of 5 sampled residents. At 1:00 PM on 2/6/24 the Manager confirmed there was no documentation on file indicating 1 out of 5 sampled residents had completed any trainings. This deficient practice is a risk for more than minimal harm for all facility residents due to failure to ensure staff education and training to safely and effectively provide resident care .	T 052	T052 The policies and procedures related to staff training specific to this facility are located in front of the training binder that is accessible to all staff. The policies and procedures related to staff training were available in the binder at the time of the audit, the auditor only looked at a part of the binder. Additionally, the policies and procedures related to staff training specific to this facility will be added to the new binder being created by 3/31/2024. This binder is reviewed monthly by the house manager who follows up with staff to ensure compliance with the trainings. The staff has been notified that they are out of compliance, and they have been working on completing the trainings. **These trainings will be completed and in compliance by the staff member by March 15, 2024 as evidence by the training log.** T052 Plan of Correction accepted by Jo A Evans on 3/18/24.	03/31/2024 03/15/2024
T 059 SS=F	V.5.10.a Resident Care and Services 5.10 Records/Reports 5.10.a The licensee shall be responsible for maintaining, filing and submitting all records required by the licensing agency. Such records shall be kept current and available on site at the licensed facility for review at any time by authorized representatives of the licensing agency. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to maintain required records on file and available on site for review on request of the representative of the licensing agency. Findings include:	T 059	T059 **Background checks will be gathered by HR and made available at the facility on a share electronic drive by 3/15/24.**	03/15/2024

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T 059	Continued From page 5 1. On the morning of 2/6/24 the surveyor requested access to resident records including admission agreements, intake summaries, medical records, treatment plans, discharge planning documents, and progress notes. Access to the requested documents was not provided during the survey on 2/6/24. The failure to ensure the requested records are maintained on file, accessible, and provided for review on request prevented review of resident records and impeded the survey process. On the afternoon of 2/6/24 the Manager confirmed the requested documents were not accessible and provided to the Survey for review. Additionally the Manager confirmed the residents medical records are not maintained on file by the facility; and stated the resident's medical records are maintained by their medical providers. 2. During the course of the survey on 2/6/24 the Manager was requested to provide documentation of staff trainings, criminal background checks, and abuse registry checks for a sample of 5 staff. One applicable staff's training records were not on file; and one applicable staff's abuse registry checks were not provided for review after two requests. Following a third request the applicable staff's abuse registry checks were provided, however the results of the child abuse registry check were redacted. When the surveyor requested the reacted information for review the Managerstated the information "may be provided by email tomorrow". The information was not provided during the survey as required or the following day. On the afternoon of 2/6/24 the Manager confirmed the training records for one applicable staff were not maintained on file and available for	T 059	T059 The auditor was provided access to the log into the EMR to review all requested records. All medical records are kept in the EMR, the facility does not keep paper records on site. The auditor indicated that [redacted] had difficulty navigating the EMR and reported that this will be a deficiency since the house manager was not able to change the view of the EMR on the auditor's computer monitor. We are unable to change the auditors view for any AHS department. Pronoun removed by DLP 3/18/24 T059 All records documenting a resident's treatment at NCSS and the facility are kept in the resident's chart in the EMR. Additionally, medical records that are received from outside providers (such as PCP) through coordination of care are scanned into the resident's chart in the EMR, they are not kept on file at the facility. A resident's PCP medical chart is maintained by their medical provider, any coordination of care is documented in the EMR. Access to charts with include a "cheat sheet" indicating where to find appropriate documents in the record provided by our EMR staff. Since the feedback during the audit on 2/6/2024 these have been made available at the facility electronically. All background checks and abuse registry checks are maintained by HR and not kept on site at the facility by March 15, 2024. **Going forward, by April 1, 2024, the House Manager will work with the HR team quarterly to ensure compliance. Paper copies are available upon request on site or uploaded to global scape.** T059 Plan of Correction accepted by Jo A Evans on 3/18/24.	2/6/24 4/1/24 04/01/2024

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T 059	Continued From page 6 review; and the results of the child abuse registry checks for one applicable staff were redacted and not provided for review on request. In conclusion this deficient practice is a risk for more than minimum harm to all facility residents due to the failure to maintain required records on file and available for review, and the failure to provide records for review by an authorized representative of the licensing agency on request.	T 059		
T 062 SS=F	V.5.10.b.4 Resident Care and Services 5.10 Records/Reports 5.10.b.4 The results of the criminal record and abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure the required background checks were completed for 5 out of 5 sampled staff. Findings include: On 2/6/24 the Manager confirmed policies and procedures related to completion of staff criminal background and abuse registry checks were not on file and available for review. Per record review there was a failure to complete all required background checks on hire for 5 out of 5 sampled staff; and a failure to disclose the findings of an abuse registry check for 1 out of 5 sampled staff. At 4:27 PM the Manager confirmed these findings. In conclusion this deficient practice is potential risk for more than minimal harm for all residents,	T 062	All background checks and abuse registry checks are maintained by HR and not kept on site at the facility by March 15, 2024. **Going forward, by April 1, 2024, the House Manager will work with the HR team quarterly to ensure compliance.** This policy "Background Checks & Changes Affecting Ongoing Employability" is on file located on the intranet for any staff to access. **A copy of this policy will be added to the binder being created to be held at the facility 3/31/2024** Addressed above. Now available as of 3/1/24. All background checks and abuse registry checks are maintained by HR on a shared drive and not kept on site at the facility. This shared drive is accessible. The records are available upon request. The House Manager will work with the HR team to ensure compliance with up to date records. Any hires from within NCSS will be confirmed with an accurate background check T062 Plan of Correction accepted by Jo A Evans on 3/18/24.	04/04/2024 03/31/2024 3/1/24

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T 062	Continued From page 7 as the requirement for criminal background and abuse checks is intended to ensure all residents are free from the risk of harm.	T 062		
T 071 SS=F	V.5.13 Resident Care and Services 5.13 Policies and Procedures Each residence must have written policies and procedures that govern all services provided by the residence. A copy shall be available for review at the residence upon request. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to develop and maintain written policies and procedures on file and available for review on request. Findings include: On the morning of 2/6/23 the manager was requested to provide a copy of all facility policies and procedures manual for review. Additional requests were made for specific policies and procedures were made throughout the course of the survey. On the morning of 2/6/24 the Manager confirmed s/he was not aware of any facility policies and procedures, and stated the agency that manages the facility has policies and procedures, however the facility does not. The Manager was not aware of how to access the agency's policies and procedures, and the specific policies and procedures requested during the survey were not provided for review. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility	T 071	T071 **A binder is being created for policies and procedures that are specific to the facility and will be available by 3/31/24. All agency policies and procedures are available on the NCSS intranet for all staff to access. Binder will be reviewed at the staff meeting by April 23, 2024 as evidence by meeting minutes.** T071 Plan of Correction accepted by Jo A Evans on 3/18/24.	04/23/2024

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T 071	Continued From page 8 residents due to failure to provide accessible information and clear instructions related to tasks staff are required to perform.	T 071		
T 142 SS=F	VIII. 8.1 Laundry Services VIII. Laundry Services 8.1 The residence shall provide laundered bed and bath linens at least once a week. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the home's Admission Agreement fails to identify the Residences requirement to provide laundered bed and bath linens at least weekly for all facility residents. Findings include: Per record review the home's Admission Agreement states, " You are responsible for washing you own laundry; staff can assist you with this if you require help. The use of the laundry facilities is permitted between 8 am and 9 pm out of respect for sleeping residents. You are encouraged to wash linens and clothing at least once a week." however the agreement does not inform residents of the facility's responsibility to provide laundered bath linens at least once a week. This finding was confirmed by the Manager on the afternoon of 2/6/24. In conclusion this deficient practice is a potential risk for more than minimal harm to all facility residents due to the failure to ensure residents are provided a sanitary and homelike sleeping environment..	T 142	T142 As of the audit all residents will be offered bed and bath linens once a week, residents will have the choice to take the offered laundry services and/ or launder their bed and bath linens independently. **Going forward as of March 8, 2024, all residents and staff have been educated on current practices By April 23, 2024 this practice will be reviewed at the house meeting with all residents as evidence by meeting minutes.** See above- **the language in the admission agreement will reflect the above changes as of 3/31/2024.** T142 Plan of Correction accepted by Jo A Evans on 3/18/24.	04/23/2024 03/31/2024

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T 146 SS=F	IX.9.1.a Physical Plant 9.1 Environment 9.1.a The residence must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure care in a safe, functional, and homelike environment. Findings include: The Manager was unable to provide policies and procedures related to maintenance of the home's physical environment during the facility tour during the survey on 2/6/24. Per observation during the facility tour commencing at 9:30 AM the paint in a shared second floor bathroom at the top of the stairs was cracked and peeling around the top of the tub, shower head, and around the doorway trim. The bathroom floor trim was soiled and had areas of chipped paint. Areas of the vinyl flooring in the bathroom were unsealed and curling up at the edges. The rugs in the first and second floor bathrooms were observed to easily slide on the floor. These observations were confirmed by the staff conducting the facility tour, and acknowledged by the Manager following the tour.	T 146	T146 **A binder is being created for policies and procedures that are specific to the facility and will be available by 3/31/24. All agency policies and procedures are available on the NCSS intranet for all staff to access. Binder will be reviewed at the staff meeting by April 23, 2024 as evidence by meeting minutes.** **This is being addressed by our facilities department and work will be completed by 3/31/2024. The walls, ceiling and trim have been scraped, repaired and repainted. The floor was also cleaned and resecured in the corners where it was starting to peel.The House Manager will complete monthly house inspections and report to facilities, as evidence by monthly checklist and agencies work order system.** **New non- slip rugs have been purchased to replace the current rugs. They will be replaced by 3/31/2024.** T146 Plan of Correction accepted by Jo A Evans on 3/18/24.	04/23/2024 3/15/2024 03/31/2024