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

August 3, 2023

Ms. April Stein, Administrator
Path At Stone Summit
Po Box 895
No Bennington, VT 05257-0895

Dear Ms.. Stein:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 19, 2023.** 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

Pamela M. Cota, RN
Licensing Chief

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
	0651	A. BUILDING: _____ B. WING _____	06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATH AT STONE SUMMIT	PO BOX 895 NO BENNINGTON, VT 05257

(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 relicensure survey was conducted by the Division of Licensing and Protection on 6/19/2023. Regulatory deficiencies were identified as a result of the survey. Findings include:	T 001	**Action** A new written policy and procedure was created for the administration/dispensing of PRN psychoactive medications **Measures** All Med Room staff to be trained on new policy and procedure and the policy has been included in PATH's Clinical Policies and Procedures handbook. **Corrective Actions** House RN and Med Room Coordinator to monitor weekly PRN psychoactive medications records to ensure staffing compliance with new policy and procedure **Date Corrected** 07/01/2023 Tag T040 Accepted 7/28/23 - J. Shea RN	
T 040 SS=E	V.5.8.5 Resident Care and Services 5.8 Medication Management 5.8.5 Staff other than a nurse may administer PRN psychoactive medications only when the residence has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the Registered Nurse failed to develop a written plan for the use of PRN (as needed) psychoactive medication for 3 applicable residents (Residents #1 #2 and #3). Findings include: Per record review Resident #1 has an order for Hydroxyzine 50 mg tablet, take 1 tablet by mouth 3 time a day as needed. Resident # 2 has an order for two PRN psychoactive medications, Clozapine (anti-psychotic medication) 25 mg, take 1 tablet by mouth as needed and Lorazepam (anti-anxiety medication) 2 mg tablet, tale 1 tablet by mouth four times a day as needed. Resident	T 040		

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T 040	Continued From page 1 #3 has an order for Hydroxyzine (anti-histamine used to treat anxiety) 50 mg capsule, take 1 capsule by mouth 3 time a day as needed At 9:40 AM on 6/18/23 the Registered Nurse confirmed a written plan had not been developed for the use of the psychoactive medications for Resident #1, #2, and #3 describing the specific behaviors the medications are intended to address; the circumstances that indicate the use of the medications; and educates the staff about the desired effects and undesired side effects of the medications.	T 040		
T 105 SS=F	VI.6.21 Residents' Rights VI. Residents' Rights 6.21 The obligations of the residence to its residents shall be written in clear language, large print, given to residents on admission, and posted in an accessible, prominent and public place on each floor of the residence. Such notice shall also state the residence's grievance procedure and directions for contacting the designated Vermont protection and advocacy organization. This REQUIREMENT is not met as evidenced by: Based on observation and interview the Manager of the home failed to ensure Resident's Rights was posted in an accessible, prominent and public place of the residence. Findings include: Per observation during the facility tour commencing at 10:00 AM the Manager failed to ensure Resident Right's were posted on the first and second floor of the home.	T 105	**Action** Residents are provided a copy of Residents' Rights upon admission which includes the residence's grievance procedure and directions for contacting the designated Vermont protection and advocacy organization. Resident's Rights are now displayed on the 1st and 2nd floor and in prominent areas **Measures** Responsibility assigned to the Program Administrator and added to the Program Manager job description **Corrective Actions** Monthly review by the Program Administrator to ensure required notices remain displayed in public areas of the residence **Date Corrected** 06/20/2023 Tag T105 Accepted 7/28/23 - J. Shea RN	

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T 105	Continued From page 2 Per interview on 6/19/23 at 3:30 PM the Human Resource Manager, confirmed a posting of Resident Right's was not located within in the residence. A phone interview with the Manager on 6/19/2023 at 4:00 PM acknowledged the requirement of Resident Right's posted within the home.	T 105		
T 130 SS=F	VII.7.2.e Nutrition and Food Services 7.2 Food Safety and Sanitation 7.2.e The use of outdated, unlabeled or damaged canned goods is prohibited and such goods shall not be maintained on the premises. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the Kitchen Manager failed to ensure outdated goods were not maintained within the pantry of the kitchen. Findings include: Per the kitchen tour commencing at 9:40 AM, the pantry of kitchen was observed to have expired goods. Items include: (2)jars of Natural Jiff Peanut Butter 2lb, expired on 8/21/22 and 12/20/22, Natural Jiff Peanut Butter 1 lb container, expired on 5/15/23, (2) containers of Marshmallow Fluff, expired on 3/17/23 and 1/16/23 and (2) containers of Teddie All Natural Peanut Butter, expired on 1/13/23 and 2/4/23. Per interview on 6/19/23 at 9:20 AM the Kitchen Manager confirmed the outdated items found.	T 130	**Action** Expired foods discovered during the survey were disposed of on the same day. Immediately after, staff examined complete inventory of all foods to ensure that no additional expired, unlabeled or damaged food remained in the kitchen. **Measures** Examination and culling of refrigerated items - will happen every 2 days. Leftovers are dated and any that are over 5 days old will be disposed of. Open containers in pantries and refrigerators such as, but not limited to, condiments and snacks will be dated upon opening and periodically checked for freshness and disposed of as needed. Older stocks of canned and dry goods will be brought to the front of pantries and newer stock of items will be placed behind the older stock. Inspection of all canned and dry goods will be completed at the first of every month to ensure no expired foods remain in the pantries. **Corrective Actions** Responsibility assigned to the Kitchen Manager and added to the Kitchen Manager job description. A checklist for each month will be created for the inspection of foods found in the pantries that will be overseen by the Kitchen Manager for completion. **Date Corrected** 06/20/2023 Tag T130 Accepted 7/28/23 - J. Shea RN	

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T 184	Continued From page 3	T 184		
T 184 SS=D	IX.9.10 Physical Plant 9.10 Life Safety/Building Construction All residences shall meet all of the applicable fire safety and building requirements of the Department of Public Safety, Division of Fire Safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the TCR failed to ensure fire safety codes were in compliance. Findings include: Per observation at 9:40 AM during the facility tour, Room #5 was observed to have decorative "Christmas" lights hung around the sprinkler system, wrapping the piping of the system. Per NFPA 25 5.2.2.2 Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. Per interview on 6/19/23 at 2:00 PM the Director of Operations confirmed the observation and stated "The decorative Christmas light have been removed."	T 184	**Action** String lights were removed the same day of survey. The resident was notified and advised. Staff and Residents were advised of the fire safety regulations for Residents rooms **Measures** Responsibility assigned to the House/Program Manager and added to the job description. Bi-weekly room inspections have been changed to weekly and all residents have been reminded/ notified of safety requirements **Corrective Actions** Monthly inspections by the Operations Director to ensure compliance **Date Corrected** 07/01/2023 Tag T184 Accepted 7/28/23 - J. Shea RN	
T 187 SS=D	IX.9.11.c Physical Plant 9.11 Disaster and Emergency Preparedness 9.11.c Each residence shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed	T 187		

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T 187	Continued From page 4 periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the Manager failed to ensure fire drills were completed on a quarterly basis with rotating times of day. Findings include: Per review of the facility fire drill records, Fire drills were not conducted during the first and fourth quarter and did not demonstrate drills conducted during morning and night times of day. Per interview on 6/19/23 at :300 PM the Director of Operations, confirmed the fire drills were not completed in the first and fourth quarter and with rotating times of day.	T 187	**Action** The staff member previously assigned to the fire drills is no longer employed at PATH. The responsibility has been assigned to and added to the House/ Program Manager job description. An Emergency Policy and Procedure remains displayed in a prominent area in residence (next to front door) and has been reviewed with staff and residents **Measures** House/Program Manager has received instruction and training on the frequency and timing of the drills by the Operations Director **Corrective Actions** Monthly review by the Operations Director to ensure compliance **Date Corrected** 07/01/2023 Tag T187 Accepted 7/28/23 - J. Shea RN	
T 192 SS=D	X.10.1.a.b.c Pets 10.1 A residence may permit pets to visit the residence providing the following conditions are met: 10.1.a The pet owner must provide evidence of current vaccinations.	T 192		

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T 192	Continued From page 5 10.1.b The pet must be clean, properly groomed and healthy. 10.1.c The pet owner is responsible for the pet ' s behavior and shall maintain control of the pet at all times. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the TCR failed to maintain the health records of animals at the residence. Findings include: Veterinary files were found to be incomplete upon review at the residence. The vaccination records were incomplete for one dog that visits the community. Per interview on 6/19/23 the Program Manager confirmed, the records were for incomplete for required vaccinations.	T 192	**Action** Incomplete vaccination records on dog completed on 07/02/2023 **Measures** At the time of the audit, vaccine and health records for pets were stored in a binder by the Farm and Animal Manager. In addition to the binder, vaccines and health records are now stored on a Google spreadsheet to better track vaccines and health requirements, and to aid in notifying residents and staff when a vaccine or health requirement is about to expire. This will allow sufficient time for resident/staff to meet requirements in a timely manner and to keep vaccines and health requirements current **Corrective Actions** Monthly review by the Farm and Animal Manager, and the Program Administrator to ensure compliance **Date Corrected** 07/02/2023 Tag T192 Accepted 7/28/23 - J. Shea RN	