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

February 6, 2018

Mr. Adam Lawrence, Manager
The Residence At Quarry Hill
465 Quarry Hill Road
South Burlington, VT 05403

Dear Mr. Lawrence:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 3, 2018.** 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

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1012	A. BUILDING: _____ B. WING _____	01/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT QUARRY HILL	465 QUARRY HILL ROAD SOUTH BURLINGTON, VT 05403

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R100	Initial Comments: An unannounced on-site re-licensing survey was completed on 1/3/18 by the Vermont Division of Licensing and Protection to determine compliance with Vermont Assisted Living Residence Licensing Regulations. The following regulatory violations were identified.	R100	**R100 Initial comments:** The submission of this plan does not constitute any admission of any wrong doing. Rather, this plan of correction is submitted in the spirit and in the letter of cooperation to demonstrate The Residence at Quarry Hill's commitment to continued quality.	
R123 SS=C	V. RESIDENT CARE AND HOME SERVICES 5.4 Refunds 5.4. a When a resident is discharged, the resident shall receive a refund, within 15 days of discharge, for any funds paid in advance for each day care was not provided. In the case of a discharge to a hospital or other temporary placement, the effective date for this provision shall be the day the home is notified the resident will not be returning. For the purposes of providing refunds, "day of discharge" shall be considered the day the resident's room is empty of the resident's belongings, if those belongings are too large or difficult for the home to store temporarily. The facility shall temporarily store small items such as clothing and other personal items if necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that resident admission agreement language was in accordance with Vermont State Assisted Living Regulations for 3 of 3 applicable residents sampled. (Residents # 2, 5 and 6). Findings include: Per review of the admission agreement form used by the facility on 1/3/18, the language	R123	**R123 Action to correct Deficiency:** Current residents will be provided with an addendum to their current residency agreement to reflect all refunds to be given within 15 days of discharge. **Steps to prevent recurrence –** The Quarry Hill residency agreement will be reviewed and revised to reflect requirements listed in 5.4.a. Any new residents moving into the community shall receive the revised residency agreement.	3-1-18 by ED

R123 - R253 POCs accepted 2/5/18 KCampos RN/PMC

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R123	Continued From page 1 related to resident refunds was not in agreement with the stated Vermont regulations for time requirements for refunds after discharge. The facility's admission agreement stated that refunds will be made within 30 days of discharge; the required regulatory time period for refunds is within 15 days of discharge. Per review of a sample of 3 signed and dated admission agreements, all of the agreements included the incorrect time period for return of unused funds after discharge from the facility. The error regarding the required time period for refunds after discharge was confirmed during interview with the Executive Director on the afternoon of 1/3/18.	R123		3-1-18 by Executive Director.
R128 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5. c. Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that each resident's medication, treatments and dietary services were consistent with physician orders for 2 of 6 residents in the sample. (Residents #1 and #5). Findings include: 1. Per review of the medical record for Resident #5, there was no provider order, including a dated signature on the initial visit summary to establish care dated 11/8/17, which included a list of the	R128	**R128: Action to correct deficiency:** Signed Physician orders for all medications for residents #1 and 5 will be obtained. **Steps to prevent recurrence:** All nurses will be provided with re-education on policies, procedures and requirements listed in 5.5.c pertaining to obtaining physician orders. The RCD or designated nurse will be responsible for ensuring all physician orders are signed appropriately for new and current residents. The RCD or designated nurse will monitor this with each new resident admission.	3-15-18 by RCD

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R128	Continued From page 2 resident's current medications. (Resident #5 was admitted to the facility on 10/31/17). During interview with the RN on 1/2/17 at 2 PM, the nurse indicated that this visit summary was considered to be the initial order set of the provider after admission to the facility from another state. The RN had not realized that the orders were not properly executed, including the provider signature and date signed. As of the date of survey, (1/2/18), there were signed, dated orders for only 2 of 11 current medications, (telephone orders of 11/20/17 and 11/9/17). 2. Per record review, Resident #1 was admitted in November 2017, and is administered medications by staff, including two types of insulin. There were MD signed orders for the insulin regime as provided by an endocrinologist. The other medications listed by the primary care physician for this resident were not signed as part of the admission orders. The physician signed the first page of the resident's medical information, however the medication list was not signed and dated. The signed page stated to "see attached" under medications section, however there was no indication of which documents were "attached" to the signed orders. There was also no evidence of an electronic signature on the medication list page. Per interview on 1/3/17 at 10:45 AM, the Registered Nurse confirmed that the medication list was not signed as part of the admission orders.	R128		
R134 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.7 Assessment 5.7.a An assessment shall be completed for	R134	**R134: # 1 Action to correct deficiency**: All medication assessments will be brought current.	3-15-18by RCD

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R134	Continued From page 3 each resident within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The resident's abilities regarding medication management shall be assessed within 24 hours and nursing delegation implemented, if necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the Registered Nurse (RN) failed to complete an admission assessment within 14 days of admission to the facility, and/or failed to assess the resident's abilities related to medication management within 24 hours if necessary, for 3 of 6 residents in the total sample. (Residents #2, 4 and 6). Findings include: 1. During interview (1/3/18 at 10:30 AM) regarding the regulatory requirements for assessments upon admission, the RN (registered nurse) RCD (Resident Care Director) confirmed that s/he had not assessed residents currently residing in the facility regarding their medication management abilities (if appropriate) within 24 hours of admission, as required. 2. Per record review, the following resident admission assessments were not completed within 14 days of admission to the facility: a. Resident #6, admitted 10/27/16 and admission assessment completed 12/9/16; b. Resident #2 was admitted on 7/16/16, and the initial admission assessment was dated as completed before the move-in date of admission on 6/28/16. There was no assessment completed after admission within 14 days of the move-in date. C. Division of Licensing and Protection	R134	**Steps to prevent recurrence:** Quarry Hill policy and procedure regarding assessing the resident's ability to self-manage medications will be reviewed and revised to meet requirements listed in 5.7a. All nurses will be re-educated in regards to policy changes and requirements listed in 5.7a Medication assessments will be tracked through the Yardi Dashboard. The dashboard will be monitored daily by the RCD or designated nurse. **R134 # 2 a, b, and c Steps to prevent recurrence:** Quarry Hill policy and procedures regarding new resident admission assessments will be reviewed and revised to reflect requirements listed in 5.7 a to include specific assessment time frame of within 14 days of admission. . All nurses will be re-educated in regards to the policy change and requirements listed in 5.7a by the RCD. Assessments will be tracked through the Yardi dash board.	3-15-18 by RCD 3-15-18 By RCD

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R134	Continued From page 4 d. Resident #4 was admitted on 3/22/17, and the resident's assessment signed as completed before the move-in date on 3/16/17. There was no assessment completed after admission within 14 days of the move-in date. During interview (1/3/18 at 10:30 AM) the RCD also confirmed at this time that the resident assessments were sometimes completed before the actual move in (admit) date and not within 14 days of admission as required.	R134		
R136 SS=E	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 staff interview and record review, the Registered Nurse (RN) failed to complete an annual reassessment within a year of their last assessment, for 2 of.6 residents in the total sample. (Residents #2 and #3).Findings include: 1. Per record review, Resident #2 was admitted 7/16/16. The annual reassessment of this resident was signed as completed and dated 8/23/17. 2. Per record review, Resident #3 was admitted 10/31/16, and the admission assessment	R136	**R136 Action taken to correct the deficiency**: Annual reassessments for residents #2 and # 3 will be updated. **Steps to prevent recurrence**: nurses will be re-educated on requirement listed in 5.7c. to include annual re-assessment and change of condition policies. Assessments are tracked through the Yardi dashboard. The RCD or designated nurse will be responsible for checking this dashboard daily. Additionally the RCD or designated nurse will randomly audit a sample of charts at minimum twice yearly to ensure policies are upheld by staff. The audit will include a review of completed assessments and service plans.	3-15-18 by RCD

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R136	R136 Continued From page 5 completed on 10/31/16. The annual reassessment has not yet been completed for this resident. Per staff interview on 1/3/18 at 10:30 AM, the Resident Care Director confirmed that the above annual reassessments were not completed within the required timeframe, within 365 days of the previous assessment.	R136		
R145	R145 V. RESIDENT CARE AND HOME SERVICES SS=E 55.9(C)2 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; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the Registered Nurse (RN) failed to develop a care plan to address the all of the identified needs for 4 of 6 residents in the total sample. The care plans also failed to include measurable goals and specific interventions to achieve those goals. (Residents #1, 2, 5 and 6). Findings include: 1.) The care plan for Resident #5, who was admitted to the facility approximately 2 months ago, failed to address the following resident needs: a. Failed to accurately reflect the resident's		**R145 Action taken to correct deficiency:** Service Plans for residents #1,2,5, and 6 will be brought up to date to reflect the residents current needs and to meet requirements listed in 5.9c (2). **R145 # 1 A B, C, and D** – A reassessment will be completed for resident # 5 and the service plan will be updated to reflect current level of care needed to include specific interventions for bowel and bladder incontinence, nutritional needs ,and non-pharmacological approaches for depression. Language that incorrectly states the resident receives anti-anxiety medication will be removed.	3/15/18 By RCD

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R145	Continued From page 6 needs related to the level of staff participation/assistance required for completion of AOL (activities of daily living). During interview on 1/2/18, the RN staff nurse confirmed that this resident did not require extensive physical assist for dressing and bathing, as stated in the care plan. b. Failed to state the resident's potential for weight loss and/or actual weight loss, based on a review of recorded weights since admission. The first recorded weight in the record was on 11/8/17 during a visit to the provider, and was 130 pounds. The next weight was dated 11/15/17 and recorded as 112.2 pounds; a December, 2017 weight was 115.2 pounds. There was no evidence of an immediate re-weigh after the weight of 112.2 pounds. Per interview on 1/2/18 at 2 PM, the RN staff nurse acknowledged the weight discrepancy should have been verified by a re-weigh and potential weight loss was a concern for this resident due to isolating behaviors. The care plan also failed to include the intervention (per MAR) that the resident was offered a nutritional supplement, Resource, 2 x daily. c. Failed to address bowel and bladder occasional incontinence; there were no specific interventions to help maintain continence; d. Failed to provide any non-medication related interventions to address the resident's symptoms regarding depression; the care plan also stated that the resident was receiving an anti-anxiety medication and there was no medication ordered to treat anxiety per review of the eMAR summary provided by the RCD. 2.) The care plan for Resident #6 failed to address the resident's current needs regarding a history of falls with recent injury/fracture, ongoing pain assessment and management after injury,current mobility/transfer needs post rehab	R145	**R145 #1b** – A re-weight of resident #5 has been obtained, the resident has since gained weight and the physician is aware. Nurses will received re-education on the requirements listed in 5.7 9 (c). The community weight sheets will be updated with instructions to re-weight any resident with a weight lost 3 lbs. or greater within 24 hours. The RCD or designated nurse will be responsible for monitoring the weight sheets monthly, communicating with the resident's, Family or legal representative, physician and dietician. The RCD or designated nurse will also be responsible for ensuring dietary recommendations are followed through per physicians order. **R145 #1 D**- Nursing and Care staff will be provided with re-education of non-pharmacological interventions for depression and anxiety through the community Brass Ring Wellness in – service. Brass Ring Wellness training is a nationally certified training through the National Institute of Dementia Education	3-27-18 By RCD 3-15-18 By RCD

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R145	Continued From page 7 services, and resident use of over the counter medication without RN/staff knowledge (per incident report of 12/22/17). During interview on 1/2/18, the RN confirmed that the resident's spouse had given the resident a bottle of medication and it was not reported to facility staff nor approved by the provider, posing a safety risk to the resident and any other residents on the dementia unit who might gain access to the unsecured medication. Refer also to R 150. 3.) The care plan for Resident #1 failed to address all aspects of care for Diabetes such as the Insulin regime which includes a sliding scale administration and blood glucose checks. The care plan also did not contain interventions regarding the response to abnormal glucose readings, including a prescribed glucose tablet for hypoglycemic episodes. Per interview on 1/3/18 at 10:00 AM, the Resident Care Director confirmed that there was nothing in the plan of care to address these concerns. 4.) The care plan for Resident #2 failed to address the behavior concerns of the resident. The resident was documented as having very combative behaviors with staff during the provision of care. Per interview with two of the Resident Care Aides familiar with the resident, they stated that they always use two people to provide care as the resident was sometimes physically combative with them, and somewhat unpredictable. The resident was also prescribed antipsychotic medication, including a PRN dosage which were also not addressed in the plan of care. Per review of the resident's plan of care, there was nothing to address the behavior or any interventions to assist in caring for the resident. Per interview on 1/3/18 at 10:05 AM, the	R145	**R 145 # 2 – Action taken to prevent deficiency**: A reassessment for Resident # 6 will be completed to include a fall risk assessment. A change of condition assessment and service plan will be completed reflect the resident's current needs and will include specific interventions for fall reduction and pain management. Refer to tag 150 for unauthorized medication found. **R 145 # 3 – Action taken to correct Deficiency:** The service plan for resident # 1 will be updated to reflect the items listed in R145 # 3. A hypoglycemia protocol will be obtained from the physician and will be noted on the medication administration record. **Steps to prevent recurrence**: The community insulin policy will be reviewed and revised to reflect requirements listed in R145 # 3 and all nurses and med techs will be provided re-education in regards to new or revised policies. The RCD or designated nurse will be responsible for monitoring through random audit to ensure staff are Quarry Hill policies and procedures. **R145 # 4 Action taken to correct deficiency** : Resident # 2 will be reassessed and the service plan will be updated to reflect the residents current needs to include specific behavioral interventions and PRN medication usage.	3-15-18 By RCD 3-15-18 By RCD 3-15-18 By RCD

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R145	Continued From page 8 Resident Care Director confirmed that there was nothing in the plan of care to address these concerns.	R145	**Steps to prevent recurrence:** Nursing and care staff will be re-educated on the Quarry Hill PRN psychoactive medication policy and the requirements listed in 5.9c (2). And receive in – servicing on non-pharmacological behavior interventions through Quarry Hill Brass Ring Wellness training and behavior intervention map .A behavior log for all residents with PRN psychoactive medication orders will be implemented to include behavior tracking and specific non pharmacological interventions tried prior to PRN medication administration. The RCD or RD will be responsible for monitoring behavior tracking and interventions through random chart audits which will include review of behavior logs and PRN medication usage. **R150 Action taken to correct deficiency:** The bottle of medication has been removed and the RD and RCD have reviewed policies and requirements listed in 5.9 c (7) with the family that provided the unauthorized medication. **Steps to prevent recurrence** : Nursing and care staff will be re-educated in regards to requirements listed in 5.9.c (7) as well as in serviced on Quarry Hill policies and procedures to include incident reporting, physician and family notification, and safety programs. Quarry Hill has a detailed Safe Haven program that ensures for the safety of all residents residing on the Reflection memory care neighborhood. The safe Haven program included procedures for locking personal items, and completing environmental safety rounds. The RD	3-15-18 By RCD 3-15-18 By RCD
R150 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9. c (7) Assure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RN failed to assure that symptoms or signs of illness or accident were recorded in the record, along with actions taken at the time of occurrence for 1 of 6 residents in the sample. (Resident #6) Findings include: Per review of an incident report regarding an unsafe resident situation that occurred during December, 2017, staff failed to notify the Resident #6's physician when a bottle of medication was found in the resident's belongings and the resident stated that they had just taken 2 pills. The residen.t resided on the Reflections Memory Care unit and was not deemed safe to self-administer their own medications. Staff were unaware that the resident had obtained this medication from some outside source. Although staff notified the family of the concern, they failed to notify the physician. The lack of physician notification was confirmed during interview with the RN Resident Care Director on 1/3/18 at 5:10 PM. Refer also to R 145.	R150		

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R151 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9. c (8) Ensure that the resident's record documents any changes in a resident's condition; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RN failed to assure that staff documented all changes in condition in the medical record for 1 of 6 residents in the total sample. (Resident # 5) Findings Include: 1. Per record review, during an office visit summary of 11/8/17, the provider wrote orders that stated; "Do vital signs 3 x weekly at different times, notify provider if blood pressure < 90/60." Per review of the documented vital signs in the resident's record, on 12/17/17, the blood pressure was documented as 80/54 and there was no written evidence in the medical record (MR) that the provider was notified. Per interview with the RN on 1/2/17 at 2 PM, s/he confirmed that there was no progress note or assessment in the record related to the low blood pressure reading and that the provider had not been notified, per order instructions.	R151	will be responsible for retraining all staff on these procedures and ensuring follow through. Environmental rounds tracking sheets will be utilized and audited by the RD. The RCD or designated nurse will be responsible for insuring incident reports are completed appropriately. These will be monitored through the Yardi dashboard daily by the RCD or designated nurse. **R 151 Action to correct deficiency:** Physician orders for resident #5 will be reviewed with all med techs to include special instructions, parameters, and nurse reporting. **Steps to prevent recurrence:** The RCD or designated nurse will be responsible for reviewing all physician orders with special instructions and parameters with med techs.	3-15-18 By RCD
R153 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9. c (10) Monitor stability of each resident's weight;	R153	**R153: Action to correct deficiency:** The scale used for monthly weights will be calibrated. The current weight sheets	3-15-18 By RCD

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R153	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RN failed to assure ongoing monitoring of the stability of each resident's weight for 1 applicable resident in the targeted sample. (Resident #5) Findings include: Per record review of recorded weights since admission on 10/31/17, Resident #5's weights showed evidence of potential or actual weight loss and the nurse failed to document action taken to indicate on-going monitoring of the stability of the resident's weight The resident's first recorded weight in the record was on 11/8/17 during a visit to the provider, and was 130 pounds. The next weight was dated 11/15/17 and recorded as 112.2 pounds; a December, 2017, weight was 115.2 pounds. There was no evidence of an immediate re-weigh after the weight of 112.2 pounds. Per interview on 1/2/18 at 2 PM, the RN staff nurse acknowledged the weight discrepancy should have been verified by a re-weigh and that potential weight loss was a concern for this resident due to isolating behaviors. The RN also stated that they have had problems with obtaining accurate weights with the scale available for resident use. The nurse stated that the chair-type scale was very sensitive and would change with any slight movements by the resident being weighed. The nurse did not identify any plans to attempt to assure that resident weights were accurate.	R153	**Steps to prevent recurrence:** Nursing and care staff will be re-educated in the requirements listed in 5.9c (10). The community weight sheets will be updated with instructions to re-weigh any resident with a weight lost 3 lbs. or greater within 24 hours. The RCD or designated nurse will be responsible for monitoring the weight sheets monthly, communicating with the resident's physician and dietician. The RCD or designated nurse will also be responsible for ensuring dietary recommendations are followed through per physicians order.	3-15-18 By RCD
R1601 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management	R160	**R160 Action to correct deficiency:** A procedure will be put into place and completed to monitor residents #5 and #6 for potential side effects of psychoactive medication	3-15-18 By RCD

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	1012	A. BUILDING _____ B. WING _____	01/03/2018

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THE RESIDENCE AT QUARRY HILL	465 QUARRY HILL ROAD SOUTH BURLINGTON, VT 05403

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R160	Continued From page 11 5.10.a Each residential care home must have written policies and procedures describing the home's medication management practices. The policies must cover at least the following: (1) Level III homes must provide medication management under the supervision of a licensed nurse. Level IV homes must determine whether the home is capable of and willing to provide assistance with medications and/or administration of medications as provided under these regulations. Residents must be fully informed of the home's policy prior to admission. (2) Who provides the professional nursing delegation if the home administers medications to residents unable to self-administer and how the process of delegation is to be carried out in the home. (3) Qualifications of the staff who will be managing medications or administering medications and the home's process for nursing supervision of the staff. (4) How medications shall be obtained for residents including choices of pharmacies. (5) Procedures for documentation of medication ad-ministration. (6) Procedures for disposing of outdated or unused medication, including designation of a person or persons with responsibility for disposal. (7) Procedures for monitoring side effects of psychoactive medications. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to develop a policy/procedure for monitoring side effects of psychoactive medications. This practice had the potential to affect all residents of the facility receiving psychoactive medications; 2 of 6 residents in the	R160	**Steps to prevent recurrence:** The current psychoactive medication policy will be reviewed and revised to include all requirements listed in 5.10 a 1-7. Revised policy and procedure will be reviewed with nursing staff. The RCD or designated nurse will be responsible for monitoring and ensuring staff follow through. AIMS assessments for residents receiving antipsychotic medications will be monitored and tracked through the Yardi dash board daily. Documentation of assessment of potential side effects of other psychoactive medications will be documented in a monthly resident progress note.	3-15-18 By RCD

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R160	Continued From page 12 total sample were receiving psychoactive medications. (Residents # 5 and #6). Findings include: Per interview with the RCD on the afternoon of 1/3/18, regarding policies/procedures for monitoring side effects of psychoactive medications for residents receiving this classification of medication, the RCD confirmed that he was not aware of any policy/procedure for this type of monitoring for evidence of side effects. They do AIMS testing for residents receiving an antipsychotic classification of medication. However, Resident's #5 and # 6 were receiving antidepressant medications, which are psychoactive medications; the RCD stated that they had no policy/process for ongoing monitoring for side effects for these residents.	R160	**R165 # 1 – Action to correct deficiency :** All staff that administers medication to resident # 1 will be re-educated on the residents service plan , physician orders to include special instructions and parameters and needs related to the diabetes diagnosis.	3-15-18 By RCD
R165 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for: i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects; ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications,	R165	**Steps to prevent recurrence** : All Med techs and nursing staff will be provided with re-education on medication documentation, including what is documented in the communication log versus progress notes , eMAR documentation, and nurse notification, translating physician orders, and execution of parameters and what and when to notify the nurse. The Med tech training will be reviewed and revised to include insulin training, psychoactive medication policy and nurse delegation. All nurse will be in-service on Regulatory requirement for nurse delegation. The RCD, designated nurse, or pharmacy consultant will complete random chart audits for reviewing medication management practices at minimum twice yearly.	

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R165	Continued From page 13 as well as changes in medications; iii. Assessing the resident's condition and the need for any changes in medications; and Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the Registered Nurse failed to monitor the designated unlicensed staff performance regarding medication administration for 1 of 6 residents reviewed (Resident # 1). Findings include: 1. Per record review, Resident #1 has diagnoses that include insulin-dependent Diabetes. The physician orders include a daily scheduled long acting Insulin dose, as well as a sliding scale Novolog Insulin regime that is adjusted based on blood glucose readings by fingerstick, and given at mealtimes. The resident also has blood glucose fingersticks ordered to be done five times daily at 6:30 AM, mealtimes, and at bedtime. Per review of the Medication Administration Record (MAR) for the month of December 2017, there were multiple missing staff initials to indicate the Novolog Insulin had been administered as ordered. On December 10th there were blank spaces with no initials for the signing of administration of the breakfast and lunch dosages of the Novolog. On 12/15/17, the breakfast dose was not signed *off*.On 12/25/17, all three mealtime dosages were not signed as given. Besides these dates listed, there were multiple blank spaces on the MAR for the dinnertime administration of the Novolog. There was no staff initials on the MAR for Dec. 7 -15, 17, 18, 21, 22, 25, and 27th for the dinnertime dose of Novolog. Also a concern in this resident	R165	All nurse will be in-service on Regulatory requirement for nurse delegation. The RCD, designated nurse, or pharmacy consultant will complete random chart audits for reviewing medication management practices at minimum twice yearly.	3-15-18 By RCD

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R165	Continued From page 14 record was the missing signage in the MAR of the 6:30 AM fingerstick readings. Per interview on 1/3/18 at 2:45 PM, the Registered Nurse confirmed that there were missing staff initials in the December MAR for the administration of the Novolog and that the nurse was not aware of the missing documentation. The nurse also confirmed that the night staff responsible for taking the 6:30 AM glucose reading had been documenting the readings in a notebook that contains staff notes regarding residents, and not on the MAR as was the expectation and the way all other staff were documenting this. The Resident Care Director confirmed that they were not aware that the staff had not been properly signing off the administration in the MAR, and that they had not audited staff performance documenting administration of Insulin for this resident. During the review of the notebook readings recorded, the nurse confirmed a log entry that morning on 1/3/18 that the resident had a fingerstick reading of 60. Per review of the physician's orders, the resident was to receive a glucose tablet if the blood glucose reading was under 80. The administration of the glucose tablet was not documented in either the notebook or the MAR, and the RN confirmed that there was no way to know whether the staff person had recognized the need to give the glucose tablet, and did not document administration. They also did not alert the nurse regarding the low reading. The Resident Care Director (RCD) confirmed that they were not aware that the staff had not been properly signing off the administration in the MAR, that they had not alerted nursing to the low reading, and did not document carrying out the	R165		

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	R165 Continued From page 15 physician order for the glucose tablet. The RCD also confirmed that as the nurse responsible for delegating medication administration to unlicensed staff, they had not audited staff performance documenting administration of Insulin and related diabetes management closely enough to detect these discrepancies and missing documentation.	R165		
R167 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d if a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (5) Staff other than a nurse may administer. PRN psychoactive medications only when the home 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 staff interview and record review, the Registered Nurse failed to ensure that residents receiving 'as needed' (PRN) psychoactive medications had a written plan for delegated unlicensed staff to appropriately administer them for 1 of 6 residents reviewed (Resident #2).	R167	**R167 Action to correct deficiency:** Updated Physician orders for resident #2 will be obtained to include specific behavioral indications and time parameters for PRN Risperidone. A behavior log will also be put in place for this resident. Revised orders will be reviewed with all nurses and med tech, and education on potential side effects will be given. The resident's service plan will be updated if needed to include non-pharmacological approaches for behavior. An AIMS assessment will be completed for this resident. **Steps to prevent recurrence:** Quarry Hill Psychoactive medication policy will be reviewed and revised if needed to include all requirements listed in 5.10.d (5). The Quarry Hill Psychoactive medication policy will be reviewed with Nurses and Med Techs by the RCD or RD. The RCD or RD will be responsible for monitoring to ensure staff is upholding policies through the Yardi PRN medication report weekly.	3-15-18 By RCD 3-15-18 By RCD

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R167	Continued From page 16 Findings include: Per record review, Resident #2 has diagnoses that include dementia and sometimes exhibits aggressive behavior toward staff. Medication regime includes Risperidone, both a scheduled dosage twice daily, and a PRN dose which reads "Risperidone 0.25 mg., take one tab by mouth twice daily as needed." Per interview on 1/3/18 at 11:30 AM, the Registered Nurse confirmed that there is no written plan in place for staff that includes the specific targeted behaviors, circumstances that indicate the use of the medication, educates staff about the desired effects and undesired side effects that staff must monitor for, and documents the tine of, reason for and specific results of the medication use. There were also no time parameters set for staff to know how close together the scheduled and PRN doses can be administered. The nurse also confirmed at this time that there is no written behavior plan for any other residents receiving psychoactive PRN medications in the facility that meets the regulatory requirement.	R167		
R168 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (6) Insulin. Staff other than a nurse may administer insulin injections only when: i. The diabetic resident's condition and medication regimen is considered stable by the	R168	**R168 Action to correct deficiency:** All Med tech insulin training will be brought up to date and documented to include using a pen, accuracy of determining sliding scale, and return demonstration. **Steps to prevent recurrence**: The Quarry Hill insulin policy will be reviewed and revised to reflect requirements listed in 5.10.d. The policy revision will be reviewed with nurse and med tech staff by the RCD. The Quarry Hill Med Tech training is being revised to include insulin	3-15-18 By RCD

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R168	Continued From page 17 registered nurse who is responsible for delegating the administration; and ii. The designated staff to administer insulin to the resident have received additional training in the administration of insulin, including return demonstration, and the registered nurse has deemed them competent and documented that assessment; and iii. The registered nurse monitors the resident's condition regularly and is available when changes in condition or medication might occur. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the Registered Nurse failed to document that delegated unlicensed staff received additional training regarding insulin administration for 1 applicable resident. (Resident #1). Findings include: Per review of staff training for the delegation of administration of medications by unlicensed staff, 1 there was no evidence that the delegating RN documented all aspects of training regarding the administration of insulin for Resident #1. The training documentation did not show training for use of the Insulin pens, accuracy of determining a demonstration of insulin administration. Per I sliding scale dosage, or evidence of return interview on 1/3/18 at 4:55 -PM, the Resident Care: Director, who is the delegating RN, confirmed that not all of the training completed with the staff regarding the administration of insulin to Resident #1 had been documented as part of the delegation process.	R168		

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R171	Continued From page 18 R171: V. RESIDENT CARE AND HOME SERVICES SS=D 5.10 Medication Management 5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, 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 home; (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; and (5) For residents receiving psychoactive medications, a record of monitoring for side effects. (6) All incidents of medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the Registered Nurse failed to ensure that documentation was completed to indicate that ordered medications were administered appropriately for 1 of 6 residents reviewed (Resident #1). Findings include: 1. Per record review, Resident #1 has diagnoses that include insulin-dependent Diabetes. The	R171	**R171 Action to correct deficiency:** The insulin, blood glucose monitoring, parameters and nurse reporting will be reviewed with the med techs for resident # 1. **Steps to prevent recurrence**: Quarry Hill insulin policy, nurse delegation policy, and med tech training will be reviewed, revised, and enhanced to reflect best practices, documentation, and execution of physician orders, as well as the requirements listed in 5.10.g. Nurses and Med Techs will be re-educated on all policy and training revisions. All physician orders are now in the electronic medical record. The RCD or designated nurse will be responsible to check the eMar at the end of the shift to ensure orders were not missed.	3-15-18 By RCD

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R171	Continued From page 19 physician orders include a daily scheduled long acting Insulin dose, as well as a sliding scale Novolog Insulin regime that is adjusted based on blood glucose readings by fingerstick, and given at mealtimes. The resident also has blood glucose fingersticks ordered to be done five _times daily at 6:30 AM, mealtimes, and at bedtime. Per review of the Medication Administration Record (MAR) for the month of December 2017, there were multiple missing staff initials to indicate the Novolog Insulin had been administered as ordered. On December 10th there were blank spaces with no initials for the signing of administration of the breakfast and lunch dosages of the Novolog. On 12/15/17, the breakfast dose was not signed off. On 12/25/17, all three mealtime dosages were not signed as given. Besides these dates listed, there were multiple blank spaces on the MAR for the dinnertime administration of the Novolog. There was no staff initials on the MAR for Dec. 7 -15, 17, 18, 21, 22, 25, and 27th for the dinnertime dose of Novolog. Also a concern in this resident record was the missing signage in the MAR of the 6:30 AM fingerstick readings. Per interview on 1/3/18 at 2:45 PM, the Registered Nurse confirmed that there were missing staff initials in the December MAR for the administration of the Novolog and that the nurse was not aware of the missing documentation. The nurse also confirmed that the night staff responsible for taking the 6:30 AM glucose reading had been documenting the readings in a notebook that contains staff notes regarding residents, and not on the MAR as was the expectation and the way all other staff were documenting this. The Resident Care Director confirmed that they were not aware that the staff had not been properly signing off the administration in the MAR, and that they had not audited staff performance	R171		

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R171	Continued From page 20 documenting administration of Insulin for this resident. During the review of the notebook readings recorded, the nurse confirmed a log entry that morning on 1/3/18 that the resident had a fingerstick reading of 60. Per review of the physician's orders, the resident was to receive a glucose tablet if the blood glucose reading was under 80. The administration of the glucose tablet was not documented in either the notebook or the MAR, and the RN confirmed that there was no way to know whether the staff person had recognized the need to give the glucose tablet, and did not document administration. They also did not alert the nurse regarding the low reading. The Resident Care Director (RCD) confirmed that they were not aware that the staff had not been properly signing off the administration in the MAR, that they had not alerted nursing to the low reading, and did not document carrying out the physician order for the glucose tablet. The RCD also confirmed that as the nurse responsible for delegating medication administration to unlicensed staff, they had not audited staff performance documenting administration of Insulin and related diabetes management closely enough to detect these discrepancies and missing documentation.	R171		
R175 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (3) Residents who are capable of self-administration may choose to store their own medications provided that the home is able to provide the resident with a secure storage space to prevent	R175	**R175 Action to correct deficiency:** All residents that currently self-administer medications will be provided with a locked space for medications. The policy for locking medication in the apartment will be reviewed with the residents.	3-15-18 By RCD

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R175	Continued From page 21 unauthorized access to the resident's medications. Whether or not the home 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 staff interview and record review, the facility failed to establish a process/system to assure that residents who are capable of self-administration and wish to store their own medication are provided with a secure storage space to prevent unauthorized access to the resident's medications. Findings include: During interview with the RCD on 1/3/18 at 10:45 AM, regarding how the facility assures that residents who have been assessed as safe and capable of self-administering their own medications and wish to store them in their rooms are provided a secure space to store the medications. The residents must be willing to assure that all medications are kept secure in their room, and that the entrance door is locked when the resident is not their room to assure that unauthorized access does not occur. The RCD confirmed (1/3/18) that the facility had not developed any process nor policy to assure medications stored in resident rooms were locked and secured to ensure a safe environment in all areas of the home.	R175	**Steps to prevent recurrence:** The Quarry Hill medication storage policy for residents that self-medicate will be reviewed and revised to reflect requirements listed in 5.10.h (3) and all residents will be provided with a secure space for medications within their apartment. The RCD will be responsible for reviewing the updated policy with nurses, med techs, and residents that self-medicate.	3-15-18 By RCD
R189 SS=C	V. RESIDENT CARE AND HOME SERVICES 5.12.b. (3) For residents requiring nursing care, including nursing overview or medication management. the	R189		

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R189	Continued From page 22 Record shall also contain: initial assessment; annual reassessment; significant change assessment; physician's admission statement and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of physician visits, signed telephone orders and treatment documentation; and resident plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that required documentation for residents requiring nursing care, was documented in the medical record for 4 of 6 residents in the sample. (Residents # 2, 3, 5 and 6). Findings include: 1. Per record review, Resident #5 was admitted to the facility on 10/31/17 and from admission to the day of survey, 1/2/18, there was only 1 progress note dated 11/20/17. The progress note stated that ..." UA (urinalysis) ordered due to mental status changes..." There was no documentation in the record regarding the 'mental status changes' referred to in the note of 11/20/17. The note also stated that 'atenolol dose changed from PCP' (primary care provider). There were no follow up progress notes to document the resident's medical response to the dose change after the change was made. The lack of progress notes in the record regarding the resident's stability of condition and response to medication changes was confirmed with the RN and RCD during the 2 days of survey. 2. Per staff interview, Resident #6 had a fall on November 8, 2017, and admitted to the hospital 11/9/17 after diagnosis with pain from fractured thoracic vertebra. The resident was admitted to a	R189	**R189 # 1-4 Action to correct deficiency** : A progress note will be entered into the records of resident # 2,3,5, and 6 to reflect recent changes, current health status, and current level of care. **Steps to prevent recurrence**: Nursing staff will be provided in-servicing on the requirements listed in 5.12.b. A progress note will be entered at minimum 1 time monthly for all residents. Progress notes are entered into the Yardi computer system. The RCD or designated nurse will be responsible for monitoring this monthly through the Yardi progress notes reporting system. The change of condition assessment and documentation policy will be reviewed with all nurses.	3-15-18 By RCD

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	1012	A. BUILDING: ——— B. WING ———	01/03/2018

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R189	Continued From page 23	R189		

SNF (skilled nursing facility) for rehabilitation services on 11/13/17. The resident was discharged from the SNF and returned to the facility during December, 2017. There were no progress notes in the record regarding the date the resident returned to the facility post rehabilitation. During interview on 1/2/18 at 4:40 PM, the RN confirmed that the resident had returned to the facility from the SNF stay on 12/13/17. There was no progress note that day to record the return to the facility, confirmation of orders with the provider upon return and no assessment of the resident's condition at the time of the return. The first note after the re-admission to the facility was dated 12/31/17, 18 days after returning to the facility.
The failure to document the resident's condition, changes and follow up information in the progress notes was confirmed with the RN and the RCD during the afternoon of 1/3/18.

3. Resident # 2 was admitted in July of 201°6 with diagnoses that include dementia and behavioral disturbances. The resident has declined enough that they qualify to be on Hospice and was admitted to those services on 12/11/17. There are no nurse progress notes for this resident written since 6/26/17 to document the status of the resident. The RN and RCD confirmed that there were no more recent progress notes in the record for this resident.

4. Per record review, Resident #3 had multiple falls at the home. On 11/15/17, Resident #3 had a fall in the dining room that was documented in an incident report. There were no follow up nurse progress notes regarding the fall and monitoring afterwards for potential injury or assessment of the circumstances at the time of the fall. The incident report log also showed that Resident #3

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R189	Continued From page 24 had a fall in the hallway, again without apparent injury. There were no nurse progress notes to document any follow up or even to indicate that the resident had fallen.There were no nurse progress notes in the medical record since 9/15/17.The RN and RDC confirmed that there were no more recent progress notes for this resident despite the two falls in November and December.	R189		
R232 SS=C	VII. NUTRITION AND FOOD SERVICES 7.1. a. (1) Menus for regular and therapeutic diets shall be planned and written at least one (1) week in advance. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to assure that menus for regular and therapeutic diets for the Reflections Memory Care Unit were planned and written at least 1 week in advance. This practice had the potential to impact residents of the memory care unit who may be unable to state or indicate their preference/choice of meal choice on any given day. Findings include: Per interview with the chef on duty on 1/2/18, the residents of the facility may pick their meals (breakfast, lunch and dinner) from a menu of several different items offered on a daily basis. The chef stated that the rotation of the menu items offered is about every 6 months. During interview with the Reflections Unit Director on 1/2/18 regarding how they assure meals for residents who may not be cognitively able to	R232	**R232 Steps to prevent recurrence:** Dining and care staff will be in-serviced on the requirements listed in 7.1.a. as well as Quarry Hill policies and procedures. All menus are planned and written at minimum 1 week in advance. The Reflections neighborhood utilizes a 2 plate method for serving. Residents that are cognitively impaired are visually presented with two plated meals to choose from. A full menu of alternate options is available above and beyond the 2 meal choices. If a resident is unable to choose due to cognitive impairment menus will be available in advance to the resident and responsible party to assist in preplanning meals. The dining services director will be responsible for above responsibilities and ensuring follow through of staff to uphold policies.	3-15-18 By Dining Services Director

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R232	Continued From page 25 indicate or voice their choice of meal, the Director stated that 'we make the choice for them if they are not able, since we know them. Resident meals must be planned in advance for residents not able to utilize the system of selecting from the menu a choice for themselves for each meal. (This does not affect the right of every resident to have alternate choices that are nutritionally equivalent if they do not like the meal offered on the written menu.)	R232		
R247 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2. b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to assure that all perishable foods were labeled and dated and disposed of timely per facility policy regarding safe food handling practices. This practice had the potential to affect all residents who dine at the home. Findings include: Per observation of the kitchen during the initial tour of the dietary areas on 1/2/18, the following observations were made regarding storage of perishable foods: a. The walk-in refrigerator had multiple foods that were not labeled and/or dated in accordance with the facility's policy/procedures regarding safe	R247	**R247 Action to correct deficiency:** The Dining Services Director will complete an audit of current food storage and ensure all is dated and labeled appropriately. **Steps to prevent recurrence:** The Dining services Director will be responsible for in-servicing dining staff on Quarry Hill policies regarding food storage. The Dining Services Director will be responsible for ensuring follow through, with random inspections of food storage performed at minimum twice monthly.	3-15-18 By Dining Services Director

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R247	Continued From page 26 food handling practices: foods that were dated 12/29/17 on 1/2/18, included mashed squash and cooked spaghetti. When the chef was asked what the facility's policy was for keeping prepared fresh foods before disposing of them, they stated 4 or 5 days, but they were not certain. The reach in cooler on the cook's line had a food container that was dated 12/25/17, not labeled, and was identified by the chef as caramelized pears) and a container that had a brown sauce/gravy with that had no label and no date. Per review of the written policy regarding food dating and labeling with the ED (executive director) on 1/3/18, the policy stated to dispose of the dated food by the end of the third day.	R247		
R253 SS=F	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3. c All food service equipment shall be kept clean and maintained according to manufacturer's guidelines This REQUIREMENT i s not met as evidenced by: Based on observations and staff interview, the facility failed to assure that all kitchen areas and food service equipment was kept clean. This practice had the potential to affect residents who dine at the facility. Findings include: Per observation during tours of the kitchen on 1/2/18 at 9:45 AM and 1/3/18 at 1:15 PM, the following areas were not kept clean and had visible soiling: the magnetic wall knife storage area (for storage of clean knives) had a buildup of visible dust on the individual slats; the 2	R253	**R253 Action to correct deficiency:** The kitchen will be thoroughly cleaned to include dry spice storage, lower shelf of the prep table, back panel of stove, and all appliances. **Steps to prevent recurrence:** All above areas will be added to the posted cleaning list. The dining services director will be responsible to in service staff on Quarry Hill policies and procedures, and the revised cleaning schedule, and to monitor and ensure staff is adhering to the cleaning schedule. The Dining service director or designated staff will be responsible for doing weekly inspections of the kitchen and cleaning schedule.	3-15-18 By Dining Services Director

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R253	Continued From page 27 shelves in the same area where dry spice containers were stored had a layer of dust and crumbs; the lower shelf of a prep table on the cook's line was heavily soiled with a buildup of grease, soiled greasy paper, and food crumbs. Additionally, the back panel of the stove back, the grill, the fryolator and the toaster all had a build-up of grease on various areas of the equipment; per review, these areas were not included on the posted cleaning schedule. The tours on 1/2/18 and 1/3/18 were conducted with the 2 chefs working on those days.	R253		