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

October 23, 2023

Mr. Sam Jackson, Manager
The Residence At Quarry Hill
465 Quarry Hill Road
South Burlington, VT 05403

Dear Mr. Jackson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 29, 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,

Carolyn Scott, LMHC, M.S.
State long Term Care Manager

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
	1012	A. BUILDING: _____ B. WING _____	C 08/29/2023

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

(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
R100	Initial Comments: On 8/29/23 the Division of Licensing and Protection conducted an unannounced on-site investigation of two facility reported incidents and one complaint investigation. The following regulatory deficiencies were identified during the investigation:	R100		
R123 SS=A	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 there was a failure to provide a refund within 15 days following discharge from the home. Findings include: Per record review Resident #4 passed away 9/23/22. Per Resident #4's admission agreement his/her financial obligation to the facility ended 30 days after his/her death on	R123	Executive Director will review the LCB Residency Agreement for Quarry Hill – specifically pages 24-25 as an in-service training with the Business Office Director and each sub section • Specifically Section F: Termination of Residency Agreement/Discharge or Transfer of Resident o Item Number 10 (a) – Vacating Apartment o Item Number: 10 (b) – Amount of Refund o Item Number 10 (c) – Refund for Involuntary Discharge • Each item was reviewed, and Business Office Director signed-off on each subsection to verify the refund policy and process is understood and followed in accordance to the Residency Agreement and the timebound requirements • Residency Agreement Pages 24-25 and the In-Service sign off attached for the POC R 123 Plan of Correction Accepted by Jo A Evans 10/21/23	Completed on 09/22/23 Completed on 09/22/23

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R123	Continued From page 1 10/22/23. A refund check was dispersed to Resident #4's family on 2/15/23. On the afternoon of 8/29/23 the Business Officer and Executive Director confirmed a refund was not provided within 15 days following Resident #3's discharge.	R123		
R177 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (5) Narcotics and other controlled drugs must be kept in a locked cabinet. Narcotics must be accounted for on a daily basis. Other controlled drugs shall be accounted for on at least a weekly basis. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to enter 2 controlled substances belonging to 2 residents (Residents #1 and #2) into the controlled substance record, and to account for these medications. Findings include: 1. Per record review Resident #1 was prescribed Alprazolam 0.25 mg as needed for agitation. Per review of a facility Corrective Action Plan a delivery of this medication was received by facility staff on 1/9/23. The Alprozolam was placed in the non-controlled medications section of the medication cart rather than the double locked controlled substance section of the cart; and the medication was not entered into the facility's controlled substance inventory book. There was no accounting for Resident #1's Alprazolam until	R177	Medication Management Violation: On 3/13/23: In-serviced associate in question and others on policies regarding controlled medication storage and delivery into facility. On 6/9/23- Enacted and in-serviced community best practice of having 2 medication technicians present at time of pharmacy delivery. They will bring all appropriate narcotic books to the reception desk for prompt entering of deliveries into index.	Completed on 03/13/23 Completed on 06/09/23

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R177	Continued From page 2 the medication was discovered in the non-controlled section of the cart on 3/9/23. When the Alprazolam was discovered in the medication cart the medication card was missing one tablet which could not be accounted for. Per review of Resident #1's Medication Administration Record there is no documentation of Alprazolam administered to Resident #1 between 1/9/23-3/9/23. 2. Per record review Resident #2 was prescribed Lorazepam 0.5 mg as needed for nausea/vomiting, anxiety, insomnia, and myoclonus (muscle spasms). Per review of a facility Corrective Action Plan a delivery of this medication was received on 3/5/23. The Lorazepam was not entered into the controlled substance record and accounted for until it was discovered in the non- controlled medication section of the cart on 3/9/23. During an interview commencing at 2:26 PM on 8/29/23 the Executive Director and the Residential Care Director confirmed 2 controlled substances belonging to Resident #1 and #2 were not entered into the controlled substance log and counted as required; and the facility was unable to account for one tablet of Resident #1's Alprazolam,	R177	To be completed by 10/6/2023: All medication technicians will be in-serviced on: Narcotic storage regulations, community best practices for controlled substance pharmacy deliveries, and the facility policy and regulations for counting and maintaining controlled substances. On-going: Nursing will audit pharmacy manifests weekly. All new medication technicians will be educated and in-serviced on all controlled medication policies by RCD upon hiring and completing medication technician competencies. R177 Plan of Correction Accepted by Jo A Evans on 10/21/23	10/6/23 Ongoing
R224 SS=D	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14.	R224		

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R224	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure one applicable resident (Resident #3) was free of neglect. Findings include: Per review of a facility Corrective Action Plan, on the evening of 7/25/23 the Memory Care Center Med Tech did not respond in a timely manner after s/he was notified a resident had fallen and was on the floor. During an interview commencing at 4:02 PM on 8/29/23 the Director of Health Services and the Memory Care Center Director stated Resident #3 was on the floor for over an hour while awaiting response by the Med Tech who was responsible for evaluating the resident and contacting the on call Registered Nurse to determine if s/he could safely be assisted off the floor. The Staff who found Resident #3 on the floor made several attempts to contact the Med Tech without response before placing a call directly to the Registered Nurse who was on-call. The On-Call Nurse was also unable to reach the Med Tech who was off the unit on a meal break for longer than the amount of time allowed. While awaiting evaluation Resident #3 was tended by Direct Care Staff who reported the resident was found on the floor with his/her head under the bed following an unwitnessed fall; and stated s/he was attempting to get up. A Staff member who heard repeat calls for assistance from the Staff tending to Resident #3 stated s/he informed the Med Tech on duty regarding the fall and the Med Tech displayed "absolutely no sense of urgency at all". Per interview with the Director	R224	Resident Right' s Violation: To be completed by 10/6/2023: All care associates to be in-serviced on best practice for medication technician break sign-off for meal breaks. Reviewed and in-serviced all associates on current LCB fall policy. On-going: All new hires will be in-serviced on both topics. R224 Plan of Correction Accepted by Jo A Evans RN on 10/21/23	10/6/23 Ongoing

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R224	Continued From page 4 of Health Services and the Memory Care Center Director the Med Tech was observed on camera leaving the area after s/he was notified, then returned approximately 20 minutes later. The Corrective Action Plan also noted a 20 minute lag in the Med Tech's response after receiving notification, and stated his/her "physical response indicated a lack of urgency". The Med Tech was suspended pending an investigation for neglect on 7/26/23, and his/her employment was terminated the following day. On the afternoon of 8/29/23 the Residential Care Director and Memory Care Center Director confirmed Resident #3 remained on the floor following an unwitnessed fall for an extended period of time due to lack of response by a Med Tech who was aware the resident had fallen and failed to respond in a timely manner.	R224		