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

March 19, 2024

Lydia Raymond, Manager
The Residence At Quarry Hill
465 Quarry Hill Road
South Burlington, VT 05403

Dear Ms. Raymond:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 27, 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
	1012	A. BUILDING: ____ B. WING ____	C 02/27/2024

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: An unannounced on-site complaint investigation of two complaints was conducted by the Division of Licensing and Protection on 2/27/24. The following regulatory violations were identified:	R100		
R128 SS=E	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 there was a failure to administer medications as ordered for 2 applicable residents (Resident #1, and Resident #2). Findings include: The facility's Policies and Procedures titled Assisting with Routine Medications provided by the Director of Nursing on 2/27/24, states "Staff assisting residents with a routine or PRN medications should: Read the information regarding the medication in the resident's medication record, and must follow the 6 R's, right resident, right medication, right dose, right route, right time, and right documentation." Per record review Resident #1's physician ordered Lorazepam 0.5 mg received on 12/27/23 for increased agitation/anxiety was placed on hold per physicians order due to Resident #1 exhibiting signs and symptoms of an adverse effect of Lorazepam on 12/28/23. On 12/30/23 at approximately 12:15 PM Resident #1 was	R128	R128 The actions taken to correct this deficiency and ensure the deficient practice does not recur along with dates of correction: Resident #1: In-serviced associates involved in medication error on policies regarding medication administration and medication orders at time of incident. Reviewed with associates involved the 6 Rights to medication administration, focusing on documentation. In-servicing of all active nurses and medication technicians to be completed on 3/22/2024. Ongoing in-servicing of new medication technicians to be completed during initial training.	

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Executive Director	3/18/24

Division of Licensing and Protection

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R128	Continued From page 1 administered Lorazepam 0.5 mg without a current physicians' order. Per record review of Resident #2 medication administration record it was noted that on 1/3/24 Resident #2's orders were Carbidopa-Levodopa 25-100 mg immediate release give 2 tablets by mouth three times a day at 10:00 AM, 2:00 PM, 6:00 PM; and Carbidopa-Levodopa 25-100 mg extended release give 2 tablets by mouth one time daily at 8:00 PM. On 1/3/24 Resident #2 was not administered his/her 6:00 PM dose of Carbidopa-Levodopa 25-100 mg immediate release as ordered. Additionally, on 1/3/24 at approximately 9:45 PM Resident # 2 received Carbidopa-Levodopa 25-100 mg immediate release in error instead of Carbidopa-Levodopa 25-100 mg extended release as ordered. On the afternoon of 2/27/24 the Director of Nursing acknowledged medication errors had occurred at the facility. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents due to failure to administer medications according to the physician orders which ensures residents symptoms are being treated correctly and for the benefit of the resident.	R128	Resident #2: At time of incident, In-serviced associates involved in medication error on policies regarding following medication orders, including focus on formulations and administration window regulation. Reviewed the 6 rights of medication administration, focusing on right time and right drug. Reviewed with nurse involved the appropriate process to report and document medications not given per MD order. Reviewed facility protocol for incident reporting and notification to responsible party. In-servicing of all active nurses and medication technicians to be completed on 3/22/2024. Ongoing in-servicing of new medication technicians to be completed during initial training. The corrective actions will be monitored to ensure the deficiencies do not recur by Nursing reviewing all missed medications at the end of each shift. RCD reviews all missed medications and incident reports for medication errors. R128- Accepted on 3/19/24. Sherry Ross, RN	