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 8, 2024

Stacey Bowen, Manager
St Joseph Kervick Residence Iii
131 Convent Avenue
Rutland, VT 05701

Dear Ms. Bowen:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 13, 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
	0298	A. BUILDING: ______ B. WING ______	C 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH KERVICK RESIDENCE III	**131 CONVENT AVENUE** **RUTLAND, VT 05701**

(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 one facility reported incident was conducted by the Division of Licensing and Protection on 3/13/24. The following regulatory violations were identified:	R100		
R155 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.9.c. (12) Assume responsibility for staff performance in the administration of or assistance with resident medication in accordance with the home's policies. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the Director of Nursing failed to ensure medications for two residents (Resident #1, #2) were administered according to facility policies. Findings include: Based on record review Resident #1 is prescribed Hydromorphone 1 tablet by mouth every 4 hours as needed for pain. On 2/19/2024 two facility nurses were conducting narcotic count at the change of shift when a discrepancy was observed in the narcotic logs last entry, dated 2/3/24 (log entry dated 2/3/23) one tablet of Hydromorphone was noted to be signed out under a nurse's name that no longer worked for the facility. This discrepancy was not reported to facility management until the morning of 2/20/24. Per record review Resident #2 is prescribed Oxycodone 5mg give 1 tablet by mouth every 8 hours as needed for chronic pain. Per	R155	R155 Accepted on 4/8/24. Sherry Ross, RN	

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stacey Bower 4/5/2024

TITLE: Administrator

(X6) DATE

Division of Licensing and Protection

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R155	Continued From page 1 observation of the facility narcotic log on 3/13/24 Resident # 2's Oxycodone 5mg tablets were signed out of the narcotic log a total of 16 times without corresponding signatures entered into Resident # 2's Medication Administration Record. Per the facility policy and procedure titled Fundamentals of Medication Administration stated the medication record is documentation that medications and treatments have been administered as prescribed. Therefore, the current medication sheet will be present when and where the medication is being administered so that accurate documentation will occur. Any omissions, refusals, or irregularities with taking medications should be noted on the medication record by circling the appropriate space. Medication records will be reviewed by the nurse. This deficient practice has more than minimal risk for all residents due to the lack of nursing administration over-site to ensure all staff are documenting according to the facility policies.	R155		
R171 SS=F	V. RESIDENT CARE AND HOME SERVICES 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,	R171	R171 Accepted on 4/8/24. Sherry Ross, RN	

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R171	Continued From page 2 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 staff interview and record review, RCH staff failed to administer prescribed medications and failed to document all instances of medication refusal or when a medication was omitted for 2 applicable residents (Resident #1, and #2) Findings include: Per record review conducted on 3/13/24 Resident #1 is prescribed Hydromorphone 1 tablet by mouth every 4 hours as needed for pain. On 2/19/2024 two facility nurses were conducting narcotic count at the change of shift when a discrepancy was observed in the narcotic logs last entry, dated 2/3/24 (log entry dated 2/3/23) one tablet of Hydromorphone was noted to be signed out under a nurse's name that ended her/his employment in December of 2023. This discrepancy was not reported to facility management until the morning of 2/20/24. Additionally, this medication was not signed in Resident #1 Medication Administration Record (MAR) as being administered as ordered. Per record review Resident #2 is prescribed	R171		

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R171	Continued From page 3 Oxycodone 5mg give 1 tablet by mouth every 8 hours as needed for chronic pain. Per observation of the facilities narcotic log on 3/13/24 Resident # 2's Oxycodone 5mg tablets were signed out of the narcotic log a total of 16 times without corresponding signatures entered in Resident # 2's MAR to account for administration. a. Oxycodone 5mg (used for pain management) 1/1; 1/2; 1/5;1/6;1/12;1/14;1/15;1/17;1/18/1/19; 1/20;1/21;1/22;1/26;1/28;1/30. Per interview at 11:25 AM on 3/13/24 the Executive Director confirmed there was a failure to account for administration of identified medications. Further review of the electronic MAR, no reason was listed for the omission of the medications or whether the resident had refused to accept the medications. Per the facility policy and procedure titled Fundamentals of Medication Administration stated the medication record is documentation that medications and treatments have been administered as prescribed. Therefore, the current medication sheet will be present when and where the medication is being administered so that accurate documentation will occur. Any omissions, refusals, or irregularities with taking medications should be noted on the medication record by circling the appropriate space. Medication records will be reviewed by the nurse. Additionally, failing to document the administration of a medication is defined as a medication error. The deficient practices identified during the investigation on 3/13/24 is risk for more than minimal harm of all facility residents due to the	R171		

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R171	Continued From page 4 failure to administer medications that assist with pain management as ordered and to accurately document medication administration.	R171		

R155 5.9.c Resident Care and Home services

What action you will take to Correct the deficiency?
2/26/2024 DON and Nurse Administrator met with LPNs/ Med Techs to discuss Medication Management Policy, medication errors, sign off, PRN's, observing residents taking medication.

What measure will be put into place or systemic changes you will make to ensure that the deficient practice does not occur? March 4, 2024
DON and Nursing Administrator instituted daily audits of MAR/Narcotic books. Weekends are completed on Monday morning.

How corrective actions will be monitored so deficient practice does not recur?
Daily audits of MAR/Narcotics books, until May 31, 2024, then weekly.

The dates corrective action will be completed: May 4, 2024.

R155 Accepted on 4/8/24. Sherry Ross, RN

R171 5.10 Resident Care and Home Services: Medication Management

What action you will take to Correct the deficiency?
On March 14, 2024, LPN's/Med Techs were required to read the medication management policy in its entirety and confirm in writing they understood the policy. They were also required to sign a document with their printed name, signature, and initials for identification as it appears in the MAR/nursing record. This document is in each employee's personnel file. New employees will be required to do both at the time of new employee orientation.

What measure will be put into place or systemic changes you will make to ensure that the deficient practice does not occur? DON, Nursing Administrator and RN oversight will meet 1:1 with all LPNs/Med Tech's to review medication administration process and documentation as well as narcotic administration and documentation. Employees will be reminded that it is essential that any discrepancies in the MAR / Narcotic Book must be reported to the administration immediately.

Target Completion date: May 1, 2024.

How corrective actions will be monitored so deficient practice does not recur?
Daily audits of the MAR/Narcotics books through May 31, 2024, then weekly.

The dates corrective action will be completed: Daily audits through May 31, 2024, then weekly ongoing.

R171 Accepted on 4/8/24. Sherry Ross, RN

Stacey Bowe
Administrator
4-5-2024
St. Joseph Kerrick