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 4, 2023

Angela Zizza
Valley Terrace
2820 Christian Street
White River Junction, VT 05001-9822

Dear . Zizza:

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1004	A. BUILDING: _____ B. WING _____	C 08/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY TERRACE	2820 CHRISTIAN STREET WHITE RIVER JUNCTION, VT 05001

(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 onsite complaint investigation survey for two facility self reports and one complaint was conducted on 8/29/23 by the Division of Licensing and Protection. As a result of the investigation, regulatory deficiencies were identified related to 2 out of 3 of the investigation. Findings include:	R100	**R161 SS=E** **5.10b** The action taken to correct the deficiency is outlined as follows: Staff member 1 and 2 involved with signing off on a narcotic count and not noting the discrepancy. Re-education on the Policy and Procedure of recording, administration, and navigating discrepancies of narcotics will be complete for current Nurses and Med Techs by October 5, 2023 and will continue for new employees.	8/30 - 10/5/23
R161 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.b The manager of the home is responsible for ensuring that all medications are handled according to the home's policies and that designated staff are fully trained in the policies and procedures. This REQUIREMENT is not met as evidenced by: Based on observation, record review and record review there was a failure to ensure all medications are handled according to facility policies and procedures. Findings include: 1. Per record review conducted on the afternoon of 8/29/23, it was noted that on 8/24/22 at 10:51 PM Staff #1 and Staff #2 were performing a shift change controlled substance count when staff #2 noticed there was a discrepancy on page #7 regarding Resident #1's Lorazepam 1mg/ml gel. Page #7 controlled substance record was recorded to have a count of 29 packets of Lorazepam 1mg/ml whereas the medication cart contained 28 packets of Lorazepam 1mg/ml. On further review of the controlled substance book both Staff #1 and Staff #2 signed on 8/24/22 as to attest that the controlled substance count was	R161	Health Service Director RN followed up with Nurses and Med Techs on the same Policy and Procedure of recording and administration of narcotics and documentation procedures in the new narcotic bound books. Controlled Drug Policies and Procedures have been updated and contain step-by-step instruction on what to do for a diversion and if the drug count is inaccurate. Nurses and Med Techs are presently being re-educated on the updated policy and will be completed by 10/5/23 All findings with progress notes are reported and reviewed at the QAPI meetings x 6 months	8/16 - 8/22/22 8/30 - 10/5/23

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R161	Continued From page 1 correct without noting the discrepancy on page #7. On 9/1/22 at approximately 7:30 AM seven days after discrepancy was noted 1 packet of Lorazepam 1mg/ml gel was located in the medication cart and reentered into the narcotic count. 2. Per record review on the afternoon of 8/29/23 of the controlled substance log, on page #29 Morphine was noted as administer to Resident # 4 without a signature as to who administered the medication on 10 separate occasions between 2/28/22-3/2/22. Per review of the Policy and Procedure titled Narcotic Protocol revised on 4/27/16 stated "Narcotic count and documentation must be done by every staff member every shift. There can be no blank spaces on the narcotic sheet". Per interview with the Medication Technician (MT) conducted on 8/29/23 at 1:15 PM, when asked what s/he would do if a staff member forgot to sign out a medication in the narcotic book s/he stated we normally write the staff members initial and have her/him sign it on their next shift. Per interview on the afternoon of 8/29/23 the HSD confirmed that on 8/24/22 there was a discrepancy in Resident #1's Lorazepam which was later located by a staff within the medication cart. S/he further confirmed that there were missing signatures in the controlled substance log on multiple occasions stating " It looks like my staff needs more training.	R161	R161 SS=E Continued: 2. Staff initialed and did not sign their full signature of a controlled drug. Health Services Director has begun to educate Nurses and Med Tech staff on the importance of using full signatures when signing out controlled drugs. Nurses and Med Tech Controlled Drug Protocol: Upon discover of blank spaces whether it's a signature page or drug sign out the corresponding staff member will be called to come in and immediately rectify the omission. The Health Services Director will conduct weekly, for 4 weeks a quality assurance audit. This will be documented on a checklist, monitoring for the facility's compliance with its Policy and Procedures for Controlled Drugs. If compliance during the 4-week period is achieved, then this checklist will be completed monthly for 3 months. If non-compliance is found, then the compliance check will continue weekly until 4 weeks of compliance is achieved, then changed to monthly for 3 months. This Plan of Correction will be reviewed during the facility's Quarterly QAPI meeting. Tag R161 Accepted 9/26/23 Jenielle M. Shea, RN	9/22-10/5/23
R181 SS=D	V. RESIDENT CARE AND HOME SERVICES	R181		

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R181	Continued From page 2 5.11 Staff Services 5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the Manager failed to take all reasonable steps to obtain background checks and contacting the licensing agency for 1 out 5 staff of the applicable sample (Staff #3). Findings include: Per review of Staff #3 employee file, The employment application submitted by Staff # 3, indicated to have a current residential address in New Hampshire and answered the question "Have you ever been convicted of a misdemeanor or felony?" Answer: misdemeanor charge in the state of New Hampshire. A background check was completed for criminal history in Vermont,	R181	R181 SS=D The action taken to correct the deficiency is outlined as follows: On April 5, 2023 the facility put into place a requirement that all prospective employees must have a National background report completed before an employment offer can be made. As of August 1, 2023 a National background report was completed on all employees that had already been employed prior to the requirement of April 5, 2023 and will continue on an annual basis. As of 8/29/23 the manager of the facility will ensure that If a prospective or current employee's background check is returned with a criminal offence the facility will inform the Division of Licensing and protection with the employee's name, the criminal offence, and the reason the facility had determined that the employee poses no threat of abuse, neglect, or exploitation to residents prior to an employment offer is made. Audits of employee files to ensure compliance of all background checks were completed on August 31, 2023. Audits will continue with all new employee files and will be reviewed during the facility's Quarterly QAPI meeting.	4/5/23 8/1/23 8/29/23 8/31/23

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R181	Continued From page 3 and not other states. The employee file did not contain documentation for review of the admission of criminal history. The employee was granted employment by the Manager on 7/22/21. Per interview on 8/29/23 at 1:30 PM, the Manager confirmed the employee application for Staff # 3, is documented with answering to having a misdemeanor in the state of New Hampshire. The manager confirmed a background check was only completed for criminal history in Vermont. The manager further confirmed the employee file does not have documentation for further review of the misdemeanor or to have contacted the licensing agency. The manager confirmed the employee was hired and employment was suspended due to conduct and placed on administrative leave on 1/5/22, and terminated following lack of communication from Employee #3 in regards to the internal investigation process and the determiniation of employee conduct from the internal investigation.	R181	Tag R181 Accepted, 9/26/23 Jenielle M. Shea, RN	
R224 SS=F	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. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the Manager failed to to ensure Resident # 2 was free from exploitation related to the diversion of medication and Resident #3 was free from	R224	R224 SS=F The facility will continue to educate each employee on Resident Rights upon hire and on an annual basis. Nurses and Med Techs have had further education on proper recording of all medications in particular narcotics. Staff were also educated on the consequences of diversion. On 1/3/22 upon knowing of the misappropriation of funds of Resident #3 an immediate investigation too place.	8/30-10/5/23 1/3/22

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R224	Continued From page 4 misappropriation of property. Findings include: 1. Per record review on 8/29/23 at 10:30 AM Resident #2 was prescribed Fentanyl 25mg patches for pain. On 8/25/22 at approximately 2:30 PM the on duty Licensed Practical Nurse (LPN) notified the Health Services Director (HSD) that s/he had called the pharmacy to inquire about 2 Fentanyl 25mg patches for Resident #2 that were pending delivery. The pharmacy informed the LPN that the Fentanyl 25mg patches had been delivered the evening of 8/22/22. At 3:10 PM the HSD called Staff #1 inquiring about the pharmacy delivery of 2 Fentanyl 25mg patches for Resident #2, Staff #1 stated to HSD that no patches had been delivered. On 8/26/22 at 9:00 AM the HSD confirmed with the pharmacy that 2 Fentanyl 25mg patches were delivered and signed for by Staff #1. On 8/26/22 at 1:30 PM the HSD met with Staff #1, during this meeting the HSD showed Staff #1 the pharmacy delivery slip containing staff #1 signature as the person receiving delivery of this medication. At that time Staff #1 stated that s/he remembered the delivery, but that s/he did not know what s/he did with the medication. Per review of the Policy and Procedure titled Medication Management revised on 1/25/13 stated "When resident medication are delivered by the pharmacy, the staff person receiving the order should verify that all medications noted on the delivery slip are included in the delivery. The slip is initialed. Staff should verify the order in the medication book matches the medication label. Once the medication is verified, the medication should be put away in a proper storage location". Per interview on 8/29/23 at 1:30 PM, the Executive Director confirmed 2 fentanyl patches	R224	R224 SS=F Continued: On 1/5/22 Staff #1 was immediately terminated related to the misappropriation of funds. 1. Controlled Drug policies and procedures have been updated and Nurses and Med Techs are presently being re- educated on the updated policy and will be completed by 10/5/23 Presently our policy for controlled medication is being updated and contains step-by-step instruction on what to do for a diversion and if the drug count is inconsistent. Nursing Staff and Med Techs will complete education by 10/5/23 On 3/5/2023, as part of a training session, residents rights were reviewed with nursing staff. 5/1/23 a Relias course on residents rights was mandated for all staff to be completed no later than 6/1/23. In September of 2023, the policy titled Controlled Substance Diversion was updated to include the effect of diversion in direct relation to residents rights. .	1/5/22 8/30-10/5/23 10/5/23 3/5/23 5/1-6/1/23 9/22/23

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R224	Continued From page 5 were signed as received by staff #1, and not accounted for within the medication cart, controlled substance log, and were unlocateable for administration The ED confirmed the resident medication was replaced upon finding the medication was unavailable. 2. Per record and interview with the Executive Director and HSD on 8/28/23 at 1:15 PM revealed that the facility implemented corrective actions for the above deficiency involving misappropriation of property for Resident #3. The facility offers secure storage safes to each resident within their apartment. The manager ensures upon hire Vermont and multi-state back ground checks are performed new staff, and annually with employment for all staff. New hired staff complete the mandatory training including Mandated reporting including abuse, neglect and exploitation, prior to performing job related training. The DNS monitors residents who present to be at risk for maintain safety of personal funds, and arranges care conferences with families to discuss options for securing items. Based on the corrective actions completed prior to the onsite investigation related to the misappropriation of Resident #3 property , the citation is designated as past-noncompliance.	R224	Tag R 224 Accepted 9/26/23 Jenielle M. Shea, RN R224 SS=F Continued: In September of 2023, Valley Terrace implemented the practice of having two staff members sign for controlled medications when they arrive from the contracted pharmacy in addition to requiring two staff members to log in new controlled medications into the appropriate bound book. HSD notified contracted pharmacy, HealthDirect, of this practice change on 9/22/2023 In September of 2023, Valley Terrace implemented the practice of placing a copy of the double signed controlled medication manifest from the contracted pharmacy on the HSDs clipboard for immediate audit the next time HSD is present in the facility. HSD began education of all current Nurses and Medication Delegates on the new practices above on 9/22/2023 and will complete education with current Nurses and Medication Delegates by 10/5/2023. Practices will then be taught as new Nurses or Medication Delegates are added.	9/22/23 9/22/23 9/22 - 10/5/23