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

August 25, 2023

Ms. Joanne Blanchard, Manager
West River Valley Assisted Living Residence
Po Box 341
Townshend, VT 05353-0341

Dear Ms. Blanchard:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 20, 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
	1007	A. BUILDING: _____ B. WING _____	C 06/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST RIVER VALLEY ASSISTED LIVING RESIDENCE	PO BOX 341 TOWNSHEND, VT 05353

(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 re-licensure survey and complaint investigation was conducted on 6/20/23 by the Division of Licensing and Protection. The following regulatory violations were identified related to both the re-licensure survey and 2 complaints:	R100	R128 Failure to follow physician PRN medication orders. Action to correct deficiency: 1. Education reinforced with the individual Residential Assistant involved and then all Residential Assistants on PRN medication monitoring and administering correct dosing. 2. Standing orders were reviewed and reconciled with facility Pharmacy. Standing orders for Tylenol will be 325 or 500 mg every 3 to 4 hours, 650 mg every 4 to 6 hours, or 1000 mg every 6 hours as needed. Measure/Systemic Change to ensure no recurrence: 1. Going forward, Standard orders will no longer be used for Hospice residents. The Hospice Medical director will order all medications and determine what doses to use and not to exceed. Monitor: 1. Facility nurses will fax Standing PRN orders on admission of a new resident. PCP will specify preferred dosing at that time if different from facility Standing order. The orders will be entered into the resident's electronic chart. 2. When the facility has a resident that needs Hospice services, the Facility standing orders will be removed from the resident's chart. The Hospice medical director will determine what medications the resident will be prescribed. 3. When the facility has a resident that needs Hospice services, the Facility Nurses will meet weekly with the hospice nurse to monitor medications and dosing. Completion: 1. Education to staff was completed on 6/27/23 at the mandatory Residential Assistant meeting. 2. Following the R.A mandatory meeting on 6/27/23, the R.A's met with Bayada Hospice nurses who provided education about hospice services and answered questions the R.A's had. 3. The implementation process for residents needing hospice services was completed and fully implemented on 6/21/23.	6/27/23 6/21/23 6/21/23 on-going
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 follow physician medication orders for 1 applicable resident. (Resident #1) Findings include: Per record review of the Medication Administration Record (MAR) Resident #1 has an order for Tylenol 160 mg/5 ml, Give 20 ml (640 mg) every 4 hours as needed for pain, to be used in between Hydromorphone doses to manage pain, do not exceed 4 doses per day; not to exceed 3,000 mg of Tylenol per 24 hours. On 6/10/23 the MAR indicated the PRN (as needed) Tylenol medication was given 5 times, documentation was recorded at 6:31 AM, 10:31 AM, 2:47 PM, 7:47 PM, 11:50 PM and the total administered dosage in 24 hours exceeded 3,000 mg. Per interview on 6/20/23 at 4:05 PM the Licensed	R128	Tag R128 Accepted on 8/25/23 - M. McIntosh	

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R128	Continued From page 1 Practical Nurse (LPN), confirmed the order as written, and confirmed the administrations of the medications did not follow the order directions of max daily administrations and exceeded the dosage in a 24 hour period.	R128	R139 Failure to notify the attending physician when a resident repeatedly refused specific prescribed medication. Action to correct deficiency: 1. Education provided and reinforced to Residential Assistants to notify facility nurses when a resident consistently refuses prescribed medications. 2. Residential Assistants have been instructed to document refusal of medications and why the resident is refusing the medication. This is to be done under individual resident's progress notes in Point Click Care.	6/27/23, 7/12/23, 7/13/23
R139 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.8 Physician Services 5.8.c Any refusal of medical care and the reasons for the refusal must be documented in the resident's record. If the resident has an attending physician, the physician shall be notified. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, there was a failure to notify the attending physician when a resident repeatedly refused specific prescribed medications. (Resident #1) Findings include: Per review of the MAR Resident #1 had medication orders for Tylenol Arthritis 650 and Magnesium 250 mg tablet, both to be given once daily, scheduled in the evening at 7:00 PM. The MAR reviewed for June 2023 indicated the order for Tylenol arthritis was not administered 19 times and the order for Magnesium 250 mg tablet was documented as not administered 18 times. The record did not provide evidence of communication to the primary care physician to be notified of medications not given or refused, for the documented dates. Per interview with the LPN of 6/20/22 at 4:10 PM,	R139	Measure/Systemic Change to ensure no recurrence: 1. The question, "Has there been any refusal of medications?", will be added to the weekly morning meetings questionnaire. These meetings occur every Monday, Wednesday and Friday. 2. Facility nurses will correspond with PCPs after the morning meetings if there is any consistent refusal of medications by residents. Monitor: 1. Monthly reviews will be conducted by facility nurses to ensure no refusals of medications have been missed. 2. A reoccurring monthly reminder will be added to the Outlook calendar to remind the facility nurses to run the medication refusal report. Completion: 1. Education to staff was completed on 6/27/23 at the mandatory Residential Assistant meeting. 2. Education was reinforced verbally by Facility nurse on 7/12/23 and 7/13/23. 3. Weekly meetings with new questions will begin on 7/14/23. 4. Monthly report checks will begin on 7/28/23. Tag R139 Accepted on 8/25/23 - M. McIntosh	7/14/23 7/28/23

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R139	Continued From page 2 the documentation of the medication refusals and the medication being held was confirmed. The nurse confirmed the primary care physician was not notified of the refused and held doses.	R139	R145 Failed to update the care plan for resident who demonstrated significant changes in care needs. Action to correct deficiency: 1. Facility Nurse will complete a resident assessment for each resident upon admission, annually, upon admission to hospice services, and with any significant change.	7/12/23
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.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 nursing staff failed to update the care plan for 1 applicable resident who demonstrated significant changes in care needs. (Resident #1) Findings include: Per record review Resident #1's care plan was not updated to demonstrate the resident's current care assistance requirements for activities of daily living (ADL) related to decline in mobility and Hospice care and services. The care plan was last updated on 10/10/22. Per interview on 6/20/23 at 2:30 PM the LPN confirmed the care plan has not been updated to demonstrate current care assistance required for ADLs and does not include care and services for hospice care.	R145	Measure/systemic Changes to ensure no recurrence: 1. The facility Nurse will review the electronic progress notes and the 24/72-hour shift reports to determine if any events or issues have arisen and assure that the service plan is updated to reflect the care and services required to maintain independence and wellbeing for any resident. 2. During morning meetings on Monday, Wednesday and Friday, any significant changes observed by multiple departments will be discussed. Facility Nurse will assure the Service Plan is updated if applicable. 3. When it has been determined that a resident needs hospice services the plan of care will be updated. 4. Education will be provided to all departments on the guidelines for significant changes. Monitor: 1. The Facility Nurse will complete all resident assessments within 7-14 days of admission. 2. The facility Nurse will monitor the 24/72-hour shift reports Monday through Thursday and make any necessary changes to service plans in a timely manner. 3. Residents requiring hospice services will be monitored by the Facility Nurse and update the service plan within 7-10 days of admission. 4. Facility Nurse will monitor for any significant changes mentioned in the weekly meetings and update service plans accordingly. 5. Annual reviews for service plan updates will be put into a schedule with pop-up reminders in PCC and reminders from outlook calendar. Completion: 1. Education on what is considered a significant change completed on 7/12/23 at the weekly meeting and change of shifts. 2. The implementation process for Service Plan updates will begin 7/12/23 Before the weekly meeting. Tag R145 Accepted on 8/25/23 - M. McIntosh	7/12/23 7/12/23

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R160 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 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 administration. (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 observation, staff interview and record review, the ALR failed to develop a	R160	R160 Medication Management, the policy does not include procedures for the proper handling of dispensing and accounting of liquid narcotics or controlled medications stored in an alternate location. Action to correct deficiency: 1. West River Valley Assisted Living implemented a new Policy that became effective as of 7/14/23. The Policy is titled: Policy and Procedure for Proper Handling, Dispensing, and Accounting of Liquid Narcotics. This includes proper handling, dispensing and accounting for stored narcotic medications in an alternate location. We have changed our policy to pre-filled syringes for all liquid narcotics. This will allow for more accurate dispensing. Measure: 1. All Residential Assistants will be given a copy of the new Policy and Procedure to read with a request to sign off that they have read and understand the new Policy and Procedure. 2. Education of the new policy will be reinforced by the Facility Nurse on a 1:1 basis. Any questions or concerns will be addressed at that time. Monitor: 1. Facility Nurse will maintain on-going communication with Resident Assistants regarding liquid narcotics procedures to ensure facility procedures are being followed and questions are addressed. Completion: 1. Policy and Procedure will be handed out between 7/14/23 and 7/17/23 to all Residential Assistants. This Policy has been integrated into all Policy and Procedure manuals. 2. Over the period of one-week 7/17/23 to 7/21/23 The Facility Nurse will meet with Residential Assistants individually to assure they all understand the new Policy. Tag R160 Accepted on 8/25/23 - M. McIntosh	7/14/23 7/14/23 - 7/17/23 7/17/23 - 7/21/23 on-going

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R160	Continued From page 4 comprehensive policy and procedure for unlicensed staff who were delegated the responsibility for drawing up liquid narcotics and controlled drugs from bottles by use of a syringe and the administration, handling, and accounting of liquid based narcotic and other controlled drugs. Findings include: Per observation of the medication cart at 12:00 PM, the narcotic box contained a bottle of liquid Lorazepam (antianxiety/sedative) and Hydromorphone (narcotic analgesic). The Medication Technician (MT) reviewed the process for administering liquid narcotics. The MT indicated liquid narcotics are drawn up with a syringe from the medication bottle by the MT, or person administering the medication. The narcotic log book is to be documented each time either drug are administered. A narcotic/controlled drug count for Hydromorphone and/or Lorazepam is performed with each change of shift with the oncoming MT or nurse assuming the medication cart. At 12:10 PM the MT confirmed the narcotic log book documented the liquid Lorazepam at 119 mls. However, the bottle of Lorazepam within the lock box has a total capacity of 30 ml. At the time of observation, the MT explained the facility received 4 bottles from the pharmacy each bottle containing 30 ml, the MT noted the 3 other bottles are stored in a locked refrigerator in the medication room. The narcotic log book accounts for the bottle in the cart, and the 3 bottles of Lorazepam stored in the refrigerator of the medication room. Per review of the Facility Policy and Procedures of Medication Management the policy does not include procedures for the proper handling,	R160		

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R160	Continued From page 5 dispensing and accounting of liquid narcotic or controlled medications stored in an alternate location. Per interview on 6/20/23 at 4:15 PM the LPN, confirmed the policy and procedures does not include expectations for proper handling, dispensing and accounting of liquid narcotics or alternate storage locations of narcotics. The LPN confirmed the medication cart only contains 1 of the 4 bottles received from the pharmacy, and the narcotic book accounts for the total of milliliters of medication dispensed per prescription. The LPN confirmed the remaining 3 bottles are stored in the locked refrigerator of the medication room and the bottles are to be observed each shift to ensure the tamper seal is intact.	R160		
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, staff interview and record review the Manager and nursing failed to ensure Medication Management policy and procedures were followed by medication trained staff. Findings include: Per observation and record review of the medication narcotic/controlled drug log book at	R161		

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R161	Continued From page 6 12:15 PM on 6/20/23, the narcotic count was noted to be incorrect for two medications. Resident #1 has an order for Lorazepam 2 mg/ ml, Give 0.5 ml 7 times daily by mouth. Per the MAR the medication was administered at 8:38 AM. The narcotic log/controlled drug book recorded the medication measurement of 119 ml, the measurement was inaccurate. Upon review, the narcotic/controlled drug log book was not documented in to account for the administration of the medication at 8:38 AM. Resident #2 has a physician order for Diazepam 5 mg, take half a tablet (2.5 mg) by mouth twice daily. Per the medication administration record (MAR) the medication was administered at 7:11 AM. The narcotic/controlled log book, recorded the medication count to be 23 half tablets of Diazepam, the medication card contained 22 half tablets. Staff failed to document in the log book the administration at of 2.5 mg of Diazepam at 7:11 AM. Per record review of the ALR Policy and Procedures of Medication Management, the policy states " A separate book will be maintained to document the administration of narcotics immediately when poured." The Medication Tech at 12:15 PM confirmed the administrations of Diazepam and Lorazepam were not recorded at time of the administration. The MT acknowledged the policy and procedure for documenting narcotics at time of administration.	R161	R161 Narcotic count was noted to be incorrect for two medications. Action to correct deficiency: 1. The staff member involved with the incorrect medication count was immediately counseled and re-educated, after survey, on the Policy and Procedure of recording administration of narcotics immediately when poured and administered. 6/20/23 2. Twenty days later the Resident Assistant involved had a meeting with the Nurse Manager to follow up on the Policy and Procedure again. R.A verbalizes understanding and knows to record administration of narcotics immediately when poured and administered. 7/10/23 3. A mandatory care staff meeting was held to go over the correct procedure regarding documentation in the new narcotic books. 6/27/23 Measure: 1. Controlled Drug Policy and Procedure has been updated and distributed to the Resident Assistants. Sign copies will be on file. 7/14/23 Monitor: 1. Facility Nurses will monitor the narcotic books weekly to assure narcotic books are correct. 6/27/23 Completion: 1. Weekly monitoring of narcotic books began on 6/27/23. 2. A mandatory meeting was held on 6/27/23 to go over the correct procedures. 3. Controlled Drug Policy and Procedures updated on 7/14/23. Tag R161 Accepted on 8/25/23 - M. McIntosh	
R304 SS=E	X. PETS	R304		

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R304	Continued From page 7 10.1 Pets may visit the home providing the following conditions are met: 10.1.a The pet owner must provide evidence of current vaccinations. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, there was a failure to ensure all pets living in the ALR were current with vaccinations. Findings include: Four residents at the ALR have cats living with them. Per request of documentation to confirm the pets were up to date with vaccinations noted 2 of the 4 cats were overdue for vaccinations, noting one cat had not received required vaccinations since 9/19/2017. A second cat was overdue for 1 vaccination which was due on 12/21/22. The facility Administer acknowledged on the afternoon of 6/20/22 there was a failure to monitor the pets for required vaccinations and emergent veterinary appointments would be made.	R304	R304 Failure to obtain vaccinations for 2 out 4 pets. Action to correct deficiency: 1. Families were contacted to get pets necessary vaccinations in order to come into compliance with maintaining care records for the two cats found to have overdue records. 2. Family members made appointments with their veterinarians. Measure: 1. The Administrative Assistant/ Receptionist will obtain cat vaccinations records as part of the admission process and will assist in obtaining yearly record updates. Monitor: 1. The Administrative Assistant/Receptionist will keep a reminder calendar of when the family needs to renew residents' cats' vaccinations in the Outlook calendar. Completion: 1. Cat #1 was vaccinated within the first week of the survey. 2. Cat #2 has a scheduled appointment on 7/16/23. Tag R304 Accepted on 8/25/23 - M. McIntosh	6/20/23 6/21/23, 7/16/23 6/21/23 6/21/23