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

July 12, 2017

Mr. Peter Olson, Manager
Vernon Assisted Living Residence
13 Greenway Drive
Vernon, VT 05354

Dear Mr. Olson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on June 13, 2017. 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,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

JUL 10 2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1006	A. BUILDING: _____ B. WING _____	06/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERNON ASSISTED LIVING RESIDENCE	13 GREENWAY DRIVE VERNON, VT 05354

(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 re-licensing survey was conducted by the Division of Licensing and Protection on 6/12 and 6/13/17. The findings include the following:	R100	**R155.** This Facility does not accept the assumed level of the "SS=E" citation as neither State of Vermont's Residential Care Home Regulations nor Assisted Living Regulations from which the finding is cited contain language that defines or regulates the use of an alpha scoring system of "SS". The facility does request that the reference of "SS=E" be removed from this document as it is not based on the Vermont Residential Care Home or Assisted Living Regulations. The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To continue to remain in compliance with state regulations, Vernon Hall Assisted Living Residence will take the actions set forth in this plan of correction. At no time was any resident actually harmed as a result of this situation.	
R155 SS=E	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 observation, confirmed by staff interview and record review the facility nurse failed to assume responsibility assuring the security of medications for those residents who choose to self-administer (Resident #3 and #4) and failed to ensure that medications are being administered according to the physician's orders for 3 applicable residents (Resident #3, #4 and #6). The finding include the following: 1. Per observation on 6/13/17 at approximately 9:15 AM, located in the resident's room on top of the desk (visible on entrance), was found to have two (2) seven (7) day medication minders (holders) with pills of various over the counter and prescription drugs in each of the 14 compartments. Also located in the resident's bathroom a small uncovered dish containing five (5) pills, was stored on a the top of a plastic cabinet (approximately 3-4 feet tall). The resident later confirmed that the pills in the dish are taken at bed time. At the time of the observation the	R155	**5.9.c. (12)** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** The Facility's Nursing Staff has provided a secure storage container for the medications of resident #4. The Facility's Nursing Staff are confirming with residents' #4 and #6 that the resident is self-administered his/her prescription medications. Resident #3 has requested that the Nursing Staff provide direct medication administration. 07/06/17 **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** On a weekly basis, the Facility's Nursing Staff will confirm that each resident who chooses to self-administer medications are maintaining his/her medication in a securable storage container. This weekly confirmation will be recorded in the Medication Administration Record (MAR) document. 07/06/17	

R155 - R179 POC's accepted as circled for citations. 7/12/17 MBertrand RN/PMC

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R155	Continued From page 1 resident was signed out of the facility, the resident room was unlocked and the door was held open by a brick. The black medication storage box provided by the facility was located by the Director of Nurses (DNS) in the resident's closet. Per facility policy titled "Medication Administration Policy" identifies "A resident who is capable of self-administration may store their medications in their room provided Vernon Hall is able to provide a secure storage space to prevent unauthorized access to the resident's medication." Per interview with the DNS on 6/13/17 at approximately 9:15 AM, confirmation is made that all of the resident's medications are not secured in the locked box that has been provided by the facility. 2. Per observation on 6/13/17 at approximately 9 AM, located in Resident #4's suite, was found to store 7 medication cards (packaging provided by the pharmacy for medications) on the counter to the right of the sink. The black box provided by the facility could not accommodate the size of the medication cards. Per interview with the DNS on 6/13/17 at approximately 9:15 AM, confirmation is made that the medications are not secured in the locked box provided by the facility nor has the facility provided a larger box that accommodates the larger packaging. 3. Per interview with the Director of Nurses through out the survey, confirmation is made that the staff do not formally confirm that the resident who chooses to self administer medications have actually taken their medications. S/He confirms that there is no documentation identifying the medication are taken as prescribed. Per facility policy titled "Medication Administration" identifies that "Vernon Hall will make reasonable effort to	R155	**R155 Continued from page 1** The Facility's Nursing Staff will confirm that with resident who chooses to self-medicate an acknowledgment that the prescribed medications are being taken within the parameters of the prescription and document the resident's response according to the Facility's policy titled: "Medication Administration". This confirmation will occur daily and recorded in the Medication Administration Record (MAR) document. 07/06/17 **How the corrective actions will be monitored so the deficient practice does not recur?** The Facility's Director of Nurses (Service Coordinator) will audit Medication Administration Record of each resident choosing to self-administer medication monthly to ensure appropriate compliance for a minimum of three months and/or until 100% compliance is achieved and report this audit results to the Quality Assurance Committee. 07/11/17	

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R155	Continued From page 2 be informed and aware of the resident medications being taken by self-administration". Per interview with Resident #3 and Resident #6 on 6/13/17 after lunch, confirmation is made that they are not sure if staff ask them if they have taken their medications.	R155	**R175.** This Facility does not accept the assumed level of the "SS=E" citation as neither State of Vermont's Residential Care Home Regulations nor Assisted Living Regulations from which the finding is cited contain language that defines or regulates the use of an alpha scoring system of "SS". The facility does request that the reference of "SS=E" be removed from this document as it is not based on the Vermont Residential Care Home or Assisted Living Regulations. The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To continue to remain in comptiance with state regulations, Vernon Hall Assisted Living Residence will take the actions set forth in this plan of correction. At no time was any resident actually harmed as a result of this situation.	
R175 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (3) Residents who are capable of self-administration may choose to store their own medications provided that the home is able to provide the resident with a secure storage space to prevent unauthorized access to the resident's medications. Whether or not the home is able to provide such a secured space must be explained to the resident on or before admission. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure medications are securely stored to prevent unauthorized access when a resident chooses to self administer both prescription and over the counter medications (Resident # 3 and #4). The findings include the following: 1. Per observation on 6/13/17 at approximately 9:15 AM, located in the resident's room on top of the desk (visible on entrance), was found to have two (2) seven (7) day medication minders (holders) with pills of various over the counter and prescription drugs in each of the 14	R175	**5.10 Medication Management and 5.10.h (3)** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** The Facility's Nursing Staff has provided a secure storage container for the medications of resident #4. Resident #3 has requested that the Nursing Staff provide direct medication administration	07/06/17.
			What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; On a weekly basis, the Facility's Nursing Staff will confirm that each resident who chooses to self-administer medications are maintaining his/her medication in a securable storage container. This weekly confirmation will be recorded in the Medication Administration Record (MAR) document.	07/06/17

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R175	Continued From page 3 compartments. Also located in the resident's bathroom a small uncovered dish containing five (5) pills was stored on a the top of a plastic cabinet (approximately 3-4 feet tall). The resident later confirmed that the pills in the dish are taken at bed time. At the time of the observation the resident was signed out of the facility, the resident room was unlocked and the door was held open by a brick. The black medication storage box provided by the facility was located by the Director of Nurses (DNS) in the resident's closet. Per facility policy titled "Medication Administration Policy" identifies "A resident who is capable of self-administration may store their medications in their room provided Vernon Hall is able to provide a secure storage space to prevent unauthorized access to the resident's medication." Per interview with the DNS on 6/13/17 at approximately 9:15 AM, confirmation is made that the medications are not secured in the locked box provided by the facility. 2. Per observation on 6/13/17 at approximately 9 AM, located in Resident #4's suite, was found to store 7 medication cards (packaging provided by the pharmacy for medications) on the counter to the right of the sink. The black box provided by the facility could not accommodate the size of the medication cards. Per interview with the DNS on 6/13/17 at approximately 9:15 AM, confirmation is made that the medications are not secured in the locked box provided by the facility nor has the facility provided a larger box that accommodates the larger packaging.	R175	**R175 Continued from page 3** **How the corrective actions will be monitored so the deficient practice does not recur?** The Facility's Director of Nurses (Service Coordinator) will audit Medication Administration Record of each resident choosing to self-administer medication monthly to ensure appropriate compliance for a minimum of three months and/or until 100% compliance is achieved and report this audit results to the Quality Assurance Committee.	07/11/17
R179 SS=A	V. RESIDENT CARE AND HOME SERVICES	R179	**R179 Continued on page 5**	

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R179	Continued From page 4 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to ensure that 1 of 5 direct care attendants has completed 2 of the mandatory trainings and has not met the 12 hours of training required annually. The findings include the following: Per employee training records reviewed on 6/12 and 6/13/17, employee #4 has not completed annual training in the areas of Respectful	R179	**R179.** This Facility does not accept the assumed level of the "SS=A" citation as neither State of Vermont's Residential Care Home Regulations nor Assisted Living Regulations from which the finding is cited contain language that defines or regulates the use of an alpha scoring system of "SS". The facility does request that the reference of "SS=A" be removed from this document as it is not based on the Vermont Residential Care Home or Assisted Living Regulations. The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To continue to remain in compliance with state regulations, Vernon Hall Assisted Living Residence will take the actions set forth in this plan of correction. At no time was any resident actually harmed as a result of this situation. **5.11 Staff Services and 5.11b** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Employee #4 will complete the Annual Training in the areas of: Respectful Communication & General supervision and care of residents. The Director of Nurses (Service Coordinator) will monitor the progress of employee #4 to completion by monthly auditing of #4's course work. 07/27/17 **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** The facility's Nursing Staff will complete the required mandatory training of 12 hours each year for each staffer providing direct care to residents through online and internal training sessions. The training will include the 7 mandatory categories plus 5 additional hours of training. 12/31/17	

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R179	Continued From page 5 Communication and General Care and Supervision. This employee has only completed 7 of the 12 hours required annually. The Manager confirms on 6/13/17 at 1 PM that the the above information is correct.	R179	**R179 Continued from page 5** **How the corrective actions will be monitored so the deficient practice does not recur?** The Director of Nurses (Service Coordinator) will monitor quarterly the progress of all nursing staff to ensure staff are maintaining an appropriate percentage of completion for the required training for the quarter. The Manager will review with the Service Coordinator the status of completion of nursing staff required hours on a quarterly basis.	09/30/17