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

March 4, 2024

Valerie Cote, Manager
Allen Harbor Senior Living
90 Allen Road
South Burlington, VT 05403-7856

Dear Ms. Cote:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 16, 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
	0372	A. BUILDING: _____ B. WING _____	C 01/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEN HARBOR SENIOR LIVING	90 ALLEN 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: On 1/16/24 the Division of Licensing conducted an unannounced on-site relicensure survey and investigation of 2 facility reported incidents and 2 complaints. The Following regulatory deficiencies were identified:	R100	The filing of this plan of correction does not constitute an admission of the allegations set forth in this statement of deficiencies. This plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law.	
R128 SS=D	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 1 applicable resident (Resident #2). Findings include: The facility's Medication Program Policy effective 2/13/23 states. "The Community will assure compliance with State Law and Regulations.". The facility's procedure for Medication Ordering and Packaging states, "All medication s including PRNs shall be re-ordered when there is a 5 day supply left."; however a procedure for ordering medications when they are not available through the facility's preferred pharmacy is not included in the facility's Medication Program policies and procedures. 1. Per review of the January 2024 Medication Administration Record (MAR), as of 1/16/24 Resident #2's Ammonium Lactate 12% Lotion prescribed topically twice daily is initialed by staff	R128	Resident #2s medications are being administered per the Medication Administration policy. An updated policy is now available that includes instructions on obtaining meds if the preferred pharmacy cannot obtain the medications as ordered. In-servicing will occur with all med techs and nurses re: the medication administration policy, focusing on documenting medications and reasons if not given, as well as having medications available per the policy. A housewide audit will occur of all medication orders to ensure all meds are available per the medication administration policy. Random audits will occur weekly times 4 and then monthly times 2 to check for meds available. Random audits of medication documentation will also be done weekly times 4 and then monthly times 2 to ensure appropriate documentation is occuring per the medication administration policy. Results of these audits will be brought to the QA committee for review.	2/23/24

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R128	Continued From page 1 as given, however the MAR Medication Notes indicate this medication was not given 1/2/24 - 1/16/24 with reasons documented including "Unable to administer", "Unable to obtain", "Resident Refused", "Self-Administered" and "Resident self-administers continue to monitor". During an interview on the afternoon of 1/16/24 the LPN was unable to determine why this medication was not given as ordered. Per review of Resident Assessments and Plan of Care on file, Resident #2 is not capable of self-administration and all medications are administered by staff. 2. Per review of the January 2024 Medication Administration Record (MAR), from 1/1/24- the day of the survey conducted on 1/16/24 Resident #2's L Lysine HCl was documented as not given using the letter "H". The MAR Medication Notes indicate this medication was on backorder. Per interview on the afternoon of 1/16/24 the LPN confirmed the documentation code "H" indicates the medication was "on hold". The LPN initially indicated this medication was put on hold on 10/13/23; however s/he was unable to produce a signed physician's order placing the medication on hold, and signed medication orders for Resident #2 dated 11/1/23 were confirmed by the LPN to include an order for administration of L Lysine HCL 500 mg tablets 1 tablet by mouth daily. L Lysine HCL 500 mg tablets are an inexpensive over the counter amino acid nutritional supplement which can be obtained from a local pharmacy if not in stock and available through the facility's contracted pharmacy. These findings were confirmed by the LPN on	R128		

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R128	Continued From page 2 duty and the Wellness Nurse on the afternoon of 1/16/24. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents due to medication errors including missed medications, medication not maintained in stock, inaccurate documentation when medication is not taken, and self-administration by residents incapable of managing this task.	R128	R128 Plan of Correction accepted by Jo A Evans RN on 3/3/24	
R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to complete a significant change assessment in a timely manner , and to ensure the accuracy of a Resident Assessment for one applicable resident (Resident #2) who experienced a decline in physical health. Findings include: The facility's Assessment/Service Plan policy and procedures effective 2/13/23 states, "A comprehensive Assessment will be conducted at least every 6 months or more frequently if required by the specific State, and with any	R136	Resident #2s significant change assessment has been re-done and verified for accuracy. In-servicing will occur with the Wellness Director and nurses re: the significant change/change in condition policy for assessments and accuracy of assessments. A housewide audit will occur on all Residents to ensure they have a change of condition/significant change assessment on file per policy as indicated. The assessments will be audited for accuracy as well. Random audits will occur weekly times 4 and then monthly times 2 of change of condition/significant change assessments. Results of these audits will be brought to the QA committee for review.	2/23/24

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R136	Continued From page 3 change in condition." Per review of a Progress Note written by a home health Physical Therapist on 10/18/23, Resident #2 was observed to have limited progress towards PT goals due to limited cognition, poor compliance and limited participation in the prescribed physical therapy program. The Physical Therapist stated Resident #2 was only able to ambulate approximately 20 feet due to shortness of breath, and had difficulty ambulating on his/her left foot. Resident #2 was assessed to be wheelchair dependent for all functional mobility, required assistance for all Activities of daily living; and it was determined cardiac rehab was not appropriate treatment for Resident #2 due to severe cardiovascular, cognitive and left foot dysfunction. Per review of a General Note written by Nursing staff on 10/30/23 Resident #2's guardian was notified regarding Resident #2's current status of increased fatigue, not eating anything substantial for last 4 days, increased incontinence, and overall decline. Per Progress Notes Resident #2 was admitted into hospice care on 11/1/23. Per record review a significant change assessment was not completed for Resident #2 in response to the significant physical decline noted on 10/18/23 and 10/30/23 with subsequent admission into hospice care on 11/1/23. A significant change assessment was signed as completed by the Director of Nursing on 11/21/23, 20 days after admission to hospice. This significant change assessment indicated Resident #2's cognitive status had not changed since the previous assessment completed on 9/26/23. Additionally, the facility's Resident Assessment Form includes an additional section P. Focus/Goals/Interventions, which is not	R136		

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R136	Continued From page 4 included in the assessment instrument provided by the licensing agency. Inconsistencies were observed in section P of the significant change assessment dated 11/21/23 which were not congruent with the sections of this Resident Assessment provided by the licensing agency and the changes noted in Resident #2's record. Inconsistencies observed in the Section P of the Resident Assessment dated 11/21/23 included: 1. Sections of the Resident Assessment Form provided by the licensing agency indicate Resident #2 requires extensive assistance with Bathing, Dressing, Toileting, and Grooming/Personal Hygiene; and requires a one person assist with these activities of daily living. In contrast the additional Section P included in the facility's Resident Assessment form indicates Resident #2 "Bathes self without assistance. May have to take sponge bath, but is independent in that function."; " Is independent with dressing/undressing needs..."; "Is independent in toileting activities"; and "Grooms self without assistance". 2. The Locomotion in Residence (Mobility) section of the Resident Assessment Form provided by the licensing agency indicates Resident #2 requires extensive assistance and a one person assist with mobility. The Modes of Locomotion section indicates Resident #2 requires a wheelchair wheeled by "other person" as his/her primary mode of locomotion. In contrast Section P indicates Resident #2 "is independent with ambulation needs", "will be encouraged to use wheelchair self propelling when fatigued", and stated Resident #2 is "able to evacuate independently during an emergency." 3. The Other Providers/Services section of the	R136		

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R136	Continued From page 5 Resident Assessment Form provided by the licensing agency indicates Resident #2 receives hospice care including nursing and social work services, however Section P does not indicate Resident #2 receives these ancillary services are received as all boxes in this section are unchecked. On the afternoon of 1/16/24 the Wellness Nurse confirmed a significant change assessment was not completed in a timely manner when s/he was admitted to hospice. In conclusion these deficient practices are a potential risk for more than minimal harm to all facility residents due to untimely, missed, and inaccurate assessment of resident abilities and needs.	R136	R136 Plan of Correction accepted by Jo A Evans on 3/3/24	
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 there was a failure to develop a written plan of care describing the care and services required to maintain the well-being of one applicable	R145	Resident #2s care plan has been updated reflecting [redacted] current status. In-serving will occur with the Wellness Director and nurses re: the care plan policy and accuracy of these care plans, including, but not limited to medication orders, significant changes, etc. A house wide audit of anyone with a significant change in condition in the last 3 months will be performed to ensure the care plan is accurate. A housewide audit of necessary medications will be performed to ensure they are care planned per policy. Random audits will then occur weekly times 4 and monthly times 2 of both of these items. Results of these audits will be brought to the QA committee for review.	2/23/24 Pronoun removed by DLP 2/14/24

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R145	Continued From page 6 residents (Resident #2). Findings include: The facility's Assessment/Service Plan policy and procedures effective 2/13/23 states, "The Wellness Director will assure all Residents have a comprehensive assessment and service plan in place to assist staff in meeting their needs. " Per review of Resident #2's most recent assessment dated 11/21/23. s/he requires extensive assistance and one person assist with Activities of Daily Living including bathing, toileting, dressing/undressing, grooming and personal hygiene, and mobility including the use of a wheelchair propelled by "other person" as his/her primary mode of locomotion. Resident #2's written plan of care indicates s/he bathes without assistance, is independent in toileting activities and dressing/undressing needs, grooms self without assistance, and is independent with ambulation needs. Updates Resident #2's plan of care regarding his/her ability to perform these activities of daily living have not been made since a significant change assessment was completed for Resident #2 on 11/21/23. Per review of Resident #2's January 2024 Medication Adnministration Record s/he is prescribed the anticoagulant medication Eliquis for due to diagnoses and history of cadiovascular conditions which pose a risk for blood clot formation; and Epinephrine injections as needed for Bee Sting due to an allergy to Bee Venom. Resident #2's Plan of Care does not address pertinent information related to administration of Eliquis including the importance of injury prevention and risk for bleeding while taking anticoagulant medications, signs and symptoms of internal bleeding, and when to seek medical assistance for uncontrolled bleeding. Resident	R145		

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R145	Continued From page 7 #2's plan of care also does not address indications for use of Epinephrine injection for bee stings, instructions and precautions for use of Epinephine injections including ensuring the resident is seated or lying down during and after the injection, and the importance of calling 911 immediately following an epinephrine injection due to risk of second anaphylactic reaction when the medication wears of approximately 30 minutes after administration. On the afternoon of 1/16/24 the Executive Director and Director of Nursing acknowledged Resident #2's Plan of Care does not include care and services required to maintain his/her well-being. In conclusion this deficient practice is a risk for more than minimal harm to all residents resulting from unidentified residents needs and interventions.	R145	R145 Plan of Correction accepted by Jo A Evans RN on 3/3/24	
R162 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure signed orders for medications prescribed to one applicable resident (Resident #3) and medications with a supporting	R162	Resident #2s medications all have supporting dxs now. Resident #3s medication orders are signed by the physician. In-servicing will occur with all nurses and med techs re: the medication administration policy focusing on MD signatures and supporting dxs. A housewide audit of medications has been done to ensure all orders are signed by the MD and that all orders have supporting dxs per policy. Random audits will occur weekly times 4 and then monthly times 2. Results of these audits will be brought to the QA committee for review.	2/23/24

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R162	Continued From page 8 diagnosis for one applicable resident (Resident #2). Findings include: The facility's Medication Program Policy effective 2/13/23 states. "The Community will assure compliance with State Law and Regulations.", and includes procedures for Medical Providers Orders which state, " All Medical Provider's Orders ... will be signed, dated, and kept in the Resident's medical chart in chronological order, with the most current order first." 1. Per record review of the January 2024 Medication Administration Record (MAR) and Prescriber's Orders on file, medication orders listed on Resident #3's January 2024 MAR for which there were no signed orders on file and available for review included: a. Metoprolol Tartrate 100 mg tablet Take one tablet by mouth twice daily in addition to 25 mg for total dose of 125 mg ** IF BP GREATER THAN 160/100 PLEASE CALL PCP** This order appears as a duplicate order for Metoprolol Tartrate in Resident #3's January 2024 MAR with administration parameters that differ from the signed orders dated 2/13/23. b. Anti-Diarrheal 2 mg tab SM (Loperamide HCl) 1 tablet by mouth every 8 hours as needed for Diarrhea. The most recent signed order on file dated 5/2/23 indicates this medication is to be administered 4 times daily. This order appears as a duplicate order for PRN Loperamide in Resident #3's January 2024 MAR. c. Methocarbamide 750 mg tablet 1 tablet by mouth 4 times daily as needed for muscle spasms. This medication order is not listed in the most recent prescriber's orders dated 5/2/23, and	R162		

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R162	Continued From page 9 only appears in unsigned orders dated 10/13/23. These findings were confirmed by the Wellness Nurse on the afternoon of 1/16/24. 2. Per review of the January 2024 MAR and the Prescriber's Orders on file for Resident #2, medications listed on the January 2024 MAR did not include a supporting diagnosis including Torsemide 20 mg tablets, Magnesium Oxide 400 mg tablets, Potassium Chloride 20 mEq Micro-Dispersible Extended Release Tablets, and L-Lysine HCl 500 mg tablets. The Wellness Nurse confirmed these findings at approximately 1:15 PM on 1/16/24. In conclusion these deficient practices are a potential risk for more than minimal harm to all facility residents due to risk of medication errors.	R162	R162 Plan of Correction accepted by Jo A. Evans on 3/3/24	
R167 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents	R167	Resident #2 did not receive any doses of the PRN psychoactives medications on order at the time of this site visit. In-servicing to occur with all nurses and med techs on the PRN psychoactive regulation and updated policy regarding documentation and education. A housewide audit will occur to ensure all Residents who are prescribed PRN psychoactive meds have a written plan in place per the regulation and policy. Random audits will occur weekly times 4 and monthly times 2 of these audits. Results of these audits will be brought to the QA committee for review.	2/23/24

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R167	Continued From page 10 the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure written plans for 2 PRN psychoactive medications for 1 applicable resident (Resident #2) were maintained on file and available for review. Findings include: On the morning of 1/16/24 the Regional Executive Director was requested to provide a copy of facility's policies and procedures for review. A binder provided for review in response to this request did not include policies and procedures related to the administration of psychoactive medications including a written policy for the administration of PRN (as needed) psychoactive medications by staff other than a nurse as required. Per record review Resident #2 is prescribed Haloperidol Lac 2 mg/ml oral solution 0.5 ml (1 mg) by mouth sublingually every 6 hours as needed, and Lorazepam 0.5 mg tablet Take 1 tablet every 6 hours as needed. On the morning of 1/16/24 the Wellness Director confirmed PRN psychoactive medications are administered by facility staff, however the required written plans for the administration of PRN psychoactive medications were not provided for review on request. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents due to administration of PRN psychoactive medications without monitoring the medication's effect, and potential medication	R167		

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R167	Continued From page 11 errors including misuse.	R167	R167 Plan of Correction accepted by Jo A Evans RN on 3/3/24	
R179 SS=F	V. RESIDENT CARE AND HOME SERVICES 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 there was a failure to ensure completion of the required trainings by 2 out of 5 sampled staff. Findings include:	R179	A policy has been developed to ensure all agency staff going forward have either had their mandatory trainings of all 7 listed items per the regulations. or will be given the trainings upon arrival to the community, before providing direct care to any Residents. In-servcing will occur with the nurse manager, Wellness Director and charge nurses on the agency competencies/trainings policy. Random audits will occur weekly times 4 and then monthly times 2 of agency files to ensure they have completed the mandatory trainings. Results of these audits will be brought to the QA commmittee for review.	2/23/24

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ALLEN HARBOR SENIOR LIVING	90 ALLEN ROAD SOUTH BURLINGTON, VT 05403

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R179	Continued From page 12 Per review of facility policies and procedures proved by the Regional Executive Director on request, a document from the online training company the facility contracts with to provide staff compliance training was provided for review. This information states, "General staff compliance trainings should be selected to ensure the organization meets OSHA and other regulatory requirements.", and further states the online training company, "does not make any guarantee that such courses will be accepted by the accrediting body(ies)." The online training company information provided for review includes: 1. A link to the current Vermont Residential Care Home Licensing Regulations, which outlines regulations Vermont Assisted Living Facilities must follow in addition to the Vermont Assisted Living Residence Regulations. 2. Regulation 5.11.b which states, "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" and "There must be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but it not limited to, the following:" 3. Suggested courses offered by the online training company related to required trainings. On the morning of 1/16/24 the Executive Director was requested to provide documentation of the required trainings completed by a sample of 5 facility staff. Per review of the documentation	R179		

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R179	Continued From page 13 provided, documentation of completion of the required trainings by 2 contracted agency staff included in the sample was not on file and available for review. Per the Executive Director, the contracted employment agency provides trainings for agency staff employed at the facility. Licensing regulations require the facility to ensure completion of the required trainings by all staff including contracted agency staff before providing any direct care to residents on hire and yearly; and the facility is required to maintain on file and available for review documentation of completion of the required trainings for all staff including contracted agency staff. At 5:30 PM on 1/16/24 the Executive Director confirmed documentation of the required trainings completed by 2 out of 5 sampled staff was not on file and available for review. In conclusion this deficient practice is a potential risk for more than minimal harm to all facility resident due to failure to ensure all staff are competent in the skills and techniques they are expected to perform before providing direct care to residents.	R179	R179 Plan of Correction accepted by Jo A Evans RN y on 3/3/24.	
R190 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure criminal background and	R190	The 2 staff members noted in this deficiency were contracted and no longer come to the facility. In-servicing will occur with the Wellness Director, nurse manager and charge nurses on background check needs for contracted staff per the policy.	2/23/24

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R190	Continued From page 14 abuse registry checks were completed, maintained on file, and available for review for 2 out of 5 sampled residents. Findings include: The facility's Abuse/Neglect/Exploitation policy and procedures effective 1/1/20 states, "The Community will assure all employees, any adjunct workers, contractors, and Volunteers have the required criminal background check, registry check, licensure check and any other check as required by law or regulations, before hire or while under agreement to provide services to the Community. " On the morning of 1/16/24 the Executive Director was requested to provide criminal background and abuse registry checks for a sample of 5 staff. In response the Executive Director confirmed the required checks were not on file and available for review for 2 out of the 5 staff sampled. The two staff without documented completion of the required checks were both contracted staff who were hired through a temporary staffing agency before the current Executive Director was employed at the facility. The Executive Director stated the temporary staffing agency was contacted to request copies of the checks completed for two sampled staff, however the required checks were not provided for review. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents as the background checks are intended to prevent harm to residents.	R190	A housewide audit of current contracted staff will occur to ensure background checks are in place per policy. Random audits will then occur weekly times 4 and then monthly times 2 to ensure continued compliance. Results of these audits will be brought to the QA committee for review. R190 Plan of Correction accepted by Jo A Evans on 3/3/24.	
R191 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12 Records/Reports	R191	See next page	

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R191	Continued From page 15 5.12.c A home must file the following reports with the licensing agency: 5.12.c.(1) When a fire occurs in the home, regardless of size or damage, the licensing agency and the Department of Labor and Industry must be notified within twenty-four (24) hours. A written report must be submitted to both departments within seventy-two (72) hours. A copy of the report shall be kept on file. 5.12.c.(2) A written report of any accident or illness shall be placed in the resident's record. Any untimely deaths shall be reported and a record kept on file. 5.12.c. (3) A report of any unexplained absence of a resident from a home for more than 12 hours shall be reported to the police, legal representative and family, if any. The incident shall be reported to the licensing agency within twenty-four (24) hours of disappearance followed by a written report within seventy-two (72) hours, a copy of which shall be maintained. 5.12.c.(4) A written report of any breakdown or cessation to the home's physical plant's major services (plumbing, heat, water supply, etc.) or supplied service, which disrupts the normal course of operation. The licensee shall notify the licensing agency immediately whenever such an incident occurs. A copy of the report shall be sent to the licensing agency within seventy-two (72) hours. 5.12.c. (5) A written report of any reports or incidents of abuse, neglect or exploitation reported to the licensing agency.	R191	The incident in this deficiency occurred in 2021. In-serving will occur with all staff regarding the abuse, neglect, exploitation policy, including reporting guidelines. Random audits will occur weekly times 4 and then monthly times 2 to ensure the abuse, neglect, exploitation policy is being followed and reported per regulations. Results of these audits will be brought to the QA committee for review.	2/23/24

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R191	Continued From page 16 5.12.c. (6) A written report of resident injury or death following the use of mechanical or chemical restraint. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to report the exploitation of one applicable resident (Resident #1) to the Division of Licensing and Protection as required. Findings include: The facility's policy and procedures related to abuse, neglect, and exploitation effective 2/15/20 states, "The Community will have a system in place to monitor for abuse, neglect, and exploitation of Residents and for reporting any type of abuse, neglect, and/or exploitation.", and defines Exploitation as "Misuse of a Resident's property (belongings, money, medication), or the intentional taking advantage of a Resident's physical or financial resources.". The facility's procedure for reporting Abuse, Neglect, and Exploitation states, "Employees will receive training during orientation and no less than annually in the detection, prevention, reporting, and documentation of abuse, neglect, and exploitation. Training will include a review of the consequences of abuse, neglect, and exploitation as well as failure to immediately report." Resident #1 was admitted to the home on 1/28/21. Per record review, on 4/13/23 Resident #1's Durable Power of Attorney notified the facility approximately $750 in fraudulent charges were made on Resident #1's credit card between 4/9/21- 4/12/21. Resident #1's credit card was	R191		

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R191	Continued From page 17 stored in his/her apartment. Per record review Resident #1 was transported to the hospital at 4:40 AM on 4/10/21 following a fall, and was diagnosed with rib fractures and a collapsed lung requiring critical care during the time many of the fraudulent charges were made to his/her credit card. During an interview commencing at 11:52 AM on 1/16/24 the Wellness Nurse confirmed the facility failed to report the exploitation of Resident #1 to the licensing agency. In conclusion this deficient practice is a risk for more than minimal harm to all facility residents due to the failure to report abuse, neglect, and /or exploitation to the licensing agency to ensure the protection and rights of the residents. Please refer to tag 224.	R191	R191 Plan of Correction accepted by Jo A Evans RN on 3/3/24.	
R200 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to develop written policies and procedures for the administration of psychoactive mediations including the administration of PRN (as needed) psychoactive medications by staff other than a nurse. Findings include:	R200	The medication administration policy has been updated to include the regulations surrounding a written plan for the use of PRN psychoactive medications. In-servicing will occur with all nurses and med techs re: this new policy.	2/23/24

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R200	Continued From page 18 On the morning of 1/16/24 the Regional Executive Director was requested to provide access to a copy of facility policies and procedures for review. A binder provided for review in response to this request did not include policies and procedures related to the administration of psychoactive medications including a written policy for the administration of PRN (as needed) psychoactive medications as required per section 5.10 Medication Management regulation 5.10.d (5) of the Vermont Residential Care Home Licensing Regulations. On the morning of 1/16/24 the Wellness Director confirmed PRN psychoactive medications are administered by facility staff, however the required written plans for the administration of PRN psychoactive medications by staff other than a nurse were not provided on request. Per follow-up discussion and review of email communication with the Regional Executive Director on the afternoon of 1/24/24 policies and procedures for the administration of psychoactive medications including, but not limited to, administration of PRN psychoactive medications by staff other than nursing had not been developed by the organization that manages the facility. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents due to failure to provide accessible information and clear instructions related to tasks staff are required to perform. Please refer to tag 167.	R200	R200 Plan of Correction accepted by Jo A Evans RN on 3/3/24.	

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R224	Continued From page 19	R224		
R224 SS=G	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 there was a failure to ensure one applicable resident (Resident #1) remained free of exploitation related to identity theft and theft of personal property. Findings include: The facility's Abuse, Neglect, and Exploitation policy effective 2/15/20 defines Exploitation as "Misuse of a Resident's property (belongings, money, medication), or the intentional taking advantage of a Resident's physical or financial resources.". Per record review Resident #1's credit card was stored his/her apartment. On 4/13/21 Resident #1's Durable Power of Attorney (DPOA) discovered fraudulent charges were made on Resident #1's credit card totaling approximately $750.00 between 4/9/21 and 4/12/21. The DPOA reported this finding to the facility and to the police department on 4/13/21. Per review of information provided to the licensing agency on 4/28/21 on request, the fraudulent charges were for the purchase of items Resident #1 would not typically wear and food purchases from restaurants, and Resident #1 did not receive the items purchased. Additionally, Resident #1 was transported to the hospital at 4:40 AM on 4/10/21	R224	The contracted staff member was terminated from the facility in 2021 upon discovery of the incident. In-servicing will occur with all staff regarding the abuse, neglect, exploitation policy, including reporting guidelines. See also POC for deficiencies R179 and R190.	2/23/24

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R224	Continued From page 20 following a fall during which s/he sustained rib fractures with subsequent lung collapse requiring critical care, rendering Resident #1 physically unable to make the fraudulent credit card charges. Resident #1 was hospitalized from 4/10/21 until 4/29/21 when s/he was discharged to a skilled nursing facility. Per interview with the facility's Wellness Nurse commencing at 11:52 AM on 1/16/24, during the investigation it was discovered food purchased on Resident #1's credit card was delivered to the hotel room of a contracted agency employee working at the facility, and additional facility staff were identified as parties of interest in the incident. The facility responded by terminating employment of the staff responsible for fraudulent credit card charges. During the interview commencing at 11:52 AM on 1/16/24 the Wellness Nurse confirmed fraudulent charges were made to Resident #1's card, and confirmed items purchased with Resident #1's credit card were received by contracted staff employed by the facility. In conclusion Resident #1 experienced actual harm by exploitation as evidenced by the confirmed theft of approximately $750.00 by a staff member through the use of Resident's #1's credit card to make fraudulent charges. Please refer to tag 191	R224	R224 Plan of Correction accepted by Jo A Evans RN on 3/3/24.	