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

December 11, 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 **November 13, 2024.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

If you have any questions, please feel free to contact me at (802) 585-0995.

Sincerely,

Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0372	A. BUILDING: _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEN HARBOR SENIOR LIVING	90 ALLEN ROAD SOUTH BURLINGTON, VT 05403

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R100	Initial Comments: An onsite relicensure survey along with an investigation of two facility reported incidents was conducted by the Division of Licensing and Protection on 11/13/24. Regulatory deficiencies were identified. Findings include:	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.	
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 record review and staff interview the RCH railed to ensure residential assessments were completed to accurately assess residents care needs and services for 1 out 5 residents (Resident #1) of the applicable sameple. Findings include: Per Record review Resident #1 Vermont Resident assessment was completed on 5/27/24, per the assessed care, the assessment failed to identify current care areas in which Resident #1 was receiving and required to support well-being at the time the assessment was completed. In review of Resident #1 progress notes, documentation noted Resident #1 to require daily weight monitoring, routine monitoring for lower extremity edema and shortness of breath along with monitoring coagulation therapy.	R136	Resident # 1 had been discharged from the facility at the time of this survey visit. In-Service to be performed with all facility LPN and RN staff to advise that a VT state assessment must be completed annually and/or with any change in condition (including admission to a service such as hospice care) and signed by an RN. In-Service to be performed with all facility LPN and RN staff to advise that a VT state assessment should accurately reflect the needs and wellbeing of the individual Resident and signed by an RN. A house wide audit was performed on all Residential Care assessments to verify if they are up to date according to the annual and/or change in condition needs and signed by an RN. Random audits will be done by the Executive Director and/or designee weekly times 4 and then monthly times 3 to verify assessments are complete and accurate, and that all Changes in Condition have assessments as well. Results of these audits will be brought to the QA committee for review. R 136 Accepted Jenielle Shea, RN 12/11/24	12/13/2024

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R136	Continued From page 1 In further review post the assessment date of 5/27/24, the record indicated the resident was admitted to Hospice, the first progress note acknowledging Hospice care was written on 7/24/24. Through the resident's admission to Hospice, routine acute care monitoring was provided, monitoring for safety related to falls and increased care needs. A "change in condition" assessment was not completed by the Registered Nurse to identify the care and services with hospice and Resident #1 increased support with activities of daily living. Per interview on 11/13/24 at 12:00 PM, the Executive Director (ED) confirmed the resident assessment on 5/27/24 did not appropriately assess all the care needs of Resident #1 at the time the assessment was completed. The ED acknowledged due to the increased care needs of resident #1 and Hospice care, a resident assessment for change in condition, should have been completed by the facility Registered Nurse.	R136	Resident #2 had been discharged from the facility prior to the state survey visit. In-Service to be performed with RN that all VT state assessments need to be physically signed (electronically) by the facility RN. A house-wide audit has been performed to check for RN signatures on all VT state Resident assessments. Random audits will occur weekly times 4 and then monthly times 3 by the Executive Director and/or designee to verify RN signatures on all VT state assessments. Results of these audits will be brought to the QA committee for review.	12/13/2024
R144 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c.(1) Complete an assessment of the resident in accordance with section 5.7; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure resident assessments are completed according to section 5.7 of the Vermont Residential Care Home Licensing	R144		

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R144	Continued From page 2 Regulations effective 10/3/2000 including regulations 5.7.a and 5.7.b which state resident assessments shall be completed using the assessment instrument provided by the licensing agency for all facility residents. Findings include: Per record review the Admission Assessment on file for Resident#2 was not signed as completed by a Registered Nurse. The assessment instrument utilized by the facility for all residents section, N.1 Signatures section including a line for the required signature of a Registered Nurse. On the afternoon of 11/13/24 the facility Manager confirmed Resident #2's assessment was not signed as completed by a Registered Nurse.	R144	R144 Accepted Jenielle Shea, RN 12/11/24	
R162 SS=D	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 written signed physician's orders were obtained for medication listed on the September 2024 Medication Administration Record for one applicable resident (Resident #3). Findings include:	R162	Orders for Resident # 3 have been sent to the physician for signature of all active/current orders. In-service to be done with all facility nurses (LPNs and RN) that a signed physician order is needed for all medications, and that the signed order must be obtained within 15 days of the verbal order. All Residents on medication management services will have their active/current orders sent to the PCP for signature. Random audits will be performed by the Executive Director and/or designee weekly times 4 and then monthly times 3 on order sets and PCP signatures. Results of these audits will be brought to the QA committee for review.	12/20/2024

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R162	Continued From page 3 Per record review, the medication order listing report an order was initated on 9/14/24 of Tylenol 325 mg tablets, take 2 tablets by mouth every four hours as needed for pain or fever. A signed physician's orders were not within the resident record, nor did the record include a progress note to indicate a new order was received. Per the medication audit details, the order was initiated on 9/14/24 by a licensed nurse. The facility was requested to provide the medication order of Tylenol 325 mg transcribed on 9/14/24. The LPN present during the onsite visit, confirmed to be unable to locate the order initiated on 9/14/24. Per further review of the Medication Administration Record (MAR) , on 9/16/24, Resident #3 was administered the medication. At 3:15 PM on 11/13/24 the Licensed Practical Nurse on duty confirmed a signed physician's order was not on file and available for review for the Tylenol order initiated on 9/14/24.	R162	R162 Accepted Jenielle Shea, RN 12/11/24	
R175 SS=D	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	R175	Resident #4 is no longer independent with medications and no longer has medications stored in his/her apartment. In-service to be performed with facility nursing staff (LPNs and RN) that if anyone is approved for self-medications, the medications need to be in a locked storage space. Continued next page…	12/20/2024

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R175	Continued From page 4 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, record review and interview the RCH failed to ensure 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. Findings include: Per record review Resident #4 was assessed by the Registered nurse on 10/10/24 to self administer medications. An interview on 11/13/24 at 3:00 PM, Resident #4 showed the surveyor how medication are stored within his/her apartment. The resident indicated to store medication in a pill planner, noting to leave the pill planner on the counter of the bathroom or on the night stand. The resident was unable to recall if the facility provided a storage area of the medication that could be secured. Per interview on 11/13/24 at 3:20 PM, the Executive Director (ED) acknowledged a secure area is not provided to approved residents who self-administer to store their medications. Additionally, the ED confirmed policies for self administration indicate medications are stored per State Law and Regulations in a secure manner, location and where the medication will not be accessible to other residents.	R175	House wide audit done on all Residents who are care planned for self-medications to ensure a locked storage space. Random audits will be performed by the Executive Director and/or designee weekly times 4 and then monthly times 3 to verify self-meds are locked per regulation. Results of these audits will be brought to the QA committee for review. R175 Accepted Jenielle Shea, RN 12/11/24	
R179 SS=F	V. RESIDENT CARE AND HOME SERVICES	R179	See next page...	

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R179	Continued From page 5 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 3 out of 5 sampled staff completed all required yearly trainings. Findings include: The home's policies and procedures governing staff trainings are consistent with this regulatory requirement.	R179	Annual staff education has now been completed for 2024 for all active staff (confirmed by a house wide audit). All seven pillars of required education were included. Education sent out to all active staff that the seven pillars of education are mandated annually. Random audits by the Executive Director and/or designee will be performed weekly times 4 and monthly times 3 to ensure all new staff are completing their mandatory education upon the first day of hire. In 2025, the new education calendar will be issued to all active staff to ensure continued compliance. Results of these audits will be brought to the QA committee for review. R179 Accepted Jenielle Shea,RN 12/11/24	12/6/2024

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R179	Continued From page 6 On the afternoon of 11/13/24 the Executive Director was requested to provide documentation of trainings completed for a sample of 5 staff. Per review of the staff training records provided for review, 3 out of 5 sampled staff did not complete all required yearly trainings. This finding was confirmed by the Executive Director at 12:20 PM on 11/13/24.	R179		
R189 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b. (3) For residents requiring nursing care, including nursing overview or medication management, the record shall also contain: initial assessment; annual reassessment; significant change assessment; physician's admission statement and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of physician visits, signed telephone orders and treatment documentation; and resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the RCH failed to ensure resident medical records were maintined to include all physician orders and communication to facility providers. Per record review Resident #3 had two separate Tylenol orders on the Medication Administration record. a.) An as needed (PRN) order of Acetaminophen	R189	Medical Records have been filed in appropriate files. In-Service to be done with all nursing staff (LPNs and RN) to include re-education on filing medical records timely. Random audits will be performed by the Executive Director and/or designee weekly times 4 and monthly times 3 to ensure continued compliance with filing of medical records, timely. Results of these audits will be brought to the QA committee for review. R189 Accepted Jenielle Shea, RN 12/11/24	12/13/2024

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R189	Continued From page 7 (Tylenol) 325 mg, take 2 tablets by mouth every four hours as needed for pain or fever. (*Maximum daily dose 3,000mg- note that resident has a routine Tylenol order.) Per record review of Resident #2 progress notes, on 8/30/24, the facility licensed nurse noted, to place the order on hold, as the resident had a scheduled routine order and administration from the as needed order would exceed the daily dosage limit of 3,000 mg. The order resumed to be administered on 9/2/24 and 9/3/24, and discontinued on 9/4/24. A progress note writteon on 8/30/24 by a nurse noted to communicate concerns of multiple Tylenol orders, however the record did not include communication from the provider to the facility for directions in care of the PRN Tylenol order(s), to hold or discontinue the order. b.) An as needed (PRN) order of Tylenol 325 mg tablets, take 2 tablets by mouth every four hours as needed for pain or fever. Per the medication audit details, the order was initiated on 9/14/24 by a licensed nurse. The record did not include a progress note to indicate a new order was received nor an order for the medication. Through the onsite visit on 11/13/24, the Licensed Practical Nurse (LPN) on staff was requested to provide medication orders, as the documentation was not observed within the record. Upon entering the nursing office, staff member(s) were observed to be organizing varying documents into sorted piles. In further interview on 11/13/24 at 2:45 PM, the	R189		

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R189	Continued From page 8 LPN confirmed the resident records have not been maintained on a routine basis, and unfiled medical records are being sorted to locate orders and requested supporting documentation of provider communication. The LPN confirmed to be unable to provide the supporting communication/documentation from the provider regarding directions in care to discontinue the Tylenol order on 9/4/24 and initiating the order on 9/14/24.	R189		
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 record and staff interview the RCH failed to ensure a resident (Resident #3) was free from abuse in providing care services while receiving transportation by facility staff with the facility transport vehicle. Per record review, on 10/29/24 Resident #3 was provided transport by facility staff to an appointment with the facility transport van. During the transport while driving the driver observed Resident #3 on the floor of the van, sustaining a head injury, requiring transport via rescue squad to the emergency department. Due to the injury sustained, Resident #3 required follow up care provided by the facility nursing staff and Resident # 3 primary care provider.	R224	All staff who transport Residents were re-educated on van safety and protocol by the Activities Director and/or Executive Director. A diagram of the straps has been laminated and placed into the van. A new facility protocol was developed that Residents will not be transported in "transport" wheelchairs, but "regular" wheelchairs only due to the weight of the "transport" wheelchairs. Maintenance inspected all straps in the van and found no issues. A new checklist for training was developed and reviewed. The staff member involved in the incident received further 1:1 training before transporting Residents in wheelchairs again. The education and checklist will now be done for any staff member going forward that will be transporting Residents. Resident #3 has returned to baseline with no further concerns (physically, medically, emotionally or related to wellbeing). The Executive Director and/or designee will ensure that all new staff who transport Residents continue to complete the education and checklist prior to transporting Residents on their own.	12/6/2024

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R224	Continued From page 9 Per the facility investigation conducted on 10/29/24, the van driver confirmed to not have secured the wheelchair appropriately. The van driver admitted to fastening 2 out the 4 straps that are intended to secure the wheelchair. The driver confirmed to have fastened the resident seatbelt and was unable to identify how and when the resident fell from the wheelchair to the floor of the van. Per staffing record review, the van driver was hired on 9/24/24 and provided training to include education of the facility transport and vehicle guidelines, the Activities Direction provider demonstration with return demonstration of securing wheelchairs and use of the securement traps within the vehicle. Through the orientation process, the van driver was present on transportation trips and observed providing transports. Per interview on 11/13/24 at 3:30 PM, the Executive Director confirmed the education provided to the van driver prior to assuming the role independently. The Manager confirmed the van driver admitted to not properly securing the wheelchair per the training provided by the Activities Director. Additionally, the ED explained retraining had been provided to all transport staff and updates to transport policies was completed to reflect safety changes to limit the use of transport chairs and only wheelchairs for transporting provided by the facility van. The ED confirmed the van was inspected to ensure all straps were safe condition for continued use. Additionally, the ED confirmed Resident # 3 sustained a head injury and was transported via rescue squad to an emergency department for treatment. The ED acknowledged the van driver's	R224	R224 Accepted Jenielle Shea, RN 12/11/24	

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R224	Continued From page 10 failure to following safety measures for the use of securement traps, as trained, resulted in harm to a resident.	R224		