



**AGENCY OF HUMAN SERVICES**  
**DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING**

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

October 12, 2023

Ms. Carissa Brissette, Manager  
Averte - Main House  
2122 Lower Plain  
Bradford, VT 05033-8936

Dear Ms. Brissette:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 11, 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,

A handwritten signature in black ink, appearing to read "Carolyn Scott".

Carolyn Scott, LMHC, M.S.  
State long Term Care Manager

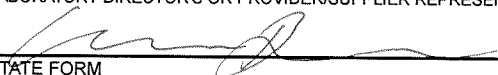
Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0520</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/11/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>AVERTE - MAIN HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2122 LOWER PLAIN BRADFORD, VT 05033</b>
--	---

(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
--------------------	--	---------------	---	--------------------

T 001	Initial Comments  An unannounced on-site relicensure survey was conducted on 9/11/23 by the Division of Licensing and Protection. Regulatory deficiencies were identified. Findings include:	T 001	<i>Please see attached</i>	
T 040 SS=D	V.5.8.5 Resident Care and Services  5.8 Medication Management  5.8.5 Staff other than a nurse may administer PRN psychoactive medications only when the residence 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 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 the Registered Nurse failed to ensure a plan for the administration of as needed psychoactive medications was developed for 1 out of 3 Residents of the applicable sample, to identify specific behaviors the medication is intended to correct and the monitoring for desired and undesired effects of the medication to be referenced by non-licensed staff for the distraction of psychoactive medications. Findings include:  Per record review, Resident #1 has physician orders to be administer Gabapentin 800 mg take 1 tablet by mouth three times a day as needed for	T 040	T 040 Accepted 10/10/23 Jenielle Shea, RN	

Division of Licensing and Protection LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Program Manager</i>	(X6) DATE <i>10/09/2023</i>
---	---------------------------------	--------------------------------

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0520</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/11/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>AVERTE - MAIN HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2122 LOWER PLAIN BRADFORD, VT 05033</b>
--	---

(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
T 040	<p>Continued From page 1</p> <p>for mood and Seroquel 100 mg take 1 tablet by mouth three times a day as needed, not with bedtime dose. The MAR indicates the Gabapentin was administered 13 times in the month of review, and Seroquel was administered twice in the month of review. The medication administrations were performed by unlicensed staff, trained to administer medications.</p> <p>Per interview on 9/11/23 at 2:02 PM, the Registered Nurse confirmed a plan was not developed to demonstrate the use of the as needed Behavior modifying medication. The nurse acknowledged the requirement of the plan, indicating the prescribing provider develops the plans, his/her role is to ensure the plan is developed and unlicensed staff are aware of the medication and the plan developed for administrations.</p>	T 040		

Averte (Trivium New England) – Main House  
Plan of Correction  
October 9th, 2023

**Deficiency –**

V.5.8.5 Resident Care and Services. Medication Management

5.8.5 Staff other than a nurse may administer PRN psychoactive medications only when the residence 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 the time of, reason for and specific results of the medication use.

**Plan of Correction -**

A written plan for the use of PRN psychoactive medications has been completed and signed by Resident #1's psychiatrist on October 9, 2023. The nurse will be asked to review and sign off on these plans during [REDACTED] next visit to the program.

It should be noted that while staff need to be aware of the plan for the administration of PRN psychoactive medications to be able to correctly assist, all of these PRNs are self-administered by our residents at the residents' request.

Medication orders written by the prescribing doctor will include dosage, reason for administration, how often the medication can be administered and total dosage that can be administered in a 24 hour period. Securing written orders including all needed information has been challenging, particularly when working with community-based providers. To try and prevent orders being written without all information included, an additional PRN information sheet was created by the program manager. This will be provided for all medical/psychiatric appointments and signed by both the prescribing physician and Averte nurse. will include the above information, in addition to possible side effects.

Averte administration is working with our psychiatrist to develop a policy that can be referenced in the case any information is missing from future orders and the prescribing physician is not responsive to attempts to gain the needed information.

Please see example of a PRN information sheet and current medication order check list (attached).

Averte's nurse and Program Manager will ensure that all PRN psychoactive medications have a written plan on file in accordance with regulations. The plans will include the following: 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 the time of, reason for and specific results of the medication use.

We will prevent future instances by adding this to our current medication order checklist that the Program Manager and/or RN references to ensure all needed plans are completed for each new PRN order.

T 040 Accepted  
10/10/23  
Jenielle Shea, RN

<b>Name of Medication</b>	<b>Form</b>
<b>Strength</b>	<b>Route of Administration</b>
<b>Dose Instructions</b>	
<b>Maximum dose in 24 hours</b>	<b>Is the medication prescribed or OTC?</b>

**Reason for Administration**

**Adverse effects to be aware of**

**Date**

**Name of person completing this form**

**Date**

**Printed Name and Signature of provider reviewing this form**

**Date**

**Printed Name and Signature of nurse reviewing this form**

### **Medication Changes Checklist**

Date: \_\_\_\_\_

Resident Name: \_\_\_\_\_

Medication: \_\_\_\_\_

New Medication

Dosage Change

Discontinue Medication Order

- Does the medication order include dosage and frequency
- Medication in the medication cart
- Medication on MAR
- Signed order In clients binder
- Signed order In best notes
- Does the medication need a PRN information sheet
- Medication Destroyed if needed