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, 2023

Ms. Lynne Stratton, Manager
Brookdale At Fillmore Pond
300 Village Lane
Bennington, VT 05201-9041

Dear Ms. Stratton:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 30, 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.

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
	0310	A. BUILDING: _____ B. WING _____	C 10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE AT FILLMORE POND	300 VILLAGE LANE BENNINGTON, VT 05201

(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 10/30/23 the Division of Licensing and Protection conducted an unannounced on-site investigation of one complaint. The following regulatory deficiencies were identified:	R100		
R138 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 Physician Services 5.8.b A resident has the right to refuse all medical care for religious reasons or other reasons of conviction, but in such cases, the home must assess its ability to properly care for the resident and document the refusal and the reasons for it 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 the right to refuse vaccinations per one applicable resident's Durable Power of Attorney for Health Care's instructions (Resident #1). Findings include: Per record review Resident #1's Designated Power of Attorney for Health Care (DPOA-HC) refused consent for administration of an annual Influenza vaccine and a SARS-COV-2 booster vaccine during a vaccine clinic conducted at the home on 10/23/23. Documentation of the refusal was not conveyed to the staff conducting the vaccine clinic and the contracted pharmacist who administered both vaccines to Resident #1 on 10/23/23 in error and without his/her DPOA- HC's consent. These findings were confirmed by the Director of Health Services and the Executive Director on the afternoon of 10/30/23.	R138	R138 Resident Care and Home Services Resident #1 did not have a written consent to receive the infuenza or Covid vaccine at the third party contracted vaccine clinic. No other residents were found to have recieved a vaccine without written consent during this clinic. Upon discovery of the incident the Health and Wellness Director (HWD) assessed the resident. NO redness or inflammation were noted at the injection site. No adverse reactions were noted. Resident #1's DPOA and physican were immediately notified. The physician gave no further orders at that time. The HWD and nursing designee were retrained on Brookdale's policy of not accepting verbal consent via phone for vaccines pn 10/31/2023. Future vaccine clinics will be administered to residents that have a signed consent by the DPOA or resonsible party. The HWD and Executive Director (ED) will maintain a list of residents that have provided written consents. This list will be compared against the written consents by the HWD, ED or designee on the day of the clinic to ensure that no resident recieves any vaccine without written consent. The ED will monitor through the Community's QA process to verify compliance. The ED will be responsible for the completion of the correction action plan. R138 Plan of Correction accepted by Jo A Evans RN on 12/10/23	

(revised POC)

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R138	Continued From page 1 Please refer to tag 171.	R138		
R146 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.9.c (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to provide instruction and supervision to direct care staff regarding monitoring for side effects of influenza and SARS-COV-2 vaccines, and to delegate the task of monitoring for vaccine side effects. Findings include: Per record review on 10/30/23, routine monitoring for side effects following administration of influenza and SARS-COV-2 vaccines was not documented in the records of residents who participated in a vaccine clinic conducted at the home on 10/23/23. During an interview commencing at 1:20 PM on 10/30/23 the Director of Health Services (DOHS) stated several of the residents who participated in the clinic presented with potential side effects of vaccines administered on 10/23/23, including residents who were evaluated at the emergency department for potential adverse reactions to the vaccines administered. On the afternoon of 10/30/23 the DOHS confirmed a plan for designated staff to monitor for vaccine side effects following the clinic on 10/23/23 had not	R146	R146 Resident Care and Home Services 5.9.c (3) The HWD and nursing designee were re-educated on 10/31/2023 regarding Vaccine Clinics & Infection Control Management Policy. This includes recognizing, documenting and reporting adverse events. Future vaccine clinics will continue to follow the above-mentioned policy. Prior to any 3rd party vaccine clinic, Brookdale associates will be provided in-service and written instructions on side effects and/or adverse events to be documented and reported. The ED will monitor through the Community's QA process to ensure compliance. The ED will be responsible for the completion of the correction action plan. R146 Plan of Correction accpeted by Jo A Evans RN on 12/10/23	

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R146	Continued From page 2 been developed; direct care staff were not provided documented instructions regarding monitoring for potential vaccine side effects; and designated staff were not delegated to monitor for side effects of the influenza and SARS-COV- 2 vaccines.	R146		
R171 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include: (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, including the reason why and the actions taken by the home; (3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect; (4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and (5) For residents receiving psychoactive medications, a record of monitoring for side effects. (6) All incidents of medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there	R171	R171 Resident Care and Home Services 5.10 Medication Management Resident #1 did not have a written consent to receive the influenza or Covid vaccines at the third party contracted vaccine clinic. No other residents were found to have recieved a vaccine without written consent during the clinic. Upon discovery of the incident, the HWD assessed the resident. No redness or inflammation were noted at the injection site. No adverse reactions were noted. Resident #1's DPOA and physician were immediately notified. The physician gave no further orders at that time. The HWD and nursing designee were retrained on Brookdale's policy of not accepting verbal consent via phone for vaccines on 10/31/2023. All resident charts were updated on 10/31/2033 to reflect administration or declination on the Covid and/or Flu Vaccines. All Resient charts were audited on 10/31/2023 for complete and legible PPOC (Physician Plan of Care), forms. Future vaccine clinics will be administered to residents that have signed consent by the DPOA or responsible party. The HWD and ED will maintain a list of residents that have provided written consents. This list will be compared agaisnt the written consents by the HWD, ED or designee on the day of the clinic to ensure that no resident recieves any vaccine without written consent. The ED will monitor through the Community's QA process to verify compliance. The ED will be responsible for the completion of the correction action plan. *PPOC form attached LK. R171 Plan of Correction accepted by Jo A Evans RN on 12/10/23	

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R171	Continued From page 3 was a failure to establish procedures sufficient to appropriately and effectively document vaccine consent or refusal, and administration of vaccinations. Findings include: 1. Per interview with the Director of Health Services (DOHS) at 1:20 PM on 10/30/23, the memory care center resident's responsible parties were contacted regarding consent for administration of annual influenza and SARS-COV-2 booster vaccines during a vaccine clinic scheduled at the home on 10/23/23. On the afternoon of 10/30/23 the DOHS confirmed the documentation of vaccine consent or refusal for the memory center residents remained in the memory care center Director's office on the day of the clinic; and each resident's consent or refusal for vaccinations was not effectively communicated to staff conducting the clinic and the contracted pharmacist who administered the vaccines. Additionally, on the afternoon of 10/30/23 the DOHS confirmed signed physician's orders for the vaccinations administered at the clinic were not obtained and entered into the records of residents vaccinated during the clinic. Additionally, documentation of vaccines administered to residents on 10/23/23 provided by the contracted pharmacy had not been entered into resident records as of 10/30/23. 2. Per record review Resident #1 resides in the home's memory care center and has cognitive decline resulting in inability to make his/her own decisions regarding medication administration. Per interview with the DOHS on the afternoon of 10/30/23, the memory care center Director contacted Resident #1's Durable Power of Attorney for Health Care (DPOA-HC) regarding administration of the influenza vaccine and a SARS-COV-2 vaccine on an undocumented date	R171		

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R171	Continued From page 4 prior to 10/23/23. Per review of the Director's paper documentation of consent or refusal for vaccine administration on 10/23/23, the Director documented "flu and Covid NO" beside Resident #1's name, indicating his/her DPOA-HC refused consent for administration of the flu vaccine and SARS-COV-2 vaccine during the clinic. On the afternoon of 10/30/23 the DOHS and the Executive Director confirmed Resident #1 received the annual influenza vaccine and the SARS-COV-2 booster vaccine on 10/23/23 in error and without consent due to the failure to effectively document and communicate Resident #1's DPOA-HC's refusal of the vaccines. Following discovery of the administration of vaccines in error, Resident #1's Immunization Report was not updated to include documentation of his/her DPOA-HC's refusal of the influenza vaccine, and documentation of the administration of influenza and SARS-COV-2 vaccines on 10/23/23. Additionally, Resident #1's record did not include signed physician's orders for influenza and SARS-COV-2 vaccines; and his/her Physician's Plan of Care (PPOC) indicated his/her physician did not approve administration of the SARS-COV-2 vaccine as recommended by the Centers for Disease Control and Prevention. On the afternoon of 10/23/23 the DOHS, Executive Director, and Director of the memory care center confirmed they were not aware Resident #1's physician did not check the box for approval of SARS-COV-2 vaccine administration on his/her PPOC. On review, the format of the home's PPOC document is observed to be ineffective due to extremely small print that is difficult to read.	R171		