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

July 27, 2018

Ms. Janine Paradee, Manager
East Terrace Home
71 East Terrace
South Burlington, VT 05403-6145

Dear Ms. Paradee:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 9, 2018.** 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 26 2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0608	A. BUILDING: _____ B. WING _____	C 07/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST TERRACE HOME (RCH)	71 EAST TERRACE 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: The Division of Licensing and Protection conducted an unannounced on site relicensure survey and investigation of a facility self-report on 7/9/2018. The following regulatory violations were identified related to the relicensure survey.	R100		
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, the residence failed to ensure that documentation of	R171	Please see attached. POC accepted R171 / R234 S Sherbrook RN 7/26/18	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Team Lead - East Terrace (X6) DATE 7/23/20

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R171	Continued From page 1	R171		

medication administration contained all elements as required by the Vermont Residential Care Home Regulations for 2 out of 6 residents in the sample (Resident #1 and Resident #2). Findings include:

1. Resident #1 had physician orders for Balmex (rash cream) to be applied to an affected area of skin every morning. Per review of Resident #1's Medication Administration Record, there was no evidence that the Balmex cream had been applied as ordered on the mornings of 6/27/2018,6/28/2018, 6/29/2018 and 7/6/2018. Per record review, Resident #1 had physician orders to receive scheduled doses of medications including baclofen (muscle relaxant) 20mg, docusate sodium (stool softener) 100 mg, montelukast (anti-inflammatory) 10 mg, pulmicort (steroid) 180 mcg, risperidone (antipsychotic) 0.5 mg and temazepam (sedative) 15 mg each evening. Per review of Resident #1's Medication Administration Record, there were blank spaces and no documentation to reflect that Resident #1 had received these medications as prescribed on 7/2/2018.

2. Resident #2 had physician orders to receive Oxybutynin (bladder relaxant) 5 mg every morning. Per review of Resident #2's Medication Administration Record, there were blank spaces and no documentation to reflect Resident #2 received the medication as ordered on the mornings of 6/24/2018 and 6/25/2018. Resident #2 received 600 mg of acetaminophen (analgesic) on 7/2/2018 as needed consistent with physicians' orders, however, there was nothing written on the Medication Administration Record to indicate the reason the medication was administered to Resident #2.

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R171	Continued From page 2 During an interview on the afternoon of 7/9/2018, the Residential Manager stated s/he had verbally informed the Residential Instructors who had administered the medication on the above dates that documentation was required, however, the corrections had not been made. The Medication Administration Records for Resident #1 and Resident #2 were incomplete at the time of the survey and did not include all required elements of medication administration and PRN (as needed) medication documentation.	R171		
R234 SS=C	VII. NUTRITION AND FOOD SERVICES 7.1.a.(3) The current week's regular and therapeutic menu shall be posted in a public place for residents and other interested parties. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the residence failed to ensure that the menu was posted in a public place for residents and other interested parties. Findings include: During an environmental tour of the residence on the morning on 7/9/2018, the menu posted in the kitchen was for the previous week. The Residential Instructor present during the tour confirmed that the current week's menu was not posted or available for viewing in a public area.	R234		

Pamela M. Cota, RN
Licensing Chief
Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 054671-2306

HOWARD CENTER
Help is here.

July 23, 2018

Dear Ms. Cota:

Listed below are the plans of correction for each deficiency cited in the re-licensing survey at East Terrace Group Home, 71 East Terrace RCH of Howard Center Developmental Services that took place on July 9, 2018.

R171 V. Resident Care and Home Services

5.10.g. Medication Management

1. The Residential Coordinator, Janine Paradee, followed up with the Residential Instructors that were responsible for the medications on 6/27/2018, 6/28/2018, 6/29/2018, and 7/06/2018, to ensure that not only the medications were administered but to have the Residential Instructors sign off in the Medication Administration Record. The house nurse was notified of the deficiency and came out to the next scheduled team meeting held on 07/11/2018 to review the process of medication administration. To ensure that deficient practices do not recur the house nurse will review weekly and the Residential Coordinator will review the Medication Administration Record daily to verify that all medications have been signed off by the Residential Instructors. Corrective action is complete.
2. The Residential Coordinator, Janine Paradee, followed up with the Residential Instructors that were responsible for the medications on 6/24/2018, 6/25/2018, to ensure that not only the medications were administered but to have the Residential Instructors sign off in the Medication Administration Record. This was also done with the PRN medication, Acetaminophen that was administered on 7/02/2018 without documenting the reason of why it was administered. The house nurse was notified of the deficiency and came out to the next scheduled team meeting held on 07/11/2018 to review the process of medication administration. To ensure that deficient practices do not recur the house nurse will review weekly and the Residential Coordinator will review the Medication Administration Record daily to verify that all medications have been signed off on by the Residential Instructors. Corrective action is complete.

R234 VII. Nutrition and Food Services

7.1.a. Menu

1. The Team Lead, Amy Quaglietta, followed up with the Residential Instructor who creates, plans, and posts the weekly therapeutic and regular menus. To ensure that deficient practices do not recur the Residential Instructor will post more than a

week, to ensure that there is enough time during the week to create the follow week's menu without a lapse and the Residential Instructors and clients will always have the current menu to refer to. Corrective action is complete.

Please feel free to contact me with any questions or comments.

Sincerely,

Amy Quaglietta
Team Lead, East Terrace
Howard Center
102 South Winooski Ave
Burlington, VT 05401
(802) 488-6515
amyq@howardcenter.org