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

May 23, 2022

Ms. Ann Bouza, Manager
Equinox Terrace
324 Equinox Terrace Road
Manchester Center, VT 05255-9253

Dear Ms. Bouza:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 7, 2022.** 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

Pamela M. Cota, RN
Licensing Chief

MAY 2 2022

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
	0127	A. BUILDING: ________ B. WING ________	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EQUINOX TERRACE	324 EQUINOX TERRACE ROAD MANCHESTER CENTER, VT 05255

(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: An unannounced onsite complaint investigation was conducted by the Division of Licensing and Protection on 4/6 -4/7/2022. There were regulatory violations identified as a result of this investigation.	R100		
R182 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.e Staff persons shall not perform any duties when their judgment or physical ability is impaired to the extent that they cannot perform duties adequately or be held accountable for their duties. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure one of five employees in the sample did not perform job duties with impaired judgement or physical ability. Findings include: On 10/18/2020 while being treated for an illness at SVMC (Southern Vermont Medical Center), the care giver reported that s/he had taken heroin at 1:30 PM while on duty at this facility and that s/he had been scheduled to work a double shift. The care giver had reported "passing out" and coworkers attempting to wake him/her. Review of the the facility schedule the care giver had been assigned to work both day and evening shift on 10/18/2020. The care givers's time sheet for 10/18/2020 confirmed s/he had left at 2:00 PM and did not return to the facility for the remainder of his/her scheduled shift.	R182	R182 Equinox Terrace will ensure that employees are not permitted to work with impaired judgement or a physical ability that does not allow them to perform duties as assigned in a professional manner. R182 Equinox Terrace will ensure adequate screening of employees arriving for scheduled shifts to identify and address behaviors or issues in a timely manner. Additionally, employees will be monitored during their shifts to identify any concerns related to unusual behaviors such as being under the influence of drugs or alcohol.	

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	RN, Exec Dir.	4/28/22

R182- R185 POC's accepted 5/19/22 SFreemanRN/PM

Division of Licensing and Protection

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R182	Continued From page 1 On 9/04/2021 the same care giver injected heroin while on duty and was found unconscious by coworkers. The coworkers presumed s/he was resting until the Team Lead on duty noticed s/he was unresponsive and his/her face was partially blue and called an ambulance. The care giver was resuscitated with Narcan (an Opioid Antagonist Medication used to treat heroin overdose), then transported to SVMC where s/he was treated for a heroin overdose. Per interview with the Executive Director (ED) and Director of Nursing Services (DNS) on 4/06/2023 at 1:44 PM both had not been aware of the incident on 10/18/2020. The ED and DNS stated that the care giver had a long history of personal and health related issues that impacted attendance and therefor the employee leaving the shift early would not raise added concern. While discussing the incident that occurred on 9/4/2021 the ED confirmed that the care giver had been on duty when s/he injected heroin. The care giver's employment was terminated on 9/04/2021 for using heroin on duty.	R182	R182 Training will be given to supervisors and staff to identify concerns and report behaviors inconsistent with professional conduct. Supervisors will be asked to report concerns to ED and/or DNS in a timely manner. A reporting tool will be made available to supervisors to document any incident or concern.	
R185 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.8 Records/Reports 5.12.a The licensee shall be responsible for maintaining, filing and submitting all records required by the licensing agency. Such records shall be kept current and available for review at any time by authorized representatives of the licensing agency. This REQUIREMENT is not met as evidenced	R185	R185 Equinox Terrace will maintain, file and submit all records required by the licensing agency.	

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R185	Continued From page 2 by: Based on staff interview and record review the facility failed to complete criminal background and abuse registry checks for one of five employees in the sample. Findings include: On 10/1/2019 the facility rehired a care giver whose employment had been previously terminated following an incident during which the employee consumed alcohol on facility grounds while off duty with a resident who was under guardianship and not permitted to drink alcohol. Per review of the employee file, on 5/16/2018 s/he was found intoxicated at the facility subsequent to consuming alcohol with a resident on premises while off duty. This incident resulted in the termination of the care givers's employment s/he was rehired on 10/11/2019. The ED stated that the care giver was rehired in an effort to give her/him a second chance after making life changes. Review of staff employee files determined documentation of criminal record and abuse registry background checks for the care giver's 10/1/2019 hire date were absent from the care givers's personnel file. On 4/06/2022 the ED confirmed that criminal record and abuse registry checks were not completed at the time of rehire as the facility administration did not realize that the criminal record and abuse registry checks are required when an employee is rehired.	R185	R185 Criminal and abuse background checks will be maintained on all new hires and rehires. R185 A closer review of any employee who wishes to be rehired, will be conducted in the future to determine suitability based on prior record. A potential candidate will not be hired without a full background check. R185 All background checks will be filed in the employee's personnel file and held in the business office.	