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

June 6, 2024

Wendy Beatty, Manager
Equinox Terrace
324 Equinox Terrace Road
Manchester Center, VT 05255-9253

Dear Ms. Beatty:

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

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 05/07/2024

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EQUINOX TERRACE	324 EQUINOX TERRACE ROAD MANCHESTER CENTER, VT 05255

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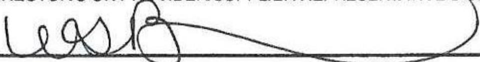
R100	Initial Comments: An unannounced on-site re-licensure survey in conjunction with one complaint investigation was conducted by the Division of Licensing and Protection on 05/07/24. The following regulatory violations were identified:	R100	This plan of correction was written to follow state and federal guidelines. It is not an admission of noncompliance. However, it is the homes commitment to demonstrate and maintain compliance.	
R145 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure development of a Plan of Care which describes the care and services required to maintain independence and well-being for 2 applicable residents (Residents #2 and #3). Findings include: The facility's Resident Care Resident Assessment and Service Plan -Vermont policy and procedures effective 4/3/2006 states, "The HSD (Health Services Director), ED (Executive Director), or designee, direct care staff and others as appropriate shall develop resident service plans for each residents needs in a manner that supports the resident's preference and independence." This document further states resident's service plans will include " aspects of	R145		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE: ED

(X6) DATE: 6.5.24

Division of Licensing and Protection

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R145	Continued From page 1 the resident's medical condition, physical health, emotional and mental health, or problems that are relevant to the services." The facility's policy and procedures for development of resident Service Plans does not indicate the Registered Nurse responsible for supervision and oversight of nursing tasks at the facility is responsible for overseeing the development of resident plans of care. Per record review Resident #2 is diagnosed with Osteoporosis and has a history of fractures. S/he has a history of multiple falls with injuries resulting including recent falls resulting in skin tears, and is prone to skin tears and wounds in general due to impaired skin integrity. Resident #2's Service Plan does not identify and address his/her impaired skin integrity and risk for injury. Per record review Resident #3 is diagnosed with multiple acute and chronic painful conditions, and is prescribed several scheduled medications and PRN (as needed) medications for pain management. His /her service plan does not address pain management, and the physical and psychological effects of chronic pain. These findings were confirmed by the Health Services Director at approximately 1:30 PM on 5/7/24. In conclusion this deficient practice is a potential risk for more than minimal harm to all residents resulting from unidentified residents needs and interventions.	R145	R145 Resident #1 & #2 service plans have been updated. Policy and Procedure has been updated to include RN supervision and oversight. All residents with skin integrity or chronic pain conditions have the potential to be effected by this alleged deficient practice. RN and LPN's have been educated on updating service plans in relation to skin integrity and or chronic pain. Service plan audits will be conducted weekly x4 then monthly x3 to ensure compliance. Results will be reported and discussed in QAPI. Responsible: RN, HDS and ED Date of Compliance 6/5/24	
R147 SS=E	V. RESIDENT CARE AND HOME SERVICES	R147	R145 Accepted on 6/6/24. Sherry Ross, RN	

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R147 Continued From page 2 — R147

5.9.c (4)

Maintain a current list for review by staff and physician of all residents' medications. The list shall include: resident's name; medications; date medication ordered; dosage and frequency of administration; and likely side effects to monitor;

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review there was a failure to ensure prescriber's orders include the specific dose and frequency of administration for all medications including the amount of time between doses for PRN (as needed) medications for two applicable residents (Residents #2 and #3). Findings include:

Page 2 of the facility's Medication Management policy effective 8/31/23 includes procedure #9 which states, " Each prescribed medication order shall legibly display the following information unless it is an emergency medication as below:
* The resident's name
* The medication name
*Strength
*Prescribed dose
*Route of administration
*The frequency of administration
*The indications for usage of all pro re nata (PRN)
*The dated signature of the ordering physician
*The expiration date of the medication "

Per review of the May 2024 Medication Administration Records (MARs) for Residents #2 and #3, the following medications were without a

Plan of correction:

R147

Resident #2 and #3 will have their medication list updated with all the required information and signed by their licensed practitioner.

All residents administered PRN medications have the potential to be effected by this alleged deficient practice.

The facility will maintain a current list of each residents medications, that includes the residents name, medication, date medication ordered, dosage and frequency of administration and likely side effects to monitor. The EMAR program has an info tab that brings up side effects.

The health services director or designee will review residents medication orders as they are due for annual renewal to ensure all required medications areas are addressed and send them to the licensed practitioner for review and signature.

Audits of annual reviews will be conducted weekly x4 then monthly x3 to ensure compliance. Results will be reported and discussed in QAPI.

Responsible: RN, HSD

Date of compliance 6/5/2024

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R147	Continued From page 3 specific dose and frequency of administration to include the amount of time between doses of PRN medications: 1. Resident #2's MAR included: a. "Antibiotic Ointment 500 unit Apply topically to affected area 1-2 times a day as needed (for 5 days)." This order does not include a specific frequency of administration or an indication for usage b. "Antifungal POW 2% Apply antifungal powder topically to the affected area as needed per MD preference" This order does not include a specific frequency of administration or an indication for usage c. "Cough Drops LOZ 5.4 mg Use one cough drop by mouth as needed (for cough)" This order does not include a specific frequency of administration or the maximum amount that can be taken in 24 hours. d. "Dextr/ Guaif 5-100 mg / 5 ml DELSYM Take 10 ml by mouth 4 times a day as needed: This order does not include the full name of the mediation, a specific frequency of administration, or an indication for usage. e. "Dicyclomine SOD tab 20 mg Take 1 tablet by mouth 2 times a day as needed (for IBS)" This order does not include a specific frequency of administration. f. "Docusate SOD CAP 100 mg Take 1 capsule by mouth twice a day as needed" This order does not include a specific frequency of administration or an indication for usage.	R147		

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R147	Continued From page 4 h. "Gold Bond POW Apply topically to affected areas twice a day as needed" This order does not include a specific frequency of administration or an indication for usage. i. "Acidophilus WAF Take 1 tablet by mouth once a day as needed" This order does not include the strength of the medication, which determines the dose, and does not include an indication for usage. j. "Geri-Tussin 100 mg/5 ml Liquid Take 10 ml by mouth four times a day as needed" This order is a duplication of medication order in example d. listed above using a different name for the same medication , which is a risk for overdose. This order does not include a specific frequency of administration or an indication for usage. 2. Resident #3's MAR included: a. . "Antifungal POW 2% Apply antifungal powder topically to the affected area as needed per MD preference" This order does not include the full n a specific frequency of administration or an indication for usage b. "Bacitracin OIN 500 /gm Apply OTC Antibiotic Ointment to the affected area 1-2 times a day for 5 days as needed." This order does not include the full n a specific frequency of administration or an indication for usage c. "Clotrimazole CRE 1% Apply OTC Antifungal Cream topically to the affected area as directed Per MD preference as needed" This order does not include the specific frequency of administration or an indication for usage d. "Geri-Tussin 100 mg/5 ml Liquid Take 10 ml	R147		

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R147	Continued From page 5 by mouth four times a day as needed" This order does not include a specific frequency of administration or an indication for usage. e. "Gold Bond POW Apply topically to affected areas twice a day as needed" This order does not include a specific frequency of administration or an indication for usage. f. "Naloxone HCL SPR 4 mg Spray 1 spray by nasal route as needed." This order does not include a specific frequency of administration. g. " Oragel 3x Gel Tooth /GU Apply topically to the affected area in mouth four times a day as needed for pain." This order does not include a specific frequency of administration. h. "Triple Antib OIN 500 /gm Apply OTC Antibiotic Ointment to the affected area 1-2 times a day for 5 days as needed." This order is a duplication of medication order in example b. listed above using a different name for the same medication. This order does not include a specific frequency of administration or an indication for usage. These findings were confirmed by the Health Services Director at approximately 2 :00 PM on 5/7/24. In conclusion this deficient practice is a risk for more than minimal harm for all residents due to administration of PRN medications at an incorrect dose and/or frequency to address the symptoms the medication is intended to treat, and the failure to ensure the information listed on the MAR conveys instructions for administration as the prescriber intended.	R147	R147 Accepted on 6/6/24. Sherry Ross, RN	

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R207	Continued From page 6	R207		
R207 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.b The licensee and staff are required to report suspected or reported incidents of abuse, neglect or exploitation. It is not the licensee's or staff's responsibility to determine if the alleged incident did occur or not; that is the responsibility of the licensing agency. A home may, and should, conduct its own investigation. However, that must not delay reporting of the alleged or suspected incident to Adult Protective Services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure the Residential Care Home (RCH) reported suspected or reported incidents of exploitation in accordance with Section 5.18b of the Vermont Residential Care Home Licensing Regulations effective 10/3/2000. Findings include: Per review of the facility policies and procedures title Division of Licensing and Protection Required Reports states, Allegations or suspicion of abuse, neglect or exploitation of a vulnerable adult is reported in 48 hours. Per interview with the Executive Director conducted on 5/7/24 at 10:15 AM she/he stated that Resident #1's family reported to facility staff that they had concerns regarding missing clothing items belonging to Resident #1. During the staff interview the Executive Director confirmed that a facility staff member had borrowed Resident #1 clothes after his/her had become soiled while on	R207	R207 Resident #1 no longer resides in the facility. All residents with items borrowed by staff have the potential to be effected by this alleged deficient practice. Staff have been educated to not borrow or take any resident items even with their permission. Any concern reports of suspected theft will be reported to the state. Audits of concern reports will be conducted weekly X4 and then monthly X3 to ensure compliance. Results will be reported and discussed at QAPI. Responsible: HSD and ED Date of compliance 6/5/24 R207 Accepted on 6/6/24. Sherry Ross, RN	

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R207	Continued From page 7 shift. S/he additionally stated that s/he did not report suspected or reported incident of exploitation to the licensing agency. These finding were confirmed by the Executive Directed at the time of finding. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents related to failure to report suspected or reported incidents of resident exploitation.	R207		
R246 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.a Each home must procure food from sources that comply with all laws relating to food and food labeling. Food must be safe for human consumption, free of spoilage, filth or other contamination. All milk products served and used in food preparation must be pasteurized. Cans with dents, swelling or leaks shall be rejected and kept separate until returned to the supplier. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure cans with dents are rejected and kept separate until returned to the food supplier. Findings include: The facility's Dining Services Food Storage policy effective 11/29/04 states, " The use of outdated, unlabelled, or damaged canned goods is prohibited and such goods shall not be maintained on the premises." The job description for facility Prep/Utility	R246	R246 No residents were effected by this alleged deficient practice. Dented cans were removed from the dry food storage area. Staff have been educated on the need to reject cans with dents in order to comply with laws relating to food and food labeling. Audits of the dry food storage area will be conducted weekly x 4 then monthly x 3 in order to ensure compliance. Results will be reported and discussed at QAPI. Responsible: FSD and ED Date of compliance: 6/5/24 R246 Accepted on 6/6/24. Sherry Ross, RN	

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R246	Continued From page 8 Workers in the Dietary Department lists job responsibilities including,"All dented cans must be removed from the kitchen area and given to the FSD [Food Services Director]." During the tour of the Kitchen and Dining Services areas commencing at 8:40 AM on 5/7/24 six dented cans were observed to be stored with in the dry food storage area along with the cans which were undamaged and safe for use. This finding was confirmed by the Food Services Director at 8:58 AM on 5/7/24. In conclusion, this deficient practice is a potential risk for more than minimal harm due to food borne illness for all facility residents.	R246		
R247 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure all perishable foods and beverages are labeled, dated, and held at or below 40 degrees Fahrenheit. Findings include: 1. The facility's Dining Services Food Storage policy effective 11/29/04 states, " All perishable food and drink shall be kept free from spoilage and shall be kept at or below 40 degreed	R247	R247 No residents were effected by this alleged deficient practice. All products identified were removed from the kitchen areas. Staff will be trained on proper labeling, dating and holding temperatures for food and beverages. Audits of kitchen products and temps will be conducted weekly x 4 then monthly x 3 to ensure compliance. Results will be reported and discussed at QAPI. Responsible: FSD and ED Date of compliance: 6/5/24 R247 Accepted on 6/6/24. Sherry Ross, RN	

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R247	Continued From page 9	R247		

Fahrenheit except for when being prepared or served. "

During a tour of the Kitchen and Dining Services areas of the facility commencing at 8:40 AM on 5/7/24 the drink dispenser in the kitchenette area adjacent to the dining room and kitchen was observed to store and serve perishable beverages above 40 degrees Fahrenheit including:
a. Raspberry Water 42.1 degrees Fahrenheit
b. Apple Juice 42.3 degrees Fahrenheit
c. Orange Juice 41.2 degrees

This finding was confirmed by the Food Services Director at 8:50 AM.

2. The facility's job description for Prep/Utility Workers in the Dietary Department lists job responsibilities and other duties which include "Label and date all food ingredients properly".

During a tour of the Kitchen and Dining Services areas of the facility commencing at 8:40 AM on 5/7/24 perishable items in the kitchenette adjacent to the kitchen and dining room, the dry storage pantry, and the walk-in freezer were observed to be without identifying labels and dates the items were opened or prepared including:

a. In the kitchenette perishables without the dates the items were opened or prepared included 3 bags of cereal, a box of Cream of Wheat, and a half gallon container of ice cream. There was an uncovered, unlabeled, and undated tray plus one additional serving of of prepared dishes of ice cream in the kitchenette freezer.

b. In the Dry Storage Pantry there were 5 open

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R247	Continued From page 10 undated bags of cake mixes, and biscuit mix. c. In the Walk-in Freezer uncovered, unlabelled, and undated tray plus one additional serving of of prepared dishes of ice cream was observed on a shelf. Undated opened bags, many of which were also without identifying labels, were observed including bags of gnocchi, bread rolls, garlic knots, chicken tenders, and diced/cubed chicken. These findings were confirmed by the Food Services Director at 9:12 AM on 5/7/24. In conclusion, this deficient practice is a potential risk for more than minimal harm due to food borne illness for all facility residents.	R247		
R291 SS=F	IX. PHYSICAL PLANT 9.6 Plumbing 9.6.d Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to maintain water temperatures at or below 120 degrees Fahrenheit in areas of the home accessible to residents. Findings include: The facility's Maintenance policies and procedures effective 10/5/04 state, "The temperature of hot water at plumbing fixtures used by residents is automatically regulated by control valves and does not exceed 120 degrees Fahrenheit."	R291	R291 No residents were effected by this alleged deficient practice. Water temperatures were adjusted in all resident areas and were maintained at below 120 degrees Fahrenheit. Maintenance staff were trained on the requirement of hot water temperatures not exceeding 120 degrees Fahrenheit. Weekly audits will be conducted to ensure compliance. Results will be reported and discussed in QAPI. Responsible: Environmental Director Date of Compliance: 6/5/24 R291 Accepted on 6/6/24. Sherry Ross, RN	

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R291	Continued From page 11 During the facility tour commencing at 8:40 AM on 5/7/24 water temperatures in areas accessible to residents including the kitchenette adjacent to the dining room and kitchen; resident rooms in the Blue and Teal Wing and the Tan and Rose Wing; and in the Memory Care Center were observed to be above 120 degrees Fahrenheit. 1. The sink in the kitchenette adjacent to the Dining Room and Kitchen was observed with a water temperature of 123.3 degrees Fahrenheit. This finding was confirmed by the Food Service Director during the tour of the Kitchen and Dining Room areas on the morning of 5/7/24. 2. Resident Rooms in the Blue and Teal Wing of the home were observed with water temperatures above 120 degrees Fahrenheit including: a. Room #25 125.6 degrees Fahrenheit b. Room #29 123.3 degrees Fahrenheit 3. Resident Rooms in the Tan and Rose Wing of the home were observed with water temperatures above 120 degrees Fahrenheit including: a. Room #24 123 degrees Fahrenheit b. Room #19 122.9 degrees Fahrenheit These findings were confirmed by the Maintenance Director at 9:42 AM on 5/7/24 4. Resident Rooms within the secured memory care unit on Rose Wing of the home were observed with water temperatures above 120 degrees Fahrenheit including: a. Room #5 135.2 degrees Fahrenheit b. Room # 7 127.8 degrees Fahrenheit c. Room # 41 124.6 degrees Fahrenheit At 10:20 AM on 5/7/24 the Maintenance Director confirmed water temperatures exceeding 120 degrees Fahrenheit were observed in the memory care unit.	R291		

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 05/07/2024

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
R291	Continued From page 12 Corrective adjustments were made to the facility's boiler, and on the afternoon of 5/7/24 the water temperatures in all resident areas listed above were observed to be maintained at temperatures below 120 degrees Fahrenheit. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents due to the risk for burns associated with water temperatures above 120 degrees Fahrenheit and increased risk for burns with injuries resulting for vulnerable adults.	R291		