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

June 11, 2024

Ashley Hudson, Manager
Four Seasons Care Home, Inc
135 South Main Street
Northfield, VT 05663-5603

Dear Ms. Hudson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 10, 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

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
	0129	A. BUILDING: _____ B. WING _____	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR SEASONS CARE HOME, INC	135 SOUTH MAIN STREET NORTHFIELD, VT 05663

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R100	Initial Comments: An unannounced on-site re-licensure survey was conducted by the Division of Licensing and Protection on 04/10/24. The following regulatory violations were identified:	R100		
R176 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (4) Medications left after the death or discharge of a resident, or outdated medications, shall be promptly disposed of in accordance with the home's policy and applicable standards of practice. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the RCH failed to ensure medications that are expired, as indicated by the pharmacy label and/or packaging label, were properly disposed of and not stored within the medication cart available for use. Per observation of the medication cart, the follow medications were observed to be expired, per the pharmacy label: Calcium Antacid 500 mg chewable tablet, the label indicated dispensed on 1/24/23 discard 6 months. Loratadine 10 mg tablet, the label indicated dispensed date of 10/31/22 discarded in 6 months. Children's pepto 400 mg tablet, the label indicated dispensed on 7/28/22 discard 6 months. Tylenol 500 mg tablet, the label indicated	R176	Refer to the following	

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R176	Continued From page 1 dispensed on 6/30/23 discard: 6 months. Ibuprofen 200 mg tablet, the label indicated dispensed on 6/30/23 discard: 6 months. Quetiapine fumarate 50 mg tablet, the label indicated dispensed 5/19/22 discard 6 months. Mucus relief ER 600 mg tablet, the label indicated dispensed 11/23/22 discard 6 months. The following medications had printed expiration dates identified on the medication packaging by the supplier: (2) bottles of Nitroglycerin 0.4 mg tablet with an expiration of 6/2023 and 12/20/2021. Meclizine 12.5 mg tablets, with an expiration of 12/5/21. (2) Albuterol HFA Inhaler 90 mcg the inhaler had a printed expiration on 9/30/2 and 7/31/23. The policy and procedure for medication management were requested for review. In review of the provided binder of facility medication management policies, a policy was not identified to account for the the procedure practices of the monitoring of expired medications and/or disposal practices of non-controlled medications. Per interview on 4/10/24 the Registered Nurse confirmed the identified expired medications per package labeling by the pharmacy and manufacturer. The deficient practice is a potential risk for more than minimal harm to facility residents, as the storage or use of expired medications, may cause a decrease the in effectives of the medication's treatment for the indicated use of the medication.	R176		

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R177	Continued From page 2	R177		
R177 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (5) Narcotics and other controlled drugs must be kept in a locked cabinet. Narcotics must be accounted for on a daily basis. Other controlled drugs shall be accounted for on at least a weekly basis. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the RCH failed to ensure controlled medications were locked, and not accessible by unauthorized personnel. Per observation during an interview , 6 blistered packs of controlled medications were resting on two different desks in the office of the RCH. The medications were 2 blistered packs of Lorazepam 1 mg tablet, with each pack containing #14 tablets and 2 blistered packs of Morphine 15 mg ER, each containing #14mg tablets, Pregablin 100 mg capsule containing #7 capsules, Clozapine 100 mg tablet containing #6 tablets. Per interview on 4/10/24 at 10:18 AM, the Shift Manager confirmed the medications observed, but unable to explain why the controlled medications were on the table and not secured. The facility policy titled Assisting with Controlled Medications states. " All controlled drugs are stored in the med cart, double locked. Controlled	R177	Refer to the following	

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R177	Continued From page 3 drugs are counted every shift." Additionally in a policy and procedure titled Storage of Medications stated " 9. Medications should never be left out in the medication room or unattended outside the medication room. All medications must be stored in the appropriate location when not being used." A follow-up interview on 4/10/23 at 10:30 AM the Manager explained medications received from a new cycle delivery on Monday, 4/10/24 and were to be sent back as the resident(s) are currently admitted to the hospital. S/he confirmed medications are not in the controlled count being accounted for and in office unsecured. The deficient practice is a potential for more than minimal harm, as medication not properly secured provides opportunity for access of use and/or misappropriation.	R177		
R179 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police	R179	Refer to the followings	

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R179	Continued From page 4 or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the RCH failed to ensure that all staff providing direct care to residents had at least twelve (12) hours of required training each year. Findings include: During the course of a re-licensing survey on 4/10/24, the manager was requested to demonstrate via training records that staff employed at the RCH who provide direct care to residents had received the twelve (12) hours of required yearly training. Per record review, 5 out 5 staff completed the training for Resident Rights, 5 out 5 staff completed training's for Fire safety and emergency evacuation, 5 out of 5 staff completed training's for Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid, 5 out 5 staff completed training's for Policies and procedures regarding mandatory reports of abuse, neglect and exploitation, 0 out 5 staff completed training's for Respectful and effective interaction with residents, and 5 out of 5 staff completed training's for General supervision and care of residents.	R179		

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R179	Continued From page 5 The facility policy titled Staff Development & Training states, " New hires will be required to demonstrate competency in all areas, as described in their job description. All staff providing direct care to residents is required to meet a minimum of 12 hours training per calendar year. The yearly training must include but is not limited to the following 7 areas; Resident Rights, Fire Safety and emergency evacuation, Abuse, neglect and exploitation, Respectful and effective interactions with residents, infection control, including but limited to; hand washing, handling of linens, clean environment, blood borne pathogens and universal precautions, and General care and supervision" Per interview on the afternoon of 4/10/24 the Owner/Manager confirmed the training records provided for review were not complete with all required 12 hours of training completed. This deficient practice is a potential risk for more than minimal harm for all facility residents due to inadequate staff education and training to provide resident care safely and effectively.	R179		
R284 SS=F	IX. PHYSICAL PLANT 9.4 Recreation and Dining Rooms 9.4.c Dining rooms shall be of sufficient size to seat and serve all residents of the home at the same time. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the	R284	Refer to the followings	

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R284	Continued From page 6 facility failed to ensure the dining room was of sufficient size with seating to accommodate all residents of the home at the same time. Findings include: During the facility tour commencing on 04/10/23 at 11:45 AM, the facility dining room was observed to have three dining tables with seating for twenty-five residents in total. On 04/10/24 the facilities' current resident census was twenty-eight residents. Per interview with the facility owner on the afternoon of 4/10/24, s/he confirmed this finding stating.	R284		
R999 SS=C	MISCELLANEOUS 4.12 License Certificate The home's current license certificate shall be protected and appropriately displayed in such a place and manner as to be readily viewable by persons entering the home. Any conditions which affect the license in any way shall be posted adjacent to the license certificate. This requirement was NOT MET as evidenced by: Based on observation and staff interview there was a failure to display a copy of the license certificate in a place and manner as to be readily viewable by persons entering the home. Findings include: On the afternoon of 4/10/24 it was observed that the facility license certificate was not displayed in a place within the facility where it could be viewed by persons entering the home. At approximately	R999	Refer to the following	

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R999	Continued From page 7 10:20 AM on 4/10/24 the facility shift Manager confirmed the home's license certificate was not displayed in the home. ********** ********** 4.14 (f) The residence shall make current written reports resulting from inspections readily available to residents and to the public in a place readily accessible to residents where individuals wishing to examine the results do not have to ask to see them. The residence shall post a notice of the availability of all other written reports in a prominent place. If a copy is requested and the residence does not have a copy machine, the residence shall inform the resident or member of the public they may request a copy from the licensing agency and shall provide the address and telephone number of the licensing agency. This requirement was NOT MET as evidenced by: Based on observation and staff interview there was a failure to ensure a current written report with results of inspection was readily available to residents. The residence shall make current written report results from inspection readily available to residents and to the public in a place readily accessible to residents where individuals wishing to examine the results do not have to ask to see them. Findings include: During a tour of the facility on 4/10/24 a copy of a current written inspection report was not posted and available to the public and residents. This was confirmed by the manager on 4/10/24 at 12:30 PM.	R999		

R176:

Deficiency Regulation	How the deficiency was corrected	Date corrected	Facility implementation to ensure compliance of the regulation going forward	FSCH personnel responsible for maintaining compliance
R176	In house RN's went through the med cart on 4/15/24 to ensure there was nothing else outdated in the medcart.	4/15/24	On 4/18/24 RN's reviewed with our evening supervisor/Med tech that this is a task that we need to pay attention to and that we would like [redacted] to spearhead the task. Our evening supervisor will have this responsibility added to [redacted] job description. [redacted] will go through the medcart on the 3rd Sunday of every month to ensure all; PRN creams, powders, pills, inhalers, drops, etc are not outdated. Management has documented on the med room calendar, all of the remaining 3rd Sundays of this year, with the task to be done.	The Manager will be responsible to oversee the followthrough. R176- Accepted 6-10-24 by LTCM

R177:

Deficiency Regulation	How the deficiency was corrected	Date corrected	Facility implementation to ensure compliance of the regulation going forward	FSCH personnel responsible for maintaining compliance
R177	There were 3 controlled drugs (Clozapine isn't a	4/10/24	We have updated our policy regarding controlled medications.	The sole responsibility of the RN's.

Pronouns removed by DLP 6-10-2024

	controlled substance). These medications were returned to the pharmacy the afternoon of 4/10, following the survey.		If the pharmacy is closed and/or RN's are unable to return controlled substances directly to the pharmacy (for any myriad of reasons), RN's will make sure that controlled medications are double locked. Controlled medications will be locked in a file cabinet, in the locked business office until returned.	R177- Accepted 6-10-24 by LTCM

R179:

Deficiency Regulation	How the deficiency was corrected	Date corrected	Facility implementation to ensure compliance of the regulation going forward	FSCH personnel responsible for maintaining compliance
R179	Mandatory in-services were completed by staff. These were in the Administrators desk file that had not been reviewed yet. ([redacted] was out of state and unavailable). These were overdue to be reviewed–but they were completed. They have since been reviewed and have been added into staff's inservice log which finalized their mandatories.	4/17/24	Management has reviewed our process' and has noted several areas in which we can improve in the process of attaining information upon an unannounced surveyor. We are compiling a binder to include the necessary information and or a detailed description as to where to find the information requested. Additionally, we have added to our calendar quarterly reviews of in-services. This will ensure that everyone has met their hours, as well as will clearly demonstrate areas in which inservice	Administrator R179- Accepted 6-10-24 by LTCM

Pronouns removed by DLP 6-10-2024

			hours are still required. Qtrly checks will occur; Feb, May, Aug, Nov and have been added to the calendar.	

R284:
Please refer to variance granted 5/31/24, related to physical plant.

R284-Accepted 6-10-24 by LTCM

R999:

Deficiency Regulation	How the deficiency was corrected	Date corrected	Facility implementation to ensure compliance of the regulation going forward	FSCH personnel responsible for maintaining compliance
R999	Both have been mounted by the main entrance.	4/19/24	The administrator will do quarterly checks of this area to make sure the license and survey results are as they should be. This will be done; Jan, April, July, Oct and has been added to the calendar.	Administrator R999-Accepted 6-10-24 by LTCM

Ashley Dunbar 6/7/24