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 29, 2024

Cassie Lambert, Manager
Gazebo Senior Living 1
1530 Williston Road
South Burlington, VT 05403-6422

Dear Ms. Lambert:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 24, 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
	0148	A. BUILDING: _____ B. WING _____	C 06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GAZEBO SENIOR LIVING 1	1530 WILLISTON ROAD 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: On 6/24/24 the Division of Licensing and Protection conducted an unannounced on-site relicensure survey and an investigation of two facility reported incidents. There were no regulatory deficiencies identified during the investigation of the two facility reported incidents. The following regulatory deficiencies were identified during the relicensure survey:	R100	The filing of this plan of correction does not constitute admission of the allegations set forth in this statement of deficiencies. This plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law.	
R144 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c.(1) Complete an assessment of the resident in accordance with section 5.7; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure completion of Resident Assessments in accordance with Section 5.7 of the Vermont Residential Care Home Licensing Regulations effective 10/3/2000 for 2 applicable residents (Residents #1 and #2). Findings include: The home's Assessment of Residents policy states resident assessments, "shall be completed for each resident within fourteen (14) days of the resident's admission, consistent with the physician's diagnosis and orders, using the assessment instrument provided by the licensing agency" and states, "Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition."	R144		

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R144	Continued From page 1 1. Per record review Resident #1 was re-admitted to the facility on 8/1/23 following transfer of licensure and ownership previous facility owner to the current owner and licensee. Per record review the Resident Assessment forms on file and available for review in Resident #1's record: a. Resident #1's Admission Assessment form on readmission to the facility under the new licensure and ownership includes a header which indicates this form is an annual reassessment initiated on 9/15/23. Question #3 of this form indicates Resident #1 was readmitted to the home on 8/1/23; however Question #5 indicates the reference date for this assessment form is 1/16/24 and the assessment form is signed by a Registered Nurse and dated as completed on 8/1/24, 38 days after the date the survey was conducted. b. A second Resident Assessment form on file for Resident #1 has a reference date of 1/22/24, indicates "Other" as the type of assessment and states the reason for the assessment is a "fall with right rib fracture"; however the header on this form indicates this form is a Significant Change Assessment dated 4/22/24 and is signed as completed by the Health Services Director on 4/22/24. There is no documentation of a fall resulting in rib fracture in Resident #1's record, however medication orders for PRN pain medications include indications for rib fracture on 4/20/24. c. Resident #1 was admitted to hospice care on 5/1/24 following a period of significant physical decline. A significant change assessment was not completed for Resident #1 in response his/her declining health and admission into hospice care.	R144	R144 5.9.c(1) 1. Action Taken to Correct Deficiency Resident #1 and #2's assessments were corrected immediately. All Resident Assessments will be audited by RN by 7/31/24. 2. Measures put into place to ensure it doesn't recur All nurses have been educated on completion of the Resident Assessment. Admission Checklists and processes were revised to include a final review by Health Services Director to ensure compliance. Education has been provided to nursing staff on the new process. The Clinical Dashboard and documentation will be reviewed by HSD for significant changes, and a Resident Assessment will be completed promptly if indicated, and after every hospice admission. 3. Corrective Action Monitoring Resident Assessments will be reviewed for accurate completion every week x 4 weeks, then monthly x 4 weeks, then quarterly during QAPI meetings. 4. Date to be Completed: 7/31/24	

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R144	Continued From page 2 At 1:20 PM on 6/24/24 the Director of Health Services confirmed the Resident Assessments on file for Resident #1 were not completed per regulatory requirements. 2. Resident #2 was admitted to the home on 4/15/24. An Admission Assessment on file for Resident #2 has a reference date of 4/15/24 and is signed by the Director of Health Services, however Section N. Signatures Question #5 does not include the date this assessment was signed as completed by the nurse. This finding was confirmed by the Director of Health Services at 1:24 PM on 6/24/24. In conclusion this deficient practice is a risk for more than minimal harm to all facility residents due to the failure to identify resident needs through the required resident assessment process, which is the basis of resident care planning	R144	R144 Plan of Correction accepted by Jo A. Evans RNon 7/28/24.	
R145 SS=D	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:	R145		

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R145	Continued From page 3 Based on staff interview and record review there was a failure to ensure care and services related to hospice care were included in the Plan of Care for one applicable resident (Resident #1). Findings include: The home's Nursing Care Requirements policy states the nurse shall, "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." Per record review Resident #1 was admitted to hospice on 5/1/24 following a period of declining health. Per review of Resident #1's Care Plan, care and services related to hospice care are not included in his/her plan of care. This finding was confirmed by the Director of Health Services and the Executive Director at 1:50 PM on 6/24/24. 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 5.9.c(2) 1.Action take to correct the deficiency Resident #1 care plan was updated to reflect hospice on 6/24/24. 2. Measures put into place to ensure it doesn't recur All nurses have been educated on the importance of care plans reflecting hospice admissions. A hospice admission checklist has been implemented, which includes reminders to complete hospice care plan. This checklist will then be reviewed by Health Services Director for accuracy and completion. The Clinical Dashboard and documentation will be reviewed by HSD for hospice admission information, and hospice care plan will be created timely. 3. Corrective action monitoring Clinical Review for hospice admission will be done every week day x 4 weeks, then monthly x 4 weeks, then quarterly during QAPI meetings. 4. Date to be completed - 7/31/24 R145 Plan of Correction accepted by Jo A Evans RN on 7/28/24	
R167 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home	R167		

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R167	Continued From page 4 has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure plans for the administration of 2 PRN (as needed) psychoactive medications by staff other than a nurse were on file and available for review. Findings include: The home's Psychoactive PRN Medications policy states, "Staff other than a nurse may administer PRN psychoactive medications with the use of a behavior care plan that is specific to the resident and the medication.", and further states the home "will have a written behavior care plan for each resident and for each PRN psychoactive medication." Per record review, Resident #2's June 2024 Medication Administration Record includes orders for Haloperidol 0.5 mg tab Take one tablet by mouth every 4 hours as needed; and Lorazepam 0.5 mg tab Take one by mouth every 2 hours as needed. On the afternoon of 6/24/24 the Director of Health Services was requested to provide copies of written plans for the administration of PRN Haloperidol and Lorazepam to Resident #1 by staff other than a nurse. At 1:25 PM the Director of Health Services confirmed written the	R167	R167 5.10 1. Action Taken to correct the deficiency Resident #1's care plan was immediately updated to reflect a PRN psychoactive medication, with behavior care plan for [redacted] PRN psychoactive medications. 2. Measures put in place to ensure it does not recur A Psychoactive Medication Checklist has been implemented and nurses have been educated on this process. Health Services Director to receive checklists and review for completion. The Clinical Dashboard and documentation will be reviewed by HSD for new medications, and PRN psychoactive care plan will be created. 3. Corrective Action Monitoring Clinical Review for new psychoactive medications will be done every week day x 4 weeks, then monthly x 4 weeks, then quarterly during QAPI meetings. 4. Date to be completed 7/31/24 R167 Plan of Correction accepted by Jo A Evans RN on 7/28/24	

Pronouns removed by DLP 7/25/25

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R167	Continued From page 5 requested written plans were not on file and available for review. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents due to risk for medication errors and adverse effects resulting from administration of PRN psychoactive medications by staff without information necessary to ensure the psychoactive medications are administered as the prescribing physician intended and monitor for potential side effects.	R167	R190 1. Action Taken to correct deficiency The Background Check policy was updated to reflect the current Residential Care Home policies with regards to background checks. The misplaced VCIC check was completed immediately, All Employee files were reviewed for completion. 2. Measures put into place ot ensure it does not recur A New hire checklist has been implemented, and Business Office Director has been educated. 3. Corrective action monitoring All new hire folders will be reviewed for completion by Executive Director, or designee, before orientation starts, every week x 4 weeks, monthly x 4 weeks, then quarterly during QAPI meetings. 4. Date to be completed. 7/31/24	
R190 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure completion of all required criminal record checks for 1 out of 5 sampled staff. Findings include: The home's Employee Background Checks policy states it is the policy of the home to "conduct personal reference checks, adult abuse registry, and criminal investigation checks on all candidates making application for employment with the facility and those persons applying to volunteer." This policy does not include the requirement to conduct Child Abuse Registry checks, and the requirement to conduct Vermont Criminal Information Center and National criminal record checks per policy updates effective May	R190		

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R190	Continued From page 6 2023. On the morning of 6/24/24 the Executive Director was requested to provide copies of criminal record checks, and adult and child abuse registry checks for a sample of 5 staff. Per review of the background checks provided for review, all required criminal record checks were not completed as required for 1 out of 5 sampled staff. A Vermont Criminal Information Center criminal record check completed prior to hire was not on file and available for review for one sampled staff. This finding was confirmed by the Executive Director at 1:46 PM on 6/24/24. In conclusion this deficient practice is a potential risk for more than minimal harm for all residents, as the requirement for criminal background and abuse checks is intended to ensure all residents are free from the risk of harm.	R190	R190 Plan of Correction accepted by Jo A Evans on 7/28/24.	