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

January 12, 2023

Ms. Valerie Cote, Manager
Homestead Senior Living
64 Harborview Drive
St Albans, VT 05478-4477

Dear Ms. Cote:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 8, 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

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
	0605	A. BUILDING: _____ B. WING _____	R-C 11/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD SENIOR LIVING	64 HARBORVIEW DRIVE ST ALBANS, VT 05478

(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 follow-up survey was conducted on 11/8/22 by the Division of Licensing and Protection to determine regulatory compliance from a re-licensure survey completed on 7/14/22. The following regulatory violations were found not to be back in compliance with the Residential Care Home Licensing Regulations effective 10/3/2000:	{R100}	The filing of this plan of correction does not constitute an admission of the allegations set forth in this statement of deficiencies. This plan of correction if prepared and executed as evidence of the facility's continued compliance with applicable law.	
{R141} SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9 Level of Care and Nursing Services 5.9.a Residents who require more than nursing overview or medication management shall not be retained in a residential care home unless the provisions of the following subsections (l)-(5) are all met: (1) The nursing services required are either: i. Provided fewer than three times per week; or ii. Provided for up to seven days a week for no more than 60 days and the resident's condition is improving during that time and the nursing service provided is limited in nature; or iii. Provided by a Medicare-certified Hospice program; and (2) The home has a registered nurse on staff, or a written agreement with a registered nurse or home health agency, to provide the necessary nursing services and to delegate related appropriate nursing care to qualified staff; and (3) The home is able to meet the resident's needs without detracting from services to other residents; and	{R141}	Resident #20's medications noted in this statement have been corrected and are being provided in pre-filled syringes. Medication Techs and LPNs/RNs to be provided in-service on the medication program policy to ensure that Residents are receiving the appropriate nursing services for their level of care. Admissions Director also provided in-service for new admits. Facility's 2 Hospice providers updated by Wellness Director on the medication program policy. A house wide audit will be conducted on all liquid hospice mgmt. medications. Random audits will then be conducted by the wellness director and/or designee weekly times 4 and then monthly times 2 on liquid hospice mgmt. medications.	12/20/2022

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

MBA, LHHA Executive Director 12/14/2022

R141 - R266 POC's accepted 1/9/23 FMcIntosh RN IPMU

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{R141}	Continued From page 1 (4) The home has a written policy, explained to prospective residents before or at the time of admission, which explains what nursing care the home provides or arranges for, how it is paid for and under what circumstances the resident will be required to move to another level of care; and (5) Residents receiving such care are fully informed of their options and agree to such care in the residential care home. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review there was a failure to ensure nursing services are provided by the home's registered nurse or the Hospice program to provide liquid Morphine and Lorazepam in prefilled syringes for one applicable resident (Resident #20). Findings include: Resident #20 is receiving hospice care and is prescribed liquid Morphine and Lorazepam via oral syringe. On the afternoon of 11/8/22 bottles of liquid Morphine and Lorazepam belonging to Resident #20 were observed stored in the medication lock box in med cart #1. Per record review, on 11/5/22 and 11/6/22 Morphine oral syringes were prepared by facility Med Techs and administered to Resident #20. The facility Hospice Medication Procedure dated 9/9/21 states, "Homestead staff (med techs and nurses) will require prefilled syringes for hospice pain management." Despite the facility policy requiring hospice agencies to provide prefilled syringes, bottles of liquid Morphine and Lorazepam were accepted at the facility and Resident #20's Morphine Sulfate syringes were filled by Med Techs who were not trained to	{R141}		

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{R141}	Continued From page 2 perform this task. At 1:15 PM on 11/8/22 the Director of Nursing confirmed the failure to ensure prefilled liquid Morphine and Lorazepam syringes were provided by the hospice organization for Resident #20; and confirmed facility Med Techs were not trained to prepare oral syringes.	{R141}		
{R144} SS=D	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 the registered nurse failed to sign a completed resident assessment for 1 of 3 applicable residents. (Resident #35) Findings include: A resident reassessment was completed for Resident #35 on 10/25/22, however a review and signiture was not completed by the RN, as required.	{R144}	Resident #35's assessment has been reviewed and signed by a RN. The nurse mgmt. team is to be in-serviced on assessment requirements in this level of care. The facility's electronic medical system tracks due dates of assessments for the nurse mgmt. team. A house wide audit will be completed of assessments to ensure they are reviewed and signed by a RN. Random audits will then be conducted weekly times 4 and monthly times 2 by the Wellness Director and/or designee to ensure assessments are being reviewed and signed by a RN.	12/20/2022
{R161} SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.b The manager of the home is responsible for ensuring that all medications are handled according to the home's policies and that designated staff are fully trained in the policies and procedures.	{R161}	The medication room and overflow cart were locked immediately upon notice. Resident #s 22, 42, 43, 44 and 45 have had their medications disposed of per policy. Resident #20's liquid pain/hospice medications have been corrected to pre-filled syringes. Resident #20's narcotic counts have been corrected.	12/20/2022

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{R161}	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the Executive Director of the Residential Care Home (RCH) failed to ensure all medications are handled according to facility policies and ensure the designated staff are fully trained in policies and procedures. Findings include: Per record review the facility Medication Program Policy effective 2/15/2020 states the facility will assure compliance with State Law and Regulations and the Executive Director will assure the Medication Program is in place. 1. The facility's policy for the storage of medications effective 2/15/20 states "The medication storage area is to remain secured if no staff is present. The medication cabinet, cart, refrigerators, and/or room will be locked at all times unless directly monitored by authorized medication staff." On the afternoon of 11/8/22 the medication room and the overflow medication cart were observed to be unlocked; unmonitored by medication staff, and accessible to unauthorized personnel, residents, and visitors. On the afternoon of 11/8/22 the Director of Nursing acknowledged the med room and overflow med cart were left unlocked. 2. The facility medication policy on disposal of medications effective 2/15/20 states "When a Resident's medication is contaminated, refused, expired, discontinued, or following a resident's death, unused medications, will be recorded on a Medications Returned for Destruction form, and returned to the pharmacy (if permitted) or disposed per the Community disposal procedure	{R161}	In-service to be provided to medication techs and LPNs/RNs re: the medication program policy including storage of medications, disposal of medications and providing appropriate nursing services in regard to the hospice med mgmt, and the medication diversion policy. Full house audits will be conducted of medications for disposal purposes, of all liquid hospice mgmt. medications, and of the current narcotic counts/book. Random audits will be conducted weekly times 4 and then monthly times 2 by the Wellness Director and/or designee of: medication storage locks, medications in need of disposal, liquid hospice mgmt. medications and the narcotic counts/book.	

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{R161}	Continued From page 4 as soon as practical". On the afternoon of 11/8/22 multiple medications requiring disposal were observed stored in an unlocked overflow medication cart in the med room. Medications left after the death of Resident #22 who passed away on 11/3/22 included medications to treat constipation, fluid retention, nausea and anxiety. Outdated medications and medications no longer in use belonging to Resident #42 included medications to treat Alzheimer's, fluid retention, acid reflux, high blood pressure, depression, as well as vitamins and a mineral supplement. Outdated medications and medications no longer in use belonging to Resident #43 included and anticoagulant and medications to treat high blood pressure, nausea, and a mineral supplement. Outdated medications belonging to Resident #44 included medications to treat diabetes, hypothyroidism, infection, inflammation, and overactive bladder. At 12:32 PM on 11/8/22 the Lead Med Tech and Director of Nursing confirmed outdated medications and medications no longer in use were stored in the unlocked overflow med cart in the med room. Please refer to tag 176. Boxes of Fentanyl patches containing 12.5 mcg patches and 25 mcg belonging to Resident #45 were observed in the lock box of medication cart #1. Per review of medication orders Resident # CB's 12.5 mcg and 25 mcg patches were discontinued on 10/27/22. At 2:27 PM on 11/8/22 the Director of Nursing confirmed expired Fentanyl Patches belonging to Resident #45 remained in medication cart #1. 3. The facility Hospice Medication Procedure dated 9/9/21 states, "Homestead staff (med techs and nurses) will require prefilled syringes for	{R161}		

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{R161}	Continued From page 5 hospice pain management." Resident #20 is receiving hospice care and is prescribed liquid Morphine and Lorazepam via oral syringe. On the afternoon of 11/8/22 bottles of liquid Morphine and Lorazepam belonging to Resident #20 were observed stored in the medication lock box in med cart #1. Despite the facility policy requiring hospice agencies to provide prefilled syringes, bottles of liquid Morphine and Lorazepam were accepted at the facility, and Resident #20's Morphine Sulfate syringes were prepared by facility Med Techs who were not trained to perform this task and administered on 11/5/22 and 11/6/22 At 1:15 PM on 11/8/22 the Director of Nursing confirmed the failure to ensure prefilled liquid Morphine and Lorazepam syringes were provided by the hospice organization for Resident #20; and confirmed facility Med Techs were not trained to prepare oral syringes. Please refer to tag 141. 4. The facility's Medication Diversion policy effective 2/15/20 states "The count sheet shall be signed and dated by the authorized Staff at the time the controlled substance is received ... Staff shall follow accurate documentation practices when charting the use of controlled substances. Staff shall never use white out or write over/cross out words or numbers." Per record review and staff interview there was a failure to assure the facility policies were followed to assure documentation of the receipt of Morphine oral solution on 11/5/22 for Resident #20, to assure accurate accounting of the amount remaining after administration on 11/5/22 and 11/6/22, and to ensure write overs were not used to correct a documentation error.	{R161}		

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{R161}	Continued From page 6 The Individual Narcotic Record count sheet for Resident #20's Morphine 20 mg/ml solution dated 11/5/22 does not contain an initial entry signed by the staff who received the medication that verifies the amount received. The first entry on the count sheet contains an incorrect documentation of the amount remaining after the first dose was given on 11/5/22. A write over correcting this error was entered after the second dose was given on 11/6/22, and documentation of the amount remaining after the second dose was administered is inaccurate as the staff who administered this dose subtracted the amount given from the incorrect amount remaining listed on the first entry. On the afternoon of 11/8/22 the Director of Nursing confirmed the documentation errors on the count sheets for Resident #20's Morphine 20 mg/ml oral solution.	{R161}		
{R162} SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview there was a failure to ensure all medication orders were signed by a physician for 2 applicable residents (Resident #20 and Resident #45). Findings include: 1. Per review of medication orders there was a	{R162}	Resident #20's and #45's orders have been signed by a provider. In-service to be provided to medication techs and LPNs/RNs re: the medication program policy to ensure all orders are signed by a provider. A house wide audit to be conducted of orders and provider signatures. Random audits will then be conducted weekly times 4 and then monthly times 2 by the Wellness Director and/or designee on orders and provider signatures.	12/20/2022

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{R162}	Continued From page 7 failure to obtain signed physician's orders for hospice medications including Prochlorperazine, Morphine Sulfate oral solution, Haloperidol oral solution, Lorazepam oral solution, Torsemide, and Atropine sublingual solution for Resident #20 who is receiving hospice care. At 3:15 PM on the Director of Nursing confirmed the failure to obtain signed orders for Resident #20's hospice medications. 2. Resident #45's Medication Administration Record includes a PRN (as needed) order for Imodium liquid solution for Diarrhea. At 2:57 PM on 11/8/22 the Director of Nursing confirmed the failure to obtain signed orders for the liquid form of this medication.	{R162}		
{R176} SS=E	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 there was a failure to dispose of medications left after the death of a resident, outdated medications, and discontinued medications for 5 applicable residents (Residents #22, #42, #43, #44 and #45). Findings include:	{R176}	Resident #s 22, 42, 43, 44 and 45 have had their medications disposed of per policy. In-service to be provided to medication techs and LPNs/RNs re: the medication program policy in regard to the disposal of medications. A house wide audit will be conducted of medications in need of disposal. Random audits will be done by the Wellness Director and/or designee of this and will occur weekly times 4 and then monthly times 2.	12/20/2022

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{R176}	Continued From page 8 The facility medication policy on disposal of medications effective 2/15/20 states "When a Resident's medication is contaminated, refused, expired, discontinued, or following a resident's death, unused medications, will be recorded on a Medications Returned for Destruction form, and returned to the pharmacy (if permitted) or disposed per the Community disposal procedure as soon as practical". On the afternoon of 11/8/22 multiple medications requiring disposal were observed stored in an unlocked overflow medication cart in the med room. Medications left after the death of Resident #22 who passed away on 11/3/22 included medications to treat constipation, fluid retention, nausea and anxiety. Outdated medications and medications no longer in use belonging to Resident #42 included medications to treat Alzheimer's, fluid retention, acid reflux, high blood pressure, depression, as well as vitamins and a mineral supplement. Outdated medications and medications no longer in use belonging to Resident #43 included and anticoagulant and medications to treat high blood pressure, nausea, and a mineral supplement. Outdated medications belonging to Resident #44 included medications to treat diabetes, hypothyroidism, infection, inflammation, and overactive bladder. At 12:32 PM on 11/8/22 the Lead Med Tech and Director of Nursing confirmed outdated medications and medications no longer in use were stored in the unlocked overflow med cart in the med room. 2. Boxes of Fentanyl patches containing 12.5 mcg patches and 25 mcg belonging to Resident #45 were observed in the lock box of medication cart #1. Per review of medication orders Resident # CB's 12.5 mcg and 25 mcg patches were discontinued on 10/27/22. At 2:27 PM on 11/8/22	{R176}		

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{R176}	Continued From page 9 the Director of Nursing confirmed expired Fentanyl Patches belonging to Resident #45 remained in medication cart #1.	{R176}		
{R249} SS=E	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.d The home shall assure that food handling and storage techniques are consistent with safe food handling practices. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure food handling and storage of food items consistent with safe food handling practices. Findings include: During the course of the kitchen tour on the morning of 11/8/22 the walk-in refrigerator was observed to contain open unwrapped and undated food items including a bag of shredded cheese; sliced provolone cheese; cream cheese; lettuce; and a multi-level rack of trays containing 6 whole pies, 2 partial pies, and single servings of pie, pudding. Jello, and cake. Opened undated items observed in the walk-in fridge included heavy cream, buttermilk, salad dressings, a bag of spinach, American cheese repackaged in plastic wrap, cottage cheese, chopped cucumbers and tomatoes, and a container of garlic cloves. Prepared foods including chopped garlic dated 10/28/22, lemon slices dated 10/28/22, and cake topping dated 10/25/22 were also observed in the walk-in fridge on 11/8/22. A reach in refrigeration unit contained sunburn	{R249}	All foods have been corrected to be covered and dated. Out of date items have been disposed of per policy. Food items are not stored/placed with chemicals. Boxes have been corrected to appropriate placement. In-service to be provided to dietary staff re: the food storage policy to ensure food is stored and placed properly. A house wide audit of food storage areas to be performed to ensure the food storage policy is being followed. Random audits will be done weekly times 4 and then monthly times 2 by the Dietary Services Director and/or designee.	12/20/2022

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{R249}	Continued From page 10 relief gel stored with food items; and opened undated items including a gallon of cider and bottles of apple juice, coke, grape juice, pineapple juice, and a gallon of milk. An uncovered container of melted butter with a spatula left in it was observed on a table beside the oven, and two shelves were observed to have uncovered containers of diluted sanitizing solution on the same shelves as food items. Boxes of onions, sweet potatoes, and potatoes were observed stored on shelves approximately 3 inches from the floor, which presents a risk for contamination by insects, rodents, and cleaning solutions when the floors are mopped. These findings were confirmed by the Sous Chef during the tour of the kitchen, and acknowledged by the Interim Director at 11:48 AM on 11/8/22.	{R249}		
{R266} SS=F	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review there was a failure to provide care in a safe, functional, and homelike environment. Findings include: On the morning of 11/8/22 rippling of the carpeting in the first floor hallway, in the dining	{R266}	The first floor and dining room carpeting has been repaired to ensure there are no safety concerns. Maintenance director to be provided an in-service on reporting any carpet issues to the Executive Director and/or designee immediately. A house wide audit will be conducted of the carpeting in the facility to ensure there are no safety concerns. Random audits will be conducted weekly times 4 and then monthly times 2 of the facility carpets by the Maintenance Director and/or designee.	12/20/2022

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{R266}	Continued From page 11 room walkways, and beneath dining room chairs was observed. While the Interim Director stated recent repairs had been made to the carpeting and an estimate was provided for future plans to replace the carpeting, the rippling of the carpeting continues to present an immediate risk for falls and injuries. On the morning of 11/8/22 acknowledged the repairs completed had not resolved the rippling of the carpeting in the first floor hallway and dining room.	{R266}		