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

May 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 **March 8, 2023.** 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 03/08/2023

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 3/8/23 by the Division of Licensing and Protection to determine regulatory compliance from a re-licensure survey completed on 11/8/22. 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.	
{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 Vermont State Residential Care Home Licensing Regulations Section 5.7 effective October 3, 2000 for 4 applicable residents (Residents #1, #2, #3, and #4). Findings include: 1. Resident #1 was admitted to the facility on 2/1/23. The admission assessment for Resident #1 was signed as completed by the Registered Nurse (RN) on 2/21/23, 20 days after admission. 2. Resident #2 was admitted to the facility on 2/22/23. An admission assessment had not been completed for Resident #2 on the day of the follow up survey on 3/8/23, which was the 14th day after his/her admission, and a Registered Nurse was not on duty on the day of survey to	{R144}	Residents # 1 and 2 have been discharged from the facility. Residents # 3 and 4 have had updated assessments completed and confirmed and signed timely by the RN on 3/26/23. LPNs and RNs in-serviced on the assessment process. Completed on 4/13/23. Executive Director and/or designee will provide a list of assessments to the facility RN weekly that are upcoming for due dates. A house wide audit was completed by the Executive Director on all current Residents and their assessments. Updated assessments for those not in compliance have been assigned to the facility RN to be completed by 4/30/23. A random audit will occur by the Executive Director and/or designee on Resident assessments weekly times 4 and then monthly times 3 to ensure continued compliance. Results of these audits will be brought to the QA committee and reviewed.	4/30/23

Tags R144 to R249 accepted 05-12-2023 - J. Evans/C. Scott

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{R144}	Continued From page 1 complete a timely admission assessment. 3. Resident #3 was admitted to the facility on 12/5/22. An admission assessment was signed as completed by the Licensed Practical Nurse (LPN) on 12/21/22, however the assessment does not include documentation of the date signed by the RN. 4. On 11/8/22 the facility was cited for failure to document the review and completion of a reassessment dated 10/25/22 with the RN's signature for Resident #4 . On review this reassessment on 3/8/23 the RN inaccurately documented the date the reassessment was signed as reviewed and completed as 10/25/22 instead of the date this corrective action was taken. The Executive Director confirmed Resident Assessments for Residents #1, #2, #3, and #4 were not completed in accordance with section 5.7 of the Vermont State Residential Care Home Licensing Regulations effective 10/3/2000 at 6:09 PM on 3/8/23.	{R144}		
{R161} SS=E	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. This REQUIREMENT is not met as evidenced by:	{R161}	Expired medications have been removed from the medication carts and disposed of per policy. Discontinued medications have been removed from the medication cart and disposed of per policy. Medication techs and LPNs/RNs have been in-serviced on the medication policy, including the	4/21/23

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{R161}	Continued From page 2 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 procedures. Findings include: 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". At 1:52 PM on 3/8/23 the Lead Med Tech confirmed expired medications belonging to 8 residents and a medication belonging to 1 resident who discharged from the facility on 2/11/23 were stored in the overflow medication cart; and at 6:12 PM on 3/8/23 the Executive Director acknowledged the failure to dispose of the medications according to the facility medication policy on disposal of medications. Please refer to tag 176.	{R161}	medication disposal piece of the policy. A medication cart audit will be conducted by a designee per the Executive Director to confirm compliance. The pharmacy came to the facility to do a medication cart audit on 4/14/23. The facility's back up medication cart is no longer being used for active medications and only being used for discontinued medications that are awaiting family/representative pick up. Families were updated on 3/22/2023 by the Executive Director that the facility will only hold medications to be picked up for 48 hours and then they will be disposed of per policy. A tracker has been put into place for these medications. A weekly audit times 4 and then monthly audit times 3 will be done by a designee per the Executive Director to ensure continued compliance. Results of these audits will be brought to the QA committee and reviewed.	
{R162} SS=E	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	{R162}	Residents # 1, 5 and 6 have all been discharged from the facility. Med tech and nursing staff in-serviced on medication policy, including the physician's signature on orders by the Executive Director.	5/8/23

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{R162}	Continued From page 3 by: Based on record review and staff interview there was a failure to maintain signed medication orders for 3 applicable residents (Residents#1, #5, and #6). Findings include: 1. Resident #1 is on hospice. A list of all signed orders for hospice medications was not maintained in his/her record. The Executive Director provided copies of signed orders for hospice medications printed from the Bayada website at 5:42 PM 3/8/23. 2. Resident #5's record did not contain signed orders for the following medications listed on his/her March 2023 Medication Administration Record (MAR): * Bisacodyl 10 mg suppository 1 suppository per rectum daily as needed for constipation * Haloperidol 1 mg by mouth every 8 hours as needed for agitation * Lorazepam 0.5 mg every 6 hours as needed for anxiety related to Shortness of Breath due to anemia, which was listed on his/her MAR in addition to an order for Lorazepam 0.5 mg every 6 hours as needed for anxiety and appears as a duplicate order. Additionally Resident #5 is on hospice, and a list of all signed orders for hospice medications was not maintained in his/her record. The Executive Director provided copies of signed orders for hospice medications printed from the Bayada website at 5:46 PM 3/8/23. 3. Resident #6's record did not contain signed orders for the following medications listed on his/her March 2023 MAR: * Morphine 20 mg/ml solution 0.25 ml (5 mg) by mouth every 3 hours as needed for pain/dyspnea	{R162}	A house wide audit of all medication orders is being completed by nursing to ensure compliance. Orders are being re-sent to physicians for review and signature. The pharmacy came to the facility on 4/14/23 to complete chart/order audits. Random audits of orders will be performed weekly times 4 and monthly times 3 to ensure compliance. Results of these audits will be brought to the QA committee for review.	

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{R162}	Continued From page 4 (difficulty breathing) * Lorazepam 0.5 mg every 6 hours as needed for anxiety /agitation Additionally Resident #6 is on hospice, and a list of all signed orders for hospice medications was not maintained in his/her record. The Executive Director provided copies of signed orders for hospice medications printed from the Bayada website at 5:40 PM 3/8/23. At 6:16 PM on 3/8/23 the Executive Director confirmed the records for Resident's #1, #5, and #6 did not contain signed orders for all medications.	{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 discharge of a resident, outdated medications, and discontinued medications for 9 applicable residents (Residents #1, #5, #6, #7, #8, #9, #10, #11, and #12). Findings include: The facility medication policy on disposal of	{R176}	Residents # 1, 5, 6, 11 and 12 have been discharged from the facility. All of their medications have been disposed of per policy. Residents #s 7, 8, 9 and 10 remain at the facility and now only have active, non-expired medications in the medication cart. Med techs and nursing staff in-serviced on the medication policy, including the disposal of medications by the Executive Director. A medication cart audit will be conducted by a designee per the Executive Director to confirm compliance. The pharmacy came to the facility to complete a med cart audit on 4/14/23. The facility's back up medication cart is no longer being used for active medications and only being used for discontinued medications	4/21/23

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{R176}	Continued From page 5 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 3/8/22 multiple medications requiring disposal were observed stored in an overflow medication cart in the med room including: * 14 medications belonging to Resident# 1 that were discontinued on 2/14/23 when s/he was admitted to hospice. *Bubble packs of medications dated 2/14/23-3/6/23 containing morning and evening medications for Resident #5. *Hydrochlorothiazide 12.5 mg tabs expired 2/28/23 belonging to Resident #6 *Sertraline HCl 100 mg tabs expired 8/12/22 and Hydrochlorothiazide 25 mg tabs expired 2/20/23 belonging to Resident #7 *Carbidopa/Levodopa 25/100 mg tabs expired 1/31/23 belonging to Resident #8 *Mometasone 0.1% solution expired 1/2023 belonging to Resident #9 * Antacid Suspension Liquid expired 12/2022 belonging to Resident #10 *A Ventolin Inhaler for Resident #11 who was discharged from the facility on 2/11/23	{R176}	that are awaiting family/representative pick up. Families were updated on 3/22/2023 by the Executive Director that the facility will only hold medications to be picked up for 48 hours and then they will be disposed of per policy. A tracker has been put into place for these medications. A weekly audit times 4 and then monthly audit times 3 will be done by a designee per the Executive Director to ensure continued compliance. Results of these audits will be brought to the QA committee and reviewed.	

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{R176}	Continued From page 6 *30 packets of Ketoprofen 50 mg/ml gel expired 12/7/23 belonging to Resident #12 At 1:52 PM on 3/8/23 the Lead Med Tech confirmed expired medications belonging to Residents #1, #5, #6, #7, #8, #9, #10, and #12, and a medication belonging to Resident #11 who discharged from the facility on 2/11/23, were stored in the overflow medication cart; and at 6:12 PM on 3/8/23 the Executive Director acknowledged the failure to dispose of medications according to the facility medication policy on disposal of medications.	{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: 1. During the course of the kitchen tour commencing at 9:40 AM on 3/8/23 the walk-in refrigerator was observed to contain open unwrapped and undated food items, expired foods, and improperly stored foods including: a) Opened items without dates: brie cheese, parmesan cheese, 5 lb tub of peeled garlic, bag	{R249}	All foods are now wrapped and dated per regulations and expired foods have been removed. All foods are now properly stored per regulations. Sanitizing solution is now placed properly per regulations. The facility steam wells in the steam table have been addressed. They are made of plastic, so it was determined it was lime build up. The wells have been cleaned. Steam wells placed on a cleaning schedule and dietary staff in-serviced on this schedule and expectations. A new 7-day label dispenser and system was purchased and to be provided to dietary staff. Dietary staff will be in-serviced on this new label system upon arrival.	4/30/23

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{R249}	Continued From page 7 of tortillas, chicken stock, lemon juice, a pitcher containing a brown liquid labeled "Jess's Tea", two Hormel hams and a processed cooked ham for slicing thawing in a tub, and a bin of lettuce covered with plastic wrap. b) Expired foods: Boiled eggs labeled as prepared on 2/25 to be used by 3/5; Beets labeled as prepared on 3/1 to be used by 3/7; Peeled potatoes dated 2/28/23, Pesto Chicken dated 2/27/23, sliced beef dated 2/20/23, Cheddar Soup dated 3/3, Prepared pancake mix labeled for use by 3/7/23, and a ham roast covered in plastic wrap dated 2/27/23. c) Improperly stored foods: * A food service rack with a sheet of plastic covering the outside of the rack contained unwrapped trays of cake pans with various amounts of cake, single servings of sliced cake on plates, single serving cups of gelatin and pudding, and whole pies all without labels indicating dates the items were prepared. Items stored on the rack were opened and prepared on various dates, and single servings of dessert items may be stored for use over multiple meal times. Storage of these items with an airtight seal and labels with dates helps prevent serving items that have been stored on the rack longer than expected. * A stack of metal serving pans including a pan of roast pork loosely covered with plastic wrap dated 3/7, which was placed directly on top of the aluminum foil covering a pan of "Shrimp Rio" dated 3/6, which was placed directly on top of the aluminum foil covering an unlabeled and undated pan of macaroni and cheese. * An unwrapped tub of baked sweet potatoes	{R249}	Dietary staff in-serviced on proper food handling and storage regulations including wrapping, dating, expired items, food storage, and chemical placement. A house wide audit was conducted by the Executive Director of food storage and chemical Placement, as well as steam table cleanliness. Random audits of food storage, dates and placement, as well as steam table cleanliness will be conducted by the Executive Director and/or designee weekly times 4 and then monthly times 3 to ensure continued compliance. Results of the audits will be brought to the QA committee for review.	

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{R249}	Continued From page 8 without a label or date prepared * Containers of chicken fingers dated for use by 3/11, beef gravy dated 3/7, and oranges cut into quarters dated 3/8 with the lids placed on the tops of the containers without sealing them to prevent contamination. * An aluminum tray holding a box of smoked salmon was placed directly on top of meat marinating in an open uncovered tub of liquid. The tub of marinating meat was not labeled and dated, and the contents of the tub were directly exposed to the bottom of the aluminum pan which appeared to be placed on top to press the meat down into the marinade. 2. The refrigerated prep unit was observed with opened containers of food without dates including 6 salad dressings, raspberry syrup, strawberry spread, mustard, and shredded cheese, and the reach in refrigerator was observed to contain a pitcher of tea dated 2/27/23. 3. All opened bread items observed in the kitchen were observed without labels indicating when the packages were opened, and an opened bag of bread was observed to have butter smeared on the outside of the packaging. Two open boxes of donuts and a partial tray of pastry were also observed without labels indicating when they were opened. 4. An uncovered tub containing sanitizing solution and a rag used to clean kitchen surfaces was placed on a shelf with packages of dried pasta; a cardboard container of rolled oats; a box of instant mashed potatoes which expired on 9/8/20; and opened undated jugs of condiments and sauces including soy sauce, teriyaki sauce,	{R249}		

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{R249}	Continued From page 9 unsulphured molasses, vinegars, and Worcestershire sauce. In another area of the kitchen an opened bottle of sunburn relief gel was stored on a shelf with bananas, bags of sugar, and boxes of Oreos. 5. The steam wells of the facility's steam table were coated with rust, potentially harboring bacteria and creating risk for food contamination. These findings were confirmed by the Dietary Services Director at 10:41 AM on 3/8/23; and by the Executive Director at 10:45 AM on 3/8/23.	{R249}		