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 1, 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 **April 7, 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

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 _____	C 04/07/2023

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

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R100	Initial Comments: On 4/6/23 and 4/7/23 the Division of Licensing and Protection conducted an unannounced on-site investigation of a facility reported incident. The following regulatory deficiencies were identified as a result of the investigation.	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 is prepared and executed as evidence of the facility's continued compliance with applicable law.	
R126 SS=K	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to provide care and services to meet the nursing and medical needs of 2 applicable residents (Residents #1 and #2). Findings include: 1. Resident #1 sustained an unwitnessed fall on 3/13/23 resulting in a head injury. S/he was evaluated in the emergency department and discharged to the facility with instructions to seek medical help for new or worsening symptoms. There is no documentation of Staff education regarding signs and symptoms indicative of need for emergency medical care and instructions for monitoring. Resident #1's care plan was not updated to include interventions for care and monitoring following the head injury.	R126	Resident #2 has been d/ced from the facility. Resident #1 remains out of the facility in another healthcare setting at this time. If/when Resident #1 returns to the facility, he/she will be treated as a readmission/significant change. Nursing staff in-serviced on admission/re-admission/significant change policy, including assessments. Nursing staff in-serviced on communicating with med techs on medical needs of a Resident upon admission/re admission and/or significant change as indicated. RN staff educated on medication delegation. Nursing staff educated on documentation expectations when involving assessment, and/or significant change, and/or delegation as indicated.	5/3/23

tags R126 - R178 accepted 4/30/2023 J. Evans/C. Scott

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R126	Continued From page 1 On 3/16/23 Staff noted Resident #1 was not eating and a family member reported s/he had "not been acting normal" since his/her fall. Need for emergency medical care was not recognized, and it was noted a family member would follow up with Resident #1's provider. On 3/28/23 s/he presented with altered sensory perception, uncharacteristic behaviors, and confusion. S/he was transported to the emergency department, then hospitalized for a subdural hematoma (brain bleed) and a surgical procedure to relieve pressure created by bleeding inside his/her skull on 3/29/23. On 4/1/23 Resident #1 was unexpectedly and prematurely discharged from the hospital's Intensive Care Unit (ICU). Discharge paperwork included unsigned orders for new medications to treat post operative pain and prevent seizures. Staff on duty stated the Director of Nursing (DON) was notified of Resident #1's return, and the receipt of new medications without signed orders. Resident #1 was not assessed on readmission by a Registered Nurse, and a nurse did not ensure signed orders for the meds were received. The new medications were not administered, including the anti-seizure medication, which hospital discharge paperwork stated must be administered exactly as ordered. Direct Care Staff did not receive education for Resident #1's specific post-operative care needs and instructions from the Registered Nurse responsible for delegating nursing tasks to monitoring for specific signs and symptoms indicating need for emergent medical care. At 2:31 AM on 4/2/23 Resident #1 was found trying to enter another resident's room and was noted to be very confused and disoriented. The contracted Licensed Practical Nurse (LPN) on	R126	Nursing staff in-serviced on what constitutes a significant change. An admission/re admission will not be accepted back to the community without prior approval from the Executive Director and/or designee under oversite from the RN. Nursing staff will review all new orders and ensure timeliness for MD signatures. For any Resident admitted to the hospital setting, their paperwork will be reviewed by the RN and Executive Director and/or designee prior to return to ensure that facility can meet their level of care needs. Audits will be performed within 24 hours of an admission, re-admission and/or significant change by the Executive Director and/or designee to ensure the appropriate processes were followed and in compliance. Audits will be performed in these situations for a minimum of three months. Results of the audits will be brought to the QA committee for review. A house wide audit of Resident assessments will be performed by the Executive Director and/or designee to ensure compliance of all assessments. A random audit of assessments will then be performed weekly times 4 and then monthly times 3 by the Executive Director and/or designee to ensure continued compliance. Results of the audits will be brought to the QA committee for review.	

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R126	Continued From page 2 duty did not recognize Resident #1's need for medical attention, noting "We took [Resident #1] back to [his/her] room, put [him/her] to bed and turned off the lights." At 11:16 AM on 4/2/23 Staff noted Resident #1 was lethargic, barely able to move, and unable to drink or swallow. Despite this observation, Staff attempted to give him/her morning meds by putting the meds and water into his/her mouth when s/he was unable to swallow. Staff observed him/her repeatedly "leaning forward and letting the water drip out of [his/her] mouth" for 20 minutes before a call was placed to the DON and an ambulance was called. On 4/3/23 s/he was diagnosed with a brain aneurysm which was not previously observed on diagnostic imaging. As of 4/7/23 Resident #1 remained in the ICU unable to swallow or talk, was receiving nasogastric tube feedings, and was experiencing pain in all four extremities. During the on-site investigation, Staff confirmed they did not receive specific education regarding Resident #1's injury and care needs including instructions for monitoring and when to seek medical help. On the evening of 4/7/23 the Executive Director confirmed the failure to provide a physical assessment by the Registered Nurse following the return from the hospital on 4/1/23, failure to ensure signed orders were received and the new medications were administered, and failure to provide specific education and instructions to Staff which resulted in delayed emergency medical care. 2. Resident #2 was transferred into Residential Care Home services on 1/1/23 following significant decline in health due to progression of cardiovascular and respiratory diseases including periods of difficulty breathing and activity intolerance.	R126	Families/Representatives and Residents updated by Executive Director week of 4/17/23 on the facility's admission/readmission process. In-services completed in March 2023 and April 2023 and will be ongoing with medication techs and nursing by the Executive Director and RN designee on the order process, the assessment process, and the discontinued medication process. Communication process to be put into place for med tech staff.	

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R126	Continued From page 3 On 1/1/23 Resident #2 was hospitalized for surgical removal of a kidney stone. There is no record of a physical assessment performed by a Registered Nurse on return from the hospital, nursing follow up regarding discharge medications, staff instructions for post-operative care, or updates to Resident #2's care plan following this hospitalization. On 1/6/23, Resident #2 presented with pale skin, a very low oxygen saturation rate of 78% (normal values are 95-100%), and a heart rate of 145 beats per minute (normal values are 60-100 BPM). The DON (Director of Nursing) who is a Licensed Practical Nurse (LPN), noted s/he "appeared to be in distress", however there is no record of an assessment by a Registered Nurse. On 1/10/23, a Med Tech noted, "Resident is not doing well ... is having a really hard time with his/her breathing ...is sweating but also freezing ...is seeing things that are not there and is having trouble with his/her words". The DON was asked to check in with Resident #2 and noted "this writer is very concerned about [the]resident's current state of health". While the note states Resident #2's doctor was notified and s/he met with hospice, there is no documentation of an assessment by the facility's Registered Nurse. A subsequent transfer to the hospital is not documented, however, on 1/19/23 a Med Tech noted Resident #2 returned from the hospital with a Foley catheter, a "chest dressing on the left side", and admission to hospice while hospitalized. There is no documentation of a physical assessment, instructions given to staff for comfort care and administration of hospice medications, updates to the care plan, and completion of a significant change Resident Assessment by a Registered Nurse on	R126		

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R126	Continued From page 4 re-admission. On 1/21/23 and 1/22/23, facility Med Techs received instructions for Resident #2's care from a hospice nurses who are not responsible for delegation of nursing tasks to facility staff including recommendations for administration of comfort care medications and instructions to increase oxygen supplementation when Resident #2 had difficulty breathing, very low oxygen saturation rates, and pulse fluctuations from 35-111 beats per min. During the last two weeks of Resident #2's life the only note written in Resident #2's record by facility nursing staff was a report by the DON stating Resident #2 fell out of bed during the night on 1/25/23 and passed away on the floor waiting for emergency responders to arrive and lift him/her back into bed. On the evening of 4/7/23, the Executive Director confirmed the lack of nursing overview at the facility; and acknowledged Resident #2's record lacked documentation of nursing care including staff education.	R126		
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 record review and staff interview there was a failure to complete Resident Assessments	R144	Resident #s 2 and 3 have been d/ced from the facility. Resident # 1 remains at another healthcare setting. Resident #1 will be treated as a readmission/significant change if/when she/he returns.	4/30/23

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R144	Continued From page 5 for 3 applicable residents (Residents #1, #2, and #3) in accordance with Section 5.7 of the Vermont Residential Care Home Licensing Regulations effective 10/3/2000 including completion of an initial assessment within 14 days after admission, annual reassessments, and reassessments when there is a significant change in a resident's mental or physical condition. Findings include: 1. Resident #1 was admitted to the facility on 5/10/21. While a facility Admission Nursing Assessment was completed by a Registered Nurse, documentation of a Vermont State Resident Assessment completed by a Registered Nurse within 14 days of admission was not available for review. On the afternoon of 4/7/23 the Executive Director confirmed the only State Resident Assessment form in Resident #1's record was an annual reassessment completed on 9/8/22. 2. Resident #2 was transferred from Independent Living residence at the facility into Residential Care Home services on 12/1/22. His/her admission assessment was mislabeled as a significant change in status essessment, and his/her admission date was incorrectly identified as 12/3/22. This assessment was signed as completed by the Registered Nurse on 12/18/22 and was not completed within 14 days of admission as required. Additionally, a significant change reassessment was not completed for Resident #2 when s/he was admitted into hospice care on 1/18/23. The Executive Director confirmed these findings at 2:38 PM on 4/7/23. 3. Resident #3 was admitted to the facility on 8/2/22. His/her admission assessment was signed as completed by the Registered Nurse on 8/26/22. The Executive Director confirmed	R144	Nursing staff in-serviced on the assessment process. 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.	

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R144	Continued From page 6 Resident #3's admission assessment was not completed within 14 days of admission as required.	R144		
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 record review and staff interview there was a failure to ensure development of a written plan of care with overview by a Registered Nurse based on individual abilities and needs for 2 applicable residents (Residents #1 and #2). Findings include: 1. Resident #1 sustained a fall with a head injury on 3/13/23 and returned to the facility with a diagnosis of a minor head injury. Discharge paperwork listed signs and symptoms indicative of need for emergency medical help including trouble waking, grogginess, and confusion; difficulty speaking, seeing, walking or moving; headaches and vomiting; and new or worsening symptoms. Resident#1's care plan was not updated to include a plan to monitor for these signs and symptoms and when to seek medical care. On 3/21/23, it was noted Resident #1 was	R145	Resident #2 has been d/ced from the facility. Resident # 1 remains at another healthcare setting. If/when Resident #1 returns, he/she will be treated as a readmission/significant change. Nursing staff in-serviced on admission/readmission and significant change policy, including updating of care plans. Nursing staff in-serviced on communicating with med techs on new plan of care items, as indicated. A house-wide will be performed to ensure all Residents have active care plans. As new assessments are being completed, care plans will be reviewed and updated as indicated. A random audit of care plans will then be performed by the Executive Director/and or designee weekly times 4 and then monthly times 3. An audit will be performed on all new admission/readmission care plans within 24 hours by the Executive Director and/or designee for a minimum of 3 months. Results of these audits will be brought to the QA committee for review.	5/8/23

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R145	Continued From page 7 not eating and his/her daughter reported s/he "had not been acting normal" since the fall resulting in head injury. Staff failed to recognize need for emergency medical care and noted the daughter was going to follow up with his/her doctor. On 3/28/23, Resident #1 presented with altered sensory perception, uncharacteristic behaviors, and confusion. S/he was transported to the emergency department and hospitalized for a subdural hematoma (brain bleed), and a surgical procedure to relieve pressure created by bleeding inside his/her skull on 3/29/23. On return to the facility on 4/1/23, the care plan was not updated to include post-operative care and instructions to monitor for specific signs and symptoms indicative of need for emergency medical treatment. On the afternoon of 4/6/23, the Executive Director confirmed Staff failed to recognize signs and symptoms indicating s/he needed emergency medical care, which resulted in delayed treatment. 2. Resident #2 was hospitalized for surgical removal of a kidney stone. His/her care plan was not updated to include instructions for post-operative care and monitoring following this hospitalization. The date of a subsequent transfer to the hospital is not documented in his/her record, however, on 1/19/23, a Med Tech noted Resident #2 returned from the hospital with a Foley catheter, a "chest dressing on the left side" and admission to hospice while hospitalized. Resident #2's care plan was not updated to include care and services related to Foley catheter care, wound care, and admission to hospice including administration of comfort care medications and instructions for contacting hospice providers. These findings were confirmed by the Executive Director on the afternoon of	R145	Communication process to be put into place for med tech staff.	

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R145	Continued From page 8 4/6/23. Please also refer to R126.	R145		
R146 SS=K	V. RESIDENT CARE AND HOME SERVICES 5.9.c (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to provide nursing instruction and supervision to all direct care personnel regarding each resident's health care needs and to delegate nursing tasks as appropriate for 2 applicable residents (Residents #1 and #2). Findings include: 1. Resident #1 sustained an unwitnessed fall on 3/13/23 resulting in a head injury. S/he was evaluated in the emergency department and discharged back to the facility with instructions to seek medical help for new or worsening symptoms. Per record review there is no documentation of staff receiving education regarding signs and symptoms indicative of need for emergency medical care, instructions for monitoring, and when to seek medical care. On 3/16/23, Staff noted Resident #1 was not eating or coming to the dining room, and a family member reported s/he had "not been acting normal" since his/her fall. Need for emergency	R146	Resident #2 had been d/ced from the facility. Resident #1 remains at another healthcare setting. If/when Resident #1 readmits, he/she will be treated as a readmission/significant change. RN staff in-serviced on the delegation regulations, including communication on admissions/readmissions and significant changes as indicated. Admissions/Readmissions will not be accepted back to the community without prior approval from the Executive Director and/or designee under oversite from the RN. Nursing staff educated on the admission/readmission policy and the significant change policy, as well as what constitutes a significant change.	5/8/23

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R146	Continued From page 9 medical care was not recognized, and it was noted a family member would follow up with Resident #1's provider. On 3/28/23, Resident #1 presented with altered sensory perception, uncharacteristic behaviors, and confusion. S/he was transported to the emergency department, then hospitalized for a subdural hematoma (brain bleed) and a surgical procedure to relieve pressure created by bleeding inside his/her skull on 3/29/23. On 4/1/23, s/he was unexpectedly and prematurely discharged from the Hospital's Intensive Care Unit. Discharge paperwork for this hospitalization included unsigned orders for new medications to treat post operative pain and prevent seizures. The Director of Nursing was notified regarding Resident #1's return to the facility, however nursing staff did not ensure signed orders for new medications were received, and staff were not educated regarding the post operative care including the importance of administering an anti-seizure medication exactly as ordered as stated in the discharge paperwork. Resident #1 did not receive the new medications including two missed doses of the anti-seizure medication. Additionally, the Registered Nurse responsible for delegating nursing tasks did not instruct staff to monitor for the specific signs and symptoms indicating need for emergent medical care. At 2:31 AM on 4/2/23, Resident #1 was noted to be very confused and disoriented. The Licensed Practical Nurse (LPN) on duty did not recognize Resident #1's need for medical attention and took him/her back to bed. At 11:16 AM on 4/2/23 Resident #1 was lethargic, barely able to move, and unable to drink or swallow. Staff attempted to give Resident #1 morning medications by putting	R146	Nursing staff educated on documentation expectations. Med tech in-service completed on med training and RN delegation. Audits will be performed within 24 hours of an admission, re-admission and/or significant change by the Executive Director and/or designee to ensure the appropriate processes were followed and in compliance. Audits will be performed in these situations for a minimum of three months. Results of the audits will be brought to the QA committee for review.	

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R146	Continued From page 10 medications and water into his/her mouth when s/he was unable to swallow. Staff repeatedly asked Resident #1 to swallow while observing him/her "leaning forward and letting the water drip out of [his/her] mouth" for 20 minutes before a call was placed to the Director of Nursing and an ambulance was called. S/he was diagnosed with a brain aneurysm which was not previously observed on diagnostic imaging, and as of 4/7/23 s/he remained in the Intensive Care Unit unable to swallow or talk, was receiving nasogastric tube feedings, and was experiencing pain in all four extremities. During the on-site investigation, Staff confirmed they did not receive specific education and instructions for monitoring Resident #1 and when to seek medical help. On the evening of 4/7/23, the Executive Director confirmed lack of nursing overview including the failure to provide specific education and instructions to staff resulted in delayed emergency medical care. 2. On 1/1/23 Resident #2 was hospitalized for surgical removal of an obstructing kidney stone. There is no record of a Registered Nurse providing staff education and instructions for post-operative care, and updates to Resident #2's plan of care following this hospitalization. On 1/6/23 Resident #2 presented with inability to walk independently, pale skin, a very low oxygen saturation rate, and a rapid heart rate. The Director of Nursing (DON), who is a Licensed Practical Nurse (LPN) noted Resident #2 "appeared to be in distress". On 1/10/23, a Med Tech noted, "Resident is not doing well ... is having a really hard time with his/her breathing ...is sweating but also freezing ...is seeing things that are not there and is having trouble with	R146		

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(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
R146	Continued From page 11 [his/her] words". The DON was asked to check in with Resident #2, and approximately 2 hours later noted "this writer is very concerned about [the]resident's current state of health". A transfer to the hospital is not documented, however, on 1/19/23, a Med Tech noted Resident #2 returned from the hospital with a Foley catheter, a "chest dressing on the left side" and admission to hospice while hospitalized. There is no documentation of staff education and instructions for Foley catheter care, wound care, and hospice care including administration of hospice medications. On 1/21/23, facility Med Techs received instructions for Resident #2's care from a hospice nurse who is not responsible for delegation of nursing tasks to facility staff including instructions to "turn oxygen up to 5 instead of 4" via phone call when Resident #2 had difficulty breathing, pulse fluctuations from 35-111 beats per min, and very low oxygen saturation rates. On 1/21/23 and 1/22/23, a hospice nurse provided Med Techs with recommendations for administration of RN (as needed) medications for comfort care. During the last two weeks of Resident #2's life the only note written in Resident #2's record by facility nursing staff was a report by the DON stating Resident #2 fell out of bed during the night on 1/25/23 and passed away while on the floor waiting for emergency responders to arrive and lift him/her back into bed. On the evening of 4/7/23 the Executive Director confirmed lack of nursing overview at the facility and acknowledged Resident #2's record lacked documentation of nursing care including staff education. Please refer to tag 126	R146		

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	0605	A. BUILDING: _____ B. WING _____	C 04/07/2023

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R164	Continued From page 12 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: (2) A registered nurse must delegate the responsibility for the administration of specific medications to designated staff for designated residents This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure delegation of the responsibility for the administration of specific medications to designated staff for designated residents by a Registered Nurse. Findings include: Per record review, the Registered Nurse (RN) was hired by the facility on 2/16/23. The RN's signed job description does not include responsibility for the delegation of medication administration to designated staff. During an interview commencing at 6:08 PM on 4/7/23, the Registered Nurse confirmed s/he was unaware of the Registered Nurse's responsibility to delegate medication administration to the facility Med Tech's and was not informed of this job duty when hired. S/he stated "the Med Techs all went through a course". The RN further stated "I haven't been here long enough to delegate", and confirmed s/he had not delegated responsibility for the administration of specific medications to designated staff for designated residents.	R164	Resident #1 remains at another healthcare facility. If/when Resident #1 returns to this facility, he/she will be treated as a readmission/significant change. RN staff educated on medication delegation regulation. RN to complete medication delegation with all current med tech staff. This will be ongoing for any new med tech staff, and will occur at least annually with current staff, and/or under the change of RN at the facility. Med tech in-service completed on med training and RN delegation. Full Time Agency RN signed onto facility while facility is hiring for a new Wellness Director/Director of Nursing. Executive Director and/or designee will perform a house wide audit of all med tech delegations and will perform a random audit weekly times 4 and monthly times 3 of med tech delegation if there are any new med tech staff. Results of these audits will be brought to the QA committee for review. Communication process being put into place for med tech staff.	5/8/23
R164 SS=F		R164		

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R165 SS=J	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: (3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for: i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects; ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications; iii. Assessing the resident's condition and the need for any changes in medications; and Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, there was a failure to ensure a Registered Nurse accepted the responsibility for the proper administration of medications; provided appropriate information about the resident's condition, relevant medications, and potential side effects; assessed the resident's condition; and monitored and evaluated the designated staff performance in carrying out the nurse's instructions for one applicable resident (Resident #1). Findings include:	R165	Resident #1 remains at another healthcare facility. If/when Resident #1 returns to this facility, he/she will be treated as a readmission/significant change. RN staff educated on medication delegation regulation and education for admissions/readmissions/significant changes. RN to complete medication delegation with all current med tech staff. This will be ongoing for any new med tech staff, and will occur at least annually with current staff, and/or under the change of RN at the facility. Full Time Agency RN signed onto facility while facility is hiring for a new Wellness Director/Director of Nursing. Med tech in-service completed on med training and RN delegation. Executive Director and/or designee will perform a house wide audit of all med tech delegations and will perform a random audit weekly times 4 and monthly times 3 of med tech delegation if there are any new med tech staff. Results of these audits will be brought to the QA committee for review. Random audits of the communication binder will occur weekly times 4 and then monthly times 3 by the Executive Director and/or designee. Results of the audits will be brought to the QA committee for review.	5/8/23

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R165	Continued From page 14 1. Per record review, the signed job description for the facility's Registered Nurse (RN) does not include responsibility for the delegation of medication administration to designated staff. During an interview commencing at 6:08 PM on 4/7/23, the Registered Nurse confirmed s/he was unaware of his/her responsibility to delegate medication administration to the facility Med Tech's and was not informed of this job duty when hired. S/he stated "the Med Techs all went through a course" and "I haven't been here long enough to delegate". The RN and confirmed s/he had not delegated responsibility for the administration of specific medications to designated staff for designated residents. Please refer to tag 164. 2. Resident #1 sustained a head injury during a fall on 3/13/23 and returned from the emergency department with instructions to seek immediate medical help for specific signs and symptoms. A Registered Nurse did not ensure staff were educated regarding these signs and symptoms, and received instructions for monitoring and when the seek medical care. Staff did not recognize Resident #1's need for medical care when it was reported on 3/16/23 s/he was not eating and s/he had "not been acting normal" since his/her fall. On 3/28/23, Resident #1 presented with altered sensory perception, uncharacteristic behaviors, and confusion. S/he was transported to the emergency department, and hospitalized for a subdural hematoma (brain bleed) and a surgical procedure to relieve pressure created by bleeding inside his/her skull on 3/29/23. On return from the hospital a Registered Nurse did not assess Resident #1, ensure signed orders for new medications were received, and staff were not educated regarding new medications	R165		

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R165	Continued From page 15 and instructions for post-operative care including monitoring for signs and symptoms indicating need for emergent medical care. Two new medications were not given to Resident #1. That night staff did not recognize medical help was needed, resulting in delayed medical treatment. These findings were confirmed by the Executive Director on the afternoon of 4/6/23. Please refer to tag 126.	R165		
R178 SS=K	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there is a failure to ensure a sufficient number of qualified personnel available at all times to provide necessary care, maintain a safe and healthy environment; and to assure prompt, appropriate action in cases of injury, illness, and other emergencies. Findings include: 1. The only full time nurse at the facility is a Licensed Practical Nurse (LPN) who serves as the Wellness Director and the Director of Nursing. The LPN's job description, signed by the LPN and the Regional Director of Clinical Services on 9/14/22 states the LPN's Essential Clinical	R178	Facility is recruiting for a RN for the Wellness Director/Director of Nursing role. Facility has a current signed contract with an agency RN to provide full time support to the community while hiring for the WD/DNS position. Facility has a current signed contract with an agency LPN to assist in providing nursing oversight to the community. Admissions/re admissions will be scheduled when RN oversight is available to the Resident.	4/21/2023

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R178	Continued From page 16 Functions include "Maintain responsibility for development, implementation, modification, and communication of all resident assessments and customized service plans." A note on the last page of the description states all duties and responsibilities are considered requirements. Requiring an LPN to maintain responsibility for the development, implementation, and modification of Resident Assessments and Service Plans is not congruent with the Vermont State Residential Care Home Licensing Regulations and the scope of practice for an LPN in Vermont. In addition to the job duties outlined in the LPN's signed job description, the LPN's daily duties include ongoing physical assessment of residents, education of unlicensed staff, and delegation of nursing tasks to unlicensed staff which requires the LPN to perform duties outside of his/her scope of practice. 2. The Registered Nurse (RN) for the facility serves as the Compliance Nurse and has the job title of Wellness Nurse. The RN's job description, signed by the RN on 2/16/23 and the Regional Director of Clinical Services on 2/17/23 includes job duties such as " Contribute to resident assessments and customized service plans" which are more appropriately suited for an LPN's scope of practice. Per staff interviews the RN's main role at the facility is to "sign off" on Resident Assessments and Care Plans completed by the LPN. During an interview commencing at 6:08 PM on 4/7/23 the Registered Nurse stated s/he was hired to work only 8 hours per week with a flexible schedule described as "sometimes Saturdays, sometimes 3-7". 3. Due to extremely limited Registered Nurse hours and failure to retain nursing staff, resident access to nursing assessments and staff access	R178		

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R178	Continued From page 17 to education and instructions essential for the delegation of nursing tasks by an RN is limited to 8 hours a week. During an interview commencing at 6:08 PM on 4/7/23 the facility's Registered Nurse confirmed s/he was unaware of the responsibility to delegate nursing tasks to unlicensed staff, educate staff regarding the specific care needs for each individual resident, and to delegate the administration of specific medications to designated residents to designated staff. This results in a failure to ensure qualified personnel including unlicensed staff who routinely perform nursing tasks including providing resident care and administering medications. The lack of adequate nurse staffing results in Direct Care Staff, Med Techs and LPNs operating outside of their scope of practice and without adequate nursing overview. 4. Review of resident records evidence a lack of RN overview including minimal documentation of nursing care in resident notes, failure to perform physical assessments on return from hospitalizations, missing and untimely completion of Resident Assessment forms, and failure to update plans of care in response to changes in resident's abilities and needs. This finding is also evidenced by failure to ensure an RN delegates the administration of specific medications to designated residents by designated personnel; and the failure to provide Direct Care Staff education about specific medications and conditions, and instructions for specific care and monitoring to maintain resident's wellbeing and safety. Please refer to tags 126, 144, 145, and 146	R178		