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 2, 2024

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

Dear Ms. Stimson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 17, 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.

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
	0605	A. BUILDING: ___ B. WING ___	C 11/17/2023

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: On 11/15/23 the Division of Licensing and Protection conducted an unannounced on-site investigation of one facility reported incident and two complaints, with additional information received from the facility on 11/17/23. The following regulatory deficiencies were identified during 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.	
R161 SS=D	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: Based on staff interview and record review there was a failure to ensure all medications are handled according to the home's policies and that designated staff are fully trained in the policies and procedures. Findings include: 1. Per record review, the home's Medication Program policies and procedures effective 2/13/23 state, "All Medical Provider's Orders (i.e. prescriptions, discharge orders, telephone orders, faxes, Medical Provider's order form, etc.) will be signed, dated, and kept in the Resident's medical chart in chronological order, with the most current order first." a. Per record review Resident #1 was admitted to hospice on 10/30/23. Per record review Resident #1's medication orders were not signed by a	R161	Resident # 1 has been discharged from the facility. An In-service has occurred with nursing staff regarding the Medication Administration policy and the Medication Diversion Policy. A house-wide audit of all hospice orders will be conducted by the Wellness Director and/or designee to confirm signatures have been obtained per the regulation. A random audit of hospice orders will be performed weekly times 4 and then monthly times 3 by the Wellness Director and/or designee. Results of the audits will be brought to the QA committee for review. A house-wide audit of all hospice orders will be conducted by the Wellness Director and/or designee to ensure that the orders are entered properly and do not need any clarification. The medications in the medication cart will be checked against the hospice orders to ensure they match. Random audits will then occur weekly times 4 and then monthly times 3 by the Wellness Director and/or designee. Results of these audits will be brought to the QA committee for review. Continued on next page...	12/28/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] CNHA | TITLE: Area Executive Director | (X6) DATE: 12/21/2023

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 11/17/2023

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
R161	Continued From page 1 physician on admission to hospice. The hospice Medication List and hospice Team Care Plan, both of which included medication orders, remained unsigned on 11/15/23. b. Per review of Progress notes, on the morning of 10/30/23 a Registered Nurse (RN) and Physician from the hospice team came to the home to admit Resident #1 into hospice care and "to start morphine scheduled and as needed". During the on-site visit the hospice physician gave orders for Morphine 0.5 ml (10 mg) scheduled every 4 hours; and Morphine 0.25 ml (5 mg) every hour as needed for pain and shortness of breath for Resident #1, however the orders were not signed by the prescribing physician. The orders were entered as Physician's Telephone Orders by the hospice nurse, then sent to Resident #1's Primary Care Provider (PCP) on 10/31/23 to be signed. On 10/30/23 multiple conflicting signed orders for Morphine Sulfate were received from the PCP. A note written by the Wellness Director on a copy of a signed PCP order received at 10:54 AM on 10/30/23 states, "Incorrect orders, Hospice nurse [nurse's name] states s/he is contacting [PCP's office] & to continue w/orders written and approved by [hospice physician]- in chart.". When this note was written the orders "approved" by the hospice physician had not been signed by the hospice physician or the PCP. Facility policies and licensing regulations require physician's signed orders for all medications administered at the home. c. Per record review Resident #1 was given a 0.25 ml dose of Morphine Sulfate Oral Solution at 9:50 AM on 10/30/23, 26 minutes after receiving a 0.25 ml dose at 9:14 AM on 10/30/23. Per review of hospice nurse notes provided by the	R161	A house-wide audit of the narcotic book will be conducted by the Wellness Director and/or designee to ensure that anytime a narcotic order has changed, a new page is assigned to that narcotic for the Resident. This audit will also ensure there are no "write-overs" or "cross outs" in the narcotic book, per policy. Audits will then occur weekly times 4 and then monthly times 3 by the Wellness Director and/or designee. Results of these audits will be brought to the QA committee for review. The Wellness Director will re-educate the hospice providers to the community that a nurse cannot provide an order from the doctor unless it is signed. Education will be provided to all clinical staff who pass medications on comprehension of medication dosing, with a focus on "mg" vs "ml" to ensure the staff are able to read the orders and confirm medications they are giving. R161 Plan of Correction accepted by Jo A Evans RN on 1/1/24	

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 11/17/2023

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
R161	Continued From page 2 Regional Manager for Residential Homes on 11/17/23, the hospice nurse wrote, "...this author requested another dose 0.25 ml to be administered now. Medical Director is present for start of visit, s/he agrees to [discontinue] many medications, schedule Morphine 0.5 ml [every 4 hours], add Morphine PRN [as needed] 0.25 ml [every hour] for break through pain and to d/c order for lab draw." Per record review a signed order for the additional [immediate] dose of Morphine at 9:50 AM on 10/30/23 was not on file in Resident #2's record. On the afternoon of 11/15/23 the Director of Wellness and Regional Manager for Residential Homes for the organization that manages the home confirmed orders for hospice medications were not signed by the physician. The Director of Wellness and the Regional Manager acknowledged the failure to ensure signed physician's orders for hospice medications was a contributing factor in Resident #1 receiving higher than prescribed doses of Morphine Sulfate Oral Solution in error on 10/30/23 and 10/31/23. 2. Per Record review the home's Medication Program policies and procedures effective 2/13/23 state, "Staff will seek clarification for any order that is not clear, complete, and signed properly." a. On the morning of 10/30/23 the Wellness Director failed to ensure Morphine Sulfate Oral Solution orders for Resident #1 were properly entered into the record and signed by the physician who gave the orders. b. On 10/30/23 the pharmacy faxed several medication orders for Morphine Sulfate prescribed to Resident #1 which were not	R161		

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 11/17/2023

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
R161	Continued From page 3	R161		

congruent with medication orders received from the hospice team on the morning of 10/30/23. While the Director of Wellness discussed the conflicting order received at 10:54 AM on 10/30/23 with the hospice nurse and pharmacy, additional conflicting orders for Resident #1 received from the pharmacy on the afternoon of 10/30/23 were not clarified and properly corrected. On the night of 10/30/23 staff received delivery of Morphine Sulfate syringes from the pharmacy labeled with an order that required clarification due an incorrect dose and frequency of administration, and a dose range which is not permitted. Staff failed to contact the Wellness Director for assistance in clarifying provider's orders received on 10/30/23, and the wrong dose was administered to Resident #1 three times in approximately 8 hours on 10/30/23 and 10/31/23.

c. Between 10/26/23 and 11/1/23 Resident #1's PCP gave orders for Morphine Sulfate including instructions to prefill single dose syringes with incorrect doses as high as 20 times the amount to be administered as a single dose. This appeared to be due to confusing ml for mg in the order. There was a failure to seek clarification and correction when this occurred.

On the afternoon of 11/15/23 the Wellness Director and Regional Manager for Residential Homes confirmed hospice medication orders were not signed by the provider as required, and confirmed the failure to ensure clear and correct orders contributed to Resident #1 receiving 3 incorrect doses of Morphine Sulfate in error.

Please refer to tag 162

3. The facility's Medication Diversion policies and procedures effective 2/15/23 state, " If the order

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 11/17/2023

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
R161	Continued From page 4 changes for the controlled substance, a new control count sheet shall be started for the new order. 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. " a. Resident #1's order for Lorazepam changed from 0.5 mg every 6 hours as needed to 0.5 mg every 4 hours as needed for anxiety on 10/31/23. Per review of the controlled substance count sheet #88, staff failed to write a new controlled substance sheet when his/her Lorazepam order changed. Lorazepam administration every 4 hours as needed was documented on the controlled substance count sheet with the order for administration every 6 hours as needed. b. Per record review, controlled substance count sheets #88, #92, #94, #95 contained write overs; and controlled substance sheet #94 contained crossed out directions. Controlled substance sheets #87, #92, #94, #95, #96, #97, #101 did not contain clear and complete medication orders to include the medication strength; dose; route; frequency of administration including if the medication was PRN or scheduled, the time between doses, and maximum daily dose; and the indications for use of PRN medications. On the afternoon of 11/15/23 the Regional Manager and Wellness Director acknowledged the controlled substances were not charted per facility policies.	R161		
R162 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management	R162	See next page....	

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 ______	C 11/17/2023

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
R162	Continued From page 5 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 staff interview and record review there was a failure to obtain signed orders for hospice medications administered to one applicable resident (Resident #1). Findings include: Per record review the home's Medication Program policies and procedures effective 2/13/23 state, "All Medical Provider's Orders (i.e. prescriptions, discharge orders, telephone orders, faxes, Medical Provider's order form, etc.) will be signed, dated, and kept in the Resident's medical chart in chronological order, with the most current order first." 1. Resident #1 was admitted to hospice on 10/30/23. Per record review Resident #1's medication orders were not signed by a physician on admission to hospice. Per record review the hospice Medication List and Team Care Plan, both of which included medication orders, remained unsigned on 11/15/23. 2. Per review of Progress notes, on the morning of 10/30/23 a Registered Nurse (RN) and Physician from the hospice team came to the home to admit Resident #1 into hospice care and "to start morphine scheduled and as needed". Per interview with the Director of Wellness commencing at 12:45 PM on 11/15/23, during the on-site visit the hospice physician gave orders for Morphine 0.5 ml (10 mg) scheduled every 4	R162	Resident # 1 has been discharged from the facility. An In-service has occurred with nursing staff regarding the Medication Administration policy. A house-wide audit of all hospice orders will be conducted by the Wellness Director and/or designee to confirm signatures have been obtained per the regulation. A random audit of hospice orders will be performed weekly times 4 and then monthly times 3 by the Wellness Director and/or designee. Results of the audits will be brought to the QA committee for review. R162 Plan of Correction accepted by Jo A Evans Rn on 1/1/24	12/22/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED C 11/17/2023

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
R162	Continued From page 6 hours; and Morphine 0.25 ml (5 mg) every hour as needed for pain and shortness of breath for Resident #1. The updated orders were not signed by the hospice provider. Per the Director of Wellness, the hospice RN entered the morphine orders on a Physician's Telephone Orders form used by the facility. This form was sent to Resident #1's Primary Care Provider (PCP) to be signed on 10/31/23, and at 3:38 PM on 10/31/23 the PCP's office returned the signed telephone order form to the facility via fax. Morphine was administered during the hospice on site visit on 10/30/23 and continued without a signed physician's order on file until the afternoon of 10/31/23. Between the time the hospice physician's unsigned orders were received, and when the updated orders were sent to the PCP for a signature, the facility received multiple conflicting orders for Morphine Sulfate from the pharmacy which were signed by the PCP. During a period of approximately 8 hours Resident #1 was given three doses of Morphine Sulfate which were not given as ordered to include 1 ml (20 mg) doses given at 8:58 PM on 10/30/23, at 1:40 AM on 10/31/23, and 5:04 AM on 10/31/23. There were no signed orders on file for administration of Morphine Sulfate oral solution at this dose and frequency of administration. 3. Per record review Resident #1 was given a 0.25 ml dose of Morphine Sulfate Oral Solution at 9:50 AM on 10/30/23, 26 minutes after receiving a 0.25 ml dose at 9:14 AM on 10/30/23. Per review of hospice nurse notes provided by the Regional Manager for Residential Homes on 11/17/23, the hospice nurse wrote, "Patient is noted to be in 10/10 pain upon this author's arrival, s/he had Morphine 30 minutes prior to	R162		

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 ______	C 11/17/2023

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
R162	Continued From page 7 nurse arriving, this author requested another dose 0.25 ml to be administered now. Medical Director is present for start of visit, s/he agrees to [discontinue] many medications, schedule Morphine 0.5 ml [every 4 hours], add Morphine PRN [as needed] 0.25 ml [every hour] for break through pain and to d/c order for lab draw." Per record review a signed order for the additional [immediate] dose of Morphine at 9:50 AM on 10/30/23 was not on file in Resident #2's record. On the afternoon of 11/15/23 the Director of Wellness and Regional Manager for Residential Homes for the organization that manages the home confirmed orders for hospice medications were not signed by the physician. The Director of Wellness and the Regional Manager acknowledged the failure to ensure signed physician's orders for hospice medications was a contributing factor in Resident #1 receiving higher than prescribed doses of Morphine Sulfate Oral Solution in error on 10/30/23 and 10/31/23.	R162		