VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

July 26, 2024

Todd Patterson, Manager
The Residence At Shelburne Bay East
185 Pine Haven Shores Road
Shelburne, VT 05482-7805

Dear Mr. Patterson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 19, 2024.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

If you have any questions, please feel free to contact me at (802) 585-0995.

Sincerely,

Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1009	A. BUILDING: _____ B. WING _____	C 06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT SHELBURNE BAY EAST	185 PINE HAVEN SHORES ROAD SHELBURNE, VT 05482

(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 onsite relicensure survey and an investigation of a complaint and facility report incident was conducted by the Division of Licensing and Protection on 6/19/24. Regulatory deficiencies were identified through the relicenusre survey. Findings include:	R100		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure development of one applicable resident's plan of care based on individual abilities and needs related to the use of anticoagulant medications, risk for altered perception and false or inaccurate reporting related to cognitive decline, and provision of personal care only by female staff, (Resident # 1). Findings include: The home's Service Plan/Care Plans policy and procedures state Resident Service Plans shall include the following individualized care needs: a."Resident needs relating to Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLSs) [sic]"	R145		

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R145	Continued From page 1 b."Identification of the resident's problems and needs, Resident goals and intervention plans" c."The Resident Service Plan will be reviewed as required by state regulations or with any significant change [sic] ..." 1. Per record review Resident #1 is diagnosed with Vascular Dementia and a history of Cerebral Vascular Accident, which is an interruption of the blood flow to the brain often referred to as a "stroke"; and s/he is prescribed the anticoagulant medication Eliquis to reduce the risk of recurrence. Per review of Resident Assessments, Resident #1 has impaired short term memory, and difficulty remembering requiring direction and reminding 4 or more times per day. Resident #1 has left sided hemiplegia, and is dependent on staff for assistance with all Activities of Daily Living including mobility, transfers, toileting, grooming, dressing, personal hygiene, bathing, and incontinence care. Per interview with the Executive Director commencing at 12:35 PM on 6/19/24, Resident #1 has a history of "ideations inconsistent with what is going on, and reports of delusions about other residents and associates." The Executive Director stated the facility is in the process of discussing possible transition to Memory Care, and described incidents during which Resident #1's impaired cognitive function contributed to altered perception and false or inaccurate reporting of events. Per the Executive Director, a recent change was made to ensure Resident #1's personal care is only performed by female providers in an effort to provide care in an environment which Resident #1 perceives as safe. 3. Per record review, Resident #1's Plan of Care	R145		

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R145	Continued From page 2 does not include care and services related to Resident #1's individual abilities and needs related to use of anticoagulant medications; cognitive impairment and potential risk for altered perception and false or inaccurate reporting of experiences; and provision of personal care only by female staff. This finding was confirmed by the Executive Director at 12:57 PM on 6/19/24. In conclusion this deficient practice is a potential risk for more than minimal harm to all residents resulting from unidentified residents needs and interventions.	R145		
R247 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure all perishable foods and beverages are held at or below 40 degrees Fahrenheit. Findings include: During observations of the East kitchen refrigerator at approximately 11:35 am, the refrigerator thermometer indicated Refrigerator #1 at 47 degrees, a follow up temperature was observed approximately 30 minutes later with a	R247		

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R247	Continued From page 3 temperature reading of 45 degrees. This finding was confirmed by the Chef at the time of observation. The facility Holding Hot and Cold Potentially Hazardous Foods Standard Operating Procedures states " 3. Hold all food at (or per your State or local health department): Hold hot foods at 135 degrees Fahrenheit or above; Hold cold foods at 41 degrees Fahrenheit or below." Per interview on 6/19/24 at 10:30 AM the Culinary Director confirmed the facility to maintain refrigerator temperatures and staff are to monitor the temperatures. In conclusion, this deficient practice is a potential risk for more than minimal harm due to food borne illness for all facility residents.	R247		
R251 SS=F	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.a All food and drink shall be stored so as to protect from dust, insects, rodents, overhead leakage, unnecessary handling and all other sources of contamination. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure of the Assisted Living Residence (ALR) to ensure all food service equipment was kept clean and the environment was free from sources of contamination. Findings include: During the facility tour commencing at 8:55 AM,	R251		

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R251	Continued From page 4 the facility operates with two kitchen areas, a main kitchen and a East kitchen. The kitchens are separate food prep and service areas, that serve all facility residents. In observation of the serving kitchen, two fans were observed within the kitchen with dust build up the metal frame of the fan and a mop bucket with collection of brown water stored under a dishwasher sink in proximity to food service area. A freezer chest was observed with melted ice cream on the handle, along with the ice cream scoop in a container with water, the ice cream containers within the freezer chest were uncovered with lids. A large plastic container was observed resting on the freezer, within the container were ice cubes, the container was uncovered and open to air. The kitchen staff confirmed the observations indicating ice cream had not been served during the breakfast meal and the ice maker is out of service and ice is obtained from the bistro ice maker for meal service. In the dishwashing area of the Main kitchen, the wash sink was observed to have a bucket under the sink, to collect water from a leaking pipe, the bucket of water was observed with evidence of discolored water, presenting mold growth. The facility Cleaning and Sanitizing Food Contact Surfaces Standard Operating Procedures states "Wash, rinse and sanitize food contact surfaces of sinks, tables, equipment, utensils, thermometers, carts and equipment: Before each use, between uses when preparing different types of raw animal foods, such as eggs, fish, meat and poultry, Between uses when preparing ready-to-eat foods and raw animal foods such as eggs, fish, meat and poultry, Any time contamination occurs or is suspected."	R251		

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R251	Continued From page 5 Within the kitchen freezer chests in both the main kitchen and the -- Kitchen, containers of ice cream were op uncovered. In the walk-in refrigerator of the Main Kitchen, a tray of fruit was left uncovered, Per interview on 6/19/24 at 9:40 AM the Culinary Director confirmed observations and explained a cleaning schedule is in place for opening and closing procedures for all kitchen staff to be completed. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents related to potential risk of foodborne illnesses with contamination of food preparation areas and food handling practices.	R251		
R999 SS=F	MISCELLANEOUS 4.13.c The manager shall not leave the premises without delegating necessary authority to a competent staff person who is at least eighteen (18) years of age. Staff left in charge shall be qualified by experience to carry out the day to day responsibilities of the manager, including being sufficiently familiar with the needs of the residents to ensure that their care and personal needs are met in a safe environment. Staff left in charge shall be fully authorized to take necessary action to meet those needs or shall be able to contact the manager immediately if necessary. This requirement was NOT MET as evidence by: Based on observation, interview, and record review, there was a failure of the ALR to ensure	R999		

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R999	Continued From page 6 the premises had delegated authority to a staff member to carry out the day to day responsibilities of the Manager. On 6/19/24 Nurse surveyors entered the ALR at 8:30 AM for relicensure survey and two facility investigation. Upon entry a Survey Entrance Request of listed items was provided to the Licensed Practical Nurse (LPN) identified as the authority in charge. At the time of reviewing the request list, the LPN confirmed to be able to only provide 2 out of the 12 items requested, #1 Resident Roster and #2- Access to Policies and Procedures. The LPN stated, "The Managers are off as today is a Holiday." At approximately 9:45 AM the Business Office Manger arrived to the facility, the Business Office Manager, confirmed to now be the individual of authority to carry the responsibility of a Manager for the facility. The opening request list was provided at 9:50 AM, the manager was notified of the limited time available to obtain the requested documentation, noting the Resident Census/Roster had yet to be provided. The manager was oriented to the requests to be provided within 1-2 hours of the Entrance requests list provided. At 10:49 am the Business Office Manager was able to provide 2 out of the 12 items requested. Access to resident records was delayed until approximately 11:15 AM, due to the electronic health records system access was assigned to an alternate facility within the governing body. At 11:10 AM follow up of requested items, confirming to have received 4 more additional items and pending access the HER, the Business office manager confirmed access to the environmental safety records, fire drills, would be delayed as the records are maintained in the	R999		

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R999	Continued From page 7 maintenance office, and a maintenance staff personnel will be arriving to retrieve them. The records were presented at 12:50 PM. At 12:00 PM the manager on the license of the ALR arrived to the facility. The facility policy titled Office Hours /Manager on Duty (MOD), to summarize the attendance of the appointed Manager Head on weekends and holidays to be present in the ALR. An interview with the Manager at approximately 1:00 PM confirmed the facility policy for Manager on Duty practices. The Manager confirmed the date of survey to be an acknowledged Holiday by the governing body of the ALR. The Manager confirmed the Business Office Manager as the MOD, and confirmed the LPN would not have access to all the requested items to facilitate a survey and/or complaint investigation. The Manager acknowledged the delays that occurred through the survey process, due to the arrival time of the MOD and the additional delays due to limited access to records and requested items unavailable to the MOD. The deficient practice is a potential risk for more than minimal harm as facilities are to have individuals prepared to carry out the day to day responsibilities of the Manager, to include ensuring the needs of residents, maintain a safe environment and facilitate onsite visits by the state licensing agency.	R999		

The Residence at Shelburne Bay

ANNUAL, SELF REPORT SURVEYS 6/19/24: PLAN OF CORRECTION 7/23/24

R 145 V. RESIDENT CARE AND HOME SERVICES

5.9. c (2) Plan of care

R 145 Accepted 7/26/24
Jenielle Shea, RN

Action: Nursing Inservice to review findings

Systemic change: Each Nurse responsible to comply with regulation, Yardi dashboard to ensure accurate and updated Care Plans to capture change in condition

Monitoring: During Weekly Risk Meeting RCD to review Care Plans of at Risk individuals to monitor for changes in condition and approaches to address these changes

Completion Date: 7/24/24 & ongoing

R 247 VII. NUTRITION AND FOOD SERVICES

7.2 Food Safety and Sanitation

R247 Accepted 7/26/24
Jenielle Shea, RN

Action: Server Inservice to review Annual Survey reporting and Standard Operating Procedures 7/16 & 7/17/24

Chef Inservice to review Annual Survey reporting and Standard Operating Procedures 7/31/24

Systemic change: Paper sign off by Servers to confirm itemized Closing Procedures completed for each meal service and improve accountability

Review and update of existing posted closing check lists to include noted deficiency items

Monitoring: Restaurant Operations Director and Executive Chef to alternate walking of kitchens daily to ensure compliance with standard 7/19/24

Dining Room Supervisor to review completion of Closing Procedures checklist sign off daily 7/26/24

Executive Director to review Closing Procedures checklist sign off weekly 7/26/24

Completion Date: 7/16/24 & 7/17/24 for Inservice completion, 7/26/24 for system and monitoring & ongoing

R 251 VII. NUTRITION AND FOOD SERVICES

7.3 Food Storage and Equipment

R251 Accepted 7/26/24
Jenielle Shea, RN

Action: Server Inservice to review Annual Survey reporting and Standard Operating Procedures 7/16 & 7/17/24

Chef Inservice to review Annual Survey reporting and Standard Operating Procedures 7/31

Systemic change: Paper sign off by Servers to confirm itemized Closing Procedures completed for each meal service

Review and update of existing posted closing check lists

Monitoring: Restaurant Operations Director and Executive Chef to alternate walking of kitchens daily to ensure compliance with standard

Dining Room Supervisor to review completion of Closing Procedures checklist sign off daily

Completion Date: 7/16/24 & 7/17/24 for Inservice completion, 7/26/24 for system and monitoring & ongoing

R 999 MISCELLANEOUS

R999 Accepted 7/26/24
Jenielle Shea, RN

4.13c Manager on Duty

Action: Manager on Duty and Nursing Inservices to review Annual Survey reporting and deficiency

Systemic change: Completion of Survey Response Binder and procedure Inservicing to MOD and Nursing Supervisors

Monitoring: Executive Director and Resident Care Director to present Quarterly to the MOD team and Nursing Supervisors

Completion Date: 7/31/24