

**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 <u>http://www.dail.vermont.gov</u> 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

December 9, 2022

Ms. Sara Faucher, Manager The Residence At Quarry Hill 465 Quarry Hill Road South Burlington, VT 05403

Dear Ms. Faucher:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 28, 2022.** Please post this document in a prominent place in your facility.

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

Sincerely,

Jamela Mcota RN

Pamela M. Cota, RN Licensing Chief

PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING:		C 09/28	/2022
	ROVIDER OR SUPPLIER	465 QUA	DDRESS, CITY, STATE ARRY HILL ROAD BURLINGTON, VT			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
R100	was conducted on 9/	site complaint investigation 21/22 and completed on g regulatory violations were with the complaints	R100			
R145 SS=E	5.9.c (2) Oversee developmen each resident that is as identified in the re of care must describ	AND HOME SERVICES nt of a written plan of care for based on abilities and needs esident assessment, A plan e the care and services he resident to maintain vell-being;	R145			
	by: Based on staff interv Registered Nurse fa written plan of care services necessary f	T is not met as evidenced riew and record review the iled to develop and update a describing the care and to maintain the wellbeing of 3 (Residents #1 & #2) Findings			-	
	of 2016 with diagnos Osteoporosis (joint p Pain, Impaired mobi Tremors, Asthma/Er difficulty communica was 100 years old a in 2/19/22. Resident address pain interve	admitted to the home in July ses including Arthritis and pain/stiffness and bone loss), lity, history of spinal fracture, nphysema. Glaucoma, ting verbally, Resident #1 nd admitted into hospice care #1's plan of care failed to ention; and his/her needs and are during the end of life				

STATE FORM

R145-Raldo POC'S accepted 11/14/22 FMcIntosh RN/ PMC

F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		A. BOILDING.			С
	1012	B. WING			28/2022
ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
DENCE AT QUARRY H	200 Sector				
	SOUTH	BURLINGTON, VT			
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLE DATE
Continued From page	ge 1	R145	5.		
process.					
December of 2021 of Spinal Stenosis (spi puts pressure on the Cardiovascular Dise Gout, Ataxia (neuro coordination), and D of care failed to add related to his/her dia and Gout; and to add Resident #2 had a h 12/17/21 and 5/20/2 On the afternoon of	with diagnoses including inal column narrowing that e spinal nerves), ease, Cardiac Dysrhythmia, logical damage causing poor Depression. Resident #2's plan ress interventions for pain agnoses of Spinal Stenosis Idress his/her risk for falls. history of 5 falls between 22. 9/27/22 the Executive				
addressed in Resid	ent #1, #2's plans of care.	R164			
5.10 Medication M	anagement				
administration, unlie	ensed staff may administer				
responsibility for the	administration of specific				
by: Based on staff inter was a failure to ens	view and record review there ure an RN delegated the			2	
	SUMMARY S (EACH DEFICIEN REGULATORY OF Continued From page process. 2. Resident #2 was December of 2021 v Spinal Stenosis (spingle stenosis) puts pressure on the Cardiovascular Disc Gout, Ataxia (neuronon coordination), and E of care failed to add related to his/her dia and Gout; and to add Resident #2 had a h 12/17/21 and 5/20/2 On the afternoon of Director acknowledge addressed in Resident V. RESIDENT CAR 5.10 Medication M 5.10.d If a resident for administration, unlice medications under the (2) A registered numerications to designed residents This REQUIREMENT by: Based on staff inter- was a failure to ensoresponsibility for the responsibility for the	ROVIDER OR SUPPLIER       STREET A         DENCE AT QUARRY HILL       465 QU/ SOUTH         ENCE AT QUARRY HILL       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 1       process.         2. Resident #2 was admitted to the home in December of 2021 with diagnoses including Spinal Stenosis (spinal column narrowing that puts pressure on the spinal nerves), Cardiovascular Disease, Cardiac Dysrhythmia, Gout, Ataxia (neurological damage causing poor coordination), and Depression. Resident #2's plan of care failed to address interventions for pain related to his/her diagnoses of Spinal Stenosis and Gout; and to address his/her risk for falls.         Resident #2 had a history of 5 falls between 12/17/21 and 5/20/22.       On the afternoon of 9/27/22 the Executive Director acknowledged the individual needs not addressed in Resident #1, #2's plans of care.         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 staff interview and record review there was a failure to ensure an RN delegated the responsibility for the administration of specific	BUMING         STREET ADDRESS, CITY, STATE         SUMMARY STATEMENT OF DEFICIENCIES         CENCE AT QUARRY HILL         SUMMARY STATEMENT OF DEFICIENCIES         (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 1         process.       R145         2. Resident #2 was admitted to the home in December of 2021 with diagnoses including Spinal Stenosis (spinal column narrowing that puts pressure on the spinal nerves), Cardiovascular Disease, Cardiac Dysrhythmia, Gout, Ataxia (neurological damage causing poor coordination), and Depression. Resident #2's plan of care failed to address interventions for pain related to his/her diagnoses of Spinal Stenosis and Gout; and to address his/her risk for falls. Resident #2 had a history of 5 falls between 12/17/21 and 6/20/22.       R164         On the afternoon of 9/27/22 the Executive Director acknowledged the individual needs not addressed in Resident #1, #2's plans of care.         V. RESIDENT CARE AND HOME SERVICES       R164         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       Inis REQUIREMENT is not met as evidenced by:         Based on staff interview and record review threre was a failure to ensure an RN delegated	1012       STREET ADDRESS, GTV, STATE, ZIP CODE       465 QUARRY HILL ROAD SOUTH BURLINGTON, VT 05403       SIMMARY STATEMENT OF DEFICIENCES (exc) HOPCINEY WILL ROAD SOUTH BURLINGTON, VT 05403       SIMMARY STATEMENT OF DEFICIENCES (exc) HOPCINEY, WILL ROAD SOUTH BURLINGTON, VT 05403       Continued From page 1     PRETAX PRETAX       process,     R145       2. Resident #2 was admitted to the home in December of 2021 with diagnoses including Spinal Stenosis (spinal column narrowing that puts pressure on the spinal nerves), cardiovascular Disease, Cardiac Dysrhythmia, Gout, Ataxia (neurological damage causing poor coordination), and Depression. Resident #2's pian of care failed to address his/her risk for fails. Resident #2 had a history of 5 falls between 12/17/121 and 5/20/22.       On the afternoon of 9/27/22 the Executive Director acknowledged the individual needs not addressed in Resident #1, #2's plans of care.       V. RESIDENT CARE AND HOME SERVICES     R164       5.10. Medication Management 5.10.4 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 staff interview and record review three was a failure to ensure an RN delegate the responsibility for the administration of specific	Initial     Dimmediation       Device AT QUARRY HILL     STREET ADDRESS, CITY, STWE, 2P CODE       SUMMARY STREMENT OF DEFICIENCES     SUMMARY STREMENT OF DEFICIENCES       SUMMARY STREMENT OF DEFICIENCES     ID       RECULATORY OR LSC DEMTIFYING INFORMATION     PREFIX       RECULATORY OR LSC DEMTIFYING INFORMATION     PREFIX       RECULATORY OR LSC DEMTIFYING INFORMATION     ID       RECULATORY OR LSC DEMTIFYING INFORMATION     PREFIX       Continued From page 1     R145       process,     R145       2. Resident #2 was admitted to the home in     December of 2021 with diagnoses including Spinal Stenosis (spinal Column narrowing that puts pressure on the spinal nerves),       Cardiovascular Disease, Cardiac Dystriptimia, Gour, Ataxia (neurological damage causing poor coordination), and Depression. Resident #2's plan of care failed to address infer risk for fails.       Resident #2 had a history of 5 fails between 12/17/21 and 5/20/22.     R164       5.10 Medication Management     5.10.4 if a resident requires medication administration of specific medications under the following conditions:       (2) A registered nurse must delegate the responsibility for the administration of specific medication statistic on specific medications to designated staff for designated the residents       This REQUIREMENT is not met as evidenced by:       Based on staff interview and record review three was a failure to ensure an RN delegated the

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	of Licensing and Protect			ONSTRUCTION	(X3) DATE SU	RVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		COMPLET	
AND PLAN (	OF CORRECTION		A, BUILDING:		с	
						/2022
		1012	B_WING		09/20	12022
	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE		
			RRY HILL ROAD		1	
THE RESI	DENCE AT QUARRY HIL	-	BURLINGTON, VT	05403		
				PROVIDER'S PLAN OF CORREC	TION	(X5)
(X4) ID PREFIX	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID PREFIX	VEACH CORRECTIVE ACTION SHOL	ULD BE	DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OFTONE	
R164	Continued From pag	e 2	R164			
11101						
	residents. Findings ir	nclude:		7.		
		- (to use of 0/07/00 the				
		afternoon of 9/27/22 the sclosed the RN who was	1 1			
	Executive Director di	elegation of specific staff to	1 1			
	administer medicatio	ins to the ALR designated				
1 1	residents had resign	ed effective 9/6/22				
	Presently the proces	ss to re-delegate staff by an				
	employed RN has no	ot been conducted, resulting				
1	in 18 designated sta	ff performing medication	1 1			
	administration under	the license of the previous	1 1			
i oc	RN, which is not per		1 1		1	
1 I I			1 1		1	
R165	V. RESIDENT CARE	EAND HOME SERVICES	R165			
SS=D						
			1 1			
	5.10 Medication Ma	nagement	4			
	5.10.d If a resident	requires medication				
	administration, unlic	ensed staff may administer	1 1	2		
	medications under the	he following conditions:				
			1			
	(3) The registered n	nurse must accept			ž.	
	medications, and is	proper administration of responsible for:				
	i Teaching design	nated staff proper techniques			197	
	for medication admin	nistration and providing				
	appropriate infr	prmation about the resident's				
	condition relevant n	nedications, and potential				
	side effects;					
	ii. Establishing a p					
	communication with	designated staff about the				
	resident's condition	and the effect of medications,	14			
	as well as changes i					
		esident's condition and the				
		es in medications; and				
1		uating the designated staff				
	performance in carry	ying out the nurse's				-
	instructions.					
		the little second second second				

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If continuation sheet 3 of 11

Division of Licensing and Protection

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A, BUILDING:	CONSTRUCTION	(X3) DATE S COMPL	ETED
		1012	B. WING			C 28/2022
	ROVIDER OR SUPPLIER DENCE AT QUARRY HIL	465 QUA	DDRESS, CITY, STATE RRY HILL ROAD BURLINGTON, VT		a 	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
R165	Continued From page	∋ 3	R165			
	by: Based on record revie nurse failed to ensure of medications for 1 a #2) who demonstrate medication administra Resident Assessmen licensing agency and include: Per record review Re the home on 12/15/2 Assessment dated 12 #2 did not know how and a re-assessment Resident #2 had prot instructed/prescribed The instructions on th provided by the licent resident does not know medications, and if th taking medications as the resident needs m Despite the instruction required medication as the Resident Assess	Nursing Notes. Findings sident #2 was admitted to 1. An initial Resident 2/16/22 indicated Resident often to take medications, dated 3/18/2022 indicated olems taking medications as the Resident Assessment tool sing agency state if the the resident has problems is instructed/prescribed, then edication administration. ns indicating Resident administration, according to				
	Assessment dated 3/	ording to the Resident 18/22 Resident #2 controlled ad and over the counter				
Twiston of Lice	#2 reported Med Technis/her antidepressar	y Notes on 3/6/22 Resident hs were not administering nt, and stated Resident #2's f administered. A note on				

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	Licensing and Protector	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE COMP	SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A_BUILDING:			
		1012	B. WING		09	C /28/2022
			DDRESS, CITY, STATE	ZIP CODE		
IE OF PR	OVIDER OR SUPPLIER		RRY HILL ROAD	0		
ERESID	ENCE AT QUARRY HIL		BURLINGTON, VT	05403	-	-
(4) ID Refix Tag	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TON SHOULD BE	(X5) COMPLE DATE
	medications, but at t due to not letting sta low. On 4/24/22 Res cough attributed to a Note stated Resider room that s/he forgo by the nurse to take was reported a care doesn't always take pill". Resident #2 st unable to reach ther s/he needs them ev indicated Resident # medications and "is 6/10/22 it was noted	dent # 2 manages his/her own imes runs out of medications iff know supplies are running sident #2 complained of a acid reflux, and the Nurse's acid reflux, and the Nurse's at #2 "has Pepcid in his/her it s/he had" and was advised it once daily. On 5/19/22 it giver noticed Resident #2 prescribed "memory or gout ated sometimes s/he was m and sometimes didn't think ery day. This note again #2 self administers independent with meds". On d Resident #2 continued to	R165		ž	
	complain of gout an medication. The not in a pile of cards. W med cards [s/he] sa [his/her] aspirin", wi gout. For three days reach his/her medic administration of me	d wanted to take his/her gout te stated "It is next to [him/her] /hen given [his/her] pile of id 'here it is' while holding hich was not prescribed for s Resident #3 was unable to cations, and when offered staff edication Resident #2 refused.				-
	Director acknowled implement medicati indications on admi Resident #2's resid	ged the nurse failed to lon administration despite ission and throughout ence at the home that nable to self administer			(#C	
R207 SS=D	V. RESIDENT CAR	RE AND HOME SERVICES	R207			
		Abuse, Neglect or Exploitation				
	E 19 h The licensed	e and staff are required to				

Division of Licensing and Otecuon STATE FORM

f 11 If continuation sheet

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (			OATE SURVEY C
		1012	B. WING			09/28/2022
AME OF PR	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
	DENCE AT QUARRY HIL	465 QU	ARRY HILL ROAD			
		SOUTH	BURLINGTON, VT	05403		
(X4) ID PREFIX TAG	(ÉACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICII	ACTION SHOULD BE	(X5) COMPLETE DATE
R207	Continued From pag	e 5	R207			
	neglect or exploitatio	eported incidents of abuse, n. It is not the licensee's or			.#	-
	incident did occur or	o determine if the alleged not; that is the responsibility	÷			
		cy. A home may, and should,		8		
		stigation. However, that must f the alleged or suspected	i i			
	incident to Adult Prot					
	This REQUIREMEN	T is not met as evidenced				
		iew and record review, the				
	ALR failed to conduct	t its own internal reported incident of bruising			9	
	-	as identified on a resident.				
	(Resident #1) Finding	gs include:			(82	- 10 · · · ·
	On 9/1/22 Resident #	1 was found to have dark				
		ght arm, left hand and left	- E			
		s noted by 2 LNAs (Licensed who are part of Hospice				
		of life care to Resident #1.				26
	The Hospice agency	filed a report with APS (Adult	3	.*.		
		on 9/1/22 followed by a ent filed with the Licensing				
		required. However, during				
	an on-site at the ALR	on 9/27/22, evidence of an				
	internal investigation or incident resulting in	regarding potential causes	1			
		the ALR has a process to				
	conduct its own invest	stigation, there was a failure				
-		in the case of resident origin. This was confirmed				
		ector on the afternoon of	1			1
	9/27/22.					1
R249 SS=E	VII. NUTRITION AND	FOOD SERVICES	R249		.8	
1			1 1			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		3) DATE SURVEY COMPLETED
		1012	B. WING		C 09/28/2022
AME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	
HE RESI	DENCE AT QUARRY H		RRY HILL ROAD SURLINGTON, VT	05403	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	E (X5) COMPLET DATE
R249		d Sanitation all assure that food handling ues are consistent with safe	R249		
	This REQUIREMEN by: Based on observation was a failure to ens	IT is not met as evidenced on and staff interview there ure food handling and storage sistent with safe food handling			
	9:43 on 9/21/22 foo the memory care ce improperly stored . containing several p pats was stored at r shelves below the s	the facility commencing at ad items in the kitchenette in inter were observed to be A stainless steel box bounds of single serving butter oom temperature on the ervice counter, and a bowl of red with plastic cling wrap inet drawer.			-
	not labeled with the including ketchup, b toppings, 2 open bo ginger ale. An open 9/13/22, which was Pedialyte web site s discarded 48 hours the kitchenette cont cream was missing	he kitchenette contained items date they were opened alsamic glaze, dessert ttles of juice, and a bottle of bottle of Pedialyte was dated 8 days before the tour. The tates this product should be after opening. The freezer in ained a gallon container of ice a lid exposing the contents of open air inside the freezer.			
	kitchen where butter drawer; an unlabele serving bottle of wat	e observed in the "Bistro" r pats were stored in a cabinet d partially consumed single er was placed in the pened bottles of water, and a			a.

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If continuation sheet 7 of 11

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	f Licensing and Protect	tion		CONSTRUCTION	(X3) DATE SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COMPLETED
AND PLAN O	F CORRECTION		A, BUILDING:		с
		1010	B. WING		09/28/2022
		1012			
NAME OF PR	OVIDER OR SUPPLIER		DRESS, CITY, STA		
THE RESID	DENCE AT QUARRY HIL		RRY HILL ROAD URLINGTON, V		
				PROVIDER'S PLAN OF CORRE	CTION (X5)
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
R249	Continued From page	e 7	R249		4
		cream was stored in the	1		
	fridge without a lid co	overing the top.			1
	-				
	During the course of	the facility tour commencing			
	at 9:43 on 9/21/22 th	e Executive Director			
	contirmed the prese	nce of improperly stored mory care center kitchenette			Ű.
	and the Bistro kitcher				
R258	VII. NUTRITION AND	D FOOD SERVICES	R258		
SS=D		~			
	7.3 Food Storage ar	d Equipment			
	7.3 Food Storage at	id Equipment	1		
	7.3.h All garbage sha	all be collected and stored to			
9	prevent the transmis	sion of contagious diseases,			
	creation of a nuisand	ce, or the breeding of insects all be disposed of at least	(a.)		
- I	and rodents, and sha	trash in the kitchen area		1	
	must be placed in lin	ed containers with covers.			
		T is not met as evidenced	-		11
	by: Based on observatio	on and staff interview there		5 F	
	was a failure to ensu	ire all garbage or trash in the		E	1
	kitchen area is collec	cted and stored in containers			
	with covers.				
5	During the facility to	ur on the morning of 9/21/22			
4	at 10:10 AM accomp	panied by the ALR			
	Administrative Direc	tor a trash receptacle was			
	observed to be unco	overed in the food prep area			
	of the kitchenette on	the Memory Care Unit. The tor confirmed the presence of			
	uncovered trash rec	eptacle during the tour.			
		. –		-	
R266	IX. PHYSICAL PLAN	NT	R266		
SS=F					
		Э.	1		
Division of Lic	ensing and Protection		14		If continuation sheet 8 of

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TATEMENT	f Licensing and Prote OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE COMPL	SURVEY LETED
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			-
			B. WING			C 28/2022
	and a start of the	1012				
AME OF PF	ROVIDER OR SUPPLIER		DRESS, CITY, STAT	E, ZIP CODE		
	DENCE AT QUARRY HI		RRY HILL ROAD	05402		
NE RESI	DENCE AT QUARTER TH	SOUTH E	BURLINGTON, VT	PROVIDER'S PLAN OF CO	PRECTION	(X5)
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PREFIX	ICACH CORRECTIVE ACTIO	N SHOULD BE	COMPLET
PREFIX TAG	(EACH DEFICIEN REGULATORY OF	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE
170				DEHoleitory		
R266	Continued From page	16.8	R266			
11200		,				
	9.1 Environment					1
		et new ide and maintain a				
	9.1.a The home mu safe, functional, san	st provide and maintain a				18
	comfortable environ					1
		inone.				
	This REQUIREMEN	IT is not met as evidenced				
	by:					Ĩ
	Based on observation	on and staff interview, the ALR				
	staff failed to mainta	in a safe and sanitary		a		
	environment related	to poor repair, lack of				
	cleanliness, and un	safe food storage methods in	1 1	040		
	the memory center	kitchenette; unsafe storage of	3 1			1.14
	hazardous infectiou	s waste in overflowing used sk for injury due to a missing	1 1			
	snarps container, n	e kitchenette; and staff failure				
	to follow required C	ovid precautions by properly	1 1			
	wearing required fa	ce masks. Findings include:				1
	Would be the					
	1. During at tour of	the facility commencing at	J. 1			1
	9:43 on 9/21/22 the	kitchenette in the memory				
	care center was ob	served to be in need of		-		
	cleaning and repair	s. The handle on the outside	The second se			
	of the half door bet	ween the dining room and				
	kitchenette was mis	sing a handle leaving the f the door lock cylinder				
	snarp metal edge o	approximately 2 inches from				
	the deer in the kite	henette the counters and				
	cabinet facings we	e dirty, and there were coffee				
	stains in the cabine	t drawers located below the				10
	coffee machines. T	he cabinets located under the	U U			
	food service counter	er were missing doors. A				
	stainless steel box	containing several pounds of		0		
	single serving butte	er pats was stored at room		÷		
	temperature on the	shelves below the service				
	counter. A bowl of	cooked bacon covered with				
	plastic cling wrap w	vas placed in a cabinet drawer, sh can was missing a lid.				
	L and the kitchon tra					

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**Division of Licensing and Protection** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A, BUILDING: C B. WING 1012 09/28/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **465 QUARRY HILL ROAD** THE RESIDENCE AT QUARRY HILL SOUTH BURLINGTON, VT 05403 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) R266 R266 Continued From page 9 The refrigerator in the kitchenette contained items not labeled with the date they were opened including ketchup, balsamic glaze, dessert toppings, 2 open bottles of juice, and a bottle of ginger ale. An open bottle of Pedialyte was dated 9/13/22, which was 8 days before the tour. The Pedialyte web site states this product should be discarded 48 hours after opening. The freezer in the kitchenette contained a gallon container of ice cream was missing a lid exposing the contents of the container to the open air inside the freezer. Similar findings were observed in the "Bistro" kitchen where butter pats were stored in a cabinet drawer; an unlabeled partially consumed single serving bottle of water was placed in the refrigerator with unopened bottles of water, a container of whipped cream was stored in the fridge without a lid covering the top; and a trash can was overflowing with discarded items. During the course of the facility tour commencing at 9:43 on 9/21/22 the Executive Director confirmed the kitchenette cabinetry in need of cleaning and repairs, the missing handle on the half door at the entrance of the kitchenette, the presence of improperly stored food items, and missing garbage can lid in the memory care center, as well as the improperly stored food items and overflowing trash can in the Bistro kitchen. 2. The "sharps" hazardous waste storage container attached to the medication cart in the memory care center dining room was observed to contain a full plastic sharps container with a second full sharps containers placed on top of it. The second full container was not locked in a secured compartment, and the safety mechanism designed to prevent access to used sharps was **Division of Licensing and Protection** 

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R266	Continued From page		R266		
	capacity and used s container were accor- center residents, mi- capacity to understa exposure to this haz During the course of morning of 9/21/22 confirmed the risk of	of the facility tour on the the Executive Director of exposure to hazardous to improper disposal of used			
	Residential Care ar repeatedly observe wearing masks imp 9/21/22 all of the m residents in the din wearing their mask providing resident of in an open office w approximately 2 PN Nurse in the memo were not in complia requirements and i	21/22 and 9/27/22 facility nd Nursing staff were ad not wearing masks and/or properly. On the afternoon of memory care staff caring for ing area were observed s below their noses while care, and staff were observed ithout masks on. At M on 9/21/22 the Wellness ory care center confirmed staff		21	
	on 9/27/22 an LNA and a Residential ( providing close cor masks placed belo confirmed their ma and moved their m 1:45 PM a Nurse w	(Licensed Nursing Assistant) Care staff were observed ntact residential care with their w their noses. The two staff sks were improperly placed asks above their noses. At was observed working in an open without a mask on.		X	
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Corrective Action Plan The Residence at Quarry Hill Investigation of September 28, 2022

# R145, Written Plan of Care, 5.9.c(2)

All nursing staff will be retrained on assessments and service/care plan policies to include falls, hospice and pain management and will sign off on the LCB policies and procedures by 11/4/2022. The Resident Care Director (RCD) or RN Designee will review all assessments and service/care plans including assessments due to change of status as of 9/28/22 and ongoing.

Quarry Hill's (QH)contract with Bayada Home Health and Hospice includes full fall risk assessments on Residents on move in and after falls in the community currently and ongoing. Communication to QH nursing staff occurs during weekly "huddle meetings" currently and ongoing. Nursing staff will be reeducated to consistently add the risk assessments to the service/care plans and the RCD will review the updated service plans from 11/4/22 and ongoing.

# R164, Medication Management, 5.10.d

Medication delegation was completed by a trained/licensed RN that has been on staff participating in ongoing training and competencies of Med Techs. New RCD/Designee to complete new competencies by 11/11/22 and ongoing.

# R165, Medication Management, 5.10.d

All nursing staff to be retrained on medication administration per state regulations and the documentation of Resident's ability to self-administer by 11/11/22 by the RCD. LCB policy on medication administration will be reviewed and signed off by all nursing staff by 11/11/22. Weekly Resident Care tracking meeting will continue to identify high risk Resident issues which the new RCD will attend/chair and review documentation of communication/interactions between staff and the Resident, Resident's physician, and family.

# R207, Reporting of Abuse, Neglect or Exploitation, 5.18.b

All Department Leaders will be reeducated on the LCB Investigation Policy and Procedure by regional support by 11/11/22 and the leadership will sign off on the policy.

## R249, Food Safety and Sanitation, 7.2d

The kitchen in Reflections is scheduled for professional deep clean on 10/27/22. Environmental Rounds with the attached checklist (Attachment 1) will be done by the Reflections Director daily for 2 weeks through 10/21/22, two times per week through 11/11/22, and weekly ongoing. Executive Director to make spot checks from 9/29/22 and ongoing. Reflections staff to be reeducated on kitchen "hygiene" and their responsibilities and will review current infection control policies by the Reflections Director by 11/11/22. The new Director of Restaurant Operations will continue the Culinary Department's kitchen cleaning schedule attached (Attachment 2) from 11/11/22 and ongoing.

The Bistro is included on the Culinary cleaning checklist (Attachment 3) and all cookware and equipment is removed, cleaned, and stored effective 11/11/22 and ongoing.

#### R258, Food Storage and Equipment, 7.3h

The trash receptacle lids have been ordered and will arrive on or before 11/4/22.

#### R266, Environment, 9.1a

The handle on the Reflections kitchen door was scheduled for replacement on 10/19/22. Professional cleaners were scheduled for deep clean of Reflections kitchen on 10/27/22. Reflections staff will be reeducated on proper food handling and storage through in-services by the Reflections Director by 11/11/22. Cabinet doors in Reflections kitchen to be repaired or on order by 11/11/22.

Sharps containers are now audited weekly in Reflections and in the AL/IL communities by RCD or nurse designee. Please see attached revised forms (Attachment 4,5).

All staff to be retrained on current infection control policy which includes masking, and will sign off on the policy reviewed by 11/11/22.

Sara Faucher, Executive Director

Atra fande 11/9/22

# **Reflections Environmental Rounds**

Quality Assurance - Privileged and Confidential

Round completed by: \_\_\_\_\_Date: \_\_\_\_\_Reviewed by Executive Director on: \_\_\_\_\_

A + 0.0	Interpretive Guideline	Observations
Area Exits	<ul> <li>Exits are secured and alarm if opened without the security code- where applicable</li> <li>All gates are secured, lock releases when the fire alarm is activated</li> </ul>	
Alarms	<ul> <li>Associates respond immediately to security alarms and check for any elopement</li> </ul>	
Windows	<ul> <li>Window are secured and do not tilt or open more than 4"</li> <li>Window are secured and do not tilt or open more than 4"</li> </ul>	
Hazard free	<ul> <li>Dangerous, toxic, sharp or ingestible objects or substances such as uncovered electrical outlets, exposed wires, cleaning solutions, medications, kitchen knives, small objects, hot beverage dispensers, steam tables, etc. are not accessible to residents (check doors to Kitchen, Janitor's closet, etc)</li> </ul>	
Apartment	<ul> <li>Beds linins are clean</li> <li>Beds are made</li> <li>Mattress protection pads are being used when applicable</li> <li>General odors</li> <li>Towels and facecloths are restocked</li> <li>Curtains and blinds are in good repair</li> <li>Low lists are up and items are stored in tote</li> <li>Toothbrushes are labeled and stored with cover</li> <li>Equipment in good repair</li> <li>Electric panels are secure</li> <li>Call system tested</li> <li>Light bulbs in working order</li> <li>Night lights in bathrooms</li> <li>Carpet free from stains and/or odor</li> <li>Toilet seats are a contrasting color avoiding the color black</li> </ul>	
Sound Levels	<ul> <li>No trip nazards</li> <li>Radios, televisions and other sources of sound and music are used for specific interventions and are appropriate to the task, i.e. constant TV or radio music is not playing that distracts or agitates residents</li> <li>Pagers and other devices are not so loud that they create a distraction or irritation to residents</li> </ul>	
Lighting	<ul> <li>All light fixtures are working and all bulbs are in working order</li> <li>All lights are florescent natural light illuminants</li> <li>Color tints are the same in all fixtures. Blue and not soft white</li> <li>Seasonal or other decorations are adult-oriented</li> </ul>	
Program Areas	<ul> <li>Seasonal or other decorations are additional or other decoration or other decorations are additionare additional or other dec</li></ul>	

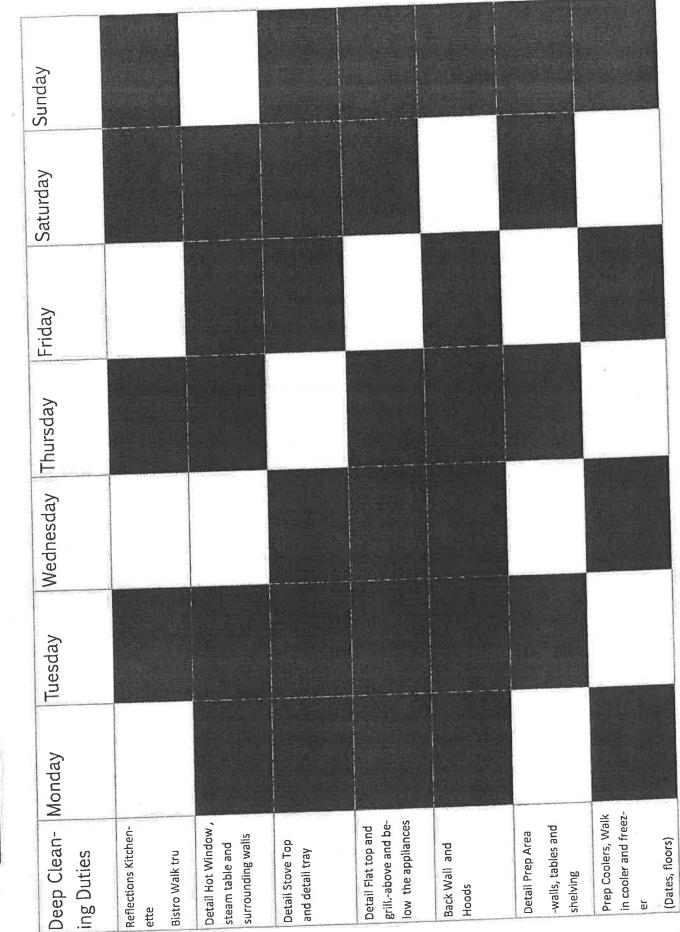
Deep Clean- Monday ing Duties Reflections Kitchen-	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Bistro Walk tru Detail Hot Window , steam table and surrounding walls Detail Stove Top							
and detail tray Detail Flat top and grill-above and be- fow the appliances							
Back Wall and Hoods Detail Prep Area							
-walls, tables and shelving Prep Coolers, Walk in cooler and freez- er (Dates, floors)							

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Attachment #2

\*This must be initialed and completed weekly.

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Attachment #3

\*This must be initialed and completed weekly.

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5 HAPach Ment #5 194/22 Notes à . INSULIN NARCOTICS Ø SHARPS 1 WEEKLY NURSING AUDIT CHECKLIST NAME ... 9.<sub>+</sub> DATE/TIME

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