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

December 5, 2024

Stacey Bowen, Manager
St Joseph Kervick Residence Iii
131 Convent Avenue
Rutland, VT 05701

Dear Ms. Bowen:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 4, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0298	A. BUILDING: ___ B. WING ___	C 11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH KERVICK RESIDENCE III	131 CONVENT AVENUE RUTLAND, VT 05701

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R100	Initial Comments: On 11/4/25 the Division of Licensing and Protection conducted an unannounced on-site investigation of one complaint. The following regulatory deficiencies were identified:	R100		
R128 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to provide dietary services consistent with the Primary Care Provider's signed orders for one applicable resident (Resident #1). Findings include: Per record review, Physician Progress Notes completed by Resident #1's Primary Care Provider on 10/21/24 included an order for a "strict gluten-free diet" for Resident #1 which states "should avoid all cross contamination - sharing utensils, cooking surfaces, prep areas should be avoided in individuals with celiac disease. Would advocate for education of all dietary staff/servers surrounding celiac/cross contamination. Reading all labels to ensure gluten-free." Per observation on the afternoon of 11/4/24 the home's kitchen did not have a designated gluten-free food preparation area and designated gluten free utensils and equipment. The	R128	See attached	

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R128	Continued From page 1	R128		

designated gluten-free storage area was observed with gluten containing/exposed products including an open unsealed box of farina (wheat hot cereal) stored in close proximity to gluten free products. This storage practice is a significant risk for cross contamination, which occurs when gluten-free products are contaminated by contact with or exposure to products that are not gluten free. On the afternoon of 11/4/24, the Kitchen Manager and Cook confirmed these findings.

The Diet Requisition and Change Order on file for Resident #1 was checked to indicate Resident #1 has a "Regular Diet". The comment section of this form indicated "Food Allergies Wheat & Gluten", however this form was dated as completed on 2/15/22 and had not been updated to include additional information related to prevention of cross contamination included in the written dietary order received from Resident #1's Primary Care Provider on 10/21/24. Per record review, a note dated 10/25/24 written by the home's Registered Dietician stated Digestive Services had put in an order to Nursing Staff for a "strict gluten free diet - should avoid all cross contamination ...". This note indicated Resident #1 currently has a rash that "may be related to allergy" and included the following statements:

a. "Impression: difficult to accommodate resident's needs and preferences in present situation."

b. "Explained it is not feasible to have totally separate area, toaster, etc for special diet in this level of care (50 other residents to serve as well) >>> if [s/he] needs more strict than can be provided, [s/he] may need to look at other alternatives in terms of placement [sic]"

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R128	Continued From page 2 Per interviews on the afternoon of 11/4/24, three Staff working in the kitchen and dining areas of the home stated they had not received specific trainings related to Resident #1's strict gluten free dietary needs including prevention of cross contamination. At 1:20 PM the Kitchen Manager confirmed documentation of specific staff training related to Resident #1's orders for a strict gluten free diet including prevention of cross contamination was not on file and available for review.	R128		
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 resident and staff interviews and record review there was a failure to develop a care plan including goals and interventions to address one applicable resident's needs related to a diagnosis of Celiac disease and provision of a strict gluten free diet ordered by one applicable resident's Primary Care Provider (Resident #1). Findings include:	R145		

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R145	Continued From page 3 The home's policies and procedures governing documents to be maintained on file and available for review in resident's records indicate resident records are to include a care plan, however the policies and procedures do not indicate what information is to be included in a resident's care plan. Per record review Resident #1 has a longstanding wheat and gluten allergy and a recent diagnosis of Celiac Disease. Resident #1's Primary Care Provider prescribed a strict gluten-free diet including prevention of cross contamination of gluten -free products. The care plan on file for Resident #1 does not identify care and services required to maintain the resident's health and well-being related to his/her diagnosis of Celiac Disease. This finding was confirmed by the Manager on the afternoon of 11/4/24.	R145		
R179 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures,	R179		

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such as the Heimlich maneuver, accidents, police or ambulance contact and first aid;
(4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation;
(5) Respectful and effective interaction with residents;
(6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and
(7) General supervision and care of residents.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review there was a failure to ensure food service staff are trained to provide a gluten free diet; and a failure to ensure food service staff demonstrate competencies in minimizing the risk of gluten exposure due to cross contamination for one resident diagnosed with celiac disease who requires a strict gluten free diet (Resident #1). Findings include:

Policies and procedures to ensure staff trainings and competencies related to resident's specific dietary needs were not on file and available for review on 11/4/24.

Per record review, Resident #1 is diagnosed with Celiac disease and is prescribed a strict gluten free diet by his/her physician. According to online dietary resources provided by the Mayo Clinic 's Gastroenterology department, following a strict gluten free diet and avoiding cross-contamination of gluten free products via exposure to products containing gluten is necessary for individuals diagnosed with Celiac to reduce symptoms and

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complications. Interventions which prevent and minimize exposure to gluten cross-contamination identified by the Mayo Clinic include using separate preparation and cooking surfaces, toasters, cutting boards, knives and utensils when preparing and serving gluten free foods.

Per observation on the afternoon of 11/4/24 the home's kitchen did not have a designated gluten-free food preparation area or designated gluten free equipment, and the designated gluten free storage area was observed with gluten containing/exposed products including an open unsealed box of farina (wheat hot cereal) stored in close proximity to gluten free products. During interviews on the afternoon of 11/4/24, the Kitchen Manager and Cook confirmed these findings.

On the afternoon of 11/4/24 the Cook stated the kitchen and dining services Staff had received training related to food preparation and service procedures required to meet Resident #1's dietary needs, however 3 dining services Staff interviewed on the afternoon of 11/4/24 stated they had not received specific training related to provision of a strict gluten free diet including prevention of cross contamination.

At 1:20 PM the Kitchen Manager confirmed documentation of specific staff trainings related to Resident #1's gluten free diet and prevention of cross contamination was not on file and available for review.

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5.12.b.(4)

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The results of the criminal record and adult abuse registry checks for all staff.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review there was a failure to complete all required background checks for 2 applicable staff. Findings include:

The policies and procedures governing staff background checks developed by the organization that manages the home have been updated to meet current regulatory requirements.

On the afternoon of 11/4/24 the Manager was requested to provide documentation of criminal record and abuse registry checks on file for 2 staff. Per review of the background check records provided for review, background checks were not completed as required for both Staff.

At 3:54 PM on 11/4/24 the Manager for Safe Environment Programs for the organization that manages the home confirmed this finding.

R207 SS=F — V. RESIDENT CARE AND HOME SERVICES — R207

5.18 Reporting of Abuse, Neglect or Exploitation

5.18.b The licensee and staff are required to report suspected or reported incidents of abuse, neglect or exploitation. It is not the licensee's or staff's responsibility to determine if the alleged incident did occur or not; that is the responsibility of the licensing agency. A home may, and should, conduct its own investigation. However, that must not delay reporting of the alleged or suspected

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incident to Adult Protective Services.

This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record review there was a failure to notify the Licensing Agency and the Adult Protective Services regarding resident reports of missing funds for 2 applicable residents for whom the home manages personal funds (Residents #1 and #2); and regarding multiple reports of a former Housekeeper's verbal abuse of 3 applicable residents (Residents #3, #4, and #5) . Findings include:

Per record review the home's policies and procedures governing mandatory reporting of abuse, neglect and exploitation are consistent with the regulatory requirements.

1. On the afternoon of 11/4/24 the Manager of the home was requested to provide information regarding a potential incident of a resident's check being reported missing.

During an interview commencing at 2:11 PM on 11/4/24 the Manager stated Resident #1 reported his/her personal funds had been stolen. The Manager stated s/he was vaguely familiar with this reported incident. The Manager was unable to recall specific information regarding the resident's report of missing funds, how s/he became aware of Resident #1's report, or when this issue was reported. The Manager stated the issue had been discussed, there was an explanation, and it had been determined the facility was not responsible for lost funds. The Manager referred the Surveyor to the Administrative Assistant stating s/he would have more information regarding this incident. During a subsequent interview commencing at 3:21 PM on

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11/4/24, the Manager stated per discussion with the Administrative Assistant there was a possible report of missing funds for another resident, Resident #2.

During an interview commencing at 4:07 PM on 11/4/24, the Administrative Assistant stated s/he vaguely recalled discussion regarding a report of missing funds belonging to Resident #1. S/he also was unable to identify specific information regarding this incident, which s/he indicated had occurred before the end of August 2023. Additionally, at approximately 4:15 PM on 11/4/24 the Administrative Assistant confirmed in July or August of 2023 Resident #2 reported missing funds to the Comptroller for the organization that manages the home, and stated s/he was asked by the Comptroller to "run a report" of Resident #2's financial transactions. The Administrative Assistant stated there was no documentation on file and available for review related to missing funds reported by Resident #1 and Resident #2's.

On the afternoon of 11/4/24 the Manager confirmed there was no written documentation on file and available for review regarding Resident #1 and Resident #2's report's of missing funds; and confirmed the Licensing Agency and the Adult Protective Services were not notified regarding Resident #1 and Resident #2's reports of missing funds as required.

2. Per Staff interview and review of Incident Statements and Corrective Action Forms on file at the home, the Licensing Agency and the Adult Protective Services were not notified by the home regarding multiple reported incidents of a former Housekeeper's verbal abuse of residents.

Per record review the following incidents of

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resident verbal abuse by the former Housekeeper were reported in Incident Statements and Corrective Action Forms:

a. On the afternoon of 12/29/21 the former Housekeeper yelled at Resident #3 because there were sheets of paper on his/her floor the day after s/he "spent 2 hours cleaning" the resident's room. Resident #3 was observed to be very upset and had tears in his/her eyes. Staff reported Resident #3 stated the former Housekeeper was abusing him/her. The resident was advised by Staff to discuss this issue with the Manager. A second report written by a different Staff on the evening of 12/29/21 indicated Resident #3 reported the former Housekeeper yelled at him/her, stated s/he needed to clean up his/her room, and was critical about the way Resident #3 stored clothing in his/her closet. It was also reported that prior to 12/25/21 the former Housekeeper had threatened to break Resident #3 's fingers off if s/he touched the Christmas tree.

b. On 1/6/22 Staff members reported receiving multiple complaints regarding the former Housekeeper's inappropriate language and disrespectful treatment of residents. Staff reported the former Housekeeper was swearing, threatening, and yelling at residents; and indicated Resident #4 was very upset due to the former Housekeeper yelling at him/her that s/he needed to clean his/her room. Resident #4 reportedly stated this compounded feelings of wanting to leave the home.

c. On 4/28/23 the former Housekeeper told Resident #5 s/he needed to wear pull-ups and stated if s/he continued to wet his/her bed and urinate in his/her underwear his/her laundry would

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R207	Continued From page 10 not be washed. The incident report stated for a one-month period prior to this incident the former Housekeeper asked Resident #5 to wear diapers because s/he was going through too much underwear. A family member reported the resident was bringing clothing items to a their home to wash them due to embarrassment caused by the former Housekeeper's statements. The family member stated the impact of the former Housekeeper's comments was degrading to the resident. On the afternoon of 11/4/24 the Manager confirmed the Licensing Agency and the Adult Protective Services were not notified regarding reports of the former Housekeeper verbally abusing Residents #3, #4, and #5.	R207		
R224 SS=I	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure 3 applicable residents (Residents #3, #4, and #5) remained free of verbal abuse by the former Housekeeper employed by the home. Findings include: The home's policies and procedures identify resident's rights to be free of abuse and to be treated with dignity and respect.	R224		

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Per record review the following incidents of verbal abuse of Residents #3, #4, and #5 by the former Housekeeper were documented in Incident Statements and Corrective Action Forms on file at the home:

a. On the afternoon of 12/29/21 the former Housekeeper yelled at Resident #3 because there were sheets of paper on his/her floor the day after s/he "spent 2 hours cleaning" the resident's room. Resident #3 was observed to be very upset and had tears in his/her eyes. Staff reported Resident #3 stated the former Housekeeper was abusing him/her. The resident was advised by Staff to discuss this issue with the Manager. A second report written by a different Staff on the evening of 12/29/21 indicated Resident #3 reported the former Housekeeper yelled at him/her, stated s/he needed to clean up his/her room, and was critical about the way Resident #3 stored clothing in his/her closet. It was also reported that prior to 12/25/21 the former Housekeeper had threatened to break Resident #3 's fingers off if s/he touched the Christmas tree.

b. On 1/6/22 Staff members reported receiving multiple complaints regarding the former Housekeeper's inappropriate language and disrespectful treatment of residents. Staff reported the former Housekeeper was swearing, threatening, and yelling at residents; and indicated Resident #4 was very upset due to the former Housekeeper yelling at him/her that s/he needed to clean his/her room. Resident #4 reportedly stated this compounded feelings of wanting to leave the home.

c. On 4/28/23 the former Housekeeper told

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R224	Continued From page 12 Resident #5 s/he needed to wear pull-ups and stated if s/he continued to wet his/her bed and urinate in his/her underwear his/her laundry would not be washed. The incident report stated for a one-month period prior to this incident the former Housekeeper asked Resident #5 to wear diapers because s/he was going through too much underwear. A family member reported the resident was bringing clothing items to a their home to wash them due to embarrassment caused by the former Housekeeper's statements. The family member stated the impact of the former Housekeeper's comments was degrading to the resident. On the afternoon of 11/4/24 the Manager provided copies of the Incident Statements and Corrective Action forms referenced above and confirmed the former Housekeeper's treatment of Resident's #3, #4, and #5 was abusive. The former Housekeeper remained an employee of the home until s/he was terminated on 8/2/23 after refusing to assist with Housekeeping at another home managed by the same organization.	R224		
R232 SS=F	VII. NUTRITION AND FOOD SERVICES 7.1.a.(1) Menus for regular and therapeutic diets shall be planned and written at least one (1) week in advance. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to develop, and post in a public area, a written menu for the therapeutic diets	R232		

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ordered for residents of the home. Findings include:

The facility's policies and procedures are consistent with this regulatory requirement.

On the afternoon of 11/4/24 it was observed that a weekly therapeutic menu appropriate for the residents of the home with dietary orders related to allergies and was not posted in a public area of the home. Per resident and staff interviews and record review, therapeutic diets required for residents of the home include complete avoidance or limitation of shellfish, seafood, gluten, brassicas, and raw foods.

At 1:15 PM on 11/4/24 the Kitchen Manager and Cook confirmed written therapeutic menus are not developed by the home and posted as required.

Plan of Correction November 4, 2024, Survey for St. Joseph Kervick Residence, Rutland, VT

RESDIENT CARE AND HOME SERVICES:

5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders- (Tag R128).

What action will you take to correct the deficiency?

Any new or changes in dietary orders will be communicated to the Food Service Department.

The Food Service Department will maintain gluten free areas and has procedures in place to clean gluten free workspaces and kitchen utensils and cookware separately to avoid cross contamination. Staff training has been completed by Registered Dietician and Registered Nurse on Importance of Gluten Free Diet and Cross Contamination to staff and resident.

Resident Reassessment completed, Multidisciplinary Care plan team meeting 11/13/2024, education provided to resident about Gluten Free Diet and menu provided.

What measures will be put into place or systemic changes will you make to ensure that the deficient practice does not recur?

Education has been provided to nursing staff about updating food service orders to the Food Service Department.

Food Service Department understands and uses processes to prevent cross contamination in preparing and serving Gluten free meals, through labeling of products, separate storage areas for dry goods, and refrigerated items and washing kitchens utensils and pans specifically for gluten free foods.

How the corrective actions will be monitored so the deficient practice does not recur

DON and Charge Nurse will monitor through chart review.

The Food Service Manager and cooks will monitor the area and use appropriate kitchen tools.

Date corrective action will be completed

11/13/24.

R128 Plan of Correcton accepted by Jo A Evans RN on 12/4/24

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 (Tag 145).

What action will you take to correct the deficiency?

Resident care plan updated and written for physicians' diagnosis of "likely" celiac disease to include provision of gluten free diet and to avoid cross contamination., including education to resident and staff about gluten and cross contamination. Multidisciplinary team approach has been used through planning and team meetings.

What measures will be put into place or systemic changes will you make to ensure that the deficient practice does not recur?

The Food Service Department will maintain gluten free areas and has procedures in place to clean gluten free workspaces and kitchen utensils and cookware separately to avoid cross contamination. Staff training has been completed.

How the corrective actions will be monitored so the deficient practice does not recur

The Food Service Manager and cooks will monitor the area and use appropriate kitchen tools.

Date corrective action will be completed

R145 Plan of Correction accepted by Jo A Evans RN on 12/4/24

Completed 11/21/24.

V. RESIDENT CARE AND HOME SERVICES:

5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. (Tag R179)

What action will you take to correct the deficiency?

Understanding Gluten Training provided by Registered Dietician [redacted] 11/21/24.

The Nursing Department received in-service on Celiac Disease by [redacted], BSN, RN.

What measures will be put into place or systemic changes will you make to ensure that the deficient practice does not recur?

This in-service training will be added to our annual training and all new staff upon hire.

How the corrective actions will be monitored so the deficient practice does not recur

Ongoing education and monitoring of practices in the kitchen will occur by the Food Service Manager.

Date corrective action will be completed

Initial training was completed 11/21/24.

R179 Plan of Correction accepted by Jo A Evans RN on 12/4/24

V. RESIDENT CARE AND HOME SERVICES

5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff (Tag 190).

What action will you take to correct the deficiency?

Vermont Catholic Charities runs complete background checks for all new employees and runs background checks annually on all employees.
Vermont Catholic Charities contracts with Sterling and they run complete background checks including VTAHS Adult/Child Registry checks and VCIC.
Starting in January 2024, Vermont Catholic Charities started running the VT AHS and VCIC internally and prints and scans the VTAHS Adult/Child Registry and VCIC checks to supplement the Sterling report.

Names removed by DLP 12/5/24

New hires background checks are run immediately. The existing staff are run annually.
New and current employees (annuals} will have state checks printed and included in the background check package, then uploaded to the individual SharePoint sites.

What measures will be put into place or systemic changes will you make to ensure that the deficient practice does not recur?

New hires; run immediately. Existing staff annually.

How the corrective actions will be monitored so the deficient practice does not recur

The manager is responsible for ensuring all needed background checks are completed.

Date corrective action will be completed

R190 Plan of Correction accepted by Jo A Evans RN on 12/4/24

Process was updated in January 2024.

V. RESIDENT CARE AND HOME SERVICES:

5.18 Reporting of Abuse, Neglect or Exploitation 5.18.b The licensee and staff are required to report suspected or reported incidents of abuse, neglect, or exploitation. It is not the licensee's or staff's responsibility to determine if the alleged incident did occur or not; that is the responsibility of the licensing agency. A home may, and should, conduct its own investigation. However, that must not delay reporting of the alleged or suspected incident to Adult Protective Services. (Tag R207)

What action will you take to correct the deficiency?

For resident #1 and resident #2 no funds went missing. We will report any future suspected or reported incidents with APS and DAIL as we conduct our own investigation. The Administrator or DON will monitor and report to APS and DAIL. Plan implemented 11/25/2024.

R207 Plan of Correction accepted by Jo A Evans RN on 12/4/24

VI. RESIDENTS' RIGHTS

6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14 (Tag R224).

What action will you take to correct the deficiency?

Staff training on resident rights with a highlight on abuse and neglect. Staff have been instructed to complete an incident report about any resident concerns immediately to direct supervisor or Manager.

What measures will be put into place or systemic changes will you make to ensure that the deficient practice does not recur?

Annual training sessions, prompt one-on-one counseling as required, and immediate reporting of any concerns to APS.

How the corrective actions will be monitored so the deficient practice does not recur

Educational files on record, managers trained on the above.

Date corrective action will be completed

1/15/2025.

R224 Plan of Correction accepted by Jo A Evans on 12/4/24

VII. NUTRITION AND FOOD SERVICES

7.1.a.(1) Menus for regular and therapeutic diets shall be planned and written at least one (1) week in advance. (Tag R232)

What action will you take to correct the deficiency?

Menu for Gluten Free diet has been handed to resident for full 5-week cycle (not posted per resident request) Completed 11/13/24.
Alternative menus for shellfish allergies are always listed in the kitchen for review as to what was served.

What measures will be put into place or systemic changes will you make to ensure that the deficient practice does not recur?

The Food Service Manager has Gluten Free menu updated on same cycle as regular menu and will ensure resident has menu and is posted in kitchen area.

How the corrective actions will be monitored so the deficient practice does not recur

The Food Service Manager will meet with the Registered Dietician to write a menu for food cycles for therapeutic diets at same time as regular diets.

Date corrective action will be completed

Gluten Free menu provided to resident on 11/13/24 and further menus on cycle with regular menu changes.

R232 Plan of Correction accepted by Jo A Evans RN on 12/4/24

Updated as requested by SBowen BSN, RN Administrator 12/2/2024