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

December 19, 2024

Dawn Palowski, Manager
The Gary Residence
171 Westview Meadows Road
Montpelier, VT 05602

Dear Ms. Palowski:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 7, 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
	0130	A. BUILDING: _____ B. WING _____	C 10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARY RESIDENCE	171 WESTVIEW MEADOWS ROAD MONTPELIER, VT 05602

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R100	Initial Comments: On 10/7/24 the Division of Licensing and Protection conducted an unannounced on-site relicensure survey. The following regulatory deficiencies were identified: V. RESIDENT CARE AND HOME SERVICES 5.5 Special Care Units 5.6.c A home that has received approval to operate a special care unit must comply with the specifications contained in the request for approval. The home will be surveyed to determine if the special care unit is providing the services, staffing, training and physical environment that was outlined in the request for approval. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to comply with the staffing specifications outlined in the approved request for the home's memory care center special care unit. Findings include: Per record review, the approved request for the home's memory care center special care unit submitted to the licensing agency on 7/24/23 included a Description of the organizational structure of the unit consistent with the unit's philosophy, purpose, and scope of services which outlines staffing ratios for the memory care unit care unit. The direct care staff to resident ratio for the memory care unit's overnight shift outlined in the home's approved request is 2 to 9. The overnight staffing ratio approved by the licensing agency for the home's memory care unit requires	R100 R132	The submission of this plan of correction does not imply agreement with the existence of a deficiency. It is submitted in the spirit of cooperation, to demonstrate our commitment to continued improvement in the quality of our Residents lives. There was a typo/error in the application for licensure of the Special Care Unit. The staffing ratio should be 1:9, allowing for 2 staff members to be on-site for care needs. Recognizing that most residents sleep throughout the night. We have reached out to DLP to update our licensure of the Special Care Unit typo. They approved the amendment (typo) on 10/31/2024. R132 Plan of Correction accepted by Jo A Evans RN on 12/19/24	10-31-24

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R132	Continued From page 1 4 direct care staff for 18 memory care unit residents during the overnight shift. During an interview commencing at 1:17 PM on 10/7/24, the Assistant Manager confirmed the staffing pattern for the memory care center overnight shift is one Med Tech and one additional staff who provides direct care for the residents in the memory care unit and the residents who reside in residential care area of the home. During this interview the Assistant Manager confirmed the current census of the home's memory care unit as 18 residents. Per the Assistant Manager's confirmation, the overnight staffing ratio of the memory care unit is 1.5 to 18, which is not consistent with the staffing ratio for the home's special care unit plan approved by the Division of the overnight staffing ratio of 2 staff to 9 residents. Per record review and interviews with the Manager and Assistant Manager on the afternoon of 10/7/24, two residents in the residential care area of the home currently required 2 person full assists. Resident #1 experienced decline leaving him/her unable to bear weight to stand and pivot for toileting. Resident #2 has experienced a significant decline impacting bed mobility, transfers, toileting, and ambulation. Additionally, Resident #2 has increased needs related to difficulty sleeping, delusions, and confusion. Resident #2 requires frequent monitoring and 2 person full assists particularly at night. During the overnight shift, the memory care center is single staffed when residents in the residential care area require 2 staff. On the afternoon of 10/7/24 the Manager and Assistant Manager confirmed overnight staff in the memory care center are called to assist staff in the residential care center of the home during the overnight shift.	R132	This statement is inaccurate. We did not and do not have two residents that required 2 person full assists. Resident #1 was a Hospice patient, per the progress note attached you will see that the day of the survey the resident suddenly had a status change when attempting to transfer. The Hospice Nurse was called to assess if this was going to be the new care level of the resident. It was determined it was a new care level and a catheter was to be put in place and we prepared for end of life care. No time after the one incident of resident #1 "unable to bear weight to stand or pivot for toileting" did any other transfers occur. It was a fluid situation at the time of the survey. Resident #2, after returning from their rehab stay during the day resident #2 is at their baseline and does not need assistance with transfers. During the overnight hours after falling asleep, resident #2 has increased needs related to difficulty sleeping, delusions and confusion. This does not occur nightly however frequently and support is needed to help assist with re-directing and cueing.	10-31-24

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R145 SS=F	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 develop plans of care which describe the care and services necessary to assist the resident to maintain independence and well-being for 3 out of 3 sampled residents. Findings include: 1. Per staff interview and record review, on 4/2/24 Resident #1 was re-admitted to the home on hospice. Resident #1's plan of care was not updated to include care and services related to pain management and hospice care. 2. Per record review Resident #2 has diagnoses including Parkinson's Disease, Cardiovascular conditions with an anti-platelet medication prescribed which increase risk of bleeding, and history of unstable blood pressure including hypotension and hypertension (low and high blood pressure), and Benign Prostatic Hyperplasia (enlarged prostate). Resident #2 has a history of hallucinations, disturbing dreams, confusion, and falls. Resident #2 also has a history of difficulty swallowing; urinary retention	R145	Resident #1, #2, & #3, care plans have been updated and reviewed by the Manager. The Manager or Assistant Manager will review all resident care plans monthly, to ensure they are adequately updated. Our weekly resident status review meetings which includes, Manager, Assistant Manager, RN and Resident and Family Services Director, now includes, ensuring care plans have been updated if necessary. Weekly meetings occur every Tuesday and have for several months. 10/15/2024 agenda template set up. Care Plans updated Resident #1 10/12/2024 Resident #2 10/15/2024 Resident #3 10/7/2024	See add to below ↓

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R145	Continued From page 3	R145		

requiring use temporary use of a Foley catheter, and Hematuria (blood in urine).
Resident #2 was hospitalized with a transfer to a skilled nursing facility for rehab related to urinary retention; loss of ability to swallow spontaneously; and for rehabilitative therapies related to falls, mobility, transfers, and activities of daily living. Following Resident #2's return to the home on 8/8/24, Progress Notes document increasing difficulty sleeping; and loss of ability to perform transfers, bed mobility, and ambulation which results in Resident #2 requiring 2-person full assists especially during the night.

Per record review, Resident #2's plan of care had not been updated since 6/4/24. His/her outdated plan indicates s/he is independent with toileting, transfers, and mobility. This plan of care also does not address care and services related to cardiovascular and genitourinary conditions; history of falls and difficulty swallowing; hallucinations, disturbed dreams and difficulty sleeping, and confusion.

3. Resident #3 was admitted to the home's memory care center on 9/25/24 with diagnoses including Dementia with Behavioral Disturbance, Delusional Disorder with a history of audio-visual hallucinations, Anxiety and Panic Disorder, Insomnia, and Syncope and Collapse. The document provided for review on request for Resident #3's plan of care does not address care and services related to his/her Cognitive and Behavioral conditions, psychosocial supports and pharmaceutical interventions to address symptoms of anxiety and panic disorder; and safety measures related to risk for episodes of syncope and collapse. \

At 5:30 PM on 10/7/24 the Assistant Manager

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R145	Continued From page 4 confirmed the plans of care on file for Residents #1, #2, and #3 did not address care and services necessary to assist the residents to maintain independence and well-being.	R145	R 145 Plan of Correction accepted by Jo A Evans Rn on 12/19/24	
R179 SS=F	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, 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 3 out	R179	The Manager has ensured the process for staff training is now reflective of staff's hire date. Completed 10/15/2024 Business Manager and RN will monitor monthly that staff are completing their 12 hours of yearly training. Completed 10/15/2024 New Hire Training Checklists have been updated and reflect the requirement of these training as well. Completed 10/15/2024 Policy & Procedure has been updated to reflect the required yearly trainings. Completed 10/15/2024	10-15-24

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R179	Continued From page 5 of 5 sampled staff did not complete all required yearly trainings. Findings include: Per review of policies and procedures governing staff trainings provided for review on request, the Orientation and Training policy effective 3/8/11 states,"Orientation and training will be provided to employees before they are assigned responsibilities in assisting residents." and "Throughout an employees [sic] employment there will be Mandatory In-Services to be attended." The policies and procedures on file and available for review do not identify the required yearly trainings. Per review of the training records on file and available for review for a sample e of 5 staff provided for review on request, all required yearly trainings were not documented as completed for 3 out of 5 sampled staff. This finding was confirmed by the Assistant Manager at 4:42 PM on 10/7/24.	R179	R 179 Plan of Correction accepted by Jo A Evans RN on 12/19/24.	
R200 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure development of policies and procedures governing all areas of service provided by the home. Findings include:	R200		

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R200	Continued From page 6 During the survey conducted at the home on 10/7/24, the Assistant Manager was requested to provide policies and procedures governing the storage of poisonous compounds in resident accessible areas and maintenance of water temperatures in resident accessible areas of the home. On the afternoon of 10/7/24 the Manager and Assistant Director confirmed policies and procedures governing these areas of service were not on file and available for review on request.	R200	Policy and Procedures have been developed and put in place: 1. Storage of poisonous compounds 2. Water Temperatures Effective 10/10/2024 R 200 Plan of Correction accepted by Jo A Evans RN on 12/19/24.	10-10-24
R259 SS=F	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.i Poisonous compounds (such as cleaning products and insecticides) shall be labeled for easy identification and shall not be stored in the food storage area unless they are stored in a separate, locked compartment within the food storage area. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure poisonous compounds in the food storage area are stored in separate, locked compartments. Findings include: The home's Non-Food Storage policy effective 10/14/05 indicates, " Chemical and toxic products must be stored in a separate closet, closed cabinet, or outside of the kitchen area", and does not include the storage of poisonous compounds	R259		

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R259	Continued From page 7 in food storage areas outside of the kitchen. During a tour of the home commencing at 10:05 AM on 10/7/24, the food storage area in the basement of the home was observed with open framework shelves along the length of one of the walls of the room, which contained poisonous compounds including detergents, disinfectants, carpet and upholstery cleaners, air freshener, furniture polish, floor cleaners, laundry dryer sheets and spot remover, drain treatment, and lime remover. This finding was confirmed by the Assistant Manager at approximately 10:25 AM on 10/7/24.	R259	Our facility was flooded in July 2023. Our storage area is in the basement of the home. Now per new flood guidelines we have removal storage racks on wheels. All chemicals are now in a locked storage rack on wheels. The Executive Chef or designee will ensure at each delivery that all poisonous compounds are not placed in the food storage area and are locked up in the new storage rack. Manager or Assistant Manager will inspect the storage areas on a monthly basis. Please note: the poisonous compound was a box of liquid countertop cleaner placed on a storage rack that held dishes, and other non-food items. Completed 10/8/2024 R 259 Plan of Correction accepted by Jo A Evans RN on 12/19/24	
R266 SS=F	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure care in a safe environment related to the storage of unsecured poisonous compounds and cleaning products in resident accessible areas of the home. Findings include: Policies and procedures governing the secure storage of poisonous compounds and cleaning products in resident accessible areas of the home were not on file and available for review on	R266		10-8-24

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R266	Continued From page 8 request on the afternoon of 10/7/24. During a tour of the home commencing at 10:05 AM on 10/7/24 poisonous compounds including disinfectants, sanitizers, floor cleaners, laundry products, wound cleaner, body fluid spill kits, air fresheners, upholstery cleaners, furniture polish, drain treatment, and lime remover were observed to be stored in unlocked resident accessible areas including the dry food storage room and laundry room in the basement, the hallway bathroom on the second floor of the residential care area, and a storage closet on the third floor of the residential care area of the home. These findings were confirmed by the Assistant Manager during the tour of the home commencing at 10:05 AM on 10/7/24.	R266	All poisonous compounds throughout the home are in locked storage areas or compartments, staff have been educated on the need for all poisonous compounds to be in locked. All department supervisors will inspect their departments daily to ensure all poisonous compounds are locked and stored safely. R 266 Plan of Correction accepted by Jo A Evans RN on 12/19/24 The Maintenance Director was contacted immediately upon notification and temperature control was adjusted to within regulatory limits.	
R291 SS=F	IX. PHYSICAL PLANT 9.6 Plumbing 9.6.d Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure water temperatures in resident accessible areas of the home are maintained at or below 120 degrees Fahrenheit. Findings include: Policies and procedures governing water temperatures in resident accessible areas were not on file and available for review on request on 10/7/24.	R291	The Maintenance Director/designee will do weekly water temperature checks to ensure that the temperature stays within the limit of below 120 degrees F. If temperatures stay within normal range for 2 months then checks will go to monthly. Manager will be notified immediately if the water temp is above 120 degrees F. Assistant Manager will review weekly log to ensure compliance and will put her initials next to the recorded temp. Completed 10/8/2024 R 291 Plan of Correction accepted by Jo A Evans RN on 12/19/24	10-8-24

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R291	Continued From page 9 During a tour of the home commencing at 10:05 AM on 10/7/24 water temperatures in the following resident accessible areas were observed to be maintained above 120 degrees Fahrenheit: a. Salon in the basement 124.2 degrees Following adjustment to the home's boiler system, the water temperatures in these resident accessible areas were observed to be maintained at or below 120 degrees Fahrenheit. Temperatures above 120 degrees Fahrenheit were confirmed by the Assistant Manager during the tour of the home commencing at 10:05 AM on 10/7/24; and the results of corrective actions taken were confirmed by the Maintenance Director on the afternoon of 10/7/24.	R291		