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

November 3, 2023

Ms. Kerri Elkouh, Manager
Homestead, Inc.
73 River Street
Woodstock, VT 05091-1226

Dear Ms. Elkouh:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 23, 2023.** Please post this document in a prominent place in your facility.

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

Sincerely,

Carolyn Scott, LMHC, M.S.
State long Term Care Manager

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
	0135	A. BUILDING: _____ B. WING _____	05/23/2023

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HOMESTEAD, INC.	73 RIVER STREET WOODSTOCK, VT 05091

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R100	Initial Comments: On 5/23/23 the Division of Licensing and Protection conducted an unannounced on-site relicensure survey. The following regulatory deficiencies were identified:	R100		
R128 SS=E	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 record review and staff interview there was a failure to ensure medications for 2 applicable residents (Residents #1 and #2) were administered as ordered by the physician. Findings include: 1. Per record review Resident #1 was given medications prescribed for another resident in error on the evening of 11/4/22 including 500 mg of Acetaminophen (an over the counter pain medication), 30 mg Mirtazapine (antidepressant), and 5 mg of oxycodone (narcotic pain medication). Resident #1's Physician ordered Ipratropium 0.03% Nasal Spray 2 sprays in each nostril twice daily which the resident self administers. An order for Ipratropium 0.03% Nasal Spray listed on his/her Medication Administration Record (MAR) as required for self administered medications states the medication is to be taken twice daily; however the order in the MAR does not include	R128	On 12/19/22 Staff reviewed medication error policy. On 5/21/23 The Homesteads Medication error policy was reviewed and updated. Corrective action was taken for Resident #1. Changes were made in the MAR, and physician orders updated with the residents primary care physician.	5/31

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Kerri Elkouh — Executive Director — 6/9/23

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R128	Continued From page 1 the specific dose of 2 sprays in each nostril. Resident #1's Physician ordered "Artificial Tears 1 drop in both eyes as needed (PRN) for dry eyes up to four times a day [Resident #1] has requested twice daily". The order in the MAR lists "Artificial tears one drop in both eyes as needed up to four times a day Resident Request BID (twice daily)"; however the medication is scheduled in the MAR to be administered at 8:30 AM and 5:30 PM instead of being listed as a PRN medication. Additionally, the order in the MAR does not include the indications for use; and the MAR and the Physician's orders do not include the specific time between doses. 2. Resident #2's Physician ordered Urinary Tract Support 2 capsules by mouth daily as needed (PRN) for health Maintenance. This medication is an over the counter supplement containing cranberry fruit extract in combination with nutritional and herbal supplements. The order in the MAR lists "Cranberry tablet two capsules" by mouth three times daily as needed; which differs from the medication, frequency of administration, and indication in the Physician's order. These findings were confirmed by the Director of Nursing on the afternoon of 5/23/23.	R128	Resident #1, Resident #2, Physicians orders updated, and resident #1, Resident #2 MARS updated. (see enclosed orders) Corrective action was taken for Resident #1, Resident #2. Weekly audit documentation will be documented and reviewed by DON or designee to assure compliance.	
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	R145	Pharmacy Representative will do quarterly audits that will include auditiing for expired medication, review of MARS and Physicians Orders. (scheduled for 6/15/23) R128 Plan of Correction accepted by Jo A Evans RN on 11/2/23	6/15/23

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R145	Continued From page 2 necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure the written plan of care that addresses care and services necessary to maintain independence and well-being for 3 applicable residents (Resident #1 and #3). Findings include: Residents #1 and #3 have diagnoses of cardiovascular conditions indicative of risk for cardiovascular events and are prescribed Nitroglycerin as needed for chest pain, which is often caused by poor blood flow to the heart muscles. Resident #1 and #3's plans of care do not include a description of the care and services required for safe administration of Nitroglycerin, which is a medication that rapidly dilates the blood vessels that deliver blood and oxygen to the heart. Use of Nitroglycerin requires blood pressure monitoring due to risk of rapid drop in blood pressure and pulse. Administration of Nitroglycerin presents a risk for falls and injury due to dizziness, lightheadedness and fainting resulting from rapid dilation of the blood vessels. It is important to ensure the Resident is not standing when the medication is administered and gets up slowly following administration. Nitroglycerine requires storage without exposure to heat, moisture, and light; and this medication is ineffective when the bottle is not stored properly, is opened frequently or expired. On the afternoon of 5/23/23 the Director of Nursing confirmed Residents #1 and #3's plans of	R145	Residents #1 and #3 risks of administering nitroglycerin have been corrected on residents MAR and Care Treatment records. (See copes included). R145 Plan of Correction accepted by Jo A Evans RN on 11/2/23	

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R145	Continued From page 3 care did not include a plan for Nitroglycerin administration and storage.	R145		
R162 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure medication orders for 1 applicable resident (Resident #1) were signed by the physician. Findings include: Per review of physician's orders there was no signed order on record for Acetaminophen 650 mg every 6 hours as needed for pain which was listed on Resident #1's Medication Administration Record for May 2023. This was confirmed by the Director of Nursing on the afternoon of 5/23/23.	R162	Resident #1 orders reviewed and corrected by physician. Continue with weekly medication order audits performed by DON or designee to assure compliance. R162 Plan of Correction accepted by Jo A Evans RN on 11/2/23	6/05/23
R175 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (3) Residents who are capable of self-administration may choose to store their own medications provided that the home is able to provide the resident with a secure storage space to prevent	R175	Pharmacy Representative will do quarterly audits that will include auditing for expired medication and review MARS and Physicians orders.	

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R175	Continued From page 4 unauthorized access to the resident's medications. Whether or not the home is able to provide such a secured space must be explained to the resident on or before admission. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure secure storage of a medication previously self administered by 1 applicable resident (Resident #2). Findings include: A tube of Gentamicin antibiotic ointment with an expiration date of 2/2023 was observed to be stored on Resident #2's bathroom counter at 11:35 AM on 5/23/23. While Resident #2 self administers some medications, at 12:38 PM the Director of Nursing confirmed there was no longer an order for this medication and Resident #2 was no longer self administering this medication. The expired medication previously self administered by Resident #2 was removed from his/her room and disposed.	R175	Residents tube of expired Gentamicin ointment was immediately disposed of by DON. Resident #2 had previously administered [redacted] own medications. Pronoun removed by DLP 11/2/23 Corrective action taken. Policy for Residents self administering medications reviewed and updated 5/31/23 to encourage Residents to disclose all medications po and topical. R175 Plan of Correction accepted by Jo A Evans RN on 11/2/23	05/31/23
R176 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (4) Medications left after the death or discharge of a resident, or outdated medications, shall be promptly disposed of in accordance with the home's policy and applicable standards of practice. This REQUIREMENT is not met as evidenced	R176		

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R176	Continued From page 5 by: Based on observation and record review there was a failure to dispose of expired diabetes testing supplies for 1 applicable resident (Resident #1). Findings include: On the afternoon of 5/23/23 the Director of Nursing confirmed 2 boxes of One Touch Ultra Blood Glucose Testing strips with an expiration date of 3/5/23 and 1 box of One Touch Delica Plus Lancets with an expiration date of 3/9/23 were stored in the medication cabinet. Additionally, a tube of Gentamicin antibiotic ointment that expired 2/2023 was observed to be stored on Resident #2's bathroom counter and confirmed by the Director of Nursing.	R176	Pharmacy Representative will do quarterly audits that will include auditing for expired medications, review of MARS, and Physicians Orders. (visit scheduled for 6/15/23, see enclosed pharmacist review form) R176 Plan of Correction accepted by Jo A Evans RN on 11/2/23	6/15/23
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;	R179	Corrective action for education. The Homesteads continuing education and training policy updated on 6/5/23. The Homestead is consulting with Relias for continuing education. Meeting with Relias representative [redacted] on 6/13/23 at 11:00 am for a Relias education demo. R179 Plan of Correction accepted by Jo A Evans RN 11/2/23 Name removed by DLP 11/2/23	8/08/23

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R179	Continued From page 6 (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 record review and staff interview there was a failure to ensure 3 out of 5 staff completed all required yearly trainings. Findings include: On the afternoon of 5/24/23 the Director of Nursing confirmed 3 out of 5 sampled staff had not completed the required yearly trainings to include Resident Rights; Fire Safety and Emergency Evacuation; Resident Emergency Response Procedures and First Aid; Mandatory Reporting of Abuse, Neglect and Exploitation; Respectful and Effective Interaction With Residents; Infection Control Measures; and General Supervision and Care of Residents.	R179		
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	R247		

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R247	Continued From page 7 by: Based on observation and staff interview there was a failure to ensure all perishable food items were labeled and dated. Findings include: During the facility tour commencing at 10:05 AM on 5/23/23 the Manager confirmed the freezers and refrigerators in the kitchen and basement food storage area contained perishable items that were not labeled and dated as required. Examples of items in the freezers included bags of frozen fruits, vegetables, pastries, and pasta without labels indicating what was stored in the bags; and opened undated items such as ice cream, bags of vegetables and fruit, and parmesan cheese. Examples of items in the refrigerators included opened undated milk, chocolate milk, non-dairy creamers, condiments, salad dressings, sundae toppings, and bottles of fruit juice.	R247	The Homestead purchased Freezer tape that will serve as a label to write the contents of the packages of frozen food items that have we receive from the food service company. Updated signage of correct labeling and/ or dating, posted in the kitchen on the refrigerators and freezers, and in the basement on freezers. The Homestead Manager and Kitchen Manager spoke directly to all kitchen staff about the correct labeling and dating. (see enclosed) The Freezer tape will be used as a label to date containers /boxes of frozen food items, that have been opened and still have food items to remain frozen, in the container/box. Updated signage with the correct information on labeling and dating. The Homestead Manager and Kitchen Manager spoke directly to all kitchen staff about the correct labeling and dating. Round stickers and additional masking tape has been added the kitchen to more easily write dates of items being opened. Updated signage of correct labeling and dating. The Homestead Manager and kitchen manager have spoken directly to all kitchen staff. Obtained additional items for labeling on May 29th. Signage was updated on May 24th. Kitchen staff was spoken to starting on May 24th and concluded on May 29th. The Homestead has FT and PT staff, some only working on rotating weekends. This explains the time between start to finish. R247 Plan of Correction accepted by Jo A Evans RN on 11/2/23	5/26 5/26 5/29
R258 SS=F	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.h All garbage shall be collected and stored to prevent the transmission of contagious diseases, creation of a nuisance, or the breeding of insects and rodents, and shall be disposed of at least weekly. Garbage or trash in the kitchen area must be placed in lined containers with covers. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure trash in the kitchen area	R258	New trash cans with lids were purchased for the kitchen on May 29th.The new cans have swing top lids to ensure that the tops are not removed, and provide an easy way to throw trash in and keep it covered. R258 Plan of Correction accepted by Jo A Evans RN on 11/2/23	5/26/

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R258	Continued From page 8 was placed in lined containers with covers. Findings include: During a tour of the facility kitchen commencing at 10:05 AM on 5/23/23 the Manager confirmed both kitchen garbage cans did not have covers.	R258		
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 a safe environment related to the storage of cleaning products including poisonous compounds. Findings include: During the facility tour commencing at 10:05 AM the Manager confirmed cleaning products including disinfectant sprays, bleach, peroxide based cleaners, Comet disinfecting powder, stainless steel cleaner, glass cleaner, insecticide spray, and disinfectant wipes were stored in unlocked cabinets beneath the kitchen and bathroom sinks which are accessible to facility residents. The facility is home to residents with various levels of cognitive function and ability to safely manage access to chemicals.	R266	A combination lock was added to a closet for secure storage of cleaning products/ chemicals. Kitchen cabinets have been cleared of all cleaning supplies and secured in closet. New signage on display in the kitchen and on the Housekeepers cart, reminding staff to secure cleaning products after use. An additional sign was added next to the time clock, as additional reminder, to ensure it is never forgotten. Lock was installed on May 25th and signage added May 29th R266 Plan of Correction accepted by Jo A Evans RN on 11/2/23	5/25/23 - 5/29/23
R270 SS=E	IX. PHYSICAL PLANT	R270		

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R270	Continued From page 9 9.2 Residents' Rooms 9.2.c Each bedroom shall have an outside window. (1) Windows shall be openable and screened except in construction containing approved mechanical air circulation and ventilation equipment. (2) Window shades, venetian blinds or curtains shall be provided to control natural light and offer privacy. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure the windows in 2 resident rooms were screened. Findings include: During a tour of the second floor of the home commencing at 1:37 PM on 5/23/23 the Manager confirmed windows in a single occupancy room and in a shared room on the second floor of the home were missing screens. Additionally, 1 window in the second floor hallway and 1 screen in the second floor common area referred to as The Chapel were missing screens.	R270	Screens were located and replaced on May 26th. Screens are now next to location of A.C. units. Screens are removed to accommodate Air Conditioning units in the summer. By storing screens near the units, it serves as a reminder to replace screens when units are removed. Signage was added as a 2nd reminder. R270 Plan of Correction accepted by Jo A Evans RN on 11/2/23	526/23
R302 SS=D	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed	R302		

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R302	Continued From page 10 periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to rotate times of fire drills to include an evening drill. Findigns include: At 12:05 PM on 5/23/23 the Manager confirmed an evening fire drill was not conducted in the evening during the previous year.	R302		
R303 SS=F	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.d There shall be an operable telephone on each floor of the home, at all times. A list of emergency telephone numbers shall be posted by each telephone. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure emergency phone numbers were posted beside the telephones on each floor of the home. Findings include: On the afternoon of 5/24/23 the Manager	R303	Obtained the correct times of the day/night for fire drills. The Homestead corrected the times and conducted a fire drill on May 31st, at 7:00 pm. R302 Plan of Correction accepted by Jo A Evans RN on 11/2/23	5/31/23

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R303	Continued From page 11 confirmed emergency numbers were not posted by the telephones on the first and second floors of the home.	R303	Emergency numbers were typed out, laminated, and framed at these locations. It was brought to the residents attention. These signs will be mentioned on facility tours and at admissions. R303 Plan of Correction accpeted by Jo A Evans RN on 11/2/23 R25 Plan of Correction accepted by Jo A Evans RN on 11/2/23	05/25/23