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

June 19, 2018

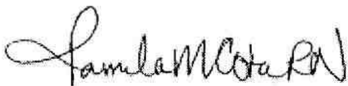
Mr. Bill Davidson, Manager
The Residence At Shelburne Bay West
185 Pine Haven Shore Road
Shelburne, VT 05482-7805

Dear Mr. Davidson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 16, 2018**. 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,



Pamela M. Cota, RN
Licensing Chief

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
	0589	A. BUILDING _____ B. WING _____	C 05/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site survey was completed by the Division of Licensing and Protection on 5/16/18. The purpose of the survey was to determine compliance with Vermont Residential Care Home Licensing Regulations and to investigate 3 facility mandated reports. The following regulatory violations have resulted from the re-licensure survey.	R100	R100 Initial Comments : 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 the Residence at Shelburne Bay's commitment to continued improvement in the quality of our residents care.	
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, nursing staff failed to implement physician orders related to physician notification of medical symptom parameters for one applicable resident in the sample. (Resident #1). Findings include: Per record review on 5/15/18, Resident #1 had physician orders for nursing staff to notify h/her if the resident had heart rates that were outside of specified parameters and there was no evidence that this order was implemented. The resident had physician orders dated 4/25/18 related to use of an antihypertensive medication (Losartin Potassium) stating "notify nurse if B/P (blood pressure) is less than 100 systolic or HR is less than 60." Per review, the resident's HR was below 60 on 7 dates during May, 2018. The HR (Heart Rate) recorded under the vital signs	R128	R128 Action to correct deficiency: The Physician will be notified of symptoms outside of specified parameters for resident #1. Steps to prevent recurrence: All nurses and med techs will be provided with reeducation on policies, procedures and requirements listed in 5.5.c pertaining to implementing physician orders. The RCD or designated nurse will ensure follow through with random audits of at least 3 resident medication records , weekly for 3 months , then monthly for 3 months, then quarterly ongoing. Completion date: July 15, 2018	

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: William A. Vaunders (signature) — TITLE: Executive Director — (X6) DATE: 6/4/18

R128 - R252 POC's accepted with addendum (attached). 6/18/18 MBolton RN/PMU

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0589	A. BUILDING ______ B. WING ______	C 05/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R128	Continued From page 1 included the following: 5/1/18 - 56; 5/2/18 - 49; 5/4/18 - 55; 5/5/18 - 54; 5/8/19 - 53; 5/9/18 - 52; and 5/10/18 - 51. Based on a review of the progress notes from 5/1/18 - 5/10/18, there was no documentation to show evidence that the MD had been notified by the facility nurse of the heart rates that were below 60 beats per minute. This omission was confirmed with the DNS (Director of Nurses) during interview on 5/15/18 at 3 PM.	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 staff interview and record review, the RN failed to develop a care plan to address all of the nutritional needs for 1 applicable resident in the sample who was at risk for weight loss. (Resident #2). Findings include: Per record review, Resident #2 was described in a progress note written by the Registered Dietician (RD) as at nutritional risk due to reduced meal intakes and lack of sleep. The care plan for nutrition failed to include the RD recommendations for offering the resident the	R145	R145 Action taken to correct deficiency: The service plans for resident # 2 will be brought up to date to reflect the residents current dietary needs and to meet requirements listed in 5.9c (2). Steps to prevent recurrence: The RCD or designated nurse will also be responsible for ensuring dietary recommendations are followed through per physicians order and that needs are reflected on the service plan through random audits of at least 3 resident files weekly for 3 months, then monthly for 3 months, then quarterly ongoing. Completion Date: July 15, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0589	A. BUILDING ______ B. WING ______	C 05/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R145	Continued From page 2 supplement Boost (strawberry flavor) when meal intakes were less than 50 % and failed to include the directive to document meal intakes daily. The failure to include these recommendations in the care plan was confirmed during interview with the DNS on the afternoon of 5/16/18.	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, 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	R179	R179 Actions to correct deficiency: All associate educational requirements per 5.11 (b) will be brought up to date. Actions to prevent recurrence: Associate trainings will be tracked by RCD or designated nurse. The RCD or designated nurse will ensure compliance with educational requirements through audits of associate files weekly for 3 months, monthly for 3 months, and quarterly ongoing. Completion Date: July 15, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0589	A. BUILDING: ____ B. WING ____	C 05/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R179	Continued From page 3 by: Based on staff interview and record review, the facility failed to assure that all staff providing direct care to residents received annual training in the 7 required trainings included in the Residential Care Home Licensing Regulations. This failure was noted for 2 of 5 employees included in the sample. Findings include: Per review of the annual training records for 5 sampled employees of the home, 2 of the 5 sampled had not completed all of the 7 trainings required to be completed annually. (One staff member was missing 3 of 7 trainings and the other staff member was missing 1 of 7 trainings). This finding was confirmed during interview with the DNS on 5/15/18 at 4 PM.	R179		
R189 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b. (3) For residents requiring nursing care, including nursing overview or medication management, the record shall also contain: initial assessment; annual reassessment; significant change assessment; physician's admission statement and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of physician visits, signed telephone orders and treatment documentation; and resident plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, there was not documented evidence of monitoring of the stability of weight for 1 of 5 residents in the	R189	R189 Action to correct deficiency: The service plan for resident # 2 will be brought up to date to reflect the residents current dietary needs and to meet requirements listed in 5.12.b (3) Steps to prevent recurrence: The RCD will provide all nurses with reeducation on requirements listed in 512.b (3) including ongoing monitoring for residents identified to be at risk. The RCD or designated nurse will also be responsible for ensuring dietary recommendations are followed through per physicians order, that needs are reflected on the service plan , and that monthly weights are monitored through random audits of at least 3 resident files weekly for 3 months, then monthly for 3 months, then quarterly ongoing. Completion Date: July 15 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0589	A. BUILDING: ______ B. WING ______	C 05/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R189	Continued From page 4 total sample. (Resident #2). Findings include: Per record review, Resident # 2 was at risk for weight loss due to decreased nutritional intakes and there was a lack of documented evidence of on-going monitoring and assessment of the resident's nutritional status. The RD (Registered Dietician) wrote in a progress note dated 3/4/18, "wgt. 2/6/18 137 lb.....resident not sleeping at night, refusing meals, intakes 25 - 85 %... The RD recommended that "if (the resident) consumes < 50 %, give Boost shake, track wgt. x 1 month, document intakes, RD will F/U in 1 month." There was no follow up note from the RD regarding the resident's status as of 5/16/18. The resident's weight as of 5/16/18 was 133 lb. The lack of follow up regarding the nutritional needs of the resident was confirmed during interview with the DNS during the afternoon of 5/16/18.	R189		
R200 SS=D	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, the facility's dietary department failed to develop a policy and procedure to address the safe heating and serving of microwaved foods to cognitively impaired residents of the home. This practice had	R200	Reeducation of all Culinary associates started on 5/21/2018 on our policy " Reheating Potentially Hazardous Food," policy, see attached. Completion date July 16, 2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0589	A. BUILDING: ______ B. WING ______	C 05/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R200	Continued From page 5 the potential to affect cognitively impaired residents. Findings include: Per observations of the noon meal on the Haven Dementia Care Unit on 5/15/18, a resident was served pureed foods that were heated in a microwave oven in the unit kitchen. When the cook was asked about the safe temperature range for serving this type of food to a resident with dementia, s/he stated first "165 degrees Fahrenheit.", then "145 degrees Fahrenheit". When the policy was requested from the FSD (Food Service Director), s/he was not aware of any policy to address this issue. The lack of written guidelines for the serving of hot microwaved pureed foods presented a potential safety issue when feeding/serving cognitively impaired residents of the home.	R200		
R247 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to assure that all perishable foods were labeled, dated and held at proper temperatures. This practice had the potential to affect all residents of the home. Findings include: During the initial tour of the kitchen on 5/14/18	R247	All Refrigerators and freezers were emptied 5/21/18 of any outdated or nonlabelled food. All associate retraining started on 5/21, 2018 policy. FSD and or designee will conduct random checks at a minimum of 1x per month to assure food storage areas are in compliance. Completion date July, 17, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0589	A. BUILDING ____ B. WING ____	C 05/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R247	Continued From page 6	R247		

commencing at 2 PM, the following perishable foods were not labeled and /or dated in accordance with regulations and safe food handling practices:

Walk-in cooler observations -
seafood salad dated 5/10/18 (out dated);
green salad - no label/date;
sliced cooked meat - no date/label, was roast beef per the Food Service Director (FSD);
dessert bars - no label/date, were lemon bars, per FSD;
fruit salad - no label/date;
block of cooked meat - no label/date , was roast beef per the FSD;
3 containers sauces - no label/dates, were various types of demi glace per the FSD;
mashed sweet potatoes dated 5/6/18 (out dated);
mashed white potatoes labeled 5/11/18 (out dated).

Per interview with the FSD at the end of the observation, he confirmed that all perishable foods should be labeled and dated; he was uncertain about the safe food dating timelines and said that most foods will last 1 week. Per review of the facility's Standard Operating Procedures: under the title of MONITORING: A designated food service associate will check refrigerators daily to verify that foods are date marked and that foods exceeding the 3 day time period are not being used or stored.

Additionally, there were items in the walk-in cooler that were identified as having been pulled from the freezer for re-use (including corned beef from March). When asked about these foods, the FSD said that they did not re-date these items and had no specific written guidance or recommended timelines to assure foods were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0589	A. BUILDING: ____ B. WING ____	C 05/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R247	Continued From page 7 used within recommended timelines.	R247		
R252 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Storage and Equipment 7.3.b Areas of the home used for storage of food, drink, equipment or utensils shall be constructed to be easily cleaned and shall be kept clean This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to assure that all areas of the where foods, drinks or equipment were stored were kept clean. This practice had the potential to affect all residents of the facility. Findings include: During the initial tour of the kitchen on 5/14/18 at 2 PM, the following areas were not clean: a. trash cans and lids used in the kitchen were heavily soiled on the outside of the containers; b. the cooking equipment, including the stove, gas grill ovens and hood ventilation screens were soiled with a build up of dirt and grease. ac. a food preparation bench with under counter shelves holding dry food supplies (flour, sugar etc.) had a build up of dust and crumbs; d. a cart storing clean dishware had crumbs and visible dust and dirt on the shelves; e. a baker's rack for storage of sheet trays/foods had greasy visible soiling on all of the shelf glides; f. there were crumbs and dust observed under the toaster tray; under counter shelves next to the prep shelving were also soiled. g. the floor mop and the mop bucket were	R252	Standard Community cleaning schedules were reviewed and revised 5/21/2018 to meet the needs of Shelburne Bay. The areas noted to unclean were cleaned on 5/21/18. All Culinary Associates began retraining of procedure involving supply storage areas. Completion Date July 16, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0589	A. BUILDING ______ B. WING ______	C 05/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R252	Continued From page 8 stored in the midst of the food preparation area due to a lack of other appropriate space per staff, in close proximity to foods being prepared; h. the wall area around the hand wash sink was visibly soiled with a build up of dirt; When a copy of the cleaning schedules was reviewed, it only addressed the cleaning to be done on a daily basis; there was no written cleaning schedule to include all areas of the kitchen, to maintain a sanitary environment. This was confirmed at the time of the observations on the afternoon of 5/14/18.	R252		

Additional and Revised Changes to the Plan of Correction

R 200 All culinary associates that handle food were re-educated on our Reheating Potentially Hazardous Foods policy. This included but not limited to:

-Heat processed, ready to eat food from a package or can is heated to an internal temperature of at least 135 F for 15 seconds;

-Reheat any precooked, processed foods that have been previously cooled to an internal temperature of 165 F for 15 seconds;

-allow all food to sit for 2 minutes after hearting in a microwave oven.

R 247 All refrigerators and freezers were emptied, cleaned, and inspected. All food that was not properly labeled and dated or any food that had been stored for longer than 3 days was discarded.

All associates were re-educated on the LCB policy of Date Marking Ready to Eat Hazardous Food and documentation of their attendance was placed in their personnel file.

Daily checks in each refrigerator, cooler, reach-in, and freezer will be performed by the FSD or designee for food storage compliance and recorded for accountability.

R 252 Monitoring of all kitchen and storage areas will be conducted daily for one month. Then monitoring will be conducted at least three times per week gong forward. Monitoring will be conducted by the FSD or designee and recorded for accountability.