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 20, 2022

Ms. Lydia Raymond, Manager
The Residence At Shelburne Bay West
185 Pine Haven Shore Road
Shelburne, VT 05482-7805

Dear Ms. Raymond:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 2, 2022.** Please post this document in a prominent place in your facility.

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

Sincerely,

Pamela M Cota RN

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 11/02/2022

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 CORRECTIVEACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: On 11/2/22 the Division of Licensing and Protection conducted an unannounced on-site investigation of two complaints. Regulatory deficiencies were identified as a result of the investigation. Findings include:	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 our commitment to continued improvements in the quality of our residents.	
R127 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.b Staff shall provide care that respects each resident's dignity and each resident's accomplishments and abilities. Residents shall be encouraged to participate in their own activities of daily living. Families shall be encouraged to participate in care and care planning according to their ability and interest and with the permission of the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to provide care that respects the resident's dignity for one applicable resident (Resident #2). Findings include: Per record review Resident #2's diagnoses included Alzheimer's Disease, Anxiety Disorder Diabetes Mellitus, bilateral vision deficits, and frequent urinary tract infections. Resident #2 required staff assistance with activities of daily living including toileting, bathing, grooming, and transfers. S/he had an unsteady gait, episodes of weakness, and at times required a wheelchair. On 6/13/20 a staff member was observed forcefully pushing Resident #2's wheelchair into	R127	R127 The action taken to correct this deficiency: The Residence at Shelburne Bay suspended the associate that was involved in the deficient practice, we completed an investigation, terminated the associate, and reported the incident to the appropriate parties per the regulations. In order to ensure the deficient practice does not recur we provide continued education on resident rights to all associates. In addition, on 5/31/21 we switched our in-service system to Relias making the monthly tracking of associate completion more efficient.	

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

Associate Executive Director — 12/19/22

R127 - R207 POC's accepted 12/19/22 JEVans RN/PMC

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R127	Continued From page 1 the dining room table causing Resident #2 to wince in pain. Per review of the facility's internal investigation documentation, on 6/15/20 an additional report was made stating the same staff was also observed telling a resident to "pick up their feet and stop being a retard" approximately one month before Resident #2 was pushed. Corrective action documentation dated 6/17/20 stated the staff member had ignored a resident's request for assistance with toileting and left the resident waiting for the staff member's convenience. An email from the Resident Care Director stated s/he met with the staff member on 6/2/20 specifically regarding "respectful approach with residents and resident's rights" and "listed a couple of examples in which the staff was observed to have interactions with residents which could be interpreted as disrespectful". On 6/19/20 the staff member's employment was terminated for "egregious violation" of resident's rights. At 4:36 PM on 11/2/22 the Assistant Executive Director and the Executive Director confirmed the mistreatment of Resident #2 by staff.	R127	R128 The action taken to correct this deficiency: We have supporting documentation showing that we communicated with the pharmacy, and primary care physician attempting to receive a new script. In order to ensure the deficient practice does not recur on 8/1/22 we switched to a new pharmacy and changed over our system from PCC to Yardi. If our pharmacy does not have a medication in stock, we then utilize a local pharmacy which ensures consistency with the physician's orders.	
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	R128		

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R128	Continued From page 2 was a failure to ensure one medication was administered according to the physician's orders for one applicable resident (Resident #1). Findings include: Resident #1 was admitted to the facility in November of 2020 with diagnoses including Alzheimer's Disease, Colitis, Major Depressive Disorder, Osteoporosis with a history of pathological fractures, and Chronic Fatigue Syndrome. S/he is prescribed Pregabalin 50 mg twice daily to treatpain related to a vertebral fracture. Per record review Resident #1 did not receive Pregabalin 50 mg twice daily for a period of 4 days beginning with the morning dose on 9/10/21 and ending with the evening dose on 9/13/21 due to the medication being out of stock. A 28 day supply of Pregabalin 50 mg capsules for Resident #1 was documented as received at 9:35 PM on 9/13/21, however the evening dose on 9/13/21 was documented as not given at 9:24 PM and administration did not resume until 9/14/21. A bottle of Pregabalin 50 mg capsules belonging to Resident #1 was being stored in an LPN's desk at the facility, however the bottle was not transferred from the LPN's desk to the med cart for administration until 9/14/21, the day after the medication refill was received from the pharmacy. On the afternoon of 11/2/22 the Assistant Executive Director confirmed Resident #1 was not administered Pregabalin according to physician's orders on 9/10/21, 9/11/21, 9/12/21, and 9/13/21.	R128		
R177 SS=D	V. RESIDENT CARE AND HOME SERVICES	R177		

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R177	Continued From page 3 5.10 Medication Management 5.10.h (5) Narcotics and other controlled drugs must be kept in a locked cabinet. Narcotics must be accounted for on a daily basis. Other controlled drugs shall be accounted for on at least a weekly basis. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure a controlled substance belonging to one applicable resident (Resident #1) was accounted for on at least a weekly basis. Findings include: Resident #1 was admitted to the facility in November of 2020 with diagnoses including Alzheimer's Disease, Colitis, Major Depressive Disorder, Osteoporosis with a history of pathological fractures, and Chronic Fatigue Syndrome. S/he is prescribed Pregabalin 50 mg twice daily to treat pain related to a vertebral fracture. Per staff interview commencing at 1:26 PM on 11/2/22, a Licensed Practical Nurse (LPN) received a bottle of Pregabalin 50 mg tablets belonging to Resident #1 from the Residential Care Director (RCD) and was instructed to store the bottle in his/her desk following Resident #1's admission in 2020. Per record review, on 10/6/21 the LPN stated the manufacturer's seal was intact, the bottle was unopened, and there were 90 capsules inside the sealed bottle, tamper evident tape was placed over the top of the bottle,	R177	R177 The action taken to correct this deficiency: Narcotics and other controlled drugs are kept in a locked cabinet/ med cart and are accounted for on a daily basis. Effective 11/1/21 Weekly audits are conducted to ensure accuracy of medication counts and narcotic book. In addition, we provided education to our nurses and med techs on medication management/narcotics per the regulations. In order to ensure the deficient practice does not recur we are ensuring that new resident admission medications are documented, inputted, and stored appropriately per the regulations.	

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R177	Continued From page 4 and the bottle was placed in the LPN's desk. The Residential Care Director and the LPN did not count the pills in the bottle when this exchange occurred, and a controlled substance count sheet was not initiated to document receipt of the medication. The facility policies and procedures for assisting with controlled medications effective 2/2/18 indicate a count is to occur and a Narcotic Inventory Sheet is to be used when a controlled substance is received The bottle remained uncounted and stored in the LPN's desk under a single lock until the bottle was transferred to the Residential Care Home (RCH) section of the facility on 9/14/21 in response to a report Resident #1 had not received the medication for 4 days due to the medication being out of stock. When the bottle was transferred to the RCH it was assumed the manufacturer's seal remained intact and the pill count was 90 capsules due to the tamper evident tape placed over the top of the bottle. A count did not occur during the transfer of the medication from the LPN to the med delegated staff in the Residential Care Home. Per review a controlled substance count sheet was initiated and indicated 90 capsules of Pregabalin were received by a med delegated staff at 7:00 PM on 9/14/21. A medication count of Resident #1's Pregabalin capsules was not performed until 10/6/21 when the Wellness Supervisor LPN noticed the tamper evident tape was no longer intact. When the medication was counted on 10/6/21 there were 75 capsules in the bottle. A med delegated staff stated s/he accidentally broke the seal on 9/15/21, and stated s/he did not open the bottle or notice if the manufacturer's seal was intact. The failure to initiate a controlled substance count sheet and count the controlled substance when it was transferred from the RCD to the LPN in 2020; to store the medication under	R177		

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R177	Continued From page 5 two locks while in the LPN's desk; and to count the medication on transfer from the LPN to med delegated staff on 9/14/21, when the tamper evident tape was broken on 9/15/21, and at least weekly as defined in the licensing regulations prevented determination of when the 15 pills were removed from the bottle. On the afternoon of 11/2/22 both LPN's, the Assistant Executive Director, and the Executive Director confirmed the failure to account for Resident #1's Pregabalin 50 mg capsules on at least a weekly basis.	R177		
R207 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the licensed agency and staff failed to report an incident of possible diversion of controlled substances belonging to one applicable resident (Resident #1) to the Licensing Agency and to Adult Protective Services. Findings include: Per record review Resident #1 was admitted to	R207		

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R207	Continued From page 6 the facility in November of 2020 with diagnoses including Alzheimer's Disease, Colitis, Major Depressive Disorder, Osteoporosis with a history of pathological fractures, and Chronic Fatigue Syndrome. S/he is prescribed Pregabalin 50 mg twice daily to treat pain related to a vertebral fracture. On 10/6/21 a facility LPN noticed the tamper evident tape placed on the top of a bottle of Pregabalin 50 mg capsules belonging to Resident #2 was no longer intact and conducted a count of this controlled substance. The bottle of Pregabalin was observed to contain 15 capsules less than the expected amount in stock as listed on the controlled substance count sheet. At 4:31 PM on 11/2/22 the Assistant Executive Director confirmed potential diversion of medication belonging to Resident #1 was not reported to the Licensing Agency and to Adult Protective Services.	R207	R207 The action taken to correct this deficiency: I (Lydia Raymond) have reported all incidents following 11/2/22 site visit to the appropriate parties per the regulations. In order to ensure the deficient practice and mitigate future occurrence we will continue to report to the appropriate parties.	