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 6, 2018

Ms. Dawn Taylor, Manager
Valley Vista
23 Upper Plain
Bradford, VT 05033-9016

Dear Ms. Taylor:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 2, 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

MAY 21 2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0540	A. BUILDING: _____ B. WING _____	C 05/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VISTA	23 UPPER PLAIN BRADFORD, VT 05033

(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
T 001	Initial Comments The Division of Licensing and Protection conducted an unannounced onsite complaint investigation on 5/2/2018. The following regulatory violations were identified.	T 001		
T 023 SS=G	V. 5.5.a Resident Care and Services 5.5 General Care 5.5.a Upon a resident's admission to a therapeutic community residence, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. The home's manager shall provide every resident with the personal care and supervision appropriate to his or her individual needs. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the residence failed to ensure that necessary nursing and medical services were provided or arranged in order to meet the individual needs of one applicable resident (Resident #1). Findings include: Resident #1 was admitted to the residence on 11/30/2017 for the treatment of substance abuse. Per History and Physical documentation, Resident #1 had medical conditions including depression, disordered sleep, and Type 2 diabetes (a chronic condition that affects the way the body processes blood sugar). Per Nurse Progress note dated 12/6/2017, Resident #1 complained, "of increasing dental pain related to	T 023	At the end of this month, Little River Health Care will be providing Valley Vista with a provider on-site one day per week at Valley Vista to see patients with any medical issues. This is in addition to our nurse midwife who is on-site one day per week seeing women and infectious disease issues. We are working in collaboration with Little Rivers Health Care to recruit a provider who will ultimately be on-site at Valley Vista for four days per week.	5/30/2018

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

Amanda Hamlet MS, LADC, MAC Treatment Director 5/18/18

POC accepted 5/31/18
with addendum
T023/T038 L. Sherbrooke, RN

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
	0540	A. BUILDING: _____ B. WING _____	C 05/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VISTA	23 UPPER PLAIN BRADFORD, VT 05033

(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
T 001	Initial Comments The Division of Licensing and Protection conducted an unannounced onsite complaint investigation on 5/2/2018. The following regulatory violations were identified.	T 001	At the end of this month, Little River Health Care will be providing Valley Vista with a provider on-site one day per week at Valley Vista to see patients with any medical issues. This is in addition to our nurse midwife who is on-site one day per week seeing women and infectious disease issues. We are working in collaboration with Little Rivers Health Care to recruit a provider who will ultimately be on-site at Valley Vista for four days per week. Michelle Hollis, RN	5/30/2018
T 023 SS=G	V. 5.5.a Resident Care and Services 5.5 General Care 5.5.a Upon a resident's admission to a therapeutic community residence, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. The home's manager shall provide every resident with the personal care and supervision appropriate to his or her individual needs. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the residence failed to ensure that necessary nursing and medical services were provided or arranged in order to meet the individual needs of one applicable resident (Resident #1). Findings include: Resident #1 was admitted to the residence on 11/30/2017 for the treatment of substance abuse. Per History and Physical documentation, Resident #1 had medical conditions including depression, disordered sleep, and Type 2 diabetes (a chronic condition that affects the way the body processes blood sugar). Per Nurse Progress note dated 12/6/2017, Resident #1 complained, "of increasing dental pain related to	T 023		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0540	A. BUILDING: _____ B. WING _____	C 05/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VISTA	23 UPPER PLAIN BRADFORD, VT 05033

(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
T 023	Continued From page 1	T 023		

a broken tooth." Resident #1 was documented to be afebrile (temperature within normal limits) with, "very mild swelling seen" on one side of his/her face. Resident #1 was documented as having "several spots" on his/her face believed to be acne and described as "swelling". Resident #1 was documented to be taking Tylenol, "with mild effect". Per Nurse Progress note on 12/7/2017 Resident #1 "presented with a stye" on right eye lash line. Resident #1 requested a needle to use to open up the stye, and s/he was advised not to do so and encouraged to take precautions including hand washing and avoidance of touching the eye. A Nurse Progress Note dated 12/7/2017 indicates new orders for ibuprofen and Tylenol were obtained for "increasing dental pain" by a Licensed Practical Nurse from the on-call medical provider. The medical record indicates Resident #1 was scheduled to see the Physician's Assistant at the facility on 12/10/2017. Per Nurse Progress note on 12/9/2019, Resident #1 disrupted the therapeutic environment by becoming "verbally upset" and telling other residents that the facility was not addressing their eye, facial and dental issues. Per note by the Licensed Practical Nurse on 12/9/2017, Resident #1 was advised to avoid touching or rubbing the eye, and instructed to apply warm compresses to the area several times a day, until s/he, "can be seen by the Physician's Assistant".

On 12/10/2017 Resident #1 was seen by the Physician's Assistant at the facility. According to the Physician Assistant documentation, Resident #1 had obtained a pair of nail clippers on 12/9/2017 which s/he used to "cut the cyst on his eyelid open". Per Physician Assistant exam documentation Resident #1 presented with an erythematous right upper eyelid, described as "very hot and swollen" with the right maxillary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0540	A. BUILDING: _____ B. WING _____	C 05/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VISTA	23 UPPER PLAIN BRADFORD, VT 05033

(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
T 023	Continued From page 2	T 023		

cheek red, hot and swollen and tender on palpitation. Resident #1 was then transported to the local Emergency Department for evaluation. Per Emergency Department physician notes dated 12/10/2017, Resident #1's skin was described to have significant redness on the left side of his face, with two large scabs on the left side of his face. The redness extended across the nose, onto the eyelid and onto the right side of the face. S/he was diagnosed with facial cellulitis and was admitted to the hospital and received three days of intravenous antibiotics prior to discharge.

Per review of Nurse Progress notes, on 12/6/2017 Resident #1 reported "increasing dental pain" and was documented to be afebrile (temperature within normal limits) However, there was no evidence of a complete set of vital signs documented in the chart. On 12/7/2017 per Nurse Progress Note, a Licensed Practical Nurse obtained a new order for pain medication due to Resident #1's complaint of "increasing dental pain". Per medical record review, there was no evidence of vital signs or a nursing assessment by a Registered Nurse of Resident #1 being completed on this date. Following Resident #1's report of becoming upset and expression that the facility was "not treating his eye/ facial/ dental issues" on 12/9/2017, there is no evidence of a nursing assessment of the resident's condition, or consideration of arrangement of medical services in order to address his physical needs.

While the Licensed Practical Nurse obtained a new order from the on-call physician for pain medication on 12/7/2017, there was no evidence that a medical provider had been consulted with in order to address Resident #1's ongoing needs, or that consideration had been made to obtain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0540	A. BUILDING: _____ B. WING _____	C 05/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VISTA	23 UPPER PLAIN BRADFORD, VT 05033

(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
T 023	Continued From page 3 medical services prior to the appointment with the Physician Assistant at the facility on 12/10/2017. During an interview, the Director of Nursing stated that, "ideally s/he would have been seen by a provider earlier, but s/he was not presenting with a medical emergency". The lack of evidence of nursing assessment, failure to monitoring for signs and symptoms of infection, and lack of evidence of consultation with a medical provider regarding Resident #1's health status was reviewed with the Director of Nursing on 5/2/2018 at 3:00 PM.	T 023		
T 038 SS=G	V.5.8.d.1.2.3.i.ii.iii.iv. Resident Care and Services 5.8 Medication Management d) If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (1) A registered nurse must conduct an assessment of the resident's care needs consistent with the physician's or other health care provider ' s diagnosis and orders. (2) A registered nurse must delegate the responsibility for the administration of specific medications to designated staff for designated residents. (3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for: i. Teaching designated staff proper techniques for medication administration and providing	T 038	We have a registered nurse that we will be available to devote to history and physicals along with these type of incidents. We currently have a licensed staff (LPN or RN) on each shift per our regulations. LPN and MA's will be provided with education around re-delegation of medication and/or new delegation of medication. This education will also provide best way to document around this. A new protocol/form has been created that reviews a new medication that has been prescribed to this patient. This medications use/side effects along with correct dispensing methods and where to find further information has been explained to any unlicensed staff that may dispense this medication. -Sent as an attachment	6/11/18 Michelle Hollis, RN 6/4/18 Michelle Hollis, RN 6/4/18 Michelle Hollis, RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0540	A. BUILDING: _____ B. WING _____	C 05/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VISTA	23 UPPER PLAIN BRADFORD, VT 05033

(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
T 038	Continued From page 4	T 038		

appropriate
information about the resident's condition, relevant medications, and potential side effects;

ii. Establishing a process for routine communication with designated staff about the resident's
condition and the effect of medications, as well as changes in medications;

iii. Assessing the resident's condition and the need for any changes in medications; and

iv. Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the residence failed to ensure that a Registered Nurse (RN) assessed the resident prior to unlicensed staff administering medications and failed to ensure a RN properly delegated medication administration for one applicable resident (Resident #1). Findings include.

Per record review, Resident #1 was admitted to the residence on 11/30/2017. Per review of Nurse Progress notes, Resident #1 reported "increasing dental pain" and was documented as having "mild swelling" seen on one side of the face on 12/6/2017. Per review of the Medication Administration Record, Resident #1 had physician orders dated 11/30/2017 for Tylenol 650 mg by mouth every 6 hours and ibuprofen 400 mg by mouth every 4 hours as needed for pain. Between 12/6/17-12/7/2017 Resident #1 received

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0540	A. BUILDING: _____ B. WING _____	C 05/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VISTA	23 UPPER PLAIN BRADFORD, VT 05033

(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
T 038	Continued From page 5 2 doses of Tylenol and 4 doses of ibuprofen for head and dental pain. Per Nurse Progress note on 12/7/2017 , a Licensed Practical Nurse received a new order from an on-call physician for increased doses of Tylenol and ibuprofen for Resident #1, "as patient is complaining of increased dental pain". The new orders were for ibuprofen 800 mg by mouth three times a day for dental pain, and Tylenol 1000 mg by mouth three times a day for dental pain as needed. Resident #1 received 8 doses of Tylenol between 12/7/17-12/10/2017 and 8 doses of ibuprofen between 12/7/2017-12/10/2017 for dental pain. Per review of the residence staffing schedule and Medication Administration records, Resident #1 received the increased doses of ibuprofen and Tylenol from Licensed Practical Nurses and unlicensed medical assistants. While a Licensed Practical Nurse obtained a new order for medication following the resident report of increased pain on 12/7/2017, there was no evidence in the medical record that a Registered Nurse had performed an assessment of the resident's condition and documented the need for any changes in medication. During an interview, the Director of Nursing confirmed that the Licensed Practical Nurses and unlicensed medical assistants had been delegated to administer the original orders for ibuprofen and Tylenol for Resident #1, and that a Registered Nurse had not delegated the administration of the new orders with increased medication doses to the Licensed Practical Nurses and Medical Assistants. The lack of evidence of a nursing assessment by a Registered Nurse and administration of medication without delegation following Resident #1's change in condition was reviewed with the	T 038		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0540	A. BUILDING _____ B. WING _____	C 05/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VISTA	23 UPPER PLAIN BRADFORD, VT 05033

(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
T 038	Continued From page 6 Director of Nursing on 5/2/2018 at 3:00 PM.	T 038		

NEW MEDICATION

PATIENTS NAME:

A new medication has been prescribed to this patient. This medications use/side effects along with correct dispensing methods and where to find further information has been explained to any unlicensed staff that may dispense this medication.

As the unlicensed staff dispensing this med, I have access to information about this medication and the process of dispensing has been explained by the RN.

NEW MED:_____ RN initial_____ Unlicensed Staff initial_____

NEW MED:_____ RN initial_____ Unlicensed Staff initial_____

NEW MED:_____ RN initial_____ Unlicensed Staff initial_____

NEW MED:_____ RN initial_____ Unlicensed Staff initial_____