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

April 25, 2024

Kevin Hamel, Manager
Valley Vista
23 Upper Plain
Bradford, VT 05033-9016

Dear Mr. Hamel:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 26, 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

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	0540	A. BUILDING: _____ B. WING _____	02/26/2024

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

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T 001	Initial Comments On 2/26/24 the Division of Licensing and Protection conducted an unannounced on-site relicensure survey. The following regulatory deficiencies were identified:	T 001	All corrective actions accepted by Jo A Evans RN on 4/24/24. Please see attached to review corrective actions for individual citations.	
T 052 SS=F	V.5.9.b.1.2.3.4.5.6.7 Resident Care and Services 5.9 Staff Services 5.9.b. The residence 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 Helmlich 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, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents	T 052		

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T 052	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure 5 out of 5 sampled staff completed all required yearly trainings. Findings include: Per review of the facility's Personnel Policies and Procedures Manual provided for review on request, the manual states: "At a minimum, in-service trainings will cover the following items: * Facility emergency and safety procedures * Boundaries and Confidentiality procedures * Acceptable behavior management techniques * Crisis Management (CPI) * Passive Physical restraint * Best Practices * Infection Control * Patient Rights * Reporting of suspected abuse and neglect * Cultural Competency * Dialectical Behavior Therapy (DBT)" This facility policy does not include the required training in emergency response and first aid. Per record review 5 out of 5 staff did not complete all required yearly trainings. At 12:37 PM on 2/26/24 this finding was confirmed by Billing and Collections Coordinator. In conclusion this deficient practice is a potential risk for more than minimal harm for all resident due to failure to ensure staff education and training to safely and effectively provide resident care.	T 052		

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T 054	Continued From page 2	T 054		
T 054 SS=D	V.5.9.d Resident Care and Services 5.9 Staff Services 5.9.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the residence as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection and the Department for Children and Families in accordance with 33 V.S.A. §6911 and 33 V.S.A. §4919 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure written documentation stating the decision to hire two direct service employees with misdemeanor convictions did not pose a threat to residents. Findings include: The facility's policies and procedures for Criminal Background Checks effective 5/15/2023 states, "Upon receipt by the Human Resources Director of written report(s) containing the results of	T 054		

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T 054	Continued From page 3 criminal, child registry, and adult registry checks, the Human Resources Director determines whether the facility should continue to consider the applicant a viable candidate for employment.", On 2/26/24 the Billings and Collections Coordinator was requested to provide employee criminal background checks for review. The results of criminal background checks indicated 2 out of 7 applicable staff had Vermont Crime Information Center criminal record findings; however the personnel records of the 2 staff members did not contain letters indicating the decision to hire the staff did not pose a threat to residents receiving treatment at the Therapeutic Community Residence. At 12:23 PM on 2/26/24 the Billing and Collections Coordinator confirmed the personnel files of 2 staff with Vermont criminal record check findings did not contain letters indicating the decision to hire the staff did not pose a threat to facility residents. In conclusion this deficient practice is potential risk for more than minimal harm for all residents, as the requirement for criminal background and abuse checks is intended to ensure all residents are free from harm.	T 054		
T 062 SS=F	V.5.10.b.4 Resident Care and Services 5.10 Records/Reports 5.10.b.4 The results of the criminal record and abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by:	T 062		

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T 062	Continued From page 4 Based on staff interview and record review there was a failure to ensure completion of all criminal record and abuse registry checks as required. Findings include: Per review, the facility's policies and procedures for Criminal Background Checks effective 5/15/23 includes the statements: a."Upon receipt by the Human Resources Director of written report(s) containing the results of criminal, child registry, and adult registry checks, the Human Resources Director determines whether the facility should continue to consider the applicant a viable candidate for employment." b." The Human Resources Director maintains the results of these background checks in a secure file separate from staff personnel files.' c."The scope of these checks is limited as follows: Department of Children and Families (DCF) checks three sources: the adult registry, the child registry, and criminal history, each of which is limited to Vermont. " The facility's policies and procedures for criminal record and abuse registry checks have not been updated to include regulatory requirements for National background checks; and yearly Vermont criminal record and abuse registry checks in effect as of May 2023. Per record review 7 out of 7 sampled staff did not have all required criminal record and abuse registry checks on file and available for review. These findings were confirmed at 2:44 PM on 2/26/24 by the Billing and Collections	T 062		

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T 062	Continued From page 5 Coordinator. In conclusion this deficient practice is potential risk for more than minimal harm for all facility residents, as the requirement for criminal background and abuse checks is intended to ensure all residents are free from harm.	T 062		
T 127 SS=F	VII.7.2.b 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 temperature. Hot foods shall be kept hot at 135 degrees F and cold foods shall be kept at 41 degrees F or cooler. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure perishable food items were labeled and dated, and to ensure refrigerated perishable items are maintained at a temperature of 41 degrees or colder. Findings include: The Food Storage: Cold Foods policy and procedures effective 4/2019 provided by the facility for review on 2/26/24 includes the following procedures: * "All perishable foods will be maintained at a temperature of 41 degrees F or below, except during the necessary periods of preparation and service." * "All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a	T 127		

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T 127	Continued From page 6	T 127		

manner to prevent cross contamination."

1. During a kitchen tour commencing at approximately 9:35 AM on 2/26/24 the following perishable food items were observed to be without the required identifying labels and dates they were opened or prepared:

a. In a reach-in refrigerator located in the kitchen, containers of milk, half and half, cream, and juices were observed to be without labels indicating the dates the containers were opened.

b. In the walk-in refrigerator 4 opened cartons of liquid eggs and opened containers of feta cheese, salad dressings, pickles, tubs of stock (beef, vegetable, and chicken), chopped garlic, and liquid margarine were without the dates the items were opened. Prepared food items without identifying labels and dates the items were opened or prepared were observed including bins of chicken and chopped vegetables, and 2 portions of American Cheese loosely packaged in unsealed plastic wrap.

These findings were confirmed by the Kitchen Manager during the kitchen tour on the morning of 2/26/24.

2. During a tour of the Dining Area commencing at 9:57 AM on 2/26/24:

a. A mini-fridge located near the cereal dispenser was observed to contain 3 unlabeled and undated bowls of leftovers and undated opened gallons of milk. This mini-fridge was observed with a thermometer which read 51 degrees Fahrenheit at 9:58 AM. During a second check at 10:10 AM on 2/26/24 the temperature of the mini-fridge was again observed to be 51 degrees Fahrenheit. A

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T 127	Continued From page 7 second mini-fridge located near the juice and coffee dispensers was also observed to contain opened undated gallons of milk. b. A juice dispenser located in the Dining Area was observed to store juices at temperatures above 41 degrees Fahrenheit including Cranberry Juice stored at 52.2 degrees Fahrenheit and Fruit Punch stored at 45.3 degrees Fahrenheit. These findings were confirmed by the Kitchen Manager during the Dining Room tour commencing at 9:57 AM on 2/26/24. In conclusion, this deficient practice is a potential risk for more than minimal harm due to food borne illness for all facility residents.	T 127		
T 146 SS=F	IX.9.1.a Physical Plant 9.1 Environment 9.1.a The residence 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 storage of hazardous items. Findings include:	T 146		

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T 146	Continued From page 8 Per review of the facility's Personnel Policies and Procedures Manual provided for review on request, the manual states: "Employees and supervisors receive periodic workplace safety training. The training covers potential safety and health hazards and safe work practices and procedures to eliminate or minimize hazards." The facility's Policy for Medical Waste effective 12/2020 states, "The environmental services staff is responsible for the storage and packaging of medical waste for pickup and destruction by the contracted licensed disposal company.", and includes the procedure, "The environmental services staff and Nursing will be responsible for control of access to the biohazard storage room. " At approximately 9:50 AM on 2/26/24 a storage room located across from the Kitchen dishwashing area with signs on the door stating "Door Must Remain Locked at All Times", "Bio-Hazard", and "Oxygen Storage" was observed to be accessible to residents with the door propped open. The room was observed to store containers of medical waste including an open uncovered cardboard box labeled "Infectious Waste" with bags of waste inside. A large shelving unit along the back wall of the room was observed with cleaning chemicals stored on the shelves. On the morning of 2/24/26 the Kitchen Manager confirmed the storage room contained hazardous medical waste and cleaning chemicals which were unsecured and accessible to residents due to the unlocked and open door, and stated the door of the storage room routinely remains propped open during the day and is closed at night.	T 146		

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T 146	Continued From page 9 This deficient practice is a potential risk for more then minimal harm to all facility residents resulting from unsecured and accessible hazardous medical waste and cleaning chemicals.	T 146		
T 187 SS=F	IX.9.11.c Physical Plant 9.11 Disaster and Emergency Preparedness 9.11.c Each residence 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 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 staff interview and record review there was a failure to ensure fire drills were conducted at least quarterly and at least once yearly during the morning, afternoon, evening, and night during the previous year. Findings include: Per review of policies and procedures provided for review on 2/26/24, facility policies and procedures for conducting fire drills on at least a quarterly basis; and with drill times in the morning, afternoon, evening, and night at least once yearly, were not on file and available for review on request.	T 187		

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T 187	Continued From page 10 Per interview commencing at approximately 3:45 PM on 2/26/24, the Director of Facilities confirmed fire drills had not been conducted since March 2023. Per record review, and per interview with the Director of Facilities, one "walk through" evaluation of the fire drill system was conducted with the Director of Nursing and the Director of Facilities on 1/15/24, however a drill was not conducted and the facility was not evacuated at this time. During the interview commencing at approximately 3:45 PM on 2/26/24 the Director of Facilities confirmed there was no documentation of fire drills conducted during the 2nd, 3rd, and 4th quarters of 2023, and during the 1st quarter of 2024 on file and available for review on 2/26/24. This deficient practice is a potential risk for more than minimal harm for all facility residents due to missed opportunities for staff and residents to practice the evacuation process, and identify effective procedures for safe and timely evacuation.	T 187		

VALLEY VISTA

Phone: 802-222-5201
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23 Upper Plain, Bradford, VT 05033
1 Alden Pl, Vergennes, VT 05491

T052
5.9 b All missing training modules were added to our education system on the day of the survey. Staff were made aware of the added modules and were given until May 1st to complete them. Going forward we will be monitoring compliance with required education utilizing our training system. This will be monitored monthly with updates given to staff. Any staff that is not compliant by May 1st, 2024, will be removed from the schedule until they become compliant with the required education per the regulations.

T052 Plan of Correction accepted by Jo A Evans RN on 4/24/24.

T054
5.9.d - All applicable staff as of 4/1/2024 we'll have a letter in their employee file recognizing the information found on a background check as the appropriate waiver that the person does not pose any harm to the residents of the facility. This letter will be signed by human resources before the first date of hire. Additionally, by May 15th, 2024, human resources will perform an audit on all employee files to make sure that the letter acknowledging anything that was found during a background check is in the file as an appropriate waiver that the person does not pose any harm to the residents of this facility.

T054 Plan of Correction accepted by Jo A Evans RN on 4/24/24.

T062
5.10 b – A file cabinet has been purchased and put in place as of April 1st, 2024, for all background checks and confidential files to be kept separate from personal files.

5.10 c - Our procedure for new hires as of April 1st, 2024, does include a national background check Vermont adult and child registry check, and Vermont State background check. Additionally, by May 15th 2024, human resources will do an audit on all personnel files to make sure background checks are performed on current employees and all future employees' human resources have set up through Outlook monthly reminders for yearly employee files to be updated on all background checks. Additionally, noncore staff members, that are contracted we'll have a file in human resources separate from our core employees.

T062 Plan of Correction accepted by Jo A Evans RN on 4/24/24.

T127 on 2/27 and 2/28, all dietary staff were educated on proper procedures for food storage and labeling. On 2/26, all perishable food and drink items were labeled, dated, and placed into proper storage containers. To stay compliant, daily checks will be done by the dietary director or supervisor. On 2/26, the mini refrigerator located next to the cereal dispenser was removed. On 2/27, the other mini refrigerator was added to the daily temperature log. On 2/27, the company to whom we lease the juice dispensers was onsite to adjust temperatures and on the same date, these machines were added to the daily temperature log.

T127 Plan of Correction accepted by Jo A Evans RN on 4/24/24

T146 on 2/26 biohazard and oxygen storage room was closed and locked. On 2/27 Environmental service staff reviewed proper procedures for bio-hazard storage and the need for the door to be closed and always locked. This is being added to a weekly check sheet for compliance.

T146 Plan of Correction accepted by Jo A Evans RN on 4/24/24.

T187 on 2/27, fire drill was conducted, Fire drill schedule was created, and all have been completed at this time to comply. We have added this to the quarterly risk management meeting as well as a standing topic.

T187 Plan of Correction accepted by Jo A Evans RN on 4/24/24.

Kevin Hurel RN VP