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

January 16, 2025

Valerie Cote, Manager
Allen Harbor Senior Living
90 Allen Road
South Burlington, VT 05403-7856

Dear Ms. Cote:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0372	A. BUILDING: _____ B. WING _____	C 12/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEN HARBOR SENIOR LIVING	90 ALLEN ROAD SOUTH BURLINGTON, VT 05403

(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: On 12/26/24 the Division of Licensing and Protection conducted an unannounced on-site investigaton of one complaint. 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 staff interview and record review there was a failure to administer medication as ordered for one applicable resident (Resident #1). Findings include: Resident #1 was admitted to the home on the morning of 9/13/24. Per review of Resident #1's Medication Administration Records for September 2024-December 2024, there was a failure to administer the following medications as ordered: The facility's Medication Program policy effective 2/15/20 states the Wellness Director (or designee) will review monthly MARs for accuracy prior to use, confirm each order on E-MAR prior to staff administering medications, and verify the accuracy of changes. The Wellness Director's Job Description identifies the responsibility to ensure medications are dispensed in a safe and effective manner, and Medication Administration Records are accurate and complete. The Wellness Nurse's Job Description identifies the	R128	Resident #1's medications have been sent to the PCP for review and signature. Incident reports are in place for all noted medication administration errors. Re-education to be completed with Wellness Nurse staff and Med Tech staff on the medication program policy. Wellness Nurse staff to be signed off on competencies, which includes responsibility of monitoring that medications are administered per the MD orders. Re-education will be provided with the Wellness Nurses re: checking the missed medication report daily and following up immediately related to any omissions. Audits of the missed medications will be performed weekly times 4 and then monthly times 3 by the Wellness Director and/or designee. Results of these audits will be brought to the QA committee for review.	1/24/2025

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R128	Continued From page 1 responsibility to ensure safe medication practices, correctly transcribe orders, and complete error free med passes. 1. Resident #1 was admitted to the home with an order for Venlafaxine 75 mg given daily at 9:00 AM. A Medication Error Report dated 11/19/24 indicates this medication was discontinued in error, and the Medication Administration Record (MAR) indicates Venlafaxine was not given from 11/15/24- 11/19/24. A Progress Note entered into Resident #1's record at 3:15 PM on 11/19/24 indicates the provider was notified of this error and an order to discontinue this medication was received. Venlafaxine is an antidepressant medication which poses a risk for a withdrawal syndrome if stopped abruptly. 2. Aspirin 81 mg was not documented as given on 9/14/24 and 9/19/24. A Medication Error Report dated 9/17/24 stated " ...resident hasn't been receiving Aspirin 81 mg tabs ...". 3. Levothyroxine 50 mcg tablet not documented as given on 9/15/24, 9/16/24, and 9/18/24. The MAR indicates this medication was not given on 9/16/24 due to hospitalization, however, there is no documentation of Resident #1 being hospitalized on this date in his/her record. The MAR indicates this medication was out of stock on 9/18/24, however a Progress Note states the medication was in the medication cart. 4. Rosuvastatin Calcium 20 mg tablet was not documented as given on 9/13/24- 9/16/24. Rosuvastatin orders in the MAR indicate is to be administered at 6:00 PM, however, from 10/18/24 - 10/21/24 an additional line appears in the MAR indicating the medication was to be administered at 12:00 AM. Rosuvastatin is documented as	R128	R128 Plan of Correction accepted by Jo A Evans RN on 1/16/25	

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R128	Continued From page 2 given on 10/19/24, however, a Progress Note entered at 11:08 PM on 10/19/24 states, "The on-call nurse said to hold it and [s/he] will change the time". The order for the 12:00 AM administration time was not discontinued until 10/22/24. Rosuvastatin is not documented as given on 10/20/21 and 10/21/24, with a chart code entered indicating "Hold/See Nurse Notes". Rosuvastatin also not documented as administered from 10/23/24- 10/25/24, with Notes during this time frame indicating the medication was out of stock. At 4:40 PM on 12/26/24 the Nurse Manager confirmed medications prescribed to Resident #1 were not administered as ordered.	R128		
R180 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.c All training to meet the requirements of 5.11.b shall be documented. Training in direct care skills by a home's nurse may meet this requirement, provided the nurse documents the content and amount of training This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure documentation of competencies in the skills the nursing staff are required to perform are maintained on file and available for review. Findings include: Per record review the home's Wellness Nurse Job Description identifies the responsibility to ensure safe medication practices, correctly	R180	All Wellness Nurses have completed a competency checklist that includes their duties in monitoring the administration of medications per MD orders. All Wellness Nurses have completed re-education related to the medication program policy. Audits will be performed weekly times 4 and monthly times 3 on any new Wellness Nurse at the community to ensure they have completed their competency checklist. Results of these audits will be brought to the QA committee for review.	1/24/2025

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R180	Continued From page 3 transcribe orders, and complete error free med passes. On the afternoon of 12/26/24 the Nurse Manager was requested to provide documentation of competency in the skills the nursing staff are required to perform related to the home's medication administration system At approximately 4:50 PM on 12/26/24 the Nurse Manager confirmed documentation of the home's nursing competencies checklist was not on file and available for review on request.	R180	R180 Plan of Correction accepted by Jo A Evans RN on 1/16/25	
R188 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(2) A record for each resident which includes: resident's name; emergency notification numbers; name, address and telephone number of any legal representative or, if there is none, the next of kin; physician's name, address and telephone number; instructions in case of resident's death; the resident's assessment(s); progress notes regarding any accident or incident and subsequent follow-up; list of allergies; a signed admission agreement; a recent photograph of the resident, unless the resident objects; a copy of the resident's advance directives, if any completed; and a copy of the document giving legal authority to another, if any. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure one applicable resident's	R188	An audit has been performed and all photographs are up to date in the medical records for all Residential Care Residents. If a Resident has refused their photograph, it is notated on their electronic medical record underneath the space for the photograph. Re-education to be provided to Wellness Nurses and Life Inspired Director of the need for photographs for each Residential Care Resident related to the medication program policy. Weekly audits times 4 and then monthly times 3 will be completed by the Executive Director and/or designee to ensure that any new Residents have a photograph (or refusal) in their electronic medical record. Results of these audits will be brought to the QA committee for review.	1/24/2025

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R188	Continued From page 4 record included a photograph of the resident or documentation of the resident's refusal to be photographed (Resident #1). Findings include: Per record review a resident photo was not on file and available for review in Resident #1 's electronic and paper records maintained by the home including the resident's Plan of Care and Medication Administration Record. The facility's Medication Program policy identifies the requirement to maintain a current photo in the front of the Medication Administration Record for resident identification prior to medication administration. This finding was confirmed by the Nurse Manager on the afternoon of 12/26/24.	R188	R188 Plan of Correction accepted by Jo A Evans RN on 1/16/25	