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

March 18, 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 **March 3, 2025.** 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 03/03/2025

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 3/3/25 the Division of Licensing and Protection conducted an unannounced on-site investigation of one facility reported incident. The following regulatory deficiencies were identified:	R100	The filing of this plan of correction does not constitute an admission of the allegations set forth in this statement of deficiencies. This plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law.	
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 interviews with staff and an individual identified as a resident's responsible party, and record review there was a failure to ensure information included in one applicable resident's record accurately documents legal authority and legal representation given to another. (Resident #1). Findings include: Per record review, Resident Assessment forms on file indicate Resident #1 has a Representative	R188	R188: Resident #1's electronic record has been updated to show that there is no legal representative assigned at this time. Education completed with all nurses (RN and LPNs) at the community to review the differences between different legal assignments, as well as the need to verify the documentation is in place for the legal assignment. A house wide audit was completed on each Resident record to ensure that their legal assigned person(s) was marked accordingly on their profile page in their electronic record, and ensured the documentation is in place/scanned into their electronic record. All records now up to date. Random audits will be performed by the Exec. Dir. And/or designee weekly times 4 and then monthly times 3 to ensure new admission record profiles are accurate. The same frequency of audits will be performed by the ED and/or designee on assessments being completed to ensure they are marked accordingly. Results of these audits will be brought to the QA committee for review. R188 Plan of Correction accepted by Jo A Evans RN on 3/17/25.	3/14/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] CHHA

TITLE: Executive Director

(X6) DATE: 3/17/2025

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R188	Continued From page 1 Payee and Legal Guardian. At 1:46 PM on 3/3/25 the individual identified as Resident #1's Representative Payee and Legal Guardian in the Resident Assessments on file confirmed legal representation and legal authority for Resident #1 have not been given to them or to any other individuals. At 3:06 PM on 3/3/25 the Executive Director confirmed this information documented in Resident #1's record regarding legal representation and legal authority is inaccurate.	R188	R 224: Resident #1 is free from harm at this time. Resident #1 presents with no distress or psychosocial or mood changes at this time. Resident #1 assured that their stay in this community remains unaffected by the event that occurred in January 2025. As stated in this statement of deficiencies, the employee was suspended immediately and eventually terminated from the community. Resident remains alert and oriented X 3 and can and will communicate any concerns, pain, mood and/or psychosocial issues to staff immediately.	3/21/2025
R224 SS=G	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on interviews with staff and a personal caregiver, and record review this regulatory requirement was not met due to the physical abuse of one applicable resident (Resident #1) by a staff employed at the home. Findings include: Per record review Resident #1 is a vulnerable adult living with severe debilitating pain as a result of a cervical spinal cord injury. Per interview with Resident #1's personal caregiver on the afternoon of 3/3/25, Resident #1 experiences constant pain that increases with movement and touch. Resident #1's pain is intractable and is not effectively relieved by administration of multiple prescribed pain medications. Due to the spinal cord injury and	R224	Abuse education was re-done with staff on January 21, 2025. Abuse education will continue to be done with all community staff upon hire, annually and as indicated. New hire and annual educations are already tracked by the Exec. Dir. And/or designee. Annual education audit for 2024 was completed by the ED in November 2024 and was complete. New hire education is tracked by the ED as they occur. Resident Rights annual education is scheduled for March 18. 2025 at the next All Staff Meeting. This education also occurs upon hire, annually and as indicated. The community performs background checks on all employees prior to hire, and annually. These checks include, but are not limited to, abuse registries in VT and a national crime check. The ED tracks annual checks based upon annual hire dates and a house wide audit was completed in November 2024 by the ED and all were up to date. New hires are tracked by the ED as they occur. The community will continue to follow the background check policy on who can and who cannot be hired, which follows the licensing agency's regulation re: background checks. Continued on next page...	

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R224	Continued From page 2 surgical interventions to treat this injury, Resident #1 also has right sided weakness and limited use of their right arm. Per record review, on the night of 1/16/25 a Staff member attempted to kiss Resident #1 after administering their 11:00 PM medication and made contact with the resident. Per record review and interview with Resident #1's personal caregiver, Resident #1 reported they responded by turning away to avoid being kissed. The Staff then put their hands on the resident's face, turned the resident's head, and kissed the resident again against their will. During an interview on the afternoon of 3/3/25, Resident #1's personal caregiver stated they are routinely in Resident #1's apartment every night; however, on the night of 1/16/25 the Staff member had been informed the personal caregiver would not be in the apartment that night. Per interview with Resident #1's personal caregiver on the afternoon of 3/3/25, Resident #1 expressed feeling disappointed by the actions of the Staff and concerned about the incident possibly jeopardizing their ability to remain at the home. Per record review and staff interview Resident #1 does not have a history of false or inaccurate reporting, accusations, or complaints about staff. Per review of nursing assessments on file, Resident #1's is free of cognitive impairment and decline, their short term and long term memory are intact, and they are never socially inappropriate or resistant to care. While Resident #1 was not available for interview during the investigation on 3/3/25, per interview with the home's Executive Director and the resident's personal caregiver Resident #1's statements regarding the incident on the night of 1/16/25 were consistent throughout the home's internal	R224	The community has a process in which all Residential Care Residents receive a monthly note in their electronic record from the nursing department to review their current status. Three questions will be added to this form/note for the nursing staff to ask upon their monthly review: 1. Do you feel safe? (Asked to the Resident) 2. Has anyone treated you inappropriately at the community? (Asked to the Resident) 3. Is the Resident exhibiting any signs/symptoms of abuse? (Nursing evaluation) If any of the answers result in a yes, the Exec. Dir. And/or designee will respond immediately and further investigate with the Resident and follow the regulations set forth by the licensing agency. The nurses will be educated on these new questions, and on how to effectively evaluate for signs/symptoms of abuse. Random audits will be completed by the Exec. Dir. And/or designee to ensure that these questions are being asked and answered, and auditing for any "yes" answers. These audits will occur weekly times 4 and then monthly times 3 once the form has been updated in the electronic medical record system. This update will occur by April 1, 2025 (the IT department has been notified of the requested changes). Results of all above audits will be brought to the QA committee for review.	

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R224	Continued From page 3 investigation process. Per the Executive Director the Staff was suspended during the home's internal investigation of this incident, and terminated upon completion of the investigation.	R224	R224 Plan of Correction accepted by Jo A Evans RN on 3/17/25.	