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 31, 2024

Melissa Byrne, Manager
Sterling House At Rockingham
33 Atkinson Street
Bellows Falls, VT 05101-1502

Dear Ms. Byrne:

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0609	A. BUILDING: _____ B. WING _____	C 12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE AT ROCKINGHAM	33 ATKINSON STREET BELLOWS FALLS, VT 05101

(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: An unannounced on-site complaint investigation of one complaint was conducted by the Division of Licensing and Protection on 12/2/24. Regulatory deficiencies identified during the investigation which resulted the need for Immediate Corrective Action to be taken by the facility. The facility did provide an Immediate Plan of Correction on 12/2/24. Findings include:	R100		
R126 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RCH failed to ensure necessary services were provided and arranged to meet the nursing and medical care needs of one applicable resident (Resident #1). Per interview on 12/2/24 at 1:10 PM, Staff #1 confirmed to have performed the medication pass on 12/1/24. Staff #1 confirmed Resident #1 Humalog insulin supply was exhausted with the 6:00 AM administration and that s/he had administered 6 units of insulin, not the full prescribed dose. S/he confirmed to have notified the RN at the time of administration, Resident #1 did not receive the full dose of insulin and the	R126		

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R126	Continued From page 1	R126		

insulin is not available to administer.

Per interview on 12/2/24 at 2:20 PM the Registered Nurse (RN) explained, on 11/26/24 staff recorded on the medication re-ordering clipboard to order Resident #1 Insulin Humalog (Lispro), s/he stated to have re-ordered the medication on 11/26/24 through the online portal with the pharmacy.

Through several interviews on 12/2/24, the Manager explained the facility had switched pharmacy providers in early November, and the facility is still becoming familiar with the system, the re-ordering process, and recognizes the need for improvement in the timeline for receipt of medications once ordered.

The RN explained the current medication procurement practice as staff are to record the medications to be re-ordered on a clipboard, within a minimum of seven days prior to supply running out. The RN indicated medications are delivered via a courier service, which are delivered in 1 to 5 days upon ordering. In an interview on 12/2/24 at 3:30 PM the RN confirmed a facility policy is not developed to account for medication procurement.

Per staff interview on 12/2/24, Staff #3 confirmed, to have recorded the medication to be re-ordered on 11/26/24, noting "opened last pen [insulin pen]". Staff #3 continued, to explain that on 11/29/24 s/he had followed up with the RN as the remaining insulin supply was low and the refill of insulin had not been received.

The facility was requested to provide a summary of medications re-ordered from 11/25/24-12/2/24. The RCH was unable to generate a report and

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R126	Continued From page 2 requested a requisition from the pharmacy. On 12/3/24 the Manager was forwarded and email to the surveyor from the dispensing pharmacy. The email contained a medication requisition from 11/25/24- 12/2/24, the requisition indicated Resident #1 Humalog (Lispro) was re-ordered on 11/30/24. Per interview on 12/2/24 at 3:30 PM, the RN acknowledged additonal care and services were not put into place to provide monitoring and/or nursing overview for Resident #1 on 12/2/24 and 12/3/24. The facility was requested to provide the policy and procedures for medication procurement. Per interview on 12/2/24 at 3:40 PM, the Manager confirmed a policy is not developed for the procurement of medications. Refer to Tag 160	R126		
R128 SS=J	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 observation, record review and staff interview, the RCH failed to ensure medications	R128		

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R128	Continued From page 3 were administered per physician orders, for 1 applicable resident, Resident #1. This required an immediate plan of correction that was submitted on 12-2-24. Findings found: Per record review, Resident #1 has a diagnosis of Diabetes and receives a long acting and rapid acting insulin, one of the prescribed insulins is Humalog, (Humalog is a rapid acting insulin) medication to aide in individuals diagnosed with diabetes to manage their blood sugar levels. The physician's medication order is prescribed to administer a scheduled dose of Humalog 20 units prior to breakfast, lunch and dinner, and to receive additional units of insulin based off the sliding scale. An insulin sliding scale is the administration of the pre-meal insulin dose based on the blood sugar level before the meal. Resident #1's medication administration record (MAR) documented that 6 units of insulin were administered on 12/1/24 at 6:00 AM. Per interview on 12/2/24 at 1:20 PM, Staff #1 (who had been delegated by the facility registered nurse to administer insulin) whom documented the administration on 12/1/24, confirmed the insulin pen was exhausted at the time of the administration, only allowing for 6 units to be administered. Staff #1 confirmed the required dose per the physician's order had not been given, and Resident #1 was to receive a total dose of 26 units of insulin. Staff #1 indicated to have reported the medication as exhausted and unavailable for additional administrations to the Registered Nurse on the morning of 12/1/24. Through continued review of Resident #1 MAR, Humalog was unable to be administered and documented as unavailable on 12/1/24 at 11:00	R128		

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R128	Continued From page 4 AM, 4:00 PM and on 12/2/24 at 6:00 AM, 11:00 AM, and 4:00 PM. Per interview on 12/2/24 at 1:10 PM Staff #2 confirmed that Resident #1's insulin is not available to be administered as the delivery of medication has not been received by the pharmacy. In additional review, Resident #1 required blood sugars to be obtained prior to each meal with the scheduled Humalog administration, to determeine the sliding scale dose administration of Humalog. The record indicated, staff continued to obtain Resident #1 blood sugar, the recorded the results on 12/2/24 as 254, 344, 285, on 12/2/24 results were 303, 417 and 335. (The electronic blood sugar log provided does not include documentation of times the blood sugars were obtained). In review of a printed receipt of the blood suagrs, Staff #1 noted, the record does not include times the blood sugars are recorded, however confiirmed they are to be obtained prior to each meal. At 3:45 PM, the RN reviewed the Resident #1 electronic record, observing Resident #1 blood sugars. At the time of review, the RN confirmed, no additional monitoring or orders from a phyisician have been received to aid in ensuring Resident #1 blood sugars are maintained, and prevent the elevation of blood sugars in ranges indicative of acute medical intervention. Per interview on 12/2/24 at 3:30 PM, the Registered Nurse indicated the primary care office was working on obtaining the medication from a local pharmacy as a local dispense, with no other interventions or care directions provided by the physician. Through the course of interview	R128		

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R128	Continued From page 5 the RN revealed to have been notified by staff on 11/26/24, to re-order Resident #1 supply of insulin, as the last remaining inuslin pen was in use, The deficient practice required an immediate plan of correction, as Resident #1 well-being was at risk for adverse effects related to elevated blood sugars, due to the failure of procuring medications, with the potential of causing harm to Resident #1.	R128		
R146 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on staff interviews, observations and record review, the RN failed to provide instruction and supervision to all direct care personnel regarding the health care needs for one applicable Resident (Resident #1). Per record review Resident #1 has a medication order for Humalog insulin to be administered prior to each meal. The prescribed directions indicated, Humalog 20 units injected subcutaneously prior to each meal, in addition there were directions to obtain a blood sugar prior to each meal, to administer additional insulin based off a sliding scale insulin order. The medication administration record documented the	R146		

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R146	Continued From page 6	R146		

medication unavailable to be administered on 12/1/24 at 11:00 AM and 4:00 PM, on 12/1/24 at 6:00 AM, 11:00 AM and 4:00 PM, the MAR documentation indicated on 12/1/24 at 6:00 AM, to administer 6 units of Humalog.

Per interview on 12/2/24 at 1:20 PM Staff #1 confirmed to have notified the RN on the morning of 12/1/24 Resident #1's remaining amount of insulin was administered, and the resident did not receive the full prescribed dose. A reply from the RN included to note the medication has been ordered and to be delivered. At the time the RN was notified, Staff #1 revealed the RN did not provide care interventions or direct staff in symptoms to monitor related to Resident #1 diagnosis of diabetes.

Per interview on 12/2/24 at 12:50 PM Staff #2 confirmed Resident #1 blood sugars are obtained prior to each meal per physician order, s/he did not recall the RN to implement additional monitoring, interventions and/or symptoms to monitor, with the missed doses of Humalog insulin.

Resident #1 Libre (digital blood sugar monitor) recorded a blood sugar on 12/2/24 at 10:55 AM with a result of 306, the previous result was obtained on 12/1/24 at 4:04 PM with a result of 289. In review of the electronic health record, the blood sugar log maintained for Resident #1, recorded the results on 12/2/24 as 254, 344, 285, on 12/2/24 results were 303, 417 and 335. (The electronic blood sugar log provided does not include documentation of times the blood sugars were obtained).

Per interview on 12/2/24 at 2:40 PM, Resident #1 confirmed to be aware his/her medication was

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R146	Continued From page 7 unavailable, the resident did not recall an assessments or observations conducted by the RN. At 12:50 PM Staff #2 confirmed the RN did not delegate a process to communicate blood sugars obtained on 12/1/24 and 12/2/24, to provide monitoring of Resident #1. At 3:30 PM, the RN confirmed to not have implemented interventions to direct care staff to aid in providing care and services to Resident #1, within the timeframe of not being able to receive the Humalog insulin.	R146		
R151 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (8) Ensure that the resident's record documents any changes in a resident's condition; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the RN failed to ensure the resident record, for one applicable resident (Resident #1) documented changes in the resident's condition. Per record review of Resident #1 progress notes, the record did not include documentation by staff or the RN to account for missed dosages of insulin on 12/1/24 and 12/2/24. The record did not include an assessment or observations of Resident #1, during the missed doses of insulin. Additionally, the record did not include documentation of communication to providers	R151		

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R151	Continued From page 8 and/or necessary follow-up care interventions to aid in the well-being of Resident #1. Per observation, a communication log utilized by staff did not include documentation of Resident #1. Per interview on 12/2/24 at 12:50 PM, Staff #2 confirmed staff utilize the communication log to relay updates on each resident shift to shift. Per interview on 12/2/24 at 2:05 PM the RN confirmed Resident #1 had not received Humalog insulin as prescribed on 12/1/24 and 12/2/24, s/he confimed progress notes were not documented to account for missed administrations, along with assessment and monitoring of Resident #1. The record did not include documentation of coordination of care with the primary care office and documentation of the RN to procure Resident #1 insulin.	R151		
R160 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.a Each residential care home must have written policies and procedures describing the home's medication management practices. The policies must cover at least the following: (1) Level III homes must provide medication management under the supervision of a licensed nurse. Level IV homes must determine whether the home is capable of and willing to provide assistance with medications and/or administration of medications as provided under these regulations. Residents must be fully informed of	R160		

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R160	Continued From page 9 the home's policy prior to admission. (2) Who provides the professional nursing delegation if the home administers medications to residents unable to self-administer and how the process of delegation is to be carried out in the home. (3) Qualifications of the staff who will be managing medications or administering medications and the home's process for nursing supervision of the staff. (4) How medications shall be obtained for residents including choices of pharmacies. (5) Procedures for documentation of medication administration. (6) Procedures for disposing of outdated or unused medication, including designation of a person or persons with responsibility for disposal. (7) Procedures for monitoring side effects of psychoactive medications. This REQUIREMENT is not met as evidenced by: Based on staff interview the RCH failed to ensure medication policies were established and updated to current practices. Per interview on 12/2/24 at 3:00 PM, the Manager confirmed a policy is not established for the procurement of medications. Through the interview, the Manager confirmed the current practice of the facility, where staff are to list medication to be re-ordered on a clipboard with in the medication room. The RN reviews the clipboard and orders the medications through an electronic portal with the preferred pharmacy.	R160		

Sterling House At Rockingham

Residential Care Home

33 Atkinson Street
Bellows Falls, Vermont 05101
802-463-0137

Carolyn Scott and Janielle Shea
Div Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060

Original: December 16, 2024

Completed:December 23,2024

Plan of Correction for survey conducted December 2, 2024.

Resident Care Home Services

R 100

Effective immediately we (The Sterling House at Rockingham) will be implementing the monitoring M.A.D for signs and symptoms of hyperglycemia and DKA.

1. We educated staff on the signs and symptoms of hyperglycemia and Diabetic Ketoacidosis.

2. Resident and staff were educated on a reduced carbohydrate intake and only eating foods that are sugar free.

3. Resident encouraged to increase water intake to assist with blood sugar levels

4. If a blood sugar reads 500 or above resident will be transferred to the emergency department for evaluation

5. We will pick up insulin from [redacted] Pharmacy, tomorrow 12/3/2024, when it becomes available unless the current shipment expected from [redacted] Pharmacy arrives.

6. Update: Insulin picked up from [redacted] Pharmacy on 12/3/2024 at 430pm. Resident received 5pm dose

Pharmacy name removed by DLP 12/27/24

R 126

1.Med Techs will list medications due to run out in 7 to 10 days. Nursing will check clipboard next business day and reorder medications listed. If a emergent medication is needed sooner such as (Insulin, antibiotics, nebulizers, etc.) The Med Tech must inform the on call nurse. Non emergent, maintenance medications, will be obtained through [redacted] Pharmacy.

2. The nurse on call will place a call to the resident's primary care office for a script to be sent to a local pharmacy, such as [redacted] or [redacted] Pharmacy in Bellows Falls, VT, that has the medication in stock for pick up that same day. This is to prevent the resident from going without an emergent medication.

3. Nursing must place a progress note in the resident's file detailing the medication requested, where the physician's office sent the medication, additional instructions from the physicians office for monitoring the resident, such as parameters for calling the PCP provider or on call physician back. Additionally symptoms to monitor the resident for.

R126 Accepted
Jenielle Shea, RN
12/30/24

R 128

1. All med techs will be re-educated to follow the exact orders for medication administration in the MAR. If a medication does not have enough for a full dose the dose must be held and the on call Nurse must be informed and Med Tech given further directions. This will be completed by 12/27/2024.

R 128 Accepted
Jenielle Shea, RN
12/30/24

R 146

1. If a resident's emergent medication is unavailable the Nurse or nurse on call will give staff members education on the signs and symptoms to monitor for while medication is being obtained by a pharmacy. Additional education also to be given such as dietary needs, vitals to be monitored, etc. This was implemented immediately. Staff verbally educated and provided education material on education board.Staff educated on the importance of passing on new information along with medication changes in shift to shift report

R146 Accepted
Jenielle Shea, RN
12/30/24

R 151

1. Nursing will document all changes in a resident's condition, medical situation, . any monitoring required, and education to staff members. Monitoring of blood glucose levels for effectiveness of dietary changes implemented immediately.

R151 Accepted
Jenielle Shea, RN
12/30/24

Pharmacy name removed by DLP 12/27/24

R 160

Policy for Medication Procurement

1. Med Techs will list medications due to run out in 7 to 10 days on a designated clipboard next to the Medication cart. Nursing will check the clipboard each morning or next business day and reorder medications listed via Pharmacy's online portal. If an emergent medication has run out and is needed sooner such as (Insulin, nebulizers, etc.) The Med Tech must inform the nurse or on call nurse. Non emergent, maintenance medications, will be obtained through [redacted] Pharmacy or resident's designated pharmacy of choice.

2. If an emergent medication needs to be ordered the nurse on call will place a call to the resident's primary care office during regular business hours or utilize the on-call line for a script to be sent to a local pharmacy, such as [redacted] or [redacted] Pharmacy in Bellows Falls, VT. Nurse is responsible for making sure that a staff member is assigned to pick up that medication.

3. If a resident returns from the Hospital and needs to start new medications immediately, such as antibiotics or Steroids, or has a change in medication dosing such as Warfarin :

a. The nurse picking up the resident needs to make sure prescriptions are sent to a local pharmacy so as to not delay treatment.

b. The nurse will then pick up the medications from that local pharmacy

c.The nurse must enter the new orders into the computer system with the appropriate start times.

4. Nursing must place a progress note in the resident's file detailing:

a. Medication requested and dosing

b Where the physician's office sent the medication

c Additional instructions from the physician's office for monitoring the resident, such as parameters for calling the PCP provider or on-call physician back. Additionally symptoms to monitor the resident for.

d Communication to support staffing regarding medication changes, monitoring procedures, and when to contact nursing.

R160 Accepted
Jenielle Shea, RN
12/30/24

Pharmacy name removed by DLP 12/27/24

Please feel free to contact me with any questions or concerns.

Sincerely,

Melissa Byrne, Director