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 2, 2025

Lydia Raymond, Manager
The Residence At Quarry Hill
465 Quarry Hill Road
South Burlington, VT 05403

Dear Ms. Raymond:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 11, 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

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
	1012	A. BUILDING: _____ B. WING _____	C 02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT QUARRY HILL	465 QUARRY HILL ROAD SOUTH BURLINGTON, VT 05403

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R100	Initial Comments: On 2/10/25 and 2/11/25 the Division of Licensing and Protection conducted an annual survey and investigation of one facility reported incident. The following regulatory deficiencies were identified:	R100	The submission of this plan of correction does not imply agreement with the existence of a deficiency. It is submitted in the spirit of cooperation, to demonstrate our commitment to continued improvement in the quality of the lives of our residents.	
R128 SS=D	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 Morphine Sulfate oral solution as ordered for one applicable resident (Resident #4). Findings include: The facility's Medication Errors policy indicates a medication error is "any preventable event that may cause or lead to inappropriate medication use...". Per record review and staff interview on 5/24/24 Resident #4's dose of Morphine Sulfate Oral Solution increased from 0.25 ml to 0.5 ml, and a delivery of 60 Morphine Sulfate 0.5 ml oral syringes was received from the pharmacy. Per record review and staff interview, on 5/24/25 receipt of the 0.5 ml oral syringes of Morphine Sulfate was incorrectly entered on the pre-existing controlled substance sheet on file for the 0.25 ml syringes that were in stock prior to the delivery of the 0.5 ml syringes and added to the count as 0.25 ml syringes.	R128	R128 All Med Techs and Nurses were in-serviced on the six rights of medication and administration and correct usage of controlled substance log sheets when receiving controlled substances on 2/12/25. To ensure this deficient practice does not recur RCD/ ED will continue to in-service the Med Techs and Nurses on the six rights of medication administration and correct usage of the controlled substance log sheets audit every 30 days. R128 Plan of Correction accepted by Jo A Evans RN on 3/31/25.	

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R128	Continued From page 1 Per record review and staff interview, nine incorrect doses of Morphine Sulfate oral solution were given to Resident #4 in error between 4:00 PM on 5/24/25 and 1:00 PM on 5/25/25 due to Staff continuing to administer one 0.25 ml syringe instead of the prescribed 0.5 ml dose of Morphine Sulfate oral solution. This finding was confirmed at 11:32 AM on 2/11/25 by the current Resident Care Director, who had not been hired into this position at the time this error occurred.	R128		
R145 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the Plans of Care for 3 out of 4 sampled residents (Residents #1, #2, and #3) did not include goals and interventions to ensure the resident's independence and well-being. Findings include: The facility's Service Plans/Care Plans/Health Care Plans policy includes a procedure which states the Resident Service Plan shall include	R145		

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R145	Continued From page 2 "Identification of the resident's problems and needs; Resident goals and intervention plans. " 1. Resident #1's diagnoses included Type II Diabetes; Multiple Cardiovascular conditions including atherosclerosis, a history of ischemia affecting circulation. and a history of gangrene; amputation of lower limb and a history of subsequent wounds and infections with use of a prosthetic limb. Resident #1's Plan of Care did not address interventions to maintain well-being and independence related to pain, wounds and risk for infection related to use of prosthetic limb and impaired circulation; and needs related to Diabetes management. 2. Resident #2's diagnoses included multiple cardiovascular conditions; frequent wounds including wounds with pain and infection requiring hospitalization; history of Hypokalemia (low blood potassium level which is a risk for cardiac dysrhythmia and falls); and a history of gastrointestinal bleeding. Resident #2's Plan of Care did not address risks for cardiac decompensation, risk for gastrointestinal bleeding; and interventions related to wounds including monitoring for pain, skin integrity, and infection. 3. Resident #3's diagnoses include multiple cardiovascular conditions. Resident #3 is prescribed the medication Nitroglycerin, which is a vasodilator that opens the blood vessels rapidly to increase circulation and reduce chest pain. Administration of this medication includes risk for rapid changes in pulse and blood pressures, falls, and headaches.. Resident #3 is also prescribed the anticoagulant medication Eliquis and the antiplatelet medication Clopidogrel which reduce the risk of blood clots; however, these	R145	R145 All resident Service Plan/ Care Plans are being reviewed and edited to ensure we are reflecting resident goals, interventions, and health status to ensure the residents independence and well-being. These plans will be completed no later than 3/21/25. In order to ensure the deficient practice does not recur we in-services our nursing team on Service Plan/ Care Plans on 2/11/25. The RCD/ED will continue to in-service the nursing team on Service Plan/ Care Plans and audit 30 days post move-in and every 90 days after. R145 Plan of Correction accepted by Jo A Evans RN on 3/31/25.	

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R145	Continued From page 3 medications also increase risk for bleeding. Resident #3's Plan of Care does not include interventions to mitigate potential risks associated with these medications. At 3:00 PM on 2/11/25 these findings were acknowledged by the Resident Care Director, Reflections Memory Care Director, and Executive Director.	R145		
R161 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.b The manager of the home is responsible for ensuring that all medications are handled according to the home's policies and that designated staff are fully trained in the policies and procedures. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review a Registered Nurse and two Med Techs failed to follow facility policies and procedures for wasting controlled substances. Findings include: The facility's Controlled Medications policy states, "Controlled substances must be disposed of by a minimum of two people and one of the people must be a nurse or other licensed professional."; and the facility's Disposal of Medications policy includes procedures which state both associates witnessing the disposal of a controlled substance must sign the Controlled Inventory Sheet. Per record review, on the evening of 8/30/24 a Registered Nurse (RN) removed controlled	R161	R161 On 9/4/24 all Med Techs and Nurses were in-serviced on proper disposal of medications. To ensure the deficient practice does not recur the RCD/ ED will continue to in-service Med Techs/ Nurses and audit every 30 days. R161 Plan of Correction accepted by Jo A Evans RN on 3/31/25.	

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R161	Continued From page 4 medications belonging to Resident #1 from the Reflections Memory Center's med cart with Med Tech #1 present. Med tech #1 signed the controlled medication count sheets for Resident #1's medications removed from the cart indicating they witnessed disposal of Resident #1's controlled medications. Per the facility's Investigation Summary, on the evening of 8/30/24 the RN also removed controlled substances belonging to Resident #2 from a med cart in the facility's Traditional Assisted Living area by obtaining a set of emergency back-up med cart keys from the Resident Care Director's (RCD's) office without permission. Per review of the facility's internal investigation documents, at 10:13 PM on 8/30/24 Med Tech #1 notified the RCD they had signed Resident #1's controlled medication count sheets without completing the wasting process with the RN, and the RN had taken the controlled medications to another area of the home without another staff present. Per the RCD's written statement, when the RCD immediately called the RN to address this issue the RN demonstrated they were aware they were not following the facility policy and procedures for wasting controlled medications and could not confirm how many tablets they had wasted without a witness when asked. The RN was directed to obtain a witness to finish wasting the controlled medications, and the RCD verified Med Tech #2 was present to witness the RN wasting the remaining medications. Per record review, Med Tech #2 did not sign the controlled medication count sheets for medications they reported witnessing the RN waste on the evening of 8/30/24. The RN refused to provide a written statement regarding this incident on request from the facility administrators and resigned.	R161		

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R161	Continued From page 5 Per review of controlled medication count sheets and the facility's internal investigation documents conducted with the current Resident Care Director on 2/11/25, all medications removed from the Traditional Assisted Living medication cart belonging to Resident #2 were accounted for on the evening of 8/30/24. The following controlled medications belonging to Resident #1 removed from the Reflections Memory Care medication cart by the RN on 8/30/25 could not be accounted for through documentation of the wasting process with two staff present per facility policies and procedures: a. 175 Lorazepam 0.5 mg tablets b. 30 Lorazepam 1 mg tablets c. An unopened 30 ml bottle of Morphine Sulfate oral solution d. An undetermined number of prefilled syringes of Morphine Sulfate oral solution belonging to Resident #1 were unaccounted for due to Med Tech #1 signing the controlled medication count sheets without witnessing the RN wasting medications and M demonstrated the RN was aware they were not following facility policy according to wasting controlled substances ed Tech #2 not signing controlled medication count sheets for medications they reportedly witnessed the RN wasting. These findings were confirmed by the current Resident Care Director and the Executive Director on the afternoon of 2/11/25.	R161		
R190 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse	R190		

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R190	Continued From page 6 registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the required background checks were not completed as required for 5 out of 5 sampled residents. Findings include: The facility's Human Resources policies and procedures related to employee background checks provided for review on request are not consistent with this regulatory requirement. Per review of criminal record and abuse registry checks for a sample of 5 staff, all required checks were not completed for 5 out of 5 staff. This finding was confirmed by the Executive Director at 3:52 PM on 2/10/25.	R190	R190 VCIC background checks were ran for all associates in July 2024 and to ensure the deficient practice does not recur the BOD/ ED runs VCIC checks prior to associate hire. R190 Plan of Correction accepted by Jo A Evans RN on 3/31/25.	
R247 SS=F	VII. 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 temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure perishables foods and beverages are labeled with the date the items are opened or prepared. Findings include: The facility's LCB Food Safety and Sanitation	R247	R247 On 2/11/25 the culinary team was in-serviced on Food Safety and Sanitation. To ensure the deficient practice does not recur the ROD/ ED will cross check all labels/ dates of opened perishable items. Additionally, the ROD/ ED will continue with frequent Food Safety and Sanitation in-services with the culinary department.	

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R247	Continued From page 7 Audit Form indicates all food items in the walk-in cooler and walk-in freezer are labeled and dated. This document does not indicate all perishables will be labeled and dated. During a facility tour commencing at 10:30 AM on 2/101/25 the following perishable items were observed to be stored without labels indicating the dates the items were opened or prepared: 1. In the Bistro Kitchen a small refrigerator contained 4 opened undated bottles of dressing and an opened undated can of whipped cream. 2. In the Main Kitchen undated opened refrigerated items included containers of sour cream, cottage cheese, clam base, horseradish and ginger; containers of cake and muffin batter; jugs of condiments, salad dressings, sauces; buckets of hard boiled eggs, sauerkraut, and an opened blue bucket without an identifying label. Additionally, a bag of shrimp dated "2/4" was thawing in the refrigerator in a perforated steam pan resting on a perforated tray positioned above an opened cardboard box of ricotta cheese. These findings were acknowledged by the Reflections Memory Care Director during the tour of the kitchen and food storage areas on the morning of 2/10/25.	R247	R247 Plan of Correction accepted by Jo A Evans RN on 3/31/35.	
R253 SS=F	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.c All food service equipment shall be kept clean and maintained according to manufacturer's guidelines	R253		

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R253	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure kitchen equipment is well maintained and kept clean. Findings include: The facility's policies and procedures are consistent with this regulatory requirement. During a facility tour commencing at 10:30 AM on 2/10/25 equipment in the kitchen was observed to be in need of cleaning as follows: 1. The hood and the fire suppression sprayers in the Main Kitchen of the home were observed to be coated with oil and dust. 2. The microwave interior was observed with splatters and spills. 3. The convection oven was observed with an oily coating covering the interior of the doors and along the floor of the oven. The area along the anterior base of the oven was observed to be covered with rust, grease, food crumbs, and plastic bread ties along a surface with exposed wires. These findings were confirmed by the Reflections Memory Care Director during the kitchen tour on the morning of 2/10/25.	R253	R253 On 2/13/24 the community maintenance/ culinary team thoroughly cleaned all listed equipment to ensure the kitchen equipment meets regulatory cleanliness. To ensure the deficient practice does not recur we edited our culinary closing assignments to reflect the listed items are on a daily/ weekly cleaning schedule. The community has our hood cleaning vendor scheduled on 3/12/25. R253 Plan of Correction accepted by Jo A Evans RN on 3/31/25.	