

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

June 9, 2016

Ms. Nancy Peers,
Brookdale At Fillmore Pond
300 Village Lane
Bennington, VT 05201-9041

Dear Ms. Peers:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 10, 2016**. 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.

Sincerely,



Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2016
NAME OF PROVIDER OR SUPPLIER BROOKDALE AT FILLMORE POND		STREET ADDRESS, CITY, STATE, ZIP CODE 300 VILLAGE LANE BENNINGTON, VT 05201		
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R100	Initial Comments: An unannounced on-site re-licensing survey was conducted on 5/9 - 5/11/16 by the Division of Licensing and Protection. The following regulatory deficiencies were identified during the survey:	R100		
R104 68-B	V. RESIDENT CARE AND HOME SERVICES 5.1 Admission 5.2.a Prior to or at the time of admission, each resident, and the resident's legal representative if any, shall be provided with a written admission agreement which describes the daily, weekly, or monthly rate to be charged, a description of the services that are covered in the rate, and all other applicable financial issues, including an explanation of the home's policy regarding discharge or transfer when a resident's financial status changes from privately paying to paying with SSI or ACCS benefits. This admission agreement shall specify at least how the following services will be provided, and what additional charges there will be, if any: all personal care services; nursing services; medication management; laundry; transportation; toiletries; and any additional services provided under ACCS or a Medicaid Waiver program. If applicable, the agreement must specify the amount and purpose of any deposit. This agreement must also specify the resident's transfer and discharge rights, including provisions for refunds, and must include a description of the home's personal needs allowance policy. (1) In addition to general resident agreement requirements, agreements for all ACCS participants shall include the	R104	Admission Assessment has been revised to include the requested addition, information and verbiage (See attachment #1) All existing residents have the potential to be affected by the alleged deficiency. Once approval of revisions to the Admission Agreement has been received, the community will proceed with reviewing of the revised admission paperwork with the required parties and will utilize the revised document for future move-ins. Upon approval of changes from Division of Licensing and Protection, the Executive Director (ED) will review revised agreements with resident/family/POA for #1, #3, #5 for signature, as well as all current and future residents at Fillmore Pond. Completion Date: August 31, 2016	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Nancy Keery 6-8-16 TITLE ED
STATE FORM 6899 YB1R11 (X6) DATE

R104 - R999 POCs accepted 6/9/16 Mithigins RN/PMC

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R104	Continued From page 1 ACCS services, the specific room and board rate, the amount of personal needs allowance and the provider's agreement to accept room and board and Medicaid as sole payment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to assure that the admission agreements included specific language required for 3 of 3 Assistive Community Care Service (ACCS) participants, Resident #1, 3 and 5 and specific information regarding the provision of toiletries for all residents being admitted. Findings include: During record reviews, Residents #1, 3 and 5 had a signed residential agreement that does not include the required addendum which included the required information and language regarding ACCS services. Additionally, there is no information in the Admission Agreement addressing the provision of toiletries to residents. In an interview the Assistant Executive Director confirmed, on 5/10/16 at 11:02 AM, that the admission agreement doesn't include the required verbiage.	R104	
R106 SS=B	V. RESIDENT CARE AND HOME SERVICES Admission 5.2.a (3) The admission agreement shall inform the resident whether the home will accept SSI or ACCS payments and allow a privately-paying	R106	

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R106	<p>Continued From page 2</p> <p>resident to continue residing in the home when the resident is no longer able to continue privately paying the home's periodic rate. Alternatively, the admission agreement shall inform the resident that the home is not required to accept SSI or ACCS payments, that the home reserves the right to make this decision on a case-by-case basis, and that the resident may be transferred or discharged from the home in the event that the resident's financial status changes and the resident is no longer able to continue privately paying the home's periodic rate.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to assure that the admission agreement included specific language regarding whether or not the facility will retain residents whose financial status changes. Findings include:</p> <p>During record review of the Admission Agreement there is no language contained that addresses whether residents will be allowed to remain in the facility should their payment source change to SSI or ACCS. The Assistant Executive Director, on 5/10/16 at 11:02 AM, confirmed that the admission agreement doesn't include the required information.</p>	R106	<p>Same as R104 stated above. Completion date: August 31, 2016</p>	
R128 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.5 General Care</p> <p>5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders.</p>	R128	<p>Resident #6: A current weight has been obtained and reported to the Primary Care Provider (PCP). PCP notified of weekly weights not obtained. Order has been transcribed onto TAR. An audit of all physician orders for correct transcription/documentation of PCP weight orders to be completed.</p>	

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R128	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to follow the physician orders for 1 of 11 residents, Resident #6. Findings include: Review of medical record for Resident #6 the service care plan dated 8/11/15 indicates that s/he is to be weighed weekly on Thursday. Review of weight monitoring log presents that the resident was weighed monthly instead of weekly in April. Confirmation made by the medication technician (med tech) at 3:13 PM on 5/9/16, that there is no evidence Resident #6 had weekly weights and further confirmed that they haven't been signed for and there was no evidence that weekly weights were done in April. The Registered Nurse confirmed at 4:15 PM that the physician order states that resident is to be weighed weekly and review of the weight monitoring log presents that s/he has not been weighed monthly.	R128	Health and Wellness Director (HWD) or nurse designee shall re-inservice all nursing staff regarding correct procedure for transcribing PCP orders and documentation off orders on the MAR/TAR. Weights will also be recorded in the Nutrition Tracker. Two nurses will review all orders when received, and sign off to verify documentation accuracy. HWD/nurse designee shall review weights being completed per PCP order utilizing Nutrition Tracker. Significant weight changes will be reviewed by the HWD and the inter-disciplinary team during twice monthly Collaborative Care Review meetings. Additional actions will be directed by the PCP upon notification by a licensed nurse of the significant weight change. Completion Date: June 30, 2016	
R134 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.7 Assessment 5.7.a An assessment shall be completed for each resident within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The resident's abilities regarding medication management shall be assessed within 24 hours and nursing delegation implemented, if necessary. This REQUIREMENT is not met as evidenced	R134		

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R134	Continued From page 4 by: Based on record review and staff interview the facility failed to assure that admission, annual, and significant change assessments conducted for residents contained the information in the Resident Assessment Instrument (RAI) required by state regulation. Findings include: Per record reviews conducted over the 3 days of survey all resident assessments are presently completed using the Service Plan document provided by the corporate offices. In an interview with the Health Care Coordinator (HCC) on 5/11/16 at 2:35 PM s/he confirmed that the Service Plan document also serves as the assessment tool and that the document does not contain the signature of the nurse completing/ reviewing the document. S/he confirmed that s/he was directed by Brookdale corporate that this tool was to be used for resident assessments.	R134	RN's are now utilizing VT assessment tool for all admissions, annual, and significant change in condition. HWD/nurse designee will re-inservice all RN's that VT assessment tool be utilized along with Brookdale Personal Service Assessment and service plan for all admission, annual, and significant changes in condition. HWD/nurse designee will audit 100% of all assessments completed during the month for compliance with use of VT assessment tool. Ongoing audits will occur monthly by the HWD/designee to verify compliance with documentation requirements. Completion Date: June 30, 2016	
R145 SS=D	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 staff interview and record review, the facility failed to insure there was written plan of care for 1 of 11 residents in the survey sample, Resident #6. Findings include:	R145	Nurse has updated Personal Service Plan/Care Plan of resident #6 to include information regarding use of PPE for VRE precautions. Nurses audited 100% of residents care plans to identify information regarding use of PPE included in their care plan. Information regarding use of PPE will be added where indicated, by the licensed nurse, to any identified service plans.	

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R145	Continued From page 5 Resident #6 was has a diagnosis of Vancomycin-Resistant Enterococci (VRE) and has an indwelling Foley catheter (cath). Per the Registered Nurse (RN) on 5/10/16 at 4:28 PM, when the Foley cath is emptied the staff is to wear gloves, goggles, mask and s/he has provided education to all the staff regarding the use of personal protective equipment (PPE) which includes gloves, mask, goggles and gowns because of contact precautions being needed. Review of the care plan indicates that Resident #6 has VRE in urine, but there is nothing to indicate the resident requires precautions regarding emptying of the cath. After review of the care plan with the RN, s/he confirmed that there is nothing in the care plan to alert the staff to the need for PPE.	R145	HWD/nurse designee will re-inservice all nurses regarding correct procedure for documenting use of PPE in resident service plan. All residents with identified VRE infections will have information documented on their service plan reflecting the need for use of PPE. HWD/designee will audit 10% of all resident service plans monthly to verify documentation of PPE information.. Additional corrective action will be taken, depending on the results of audits. Completion Date: June, 30, 2016	
R158 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9 Level of Care and Nursing Services 5.9.d. (2) If a resident requires skilled nursing services from a home health agency because the home cannot provide the services and the services will continue for more than sixty (60) days, the home must request a variance in writing from the licensing agency to retain the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to request a variance for 2 residents, Resident #2 and #6, that required skilled nursing services from a home health agency for more than sixty (60) days. Findings include:	R158	The Executive Director has requested a variance for resident #6 for VNA skilled services greater than 60 days. A variance request was not submitted for resident #2 as she has since discharged from skilled services. Nurses conducted 100% audit of all residents receiving VNA skilled services. If other residents are identified with VNA services greater that 60 days, the Executive Director will request a variance wherever appropriate.	

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R158	Continued From page 6 1.) During review of the medical record, Resident #6 has an indwelling Foley catheter (cath) and has Foley cath changes done by skilled nursing services from an outside home health agency (HHA). Notes dated 8/4, 8/28, 8/29 and 10/1/15 indicate that the cath had been changed by the HHA and irrigations and cath care was provided by the HHA. An order dated 1/21/16 from the urologist was for the HHA to do weekly cath irrigations. Confirmation that the HHA has been providing cath care for greater than 60 days was made by the Registered Nurse on the afternoon of 5/10/16 and that a variance had not been obtained. 2.) During review of the medical record, Resident #2 had an ankle wound that was documented in December 2015. Resident #2 was receiving treatment and measuring of the wound from skilled nursing services provided by Bayada, an outside HHA. The wound healed in March of 2016 and per the Licensed Practical Nurse it is a recurrent wound and the resident at one point required surgical debridement. Per interview with the Memory Care Director at 4:14 PM, the area is now healed but the HHA had been providing skilled nursing services for wound care for greater than 60 days and s/he was unaware of the need for a variance. Confirmation was made with the Registered Nurse on the afternoon of 5/11/16 that a variance had not been obtained.	R158	HWD/nurse designee will meet with VNA bi-weekly to review residents and need for continued services. Within 3 weeks prior to 60 day mark if further VNA services are anticipated, a variance will be requested by the ED. HWD/nurse designee will audit 10% of residents receiving VNA services monthly for compliance with obtaining variance for those receiving VNA services greater than 60 days. Additional corrective action will be the responsibility of the ED, based on ongoing audit findings. Completion date: June 30, 2016	
R162 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.c. Staff will not assist with or administer any	R162	Nurses obtained supporting diagnoses with specific indication for use for antipsychotic medication Seroquel 12.5 mg by mouth daily at bedtime and PRN for resident #1.	

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R162	Continued From page 7 medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on record review the facility failed to assure that the record contained an appropriate diagnosis for a resident receiving an antipsychotic medication, Resident #11 (R#11). Findings include: Per record review R#11 receives the antipsychotic medication Seroquel 12.5 mg PO (by mouth) daily at bedtime and PRN (as necessary) Seroquel 12.5 mg PO Daily. In the record there is no diagnosis which indicates the use of an antipsychotic medication found. The HCC confirmed in an interview on 5/10/16 at 3:15 PM that there was no other diagnosis for the antipsychotic medication besides Dementia.	R162	Nurses completed 100% audit of all medication records for all residents, to identify supporting diagnosis for anti-psychotic medication. Medication list sent to all PCPs requesting appropriate diagnosis for indications for use of PRN anti-psychotic medications. HWD/nurse designee will conduct in-services for nurses regarding the need for supporting diagnosis for all anti-psychotic medications. If PCP order is received without support diagnosis, order will be faxed back to the PCP for clarification of appropriate diagnosis and specific indication for use of PRN antipsychotics. HWD/nurse designee will monitor 10% of residents prescribed antipsychotic medication for compliance with supporting diagnosis and indications for use for these medications. Antipsychotic medication use will be monitored monthly using the Psychotropic Medication review form on a monthly basis (see revised form, attachment #2). Antipsychotic drug use will be reviewed bi-monthly during Collaborative Care Review meetings, where behavioral needs will be reviewed for other non-pharmacological interventions where appropriate.	
R165 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for: i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential	R165	Completion date: June 30, 2016	

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R165	<p>Continued From page 8</p> <p>side effects;</p> <p>ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications;</p> <p>iii. Assessing the resident's condition and the need for any changes in medications; and Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure that:</p> <p>A). The registered nurse (RN) responsible for the delegation teaches designated staff the proper techniques for medication administration.</p> <p>B). The nurse assesses the resident's condition and the need for changes in the medication for 3 residents on PRN psychotropic medications, Residents #8, #9 & #11.</p> <p>Findings include:</p> <p>A). Per staff interview of the HCC on 5/10/16 at 9 AM, s/he is the nurse responsible for medication delegation. S/he explains that the process for delegation is that newly delegated staff are provided a manual, then they observe Med Techs and licensed practical nurses (LPNs) during medication passes. They take an examination which they must pass with at least an 80%. At that point the RN observes the staff do a small medication pass and discusses things as they arise during the pass. S/he confirmed that there is no part of the process where she provides direct instruction to the unlicensed staff being delegated regarding proper administration techniques and procedures.</p> <p>B). Per record review there is no evidence of</p>	R165	<p>(A) Medication Aide training is facilitated with direction instruction by an RN throughout the class and skills competency.</p> <p>(B) Utilization of "Survey of Discomfort for Behavior" evaluation form (see attachment #3) is in place for all residents receiving anti-psychotics. Psychotropic Medication Review form is in place to review all residents with scheduled and/or PRN antipsychotic medications.</p> <p>(A) HWD/designee will facilitate direct instruction of classroom and skills competency for all medication trained aides and will review correct processes for medication delegation with correct documentation of medication assistance.</p> <p>(B) HWD/nurse designee will conduct re-inservice with all care staff regarding use of behavior monitoring process, including use of 24 hour log and "Survey of Discomfort for Behaviors" for documentation of each behavior and completion of Psychotropic Review form monthly, during Collaborative Care Review meetings. HWD/nurse designee will review 24 hour log daily for documentation of behaviors on each shift and verify "Survey of Discomfort for Behavior" form has been completed and Psychotropic Review completed, to determine if behavior is related to diagnosis of antipsychotic medication resident is prescribed and the effectiveness of the medication. PCP will be updated if medication is determined not to be effective.</p>	
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R165	Continued From page 9 Behavior monitoring in the records for R#8 who receives Ativan 0.5 mg PO PRN, R#9 who receives Ativan 0.5 mg PO PRN, and for R#11 who receives Seroquel 12.5 mg PO Daily PRN. In an interview on 5/11/16 the Memory Care Director confirmed that while s/he watches the behaviors of the residents in the unit there is no formal process or documentation of monitoring the behaviors for which the medication is administered. In an interview on 5/11/16 the HCC confirmed that there is no formal process for monitoring or documenting the monitoring of behaviors in the facility.	R165	HWD/nurse designee will audit resident record of 10% of residents receiving antipsychotic medications monthly for compliance utilizing "Survey of Discomfort for Behaviors" and Psychotropic Review process for monitoring effectiveness for prescribed medication. Completion date: July 31, 2016	
R167 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to assure that staff other than a	R167	Residents #8 and #9: Nurse has updated the individual Personal Service Plans (PSS) to include the specific type of behavior being monitored. Interventions, including non-pharmacological interventions will be added to the Personal Service Plan in an ongoing manner based on findings and responses to current medication plan. The MAR for both residents has been updated to indicate specific behaviors being observed, the outcome of interventions attempted, as well as the response to PRN medications utilized. The MAR will be updated to include an area to monitor for desired or undesired side effects. HWD/nurse designee will audit 100% of resident service plans and MAR, for those residents with prescribed antipsychotic medication to verify each MAR contains information regarding the specific behaviors the prescribed medication	

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R167	Continued From page 10 nurse administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use for 2 of 3 residents (R#8 and R#9) on psychoactive medications reviewed. Findings include: 1. Per record review R#8 is on Ativan 0.5mg PO TID (three times a day) PRN and there is no Psychotropic Medication Behavior Plan found. The HCC confirmed on 5/11/16 at 2:45 PM that there is no Psychotropic Medication plan available for resident #8. 2. Per record review R#9 is on Ativan 0.5mg PO BID (twice a day) PRN and there is no Psychotropic Medication Behavior Plan found. The HCC confirmed on 5/11/16 at 2:45 PM that there is no Psychotropic Medication plan available for resident #9.	R167	is intended to correct or address desired side-effects or undesired side effects the staff must monitor. HWD/nurse designee will audit 10% of resident records for those residents prescribed antipsychotic medications for compliance with documentation, in-service plan and MAR of specific behavior antipsychotic medication is intended to correct or address, and includes on the MAR the specific behavior for use of the medication and what desired effect or undesired side effect the staff must monitor. Completion date; July 31, 2016
R171 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include	R171	

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R171	<p>Continued From page 11</p> <p>(1) Documentation that medications were administered as ordered;</p> <p>(2) All instances of refusal of medications, including the reason why and the actions taken by the home;</p> <p>(3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect;</p> <p>(4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and</p> <p>(5) For residents receiving psychoactive medications, a record of monitoring for side effects.</p> <p>(6) All incidents of medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include: A). All PRN medications administered, including the date, time, reason for giving the medication, and the effect for 3 of 3 residents receiving Psychotropic medications ; and B). For residents receiving psychoactive medications, a record of monitoring for side effects.</p> <p>Findings include:</p> <p>A). Per record review R#8 received multiple doses of Ativan 0.5mg ordered as needed over 2015 and in 2016. In a review of the MARs (Medication Administration Records) there is documentation of the effects of the medication only twice. Additionally the Pharmacy reviews</p>	R171	<p>Nurses have updated MARs for residents #8, #9, #11 to reflect date, time and indication for use and effect of the medication. On the MAR below the PRN antipsychotic medication line is a line listing side effects to monitor, to be signed off by those delegated to assist with medication.</p> <p>Nurses audited 100% of MARs for residents receiving antipsychotic medication to verify the presence of required information and documentation. The HWD will direct additional corrective actions, based on audit findings.</p> <p>HWD/nurse designee will audit 10% of MARs of residents prescribed antipsychotic medications monthly, for compliance with documentation of date, time, indication for use and if any adverse side effects noted.</p> <p style="text-align: right;">Completion date: July 31, 2016</p>	
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R171	<p>Continued From page 12</p> <p>conducted on 4/8/15, 7/23/15, and 4/25/16 all contained a note to please remind staff to document the effect of the PRN medication.</p> <p>Per record review R#9 has an order for Ativan 0.5mg ordered as needed. In a review of the MARs (Medication Administration Records) R#9 received the medication only once and there is no documentation of the effect of the medication.</p> <p>Per record review R#11 has an order for Seroquel 12.5 mg Daily as necessary which was ordered 10/23/15 and s/he received the medication on 12/2/15 and 2/25/16. There is no documentation of the effects of the medication.</p> <p>B). Per record review R#11 is on the antipsychotic medication Seroquel 12.5 mg at daily at bedtime and once daily as needed. Antipsychotic medications have the side effect of extrapyramidal symptoms and should be monitored using the chosen assessment tool. The resident requires an initial assessment to establish a baseline. The first AIMS (Abnormal Involuntary Movement Scale) was conducted on 12/29/15 rather than when ordered and started.</p>	R171		
R179 SS=E	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.11 Staff Services</p> <p>5.11.b The home 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</p>	R179		

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R179	Continued From page 13 limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich 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, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that 3 of 5 employees in the sample received at least 12 hours of training, which includes the seven mandatory annual topics in the year 2015. Findings include: Review of five, randomly selected, direct care employees revealed that annual training was not completed, for the seven mandatory annual topics, per regulation. One staff had not completed education training in six of the seven required subjects since 2013, one had not completed four of the required training and one did not complete training in two areas. Interview with the Assistant Executive of Director at 3:39 PM confirmed that there is no evidence that the training had been done.	R179	The Assistant Executive Director (AED) conducted review of 100% of staff in-service trainings to determine outstanding and completed inservices. Outstanding inservices are triggered within the Learning Management System (LMS) for each associate who has not completed assigned training. All staff will be assigned a specific day and time each week to attend to inservice training. Training will be attended on their specific day each week for compliance regarding 12 hours of training, to include resident rights, fire safety and emergency evacuation, resident emergency response procedures, polices and procedures regarding mandatory reports of abuse, neglect and exploitation, respectful and effective interaction with residents, infection control measures, including hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions and general supervision and care of residents. The AED will audit 10% of care staff monthly to verify compliance with completing required inservices. Completion date: July 31, 2016	

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R188 SS-E	<p>Continued From page 14</p> <p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.12.b.(2)</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that the record contained all of the required information for 5 of 11 residents in the survey sample, Resident #1, 2, 3, 4 and 5. Findings include:</p> <p>1.) Review of the record for Resident #4 did not provide evidence of the designation of a legal representative. The resident assessment completed by the facility indicated that there was a Power of Attorney and the resident had stated during interview that his/her son will take care of his/her finances. Interview with the Assistant Executive Director on 5/11/16 that s/he had placed a call to the son and was told that that the papers had not been sent to the facility because Resident #4 was still able to manage his/her own</p>	R188 R188	<p>The ED/AED have updated the resident records for residents #1, #2, #3, and #5 to include information regarding instructions to follow in the event of the residents' death. "Not determined" verbiage has been entered if instructions have not been determined by the resident or family regarding instructions in the event of the residents' death. Nurse has updated resident #4's record with documentation of resident legal representative.</p> <p>The ED/AED will complete 100% audit of all residents' records to verify the record contains documentation of resident legal representative, if applicable, and information regarding instructions in the event of the residents' death. Upon move in, The ED/AED will request documentation of resident legal representation, if applicable and obtain information regarding instructions in the event of the residents' death. If resident/family/legal representative has not made any determination regarding these instructions, the verbiage "not determined" will be entered. The ED/AED will audit 10% of previous month's move-ins to verify the documentation of the resident's legal representative, if applicable and instructions in the event of the resident's death. Thereafter, 10% of resident records will be monitored to confirm the above information is documented in the resident record. The ED will direct additional corrective actions based on audit findings. Completion date: July 31, 2016</p>	

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R188	Continued From page 15 affairs. S/he confirmed at 11:25 AM that the documentation giving legal authority to another was not in the record. 2.) During review of medical records for Resident #1, 2, 3 and 5 did not provide evidence of instructions in the event of their death. The Registered Nurse was unable to provide the evidence of information regarding the requirement and confirmed on 5/11/16 at 4:15 PM that the information has not been included and that it is not routinely a subject that is discussed with the families or the residents.	R188		
R200 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on record review the facility failed to assure that written policies and procedures were present for all services provided by the home regarding isolation and/or contact precautions for one resident, Resident #6 (R#6). Findings include: Resident #6 was has a diagnosis of Vancomycin-Resistant Enterococci (VRE) and has an indwelling Foley catheter (cath). On 5/10/16 at 1:45 PM, the medication technician (med tech), who is also a Licensed Practical Nurse (LPN), applied gloves and emptied the	R200	The existing Brookdale policy (Infection Control VT-4) regarding contact precautions has been updated and provided to the community staff, to reflect more specific precautions to be utilized for residents diagnosed with VRE (see attachment #4). HWD/nurse designee will re-inservice all staff regarding the updated policy regarding precautions with resident's diagnosis with VRE and the use of the PPE recommended. Documentation will be placed in the Policy and Procedure Manuals at the community.	

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R200 Continued From page 16
Foley cath and then rinsed the container, removed his/her gloves and washed his/her hands and left the room. Per the Registered Nurse (RN) on 5/10/16 at 4:28 PM that when the Foley cath is emptied the staff is to wear gown, gloves, goggles, and mask and s/he has provided education to all the staff regarding the use of personal protective equipment (PPE) which includes gloves, mask, goggles and gowns because of contact precautions being needed. At 8:51 The facility was unable to provide evidence of a policy to address contact precautions, the RN stated on 5/11/16 at 4:00 PM that the only policy for precautions is for communicable disease and only addresses standard precautions.

R200 The ED and/or HWD will update the Policy and Procedure Manual as policies are initiated or updated on an ongoing basis. The HWD/nurse designee monitors all new staff members for an inservice on VRE
Completion date: July 31, 2016

R266 SS=D IX. PHYSICAL PLANT
9.1 Environment
9.1.a The home 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, the facility failed to assure a sanitary environment. Findings include:
Resident #6 has a diagnosis of Vancomycin-Resistant Enterococci (VRE) and has an indwelling foley catheter (cath). On 5/10/16 at 1:45 PM, the medication technician (med tech), who is also a Licensed Practical Nurse (LPN), applied gloves and emptied the foley cath and then rinsed the container, removed his/her gloves and washed his/her hands and left.

R266 LPN has been re-inserviced on the use of PPE with resident identified as requiring contact precautions. HWD/nurse designee will re-inservice all staff regarding the use of PPE for residents identified as requiring contact precautions (see attachment #5). A "Contact Precaution" sign will be displayed in the resident's apartment next to the PPE provided, to alert staff to the need to utilize when exposed to identified fluids/secretions.

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R266	Continued From page 17 the room. Per the Registered Nurse (RN) on 5/10/16 at 4:28 PM that when the foley cath is emptied the staff is to wear gown, gloves, goggles, and mask and s/he has provided education to all the staff regarding the use of personal protective equipment (PPE) which includes gloves, mask, goggles and gowns because of contact precautions being needed. At 8:51 AM on 5/11/16, the LPN stated that the VRE is dormant at this time and when asked if the lab tests confirmed that and s/he said that s/he hasn't been tested to see if the VRE is gone, but s/he doesn't have any symptoms. The LPN stated that there is PPE in the bathroom, but s/he doesn't use it and that s/he didn't use any other precautions except the gloves.	R266	HWD/nurse designee will conduct weekly staff spot checks to confirm correct use of PPE. Completion date: June 30, 2016	
R302 SS=D	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home 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, the	R302	A fire drill was conducted on May 24, 2016 at 7:00 p.m.	

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R302	Continued From page 18 facility failed to ensure that fire drills were conducted at specific rotating times of the day per regulations. Findings include: During review of the logs kept by the facility regarding fire drills they conduct, there was no evidence that the facility conducted fire drills per regulations during evening hours. Per interview with the Assistant Executive Director at 11:10 AM, the fire drills recorded included day shift, evening shift and night shift. S/he stated that the drills were done on the evening shift, but not during the evening hours. S/he further stated that the evening shift began at 2:00 PM and ended at 10:00 PM. Interview with maintenance at 11:15 AM presented that the fire drills have been conducted on the evening shift, but confirmed that not during the evening hours, with the latest time being 4:00 PM.	R302	The ED has in-serviced the Maintenance Director regarding policy and procedure for conducting fire drills on rotating shifts, once per quarter each shift and supporting documentation of each fire drill conducted in the Community TELS system as well as the log book located in the Executive Director's office. The ED will audit fire drills each month to confirm each shift per quarter has had a fire drill with supporting documentation of the event process and the attendees. Completion date: June 30, 2016	
R999 SS=B	MISCELLANEOUS Based on observation and staff interview, the facility failed to have results of surveys posted in a public place that was available and accessible for residents and the public as required by RCH regulation 4.14.f. Findings include: Per interview with the Assistant Executive Director at 2:35 PM, s/he stated that the results of the surveys have not been posted and that the results have been kept in a folder in the Executive Director's office. S/he stated that s/he was unaware of the need to have the reports publicly posted for the residents and the public.	R999	The results of surveys dating back to 2014 are currently posted in a public place in the community lobby area and are available and accessible to all residents and the public as required by RCH regulation 4.14.f. The additional survey findings, once completed, will be added to this binder as well as any complaints in the future should they arise. The ED/AED will periodically check to ensure binder is in its proper location. Completion date: May 9, 2016	

ATTACHMENT #1

RESIDENCY AGREEMENT – PROPOSED REVISIONS



RESIDENCY AGREEMENT

This Agreement ("Agreement") dated CONTRACT_MONTH.CONTRACT_DAY CONTRACT_YEAR is made by and between LEGAL_NAME d/b/a COMMUNITY NAME (the "Company," "us," "we" or "our") MANAGED COMMUNITY, and RESIDENT NAME ("Resident," "you" or "your").

We operate the community located at COMMUNITY ADDRESS (the "Community") which is licensed by the State of STATE as a LICENSE#_CATEGORY and residency in the Community has been requested by you or on your behalf. The terms and conditions of this Agreement are as follows:

I. SERVICES AND ACCOMMODATIONS.

A. **BASIC SERVICES.** We will provide you with the following Basic Services, which are included in the Basic Service Rate, subject to the terms of this Agreement:

- ◆ **Accommodations** You have elected to live in the Suite described in Exhibit A. You are also entitled to use and enjoy with all other residents the common areas of the Community. You are to provide your own furnishings and personal property; however, we reserve the right to limit the number and type of furnishings/small appliances. You agree that you are responsible for the maintenance and repair of any personal belongings you bring to the Community.
- ◆ **Dining Services** – Unless otherwise noted in the Addendum to the Residency Agreement, we will furnish three meals daily. Snacks are available 24 hours a day.
- ◆ **Utility Service** – Unless otherwise noted in the Addendum to the Residency Agreement, the cost of gas, electric, heat, air conditioning water, basic cable, satellite or comparable television service is included. You are responsible for paying any other utility charges including, but not limited to, telephone, internet or premium cable charges.
- ◆ **Housekeeping Service** – Unless otherwise noted in the Addendum to the Residency Agreement, we will provide light housekeeping once a week.
- ◆ **Laundry and Linen Service** – We will launder your personal belongings and bed linens as set forth in the Addendum to the Residency Agreement.
- ◆ **Activities Program** – We will provide planned social and recreational programs.
- ◆ **Parking** - Each Suite (whether occupied by one or two Residents) will have access in shared and uncovered parking spaces. Covered parking may be available as set forth in the Addendum to the Residency Agreement.
- ◆ **Transportation** We will make available scheduled routine transportation services as described in the Addendum to the Residency Agreement.
- ◆ **Toiletries and Personal Hygiene** – Unless otherwise noted in the Addendum to the Residency Agreement, we will not provide toiletries and personal hygiene products.
- ◆ **Staffing 24 hours a day** – Associates are available 24 hours a day, seven days a week.

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- ◆ **Wellness Assessments** – We will provide limited periodic wellness assessments to help you monitor your physical health.

We will provide thirty (30) days written notice of any change in Basic Services.

- B. PERSONAL SERVICE PLAN.** Prior to moving in and periodically throughout your residency, we will use a personal service assessment to determine the personal services you require. The personal service assessment will be used to develop your Personal Service Plan. The results of the assessment and the cost of providing the additional personal services (the "Personal Service Rate") will be shared with you. Your initial Personal Service Rate is set forth in Exhibit A.
- C. AVAILABLE SELECT AND THERAPEUTIC SERVICES.** Select Services and Therapeutic Services are available to you at your request. Such additional services are not included in the Basic Service Rate or the Personal Service Rate. Where available, such services may include, but are not limited to guest meals, transportation beyond that which is included in the Basic Service Rate, transportation escort services, enhanced cable television, special events or certain clinical services. The available Select Services and Therapeutic Services as well as the associated prices are found on Exhibit X and Exhibit Y to this Agreement.
- D. SERVICES NOT COVERED BY RESIDENCY AGREEMENT.** In addition to any Select or Therapeutic Services you may receive, in some circumstances, you may need the services of other third party providers in order to continue to safely remain at the Community. An outside agency or individual will be permitted to provide these services or any related personal services only if we have given prior approval.

You are responsible for obtaining and paying for all third party provider services, whether provided by Company affiliates, our subcontractors, third party health care and medical providers, or others. These services may include, but are not limited to, pharmacy, therapy, podiatry, dentistry, ophthalmology, home health, hospice, private companion, beauty/barber or other health care services. These third party provider services are not included in the Basic Service Rate, Personal Service Rate or rates for Select Services and Therapeutic Services. Fees for such services will be billed to you directly by the third party service provider, unless otherwise agreed to by the parties. All third party service providers (including, but not limited to, health care service providers) must agree to adhere to our standards for outside providers prior to being permitted to provide services in the Community.

You may not hire our current associates to provide services in the Community. You may contract with former associates to perform any services at the Community only with our consent. We reserve the right to refuse entry to (1) former associates; (2) persons whose actions may be disruptive to the Community; or (3) persons whose actions may threaten the safety of any resident or associate.

II. YOUR RESPONSIBILITIES AND REPRESENTATIONS.

- A. CARE OF SUITE.** You agree that the Community and the Suite are in satisfactory, habitable condition and we have made no promise to decorate, alter or improve the Community or Suite unless otherwise provided in writing and attached as part of this Agreement. You agree to maintain the Suite and to leave the Suite upon termination of this Agreement in good condition, except for normal wear and tear. You agree to pay all

damages, beyond normal wear and tear, which you (including your agent, employee, contractor, or other invitee) cause to our property. The Community may invoice you for the cost of such repairs.

B. ALTERATIONS. We, in our sole discretion, will permit reasonable alterations to the Suite if you have a disability and the proposed modification is necessary to afford you full enjoyment of the Suite. Structural or physical alterations, whether based on a handicap or not, may be made only upon our prior written approval. All structural or physical changes to the Suite shall remain at the Suite and be considered part of the Suite and the Community. Any changes or modifications to the Suite that require assistance of appropriately licensed and insured electricians, contractors or similar professionals must be approved in advance by us in our sole discretion. The cost of any alterations made by you shall be paid by you unless otherwise agreed to in writing. You agree that you will bear the cost of restoring the Suite to its original condition, reasonable wear and tear excepted, upon the termination of this Agreement, unless we specifically exempt you from this requirement in writing. We may enter and make any modifications or alterations to the Suite to meet the requirements of any applicable law.

C. RIGHT OF ENTRY. For your safety and comfort, our associates must be permitted to enter your Suite to provide services under the terms of this Agreement, to respond to emergencies, to make repairs and improvements, or if there is reasonable belief that your safety or the safety of others is in question or that our policies and procedures are being violated, as we deem necessary or advisable. Therefore, it is not permissible to change the locks or add additional locks to the entrance door to your Suite. When feasible, our associates will attempt to give you reasonable notice before entering your Suite.

We reserve the right to relocate you to a more appropriate Suite within the Community as required for your health or safety, or because the residents of a companion Suite are incompatible.

D. HEALTH ASSESSMENT. You agree that we may periodically assess your health to create and update a Personal Service Plan and/or to determine whether you are appropriate to remain at the Community. You agree that we may perform brief periodic wellness assessments performed by therapists, nurses or other appropriately qualified individuals to help both you and us monitor your physical health and wellbeing; but, you acknowledge that these wellness assessment will not be performed by a physician and do not replace the need for you to obtain regular and thorough medical care; and, that we are not and will not provide general medical care for you. In addition, not more than thirty (30) days prior to the date of this Agreement, and at least annually thereafter or upon our request, you agree to undergo an examination by your physician (or other licensed provider as allowed by law). You agree to undergo examination by a particular specialist, at your cost, as we determine is warranted by your current physical or mental status. You will request the examiner to provide us with recommendations, including a statement attesting to the appropriateness of your continued placement. Based upon the assessment(s) and our judgment, we may determine your appropriateness to remain in the Community. You will request the examiner to perform any tests and complete any forms required by us or applicable law.

E. HEALTH CARE PROVIDER NOTIFICATION. You authorize us to contact your legal representative/family, health care providers, and/or other persons listed in your records (1) if it is necessary in our judgment to advise them of your situation; (2) to arrange for required health care services and other assistance; or (3) in case of an emergency.

If your designated health care providers are unavailable, you authorize us to arrange for the services of other health care providers. You agree we may provide such persons with copies of your records, including, but not limited to, resident records, advance directives, living will, and the names of persons empowered to make health care decisions.

- F. **SUBSTITUTE DECISION MAKERS/ADVANCE DIRECTIVES.** You will provide us with accurate, complete and current information about yourself, substitute decision-makers and health care providers, including but not limited to addresses and phone numbers, and your health care status and needs. You will provide us with copies of any power of attorney, guardianship, living will, or conservator documents, or other legal documents relating to the making of health or financial decisions or decision-makers. You authorize us to rely on the instructions of such designees or appointees or on the instructions found within such documents. You further agree to immediately notify us of changes relating to the information stated above.

It is strongly suggested that you have advance directives in place in the event you become incapacitated. If you do not have such advance directives in place, you understand that a court may name a guardian upon application of any interested party (including the Company). Neither we nor any of our associates or agents may be your guardian. If it is necessary for us to petition the court for appointment of a guardian, any costs associated therein shall be paid by you and we may invoice you for such costs.

- G. **MOTORIZED VEHICLES AND CARTS.** Individual motorized vehicles such as electric scooters, wheelchairs, or carts and similar vehicles may be used, subject to the following:

1. Your ability to walk is substantially limited due to a disability;
2. Your operation of the vehicle does not pose a threat to the health and safety of yourself or others;
3. The vehicle is operated at a low speed setting; and
4. You agree to abide by our safety guidelines for the use of motorized vehicles on the premises, which may be modified from time to time.

Reasonable accommodations will be made to the rules, policies and practices (upon a showing of necessity) so long as the requested accommodation does not constitute a threat to the health or safety of you, the other residents, our associates or visitors.

You agree to pay for all damages to others or to the Community, which are caused by you or your motorized vehicle and that we may invoice you for such costs. You further understand and agree that we may, at our sole discretion, prohibit your further use of an electric scooter or similar vehicle at any time.

- H. **EXAMINATION OF RECORDS.** You acknowledge that we are licensed by the State of STATE as an LICENSURE_CATEGORY. You understand that regulatory officials having jurisdiction over the Community may inspect your records as part of an evaluation of the Community. You have the right to review and access your health care records in accordance with the requirements of applicable law.

- I. **RULE AND REGULATION COMPLIANCE.** You understand that the Community has shared common areas, and you agree to honor all rules of courtesy and respect for others. You agree to abide by and conform to our rules, regulations, handbook, policies and procedures as they now exist and as amended from time-to-time. You understand that failure to abide by such policies may result in your discharge from the Community.

- J. **GUESTS.** You have the right to associate with your friends and family during reasonable hours. Because the Community is a licensed building, overnight guests are generally not permitted in a resident's room. Limited exceptions may be granted by the Executive Director based upon the circumstances.

You acknowledge and understand that your guests are subject to our rules and regulations, and if your guests become disruptive to the operations of the Community and/or are verbally or physically abusive to residents, our associates or others, we may request that they leave the Community until their behavior is under control or may restrict their visitation. Where circumstances warrant, we may exclude such individuals from the Community.

- K. **RELEASE OF INFORMATION.** We will keep your health, medical, personal and other information that identifies you (collectively, "Resident Data") confidential in compliance with applicable law. You agree that we may use and disclose Resident Data for purposes of treatment, to provide to you services covered by this Agreement (collectively "Services"), to obtain payment for our Services, in connection with our operations, including training, care management and quality assessment and improvement, to coordinate with any third party providers you select, and as otherwise permitted by law. You agree that we may also use and disclose Resident Data in order for us or other companies to provide information to you about services and products offered by us or other companies that we believe may be of interest to you, to the extent permitted by applicable law.

III. RATES.

- A. **COMMUNITY FEE.** We require a one-time non-refundable Community Fee in an amount indicated in Exhibit A to be paid at the time this Agreement is signed. The Community Fee does not excuse you from financial responsibility for any damage caused to your Suite beyond normal wear and tear upon move-out.

B. **MONTHLY SERVICE RATE.**

1. **Rate.** You agree to pay the Basic Service Rate and, if applicable, the Personal Service Rate as indicated in Exhibit A (together the "Monthly Service Rate").
2. **Refund.** In accordance with Section IV, we will refund a prorated share of the Monthly Service Rate if this Agreement is terminated before the end of a month:
 - a. following thirty (30) days written notice;
 - b. because you require care that is not offered by us; or
 - c. by reason of death.

Refunds will be prorated (using 30.5 days to calculate the Daily Rate) from the later of the termination date or the date by which you have vacated and all of your belongings are removed from Community. Unless prohibited by law, you agree we may offset such refunds by any amount due under the terms of this Agreement. Once a resident is discharged or removed from the community, the resident shall receive a refund, within fifteen (15) days of discharge, for any funds paid in advance for each day care services were not provided.

C. **ABSENCES.**

1. **Notice of Absence.** Except for an emergency medical absence, if you will be absent from the Community for any period of time, you must inform us of your plans prior to leaving

and sign the Sign In/Sign Out Book upon exiting and re-entering the Community. We assume no responsibility or liability for your welfare during times that you are away from the Community.

2. **Fees During Absence.** If you are absent from the Community for any reason, such as, for a hospitalization, vacation, temporary nursing home care or rehabilitation, the Residency Agreement will remain effective and you will be charged the full Monthly Service Rate. If you provide written notice of your intent to terminate the Agreement pursuant to Section IV, termination will be effective and charges will cease the later of the end of any applicable notice period or the removal of all of your personal belongings.

D. **SELECT & THERAPEUTIC SERVICES.** In addition to the Monthly Service Rate, you agree to pay the established charges for any Select Services or Therapeutic Services provided to you by us.

E. **PAYMENT.** We will issue a monthly statement before the first day of the month itemizing the Monthly Service Rate for the upcoming month and, if any, charges incurred for Select Services and Therapeutic Services provided during the prior month. Payment for all charges shown on the statement is due on the first (1st) calendar day of each month. The first payment of the Monthly Service Rate is due prior to taking occupancy. If you move in after the first of the month, your first Monthly Service Rate will be prorated (using 30.5 days to calculate the Daily Rate).

We will charge a \$250.00 late fee if we have not received all fees when due. We will also charge a \$50.00 returned payment fee for each check or automatic withdrawal that is returned or denied for any reason. After two such occurrences, you agree to pay all amounts due by cashier's check or such other method specified by us. You also agree to pay interest on all outstanding amounts based upon the lesser of 1.5% per month or the highest rate permitted by law.

F. **RATE CHANGES.** We will provide thirty (30) days written notice of any change in the rates or pricing method for Basic Services, Personal Services, Select Services and Therapeutic Services. We may offer or require a change in the Personal Service Plan when we determine additional services are requested or required. **The new Personal Service Rate resulting from a change in your Personal Service Plan is effective immediately after written notice is given.** The Community will give each resident and the licensing agency a written ninety (90) day notice when its services, rates, retention policies or physical plan will change so as to significantly enhance or significantly restrict the potential for aging in place.

G. **DIMINISHING FUNDS.** If you are unable to meet your payment obligations to us due to a change in financial status, and you are eligible to receive Enhanced Residential Services under the Choices for Care Medicaid Waiver program (See Section III.H below), you may be eligible for continued resident at the Community, subject to space-availability. Otherwise, we will provide assistance or information to help relocate you to an appropriate outside facility. Non-payment due to diminished funds is grounds for termination of this Agreement, and you will be given a discharge notice unless we have the capacity to retain you as a Choices for Care Enhanced Residential Care Resident. It is your responsibility to notify the Executive Director or Designee within 180 days when a determination has been made that your funds will soon be diminished.

H. **CHOICES FOR CARE MEDICAID WAIVER, ENHANCED RESIDENTIAL CARE (ERC) SERVICES AND PAYMENT.** We participate in the Vermont Choices for Care Medicaid Waiver Program as an Enhanced Residential Care provider. We reserve the

right on a case-by-case basis to accept you under the ERC program. If you are eligible, you will be responsible for paying us directly for your room and board, shopping and transportation (as defined in the Vermont Residential Care Home Licensing Regulations) as specified in Exhibit D.

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—We will bill Medicaid (ERC) for your enhanced care services each day we provide you with covered services. In addition, we will Medicaid (ACCS) for each day of service provided to you. We do not accept SSI (Supplemental Security Income) payment. If you have a patient share obligation in order to be eligible for Long-term care Medicaid as determined by Economic Services Division of the Department for Children and Families, you agree to pay to us the patient share each month. The patient share is in addition to your room and board obligation.

—We agree that your Basic Service Rate, plus the funds received from Medicaid, will be the sole and complete payment for required services. These payments do not cover any Select and Therapeutic Services you may elect. We may continue to charge you the Basic Service Rate specified in Exhibit D during absences from the Community. Under the terms of the Medicaid program, we may not ask, require or accept from you or anyone, additional payment on days that you are absent from the Community or are admitted to another facility.

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—You will receive all of the afore-mentioned services, as well as the ACCS services below. In addition, you will receive the following ERC services as needed: a minimum of one (1) hour of RN services per week, two (2) hours of personal care assistance per day and daily social and recreational activities.

—We will work with your Medicaid Waiver case manager to coordinate your service package.

—ACCS Services: *Help with activities of daily living; medication assistance, monitoring and administration; 24 hour on-site assistive therapy; restorative nursing; nursing assessment, health monitoring, case management and routine tasks.*

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IV. TERM AND TERMINATION.

- A. **TERM.** This Agreement begins on the date set forth above and continues until terminated as provided below.
- B. **TERMINATION BY RESIDENT.** You may terminate this Agreement upon thirty (30) days written notice to us. Termination occurs on the later of the end of the notice period or upon the removal of all of your personal belongings.
- C. **TERMINATION BY THE COMPANY:** We may terminate this Agreement, upon providing you thirty (30) days written notice, for any of the following events, as determined by us:
1. You require care or services that we are unable to provide or which requires staff that are not available at the Community;
 2. You or your visitors' behavior impairs the well-being, care or safety of yourself or others, creates unsafe conditions, is physically or verbally abusive to others, or otherwise interferes with the orderly operation of the Community.
 3. For your welfare or the welfare of others in the Community;

4. You or your third party payor fail to pay fees and charges when due, or you breach any representation, covenant, agreement, or obligation under this Agreement.

We may, upon written notice to you, immediately terminate this Agreement, and transfer or discharge you for emergency medical or welfare reasons that would endanger the health and safety of yourself or others. We may also terminate this agreement with less than thirty days' written notice should your discharge be ordered or permitted by a court. If the emergency requires your immediate transfer, we will notify your legal representative as soon as practical. We will provide a written explanation for termination with less than thirty (30) days' notice.

Upon a ninety (90) days' written notice, we may terminate this Agreement if we discontinue all or part of our operation of the Community.

- D. TERMINATION BY EITHER PARTY.** Either party may terminate this Agreement immediately upon written notice in the event of your death or if you must be relocated due to your health. The Community may request a physician to certify in writing that based upon his/her examination, you must be relocated to facility which offers a higher level of care.

In the event of your death, your estate will be charged the Monthly Service Rate through the later of the seventh (7th) day after your death or the day on which all of your belongings are removed from the Community. If you must relocate due to your need for a higher level of care, you will be charged the Monthly Service Rate through the later of fourteen (14) days after the date of your written notice of termination or the day on which all of your belongings are removed from the Community.

- E. SERVICES PENDING TERMINATION.** You acknowledge and agree that, pending termination of the Agreement due to requiring services or staff not available in the Community, we may arrange for the provision of one-on-one care and you will pay for such care if we determine that such care is needed to protect your health or safety or the health or safety of others.
- F. COMMUNITY CEASES TO OPERATE.** If the Community's license is revoked or the Community otherwise ceases to operate, this Agreement shall terminate upon written notice from the Community on the date as stated in the notice. Any advance payment for services not received shall be refunded to the Resident.
- G. RESPONSIBILITIES UPON TERMINATION.** You will vacate premises, removing all belongings on or before the effective date of termination. If you fail to remove your belongings by the effective date of termination, you understand and agree that we may continue to charge you for the Basic Service Rate of your Suite, or have your belongings placed in storage at your cost. You further agree that we may donate any unclaimed property after forty-five (45) days. You will provide written notice of a forwarding address where you can be reached and receive mail. Termination will not release you or us from any liability or obligation to the other party under the terms of this Agreement.

V. AGREEMENT TO ARBITRATE.

Should any of sub-sections A & B provided below, or any part thereof, be deemed void or invalid, the validity of the remaining sub-sections, or parts thereof, will not be affected.

A. ARBITRATION PROCEEDINGS.

1. Any and all claims or controversies arising out of, or in any way relating to, this Agreement or any of your stays at the Community, excluding any action for involuntary transfer or discharge or eviction, and including disputes regarding interpretation, scope, enforceability, unconscionability, waiver, preemption and/or violability of this Agreement, whether arising out of State or Federal law, whether existing or arising in the future, whether for statutory, compensatory or punitive damages and whether sounding in breach of contract, tort or breach of statutory duties, irrespective of the basis for the duty or the legal theories upon which the claim is asserted, shall be submitted to binding arbitration, as provided below, and shall not be filed in a court of law. **The parties to this Agreement further understand that a judge and/or jury will not decide their case.**
2. The parties hereby expressly agree that this Arbitration Provision, the Residency Agreement and the Resident's stays at the Community substantially involve interstate commerce, and stipulate that the Federal Arbitration Act ("FAA") shall exclusively apply to the interpretation and enforcement of this Agreement, and shall preempt any inconsistent State law and shall not be reverse preempted by the McCarran-Ferguson Act; United States Code Title 15, Chapter 20, or other law. Any party who demands arbitration must do so for all claims or controversies that are known, or reasonably should have been known, by the date of the demand for arbitration, and if learned of during the course of the arbitration proceeding shall amend the claims or controversies to reflect the same. All current damages and reasonably foreseeable damages arising out of such claims or controversies shall also be incorporated into the initial demand or amendment thereto.
3. A demand for Arbitration by you, your legal representative, a person or organization acting on your behalf with your consent, or the personal representative of your estate (collectively "Resident Party") shall be made in writing and submitted to Timothy Cesar, Brookdale Senior Living Inc., 6737 W. Washington St. #2300, Milwaukee, WI 53214, via certified mail, return receipt requested. Demand for Arbitration by us shall be made in writing and submitted to you or your agent, representative, successor or assign and/or your legal representative via certified mail, return receipt requested.
4. The arbitration proceedings shall take place in the county in which the Community is located, unless agreed to otherwise by mutual consent of the parties.
5. The arbitration panel shall be composed of one (1) arbitrator. Subject to the requirements of section A.6, the parties shall agree upon an arbitrator that must be a member of the STATE Bar with at least ten (10) years of experience as an attorney. If the parties cannot reach an agreement on an arbitrator within twenty (20) days of receipt of the Demand for Arbitration, then each party will select an arbitrator. These arbitrators will act only for the purpose of appointing a sole arbitrator to hear the case, subject to the criteria above. If either party fails to select their arbitrator within the (20) days mentioned above, they effectively forfeit their right to choose an arbitrator.
6. The arbitrator shall be unbiased of all parties, witnesses, and legal counsel. No past or present officer, director, affiliate, subsidiary, or employee of a party, witness, or legal counsel may serve as an arbitrator in the proceeding.
7. Discovery in the arbitration proceeding shall be governed by the STATE Rules of Civil Procedure. However, discovery may be modified by agreement of the parties.

8. The arbitrator shall designate a time and place within the county in which the Community is located, for the arbitration hearing and shall provide thirty (30) days' notice to the parties of the arbitration hearing.
 9. The arbitrator shall apply the STATE Rules of Evidence and STATE Rules of Civil Procedure in the arbitration proceeding except where otherwise stated in this Agreement. Also, the arbitrator shall apply, and the arbitration decision shall be consistent with, STATE law except as otherwise stated in this Arbitration Provision.
 10. The arbitration decision should be signed by the arbitrator and delivered to the parties and their counsel within thirty (30) days following the conclusion of the arbitration. The decision shall set forth in detail the arbitrator's findings of fact and conclusions of law.
 11. The arbitrator's decision shall be final and binding and such decision may only be vacated or modified as allowed by the Federal Arbitration Act.
 12. The arbitrator's fees and costs associated with the arbitration shall be divided equally among the parties. The parties shall bear their own attorneys' fees and costs and hereby expressly waive any right to recover attorney fees or costs, actual or statutory.
 13. The arbitration proceeding shall remain confidential in all respects, including the Demand for Arbitration, all arbitration filings, deposition transcripts, documents produced or obtained in discovery, or other material provided by and exchanged between the parties and the arbitrator's findings of fact and conclusions of law. Following receipt of the arbitrator's decision, each party agrees to return to the producing party within thirty (30) days the original and all copies of documents exchanged in discovery and at the arbitration hearing, except those documents required to be retained by counsel pursuant to law. Further, the parties to the arbitration also agree not to discuss the amount of the arbitration award or any settlement, the names of the parties, or name/location of the Community except as required by law.
 14. This Arbitration Provision binds third parties not signatories to this Arbitration Provision, including any spouse, children, heir, representatives, agents, executors, administrators, successors, family members, or other persons claiming through the Resident, or persons claiming through the Resident's estate, whether such third parties make a claim in a representative capacity or in a personal capacity. Any claims or grievances against the Community or the Community's corporate parent, subsidiaries, affiliates, employees, officers or directors shall also be subject to and resolved in accordance with this Arbitration Provision.
 15. The terms of this Arbitration Provision are severable.
 16. The Arbitration Provision shall survive your death.
- B. BENEFITS OF ARBITRATION.** The parties' decision to select arbitration is supported by the potential cost-effectiveness and time-savings offered by selecting arbitration, which may avoid the expense and delay of judicial resolution in the court system. The parties' decision to select arbitration is supported by the potential benefit of preserving the availability, viability, and insurability of a long term care company for the elderly and disabled in STATE, by limiting such company's exposure to liability. With this Agreement, we are better able to offer our services and accommodations at a rate that is more affordable to you. In terms of the potential time-savings offered by selecting arbitration, the parties recognize that selecting a quick method of resolution is potentially to a resident's advantage.

You and/or your legal representative understand that other long term care companies' Agreements may not contain an arbitration provision. The parties agree that the reasons stated above are proper consideration for the acceptance of the Arbitration Provision. **The undersigned acknowledges that he or she has been encouraged to discuss this Agreement with an attorney.**

The parties to this Agreement further understand that a judge and/or a jury will not decide their case.

VI. MISCELLANEOUS

- A. **WAIVER OF TRIAL BY JURY.** If a court determines that the Arbitration Provision provided above is invalid, the parties express their desire to waive a jury trial and resolve any claims in the appropriate court solely before a judge.
- B. **NON-DISCRIMINATION.** We operate on a non-discriminatory basis and afford equal treatment and access to services to eligible persons regardless of race, religion, color, national origin, sex, disability or any other category protected by applicable law.
- C. **RISK AGREEMENT.** You are responsible for your personal, financial and health care decisions. You are also responsible for maintaining health, personal property, liability, automobile (if applicable), and other insurance coverages in adequate amounts. You agree to obtain insurance in an amount adequate to cover your personal property and your general liability. You acknowledge that we do not insure your person or property. You understand and agree that:
1. We may encourage you to participate in community, leisure, and social activities and to maintain an appropriate level of independence in activities of daily living, as well as your personal and financial affairs;
 2. Independent activities, responsibility for personal, financial, and health care decisions, and lifestyle and care preferences may involve risks of personal injury and/or property damage or loss;
 3. Throughout the Community, there may be public balconies and/or a balcony in your Apartment. If you choose to use such balcony, you do so at your own risk. We are not responsible for any injury that may result from use of a balcony. We are also not responsible for damage or loss of any property used or placed on a balcony;
 4. The standard of service for an assisted living community does not include one-on-one care, assistance or supervision, e.g., one resident assistant for each Resident, or immediate response to non-emergent needs. There may be short and long periods of time in which you will be left alone, unsupervised such as while watching television, listening to music, reading, and sleeping at night;
 5. We make no representations or guarantees that our associates can prevent falls. We do not represent or guarantee that your health condition will not change or deteriorate;
 6. We make no representations or guarantees that our associates can prevent the onset of skin break down or the worsening of existing skin break down.
 7. Our services may not meet all of your personal, social, or health care needs and we will attempt to assist you in arranging for such services which are not included in this Agreement;

8. Many residents suffer from cognitive impairment, including Alzheimer's disease and dementia. This condition can cause unexpected behavior such as wandering, forgetfulness, agitation towards others and confusion. We make no representations or guarantees that we can predict the behavior of our residents. Therefore, we also make no representations or guarantees that we can always prevent a resident from wandering or attempting to wander from the Community, entering into a private area, misplacing or losing items or engaging in physical contact with another resident.
9. We make no representations or guarantees that we can prevent the loss of personal items, including but not limited to clothing, jewelry, dentures, hearing aides or other medical equipment. We will not be responsible for the loss of such items. We make no representations or guarantees that we can prevent theft or other criminal acts perpetrated by another resident or person; therefore, we recommend that valuables such as jewelry and large sums of money, not be kept at the Community. If you choose to bring in valuables, you do so at your own risk and we will not be held responsible for any theft or loss of such items.
10. Due to state regulations and fire code, we may not lock our exterior doors against exiting. Therefore, we cannot guarantee that a resident will not wander from the Community. Some buildings have exterior doors that are alarmed with a delayed egress feature and our systems are designed to alert our associates to respond and assist a resident if they wander from the building.

You understand and agree to assume the risks inherent in this Agreement. You agree to hold us, our associates and agents harmless for any damages, injury or other loss resulting from: (1) reasonable acts or omissions made in good faith; (2) action by a third party, fire, water, theft or the elements; or (3) loss of personal property.

- D. **PETS.** The Community's pet policy is described in the Addendum to the Residency Agreement.
- E. **SMOKING.** Except as otherwise set forth in the Addendum to the Residency Agreement, smoking is not permitted in any part of the Community.
- F. **WEAPONS.** Weapons, as defined by us, are not allowed in the Community or on Community property. This includes but is not limited to firearms, explosive materials, ammunition, and collectible or antique weapons.
- G. **NO TENANCY INTEREST.** You have none of the rights of a tenant under this Agreement, subject to applicable state law.
- H. **ASSIGNMENT.** This Agreement is not assignable without our prior written consent. Our rights and obligations may be assigned to any person or entity which will be responsible to ensure our obligations under this Agreement are satisfied in full from the date of notification. We may engage another person or entity to perform any or all of the services under this Agreement.
- I. **AMENDMENTS.** This Agreement and any written amendments constitute the entire agreement between the parties and supersede all prior and contemporaneous discussions, representations, correspondence, and agreements whether oral or written. Except for our right to modify fees, rates and charges, amend services provided and establish and modify reasonable operating procedures and rules for the general welfare and safety of the residents, this Agreement may be amended only in writing signed by both parties.

- J. **SEVERANCE.** Should any part of this Agreement be invalid, the validity of the other parts of this Agreement will not be affected.
- K. **FINANCIAL RESPONSIBILITY.** You have designated a Guarantor, who has agreed to the terms of the attached Statement of Financial Responsibility.
- L. **SUBORDINATION.** This Agreement and the parties' rights hereunder are subordinate to any lease, mortgage or deed of trust placed upon the Community, but you may remain in your Suite so long as you comply with the provision of this Agreement.
- M. **REPRESENTATION AND WARRANTY.** By executing this Agreement you represent and warrant that all representations made by you or on your behalf, whether written or verbal, with respect to your application for admission to the Community were true when made. You understand that we rely upon the truthfulness of this information in making our decision to enter into this Agreement. Your application forms, including personal data forms, statement of financial condition (if applicable), health history and medical reports submitted by you or on your behalf to us, are incorporated by reference into this Agreement and made an express part of it. You understand and agree that any material misrepresentation or omission made by you or on your behalf in connection with these documents shall make this Agreement voidable at our option, to the extent permitted by law.
- N. **CHOICE.** You have a choice of providers for private sitters, therapy, rehabilitation, home health, hospice and other health care services. As part of the complement of services offered by the Company and its affiliates, therapy, rehabilitation, home health, hospice or other services may be available at the Community through Company affiliates. If you require such services, Community associates will assist you in obtaining such services from Company affiliates or another service provider of your choice.
- O. **OBLIGATORY INFORMATION.** You agree to provide accurate, complete and current information about yourself and about any emergency contact, including but not limited to addresses, phone numbers, and email address. You understand that you must promptly notify us of changes to the information stated above. If you do not have advance directives in place, you understand that a court may appoint a guardian to make decisions on your behalf if you are no longer able to do so. Neither we nor any of our associates or agents may be your guardian. If it is necessary for us to petition the court for appointment of a guardian, you agree to pay any costs associated therein.
- P. **ASSIGNMENT OF BENEFITS.** To the extent that the Community participates in a government payor program, long term care insurance program or other insurance program ("Third Party Payor") of which you are a beneficiary, you authorize us to disclose any medical or administrative information and request payment. You certify that the information given in applying for payment from such Third Party Payor is correct. You authorize release of all medical and administrative records required to act on this request and request that payment of authorized benefits be made on your behalf. You authorize us to disclose any medical or administrative information required in the processing of applications for financial coverage for services rendered. To the extent permitted by your Third Party Payor, you authorize direct payment of all benefits to us.
- Q. **COUNTERPARTS.** This Agreement may be executed in any number of counterparts, each of which shall be deemed an original.
- R. **NOTICES.** Notices will be written and given by personal delivery or mailing by regular mail, postage pre-paid to the following or such other persons or places as the parties may

notify each other. Notices shall be deemed given based upon the date personally delivered or upon the date postmarked.

Company:
Executive Director at Community
(At the Community)

Resident:
(At the Community)

Legal Representative/Responsible Party:
(as noted below)

We believe it is important to disclose all services and fees to the best of our ability and in accordance with the law. We recommend that you consult with legal counsel to ensure understanding of this Agreement before signing.

BY THEIR SIGNATURES, the parties or their representatives have executed this Agreement.

Resident/Legal Representative Date

For Company Title Date

LEGAL REPRESENTATIVE/RESPONSIBLE PARTY ADDRESS:

Name: LEGAL REP NAME

Address: LEGAL REP ADDRESS

Phone Nos.: LEGAL REP PHONE

Email: LEGAL REP EMAIL

OTHER RELATED MATERIALS:

1. Resident Bill of Rights
2. Community Handbook
3. Emergency Evacuation Plan
4. Admissions Package
5. Medical Records Release (if additional permission is required under state law or necessary to address a use or disclosure not covered by Section I(K))
6. Personal Service Assessment
7. Personalized Service Plan

ATTACHMENTS INCLUDED

- Addendum for Community-Specific Basic Services and Operating Policies
- Exhibit A - Schedule of Services and Rates
- Exhibit B - Statement of Financial Responsibility
- Exhibit C - Pharmacy Services Agreement
- Exhibit D - Financial, Medicaid Waiver, Enhanced Residential Care Services and Payment

ADDITIONAL EXHIBITS TO ATTACH AS PART OF THE AGREEMENT:

- X. Select Services List
- Y. Therapeutic Services List
- Z. Assessment Price Schedule

**EXHIBIT A
SCHEDULE OF SERVICES AND RATES**

Resident RESIDENT_NAME
Suite Type and Number SUITE_TYPE

COMMUNITY FEE (Prior to Move-in) \$COMMUNITY_FEE
BASIC SERVICE RATE \$BASIC_SERV_RATE
(Check below if applicable)

The Basic Service Rate above is the Basic Service Rate for a Companion Suite. If the Companion Suite converts to single occupancy, the Basic Service Rate will adjust to the then current single occupancy Basic Service Rate for such Suite.

PERSONAL SERVICE RATE \$PERS_SERV_RATE
(The current Personal Service Price Schedule is attached as Exhibit Z)
(See attached Personal Service Rate Report)

MONTHLY SERVICE RATE \$MNTH_SERV_RATE
(Add Basic Service Rate and Personal Service Rate)

SELECT SERVICES AND THERAPEUTIC SERVICES \$SELECT_SERVICES*
(The Select Service List and Therapeutic Services List are attached as Exhibits X and Y)
*Amount varies based upon monthly usage.

I acknowledge receipt of Exhibits X, Y and Z and agree to the above Schedule of Services and Rates to commence as of FIN_MONTH FIN_DATE, FIN_YEAR. I understand and agree that the Company has the right to change these rates and/or change the services provided in accordance with the provisions of the Residency Agreement.

Resident/Legal Representative Date

For Company Title Date

**EXHIBIT B
STATEMENT OF FINANCIAL RESPONSIBILITY**

GUARANTOR_NAME ("Guarantor" or "you") and LEGAL_NAME d/b/a COMMUNITY_NAME (the "Company," "us," "we" or "our"), agree as follows:

The Resident named in the attached Residency Agreement desires to live at the Community and we are willing to enter into the Residency Agreement if the Resident has an individual who is willing to fulfill the conditions of this Statement of Financial Responsibility; and

In consideration for our accepting the Resident into the Community, you agree to fulfill the provisions of this Statement of Financial Responsibility, if and as necessary.

Therefore, in consideration of the mutual covenants contained in this Statement of Financial Responsibility, the parties agree as follows:

I. PERSONAL ASSISTANCE. In the event the condition of the Resident requires such assistance, and upon our request, you will assist Resident or legally responsible person, as necessary by:

- A. Participating with our associates in evaluating Resident's needs and in planning and implementing an appropriate plan for Resident's care;
- B. Maintaining Resident's welfare and fulfilling Resident's obligations under the Residency Agreement;
- C. Relocating Resident following termination and removing the Resident's property;
- D. Transferring Resident to a hospital, nursing home, or other facility in the event that Resident requires care we do not offer;
- E. Making necessary arrangements for funeral services and burial in the event of death.

II. FINANCIAL RESPONSIBILITY. If Resident fails to make payments due to us under the Residency Agreement, you agree to pay us such amounts within thirty (30) days of receiving written notice of nonpayment.

III. REVIEW OF RESIDENCY AGREEMENT. You acknowledge that you have received and reviewed a copy of the Residency Agreement, and have had an opportunity to ask questions.

BY THEIR SIGNATURES, the parties have executed this Agreement to be effective as of FIN_MONTH FIN_DAY, FIN_YEAR.

	SSN	D.L. NO.	
Guarantor	Social Security No.	D.L. No.	Date
For the Company		Title	Date

SEND NOTICES TO GUARANTOR AT:

Address: GUARANTOR_ADDRESS
Home and Work Phone Nos.: GUARANTOR_HOME
Cell Phone No.: GUARANTOR_CELL
Email Address: GUARANTOR_EMAIL

**EXHIBIT C
PHARMACY SERVICES AGREEMENT**

We work closely with pharmacy providers to meet the needs of our residents. Preferred pharmacy providers are chosen based upon their ability to provide services to our residents to enhance their health and wellness. Important services include:

- Screening for possible negative drug interactions
- Assessments for potential allergic reactions of medications
- Recommending therapeutic substitutions and offering generic substitutions when appropriate
- Providing competitive pricing for comparable packaging
- Alerting our associates and physicians when there is a duplication of prescriptions
- Regular scheduled review and monitoring of medications
- Routine or emergency delivery 24-hours a day, 365 days a year
- Medication packaging that meets our safety standards

PREFERRED PHARMACY is our preferred provider for pharmacy services ("Preferred Provider"). The Preferred Provider will review your current medications upon your move-in and the consultant pharmacist will be in the Community on a regular schedule to meet with you individually, if needed.

If you decide to use another pharmacy provider other than the Preferred Provider, it will be required to meet our medication management standards.

Please review and sign the following statement acknowledging you understand our expectations and requirements regarding the provision of medications.

I understand that if I choose not to use the Preferred Provider, I will be charged a service fee, which is set forth on Exhibit X.

I understand that I will be required to provide medications that are packaged in a unit of use packaging system, unless I have been granted an exemption to the packaging requirement by the Company's Regional Director of Operations. I understand there is a packaging exemption fee as set forth on Exhibit X associated with a packaging exemption due to the additional administrative oversight required. **If at any time I am not able or no longer willing to provide this type of packaging system and I do not have an exemption, I understand that I need to find alternative housing.**

If I do not use the Community's Preferred Provider, I also understand that I will have the responsibility for reordering medications. If medications are not delivered **within two days prior to their depletion**, the Community will reorder my medications with the Preferred Provider. **I agree to pay for the medications and any associated service charges.** The fees associated with reordering medications from the Preferred Provider are determined by the Preferred Provider, and are in addition to the service fee described above.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ, UNDERSTAND AND AGREE TO ABIDE BY THE TERMS OF THIS PHARMACY SERVICES AGREEMENT.

Resident/Legal Representative Signature

Date

EXHIBIT D
FEE SUMMARY FOR ENHANCED RESIDENTIAL CARE (ERC) RESIDENTS

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The Community participates in Vermont's Choices for Care Medicaid Waiver program as an Enhanced Residential Care (ERC) provider. The following fee summary applies to residents who are both eligible for the ERC program and for whom we have accepted as an ERC resident at the Community.

Effective Date: _____

Apartment #: _____

Covered Services

We will bill Medicaid for both ERC services and ACCS (Assistive Community Care Services) for each day of service provided to you at the Community. The Economic Services Division of the Department for Children and Families may determine that you have a patient share obligation, which would be payable to us monthly along with your room and board payment. The Medicaid program shall determine the amount of both your patient share obligation (if any) and your room and board payment:

_____ Patient Share Obligation (if applicable): _____ \$

_____ Basic Service Rate: _____ \$

RESIDENT'S TOTAL MONTHLY PAYMENTS: _____ \$

Resident's Name (printed): _____

Resident's Signature: _____ **Date:** _____

Responsible Party's Signature: _____ **Date:** _____

Community Representative's Signature: _____ **Date:** _____

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ATTACHMENT #2

VT MONTHLY PSYCHOTROPIC MEDICATIONS REVIEW

VT Monthly Psychotropic Medications Review

This form should include the review of antipsychotic and benzodiazepine medications only.

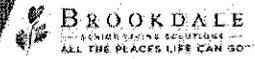
Resident	Apartment	<input type="checkbox"/> Initial	<input type="checkbox"/> Monthly	<input type="checkbox"/> Change*	
		Date:			
Diagnoses and Medical Conditions:					
Name of Drug, Dosage, Frequency	Targeted Behavior	Side Effects Noted	Frequency of PRN use		
			<input type="checkbox"/> N/A		
			<input type="checkbox"/> N/A		
			<input type="checkbox"/> N/A		
Are There Beneficial Effects for Resident in the Following Areas?		Yes	No	Not Applicable	
ADL/Personal Care					
Pain Control					
Activity Participation					
Appetite					
Highest Level of Functioning					
Sleep					
Service Plan Reflects Alternatives to Medication					
Concerned Party Aware of Drug's Use and Reason					
Service Plan Goals Met through Drug's Use					
*Is medication reduction, titration plan or elimination considered?					
*Is resident at the lowest effective dose & frequency?					
Resident Benefits from Continued Medication's Use					
*Explain the medication reduction or elimination plan					
Plan to be implemented					
Review Conducted by/Nurse Signature			Date Review Completed <input type="checkbox"/> No Changes		

ATTACHMENT #3

SURVEY OF DISCOMFORT FOR BEHAVIORS

Survey of Discomfort in Dementia

Alzheimer's and Dementia Care



Resident name: _____ Apt #: _____
 Medical diagnosis: _____ Date: _____
 Behavioral expression: _____ Temp: _____ Pulse: _____
 RR: _____ BP: _____
 Last BM: _____ Urine: _____

1. Who was there when the behavior occurred (family, staff, residents, animals, etc.)?

2. Specifically, what happened...

...before the behavioral expression?

...during the behavioral expression?

...after the behavioral expression?

3. When/what time did the behavioral expression occur?

4. How often did the behavioral expression occur...

...within the last 24 hours?

...within the last few days?

5. Where did the behavioral expression take place?

- 6. Check the areas of potential physical discomfort or distress:**
- Pain or discomfort from arthritis, diabetic neuropathy, old fracture, etc
 - Grimacing
 - Moaning
 - Groaning
 - Crying
 - Rocking
 - Rubbing body part (specify): _____
 - Holding body part (specify): _____
 - Red areas (specify): _____

A3

6. Check the areas of potential physical discomfort or distress:

- Illness (urinary tract infection, respiratory infection, skin infection, etc)
- Winded/breathless
- Constipation
- Impaired vision (inappropriate/missing eyewear, glasses not on)
- Impaired hearing (malfunctioning/missing hearing aid/hearing aid not on)
- Sleep disturbance
- Temperature intolerance (room too hot or cold)
- Improperly fitting footwear
- Requires foot care (pedicure)
- Problem with teeth/dentures (not in good repair)

7. Check the areas of potential emotional discomfort or distress:

- Unfamiliar/new staff
- Unfamiliar/new surroundings
- Boredom
- Fear
- Overstimulation

Follow-up actions:

Person filling out this form

Date:

RNCM/HWD

Date:

ATTACHMENT #4

POLICY-INFECTIION CONTROL VT-4

Policy Name: Infection Control- VT-4	Effective Date: 7/2016
Category/Sub-Function: Operations/ Clinical Services	Last Revised:
Applies to: Assisted Living, Alzheimer's and Dementia Care - VT	Policy Owner: SVP Clinical Services

Policy Overview

It is the policy of this Assisted Living residence to make any reasonable attempt to minimize the risk and/or spread of infectious disease for the mutual protection of residents, employees, families, and the public.

Policy Detail

Infections and infection transmission is prevented and managed as far as possible through the application of standard precaution practices through no less than the following:

1. Establishing and maintaining a residence-specific infection prevention program;
2. Establishing policies governing the admission and isolation of residents with known or suspected infectious diseases;
3. Developing, evaluating and revising on a continuing basis infection control policies, procedures and techniques for all appropriate areas of the residence;
4. Developing and implementing protocols for:
 - a. Discharge planning to home that include full instructions to the family or caregivers regarding necessary infection control measures;
 - b. Hospital and/or nursing facility transfer of residents with infectious diseases which may present the risk of continuing transmission. Examples of such diseases include, but are not limited to, tuberculosis (TB), Methicillin resistant staphylococcus aureus (MRSA), vancomycin resistant enterococci (VRE), and clostridium difficile (C. diff)

Prevention and Isolation Procedures:

1. Confinement to apartment will depend on resident's condition, personal hygiene, and ability to comply with instructions
2. When a resident has been identified as having a known or suspected infection disease:
 - a. Implement standard precaution.
 - b. Identify presence of infectious disease(s).
 - c. Implement contact precaution.
 - d. Communicate and educate resident/responsible party on practices to reduce risk of transmission.
 - e. Initiate appropriate isolation practice.
 - f. Implement monitoring procedures

Influenza:

In cases of influenza in the residence:

- a. Contact precautions, in addition to standard precautions, will be maintained
- b. Following reporting procedure per Vermont Department of Health guidelines
- c. Implement standard precaution

1 - 5/1

Clostridium Difficile:

In cases of Clostridium Difficile in the residence:

- a. Contact precautions, in addition to standard precautions, will be maintained
- b. Confinement to apartment will depend on resident's condition, personal hygiene, and ability to comply with instructions.
- c. Residents with diarrhea cause by Clostridium difficile are encouraged to use separate toilets
- d. Contact precautions may be discontinued once diarrhea has ceased
- e. Standard facility procedures shall be followed for cleaning rooms of residents Clostridium difficile

Methicillin Resistant Staphylococcus Aureus (MRSA)/Vancomycin Resistant Enterococcus (VRE)

In cases of MRSA or VRE in the residence:

- a. Contact precautions, in addition to standard precautions, will be maintained until resolution of signs and symptoms of infection OR until the infection/colonization can be appropriately contained (i.e. drainage, fluids, etc).
- b. Confinement to apartment will depend on resident's condition, personal hygiene, and ability to comply with instructions.
- c. As part of standard precaution for all residents, McKesson procedural masks may be needed for face-to-face contact with residents who are symptomatic.
- d. Standard facility procedures shall be followed for cleaning rooms of residents with MRSA / VRE

Tuberculosis:

In cases of Tuberculosis in the residence:

- a. Contact precautions, in addition to standard precautions, will be maintained
- b. Confinement to apartment will depend on resident's condition, personal hygiene, and ability to comply with instructions.
- c. As part of standard precaution for all residents, a McKesson particulate respirator may be needed for face-to-face contact with residents who are symptomatic.
- d. Standard facility procedures shall be followed for cleaning rooms of residents with TB

Related Documents/ Other Manuals

Communicable Disease Control
C-diff CG
TB Exposure Control Plan Policy-Associates PP
BBP Exposure Control Plan

Forms/Links

Resident Vaccination and TB Screening Record

ATTACHMENT #5

TRAINING SESSION ATTENDANCE FORM-PPE INSERVICE

Training Session Attendance Form
Facilitator, please complete the following information:

Session Title Use of PPE with Residents on Precautions + Infection Control Policy Community Name Fillmore Pond
 State Vermont Session Date 6/1/16
 Instructor Susan Freeman Beverly Doyle Duration 30 minutes

1	Last Name	First Name	Title	Signature	Have attended/has completed this session
2	<u>Brown</u>	<u>Amy</u>	<u>LPN</u>	<u>[Signature]</u>	<u>LPN</u>
3					
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