

Division of Licensing and Protection  
103 South Main Street, Ladd Hall  
Waterbury, VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 871-3317  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 871-3318

January 25, 2012

Ms. Amie Niles, Administrator  
Union Street Group Home  
215 Union Street  
Bennington, VT 05201

Provider #: 0517

Dear Ms. Niles:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 8, 2011**. 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, MS  
Licensing Chief

PC:ne

Enclosure



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0517</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ JAN 17 12 Licensing and Protection	(X3) DATE SURVEY COMPLETED  <b>11/08/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>UNION STREET GROUP HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>215 UNION STREET BENNINGTON, VT 05201</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 001	INITIAL COMMENTS  An unannounced onsite re-licensing survey was conducted by the Division of Licensing and Protection on 11/8/11 to determine regulatory compliance with the Vermont Therapeutic Community Residences Licensing Regulations. The following are regulatory violations.	T 001		
T 003	IV.A.2 Resident Care and Supervision  Medication  The Director shall assure that all medications and drugs are: a. used only as prescribed by the resident's physician b. properly labeled and kept in a locked cabinet at all times or, when a program of self-medication is in effect, otherwise safely secured.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the Director failed to assure that medication was used as prescribed for 1 of 3 residents in the survey sample (Resident #1). Findings include:  1. Per record review on 11/8/11, Resident #1 had an order to receive 'Seroquel 500mg (milligrams) at HS (bedtime)'. The record indicated that this dosage was unavailable on 8/31/11, that staff unsuccessfully attempted to contact the prescribing physician for advice due to unavailability of this medication in the prescribed dosage. Finally, staff contacted a pharmacist for advice. Per pharmacist advice, the resident was given Seroquel 400mg on the evening of 8/31/11 rather than the physician ordered Seroquel 500mg. During interview that afternoon, the home's RN (Registered Nurse) confirmed that the	T 003	<i>Error was addressed with the responsible staff person and re-training occurred with all staff. Staff are to check med supply daily &amp; re-order meds 5 to 7 days prior to running out. If this situation should occur again, staff are to ensure that they receive guidance from our RN and only follow orders from a physician. Program manager will now monitor med supply on a weekly basis.</i>  <i>T003 POC accepted 11/20/12 J. Masterson</i>	

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Kathleen Hamilton*

TITLE *DS Director, CCS* (X6) DATE *1/14/12*

*AME*

Division of Licensing and Protection

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T 003	Continued From page 1  medication had been given in an amount not ordered by the physician.	T 003		