VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

October 27, 2023

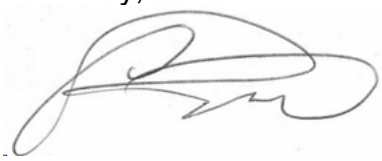
Mr. Carl Pratt, Manager
Chestnut Place
430 Berlin Mall Road
Berlin, VT 05602

Dear Mr. Pratt:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 10, 2023.** 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,



Carolyn Scott, LMHC, M.S.
State long Term Care Manager

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0673	A. BUILDING: _____ B. WING _____	C 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT PLACE	430 BERLIN MALL ROAD BERLIN, VT 05602

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: On 9/25/23 the Division of Licensing and Protection conducted an unannounced on-site relicensure survey with the intention of completing the investigation of one complaint. Due to lack of time on 9-25-23, the on-site investigation of one complaint took place on 10/10/23 . The following regulatory deficiencies were identified during the course of the re-licensure survey and complaint investigation:	R100	The filing of this plan of correction does not constitute an admission of the allegations set forth in statement of deficiency. Chestnut Place has prepared and executed a plan of correction as evidence of the facilities continued compliance with the applicable federal and state laws.	11/03/23
R134 SS=D	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 by: Based on staff interview and record review there was a failure to ensure completion of an Admission Assessment for one applicable resident (Resident #5). Findings include: Per record review Resident #5's Admission Assessment was not signed as complete by a Registered Nurse. This findings was confirmed by the Director of Health Services at 3:50 PM on 9/25/23.	R134	Resident #5 no longer resides in the facility. All residents who are admitted are at potential risk for this alleged deficient practice. A house wide audit was completed on all admission assessments to ensure an RN signature was present. All nurses were educated on the need for an RN signature for all assessments. The HSD or designee will perform a random weekly audit X4 on all new admissions to ensure an RN signature, then monthly X2. Theses results will be reviewed by the QAPI team for further interventions if necessary R134 Plan of Correction accepted by Jo A Evans RN on 10/27/23	11/03/23

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carl Pratt	Executive Director	10/25/23

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R136	Continued From page 1	R136	Resident #6 continues to reside at the facility and has had the admission assessment signed by an RN Resident #7 no longer resides at the facility. All residents who are admitted to hospice, have new oxygen use, or have weight loss are at potential risk for this alleged deficient practice. A house wide audit was completed on all residents who were admitted to hospice, have new oxygen use, and have weight loss for a change of condition assessment with RN signature present. All nurses were educated on the requirement of an RN signature for all change of conditions. The HSD or designee will conduct random weekly audits X4 on residents with change of conditions to ensure completion and RN signature present, then monthly X2. The results will be reviewed by the QAPI team for further interventions if necessary. R136 Plan of Correction accepted by Jo A Evans on 10/27/23	11/03/23
R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to complete an assessment following a significant change in two applicable resident's physical conditions (Resident #6 and #7). Findings include: 1. Per record review Resident #6 was admitted to hospice on 1/18/23. A significant change assessment dated 1/31/23 for Resident #6 was completed by Licensed Practical Nurse, however this assessment was not signed as complete by a Registered Nurse as required. This finding was confirmed by the Director of Health Services on the afternoon of 9/25/23. 2. Per record review Resident #7 experienced a weight loss of 16.5 pounds between 3/3/23 when his/her weight was documented as 108.5 pounds and 7/1/23 when his/her weight was documented as 92 pounds, which was a loss of approximately 15% of Resident #7's total body weight. Per review of progress notes Resident #7 was prescribed Oxygen via nasal cannula on 6/18/23 for exhaustion and difficulty breathing on exertion.	R136		

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R136	Continued From page 2 At 3:50 PM on 10/10/23 the Director of Health Services confirmed a significant change assessment was not completed in response to Resident #7's weight loss of 16.5 pounds over a 4 month period; and initiation of Oxygen supplementation due to exhaustion and difficulty breathing.	R136		
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 there was a failure to ensure a written Plan of Care describing care and services required to maintain the wellbeing of two applicable residents (Resident #5 and Resident #7). Findings include: 1. Per record review Resident #5 is prescribed the anti-coagulant medication Coumadin which requires routine labs to ensure the dose remains in an effective range; resident and staff education due to increased risk for bleeding and prevention of injuries; and monitoring for intake of specific foods and beverages that can change the effectiveness of this medication.	R145	Resident #5 no longer resides at the facility. Resident #7 no longer resides at the facility. All residents receiving anticoagulant therapy, oxygen or have weight loss are at the potential risk for this alleged deficient practice. A house wide audit was performed on all residents receiving anticoagulant therapy, oxygen use and weight loss to ensure a plan of care was written. The HSSD or designee will perform random weekly audits X4 to ensure residents receiving anticoagulants, oxygen or have weight loss have a plan of care in place, then monthly X2. The results will be reviewed by the QAPI team for further interventions if necessary. R145 Plan of Correction accepted by Jo A Evans RN on 10/27/23	11/03/23

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R145	Continued From page 3 At 3:48 PM on 9/25/23 the Director of Health Services confirmed Resident #5's Plan of Care does not include goals and interventions related to use of Coumadin. 2. Per record review Resident #7's Plan of Care was not updated to include goals and interventions related to initiation of Oxygen supplementation on 6/18/23 following onset of exhaustion and difficulty breathing on exertion, and a weight loss of 16.5 pounds which occurred from 3/3/23-7/1/23. At 3:50 PM on 10/10/23 the Director of Health Services confirmed Resident #7's Plan of Care did not include goals and interventions related to the use of Oxygen via nasal cannula for exhaustion and difficulty breathing on exertion, and related to a 16.5 pound weight loss from 3/3/23-7/1/23.	R145		
R146 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to delegate nursing tasks associated with Foley catheter care for one applicable resident (Resident #4). Findings include:	R146	Resident #4 continues to reside in the facility and have their needs met. All residents with catheters are at potential risk for *this alleged deficient practice.* A house wide audit was performed on all resident assistants, LNA's and MedTechs to ensure proper training. All resident assistants, LNA's and MedTechs received training and competencies in performing catheter care. The HSD or designee will perform random weekly audits X4 on all new employees to ensure education and competencies have been completed, then monthly X2. The results will be reviewed by the QAPI team for further interventions if necessary. R146 Plan of Correction accpeted by Jo A Evans RN on 10/27/23	11/03/23

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R146	Continued From page 4 Per record review Resident #4 has a Foley Catheter and a history of catheter blockage and urinary tract infections. Resident #4's Plan of Care indicates s/he requires assistance with emptying and changing the drainage bag; assistance with hygiene and routine cleaning; and monitoring for urinary output, blockage, and infection. Per review of Resident #4's Medication Administration Record Foley catheter care tasks including replacing, changing, and emptying Resident #4's Foley bag and monitoring for urinary output were completed by Licensed Nursing Assistants (LNAs) and Med Techs. At 1:48 PM on 9/25/23 the Director of Health Services confirmed s/he had not provided Foley Catheter Care training and delegated the facility's LNAs and Med Techs to perform Foley catheter care.	R146		
R172 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h All medicines and chemicals used in the home must be labeled in accordance with currently accepted professional standards of practice. Medication shall be used only for the resident identified on the pharmacy label. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure one medication was labeled with a pharmacy label. Findings include: On the afternoon of 9/25/23 a Symbicort inhaler was observed to be stored in the medication cart	R172	All residents using inhalers are at potential risk for this alleged deficient practice. A house wide audit was performed on all medication carts to ensure proper labeling of inhalers. The HSD or designee will perform random weekly audits X4 on all medication carts to ensure inhaler labeling, then monthly X2. The results will be reviewed by the QAPI team for further review if necessary. R172 Plan of Correction accepted by Jo A Evans RN on 10/27/23	11/03/23

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R172	Continued From page 5 without a pharmacy label. The inhaler had been removed from the packaging and was without a Resident's name and instructions for administration including the dose, route, and frequency of administration. The Licensed Practical Nurse on duty stated she did not know who the medication belonged to and why the unlabeled medication was stored in the medication cart. At 2:18 PM on the Licensed Practical Nurse on duty confirmed an unlabeled Symbicort inhaler stored in the medication cart had been removed from the packaging and was without a pharmacy label, and on the afternoon of 9/25/23 the Director of Health Services acknowledged this finding.	R172		
R176 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (4) Medications left after the death or discharge of a resident, or outdated medications, shall be promptly disposed of in accordance with the home's policy and applicable standards of practice. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review there was a failure to ensure prompt disposal of outdated medications. Findings include: The facility's Medication Management policy for the Disposal of Resident's Medications states,	R176	Resident #1 continues to reside in the facilty and have all needs met. Resident #2 no longer resides in the facility. All residents who have medications discontinued are at potential risk for this alleged deficient practice. A house wide audit was performed on all medication carts to ensure all discontinued medications were removed and destroyed. All nurses and medTechs were educated on the policy *of removing and destroying discontinued* medications. The HSD or designee will perform random weekly audits X4 to ensure all medications that have been discontinued are removed and destroyed, then monthly X2. The results will be reviewed by the QAPI team for further interventions if necessary. R176 Plan of Correction accepted by Jo A Evans RN on 10/27/23	11/03/23

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R176	Continued From page 6 "Medications must be disposed of when they are refused by a resident, become outdated/expired, or are discontinued by the resident's physician in a medication destroyer bottle located on each med cart or as directed otherwise." During a medication cart check in the Memory Care Center commencing at approximately 2:00 PM on 9/25/23 the following outdated medications were observed to be stored in the medication cart: 1. Oyster Shell Calcium 500 mg tablets discontinued on 4/19/23 for Resident #1 2. Nitrofurantoin ER 100 mg tablets discontinued on 9/13/23 for Resident #2 3. 4 boxes of Lidocaine 4% topical patches discontinued on 9/4/23 for Resident #3 At 2:18 PM on 9/25/23 the Licensed Practical Nurse on duty confirmed the medications listed above were stored in the medication cart; and confirmed the dates the Oyster Shell Calcium, Nitrofurantoin ER, and Lidocaine patches stored in the medication cart were discontinued.	R176		
R179 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 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 limited to, the following:	R179	A house wide audit of all staff has been performed. All residents are at potential risk for this alleged deficient practice. Weekly audits of all new hires will be conducted by the ED or [redacted] designee weekly X4 and then monthly X2. Staff will receive education in the following areas. The results will be reviewed by the QAPI team for further interventions if necessary. 1) Resident Right 2) Fire Safety and Emergency Evacuation 3) Resident emergency response procedures, such as the Heimlich manuever, accidents, police and ambulance contact. 4) Policies and Procedures regarding mandatory reports of abuse, negelect and exploitation. 5) Respectful and effective interactions with residents 6) Infection control Measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions.	11/03/23

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R179	Continued From page 7 (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 there was a failure to provide documentation of required trainings for 4 out of 5 sampled staff. Findings include: *Per review of training records, 4 out of 5 sampled* staff lacked documentation of completion of the required yearly trainings. At 1:35 PM on 9/25/23 the Executive Director confirmed documentation of the required yearly trainings for 4 out of 5 sampled staff was not on file and available for review.	R179	7) General supervision and care of residents R179 Plan of Correction accepted by Jo A Evans RN 10/27/23	
R190 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff.	R190	A house wide audit of background checks was completed by Human Resources on all current staff. All residents are at potential risk for this alleged deficient practice. Any person that is found to not have all required checks completed will have the checks completed. Weekly audits X4 and then monthly X2 will be conducted by the ED or [redacted] designee. The results will be reviewed by the QAPI team for further interventions if necessary.	11/03/23

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R190	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to complete required background checks for 4 out of 5 sampled staff. Findings include: Per record review criminal record checks for 4 out of 5 sampled staff were not completed as required; and 1 out of 5 sampled staff did not complete the abuse registry checks as required. These findings were confirmed by the Executive Director at 2:40 PM on 9/25/23.	R190	R190 Plan of Correction accepted by Jo A Evans on 10/27/23	
R246 SS=E	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.a Each home must procure food from sources that comply with all laws relating to food and food labeling. Food must be safe for human consumption, free of spoilage, filth or other contamination. All milk products served and used in food preparation must be pasteurized. Cans with dents, swelling or leaks shall be rejected and kept separate until returned to the supplier. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure cans with dents are kept separate until returned to the supplier. Findings include: During the tour of the main kitchen commencing at 9:28 AM on 9/25/23 dented cans of pumpkin and zucchini with tomatoes were observed to be	R246	Education will be provided to all dietary staff about the need to keep all damaged cans or food packaging seperaterate from all food that is to be consumed. A new shelf with cover has been ordered and all damaged cans that are to be returned must be stored on this shelf and labeled "DO NOT USE". All residents are at potential risk for this alleged deficient practice. A weekly audit X4 for damaged cans will be conducted by the FSD or designee and then monthly X2. The results will be reviewed by the QAPI team for further interventions if necessary. R246 Plan of Correction accepted by Jo A Evans RN on 10/27/23	11/03/23

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R246	Continued From page 9 stored with canned items to be used in the dry goods storage area. This finding was confirmed by the Executive Director and Director of Food Services during the kitchen tour on 9/25/23.	R246		
R247 SS=E	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure perishable food items are labeled and dated. Findings include: During the facility tour commencing at 9:28 AM on 9/25/23 perishable food items stored in the main kitchen and the Memory Care Center kitchenette were observed to be without labels and dates as follows: 1. In the Main Kitchen of the home opened undated food items included six 3 gallon containers of ice cream, and opened bags of baking ingredients including graham cracker crumbs and nuts. 2. In the Memory Care Unit kitchenette opened undated perishable food items included salad dressings, condiments, jelly, Lactaid milk, beverages including orange juice and Powerade, and a pie. Unlabeled and undated perishable food	R247	All dietary staff will be educated on the proper method of labeling and dating all food items that are stored on shelves, in freezers, and coolers. All other staff that place food in the MC refrigerator or the AL Country Kitchen refrigerator will also receive this education. All residents are at a potential risk for this alleged deficient practice. Weekly audits of these areas will be conducted by the ED X4 and then monthly X2. The results will be reviewed by the QAPI team for further interventions if necessary. R247 Plan of Correction accepted by Jo A Evans RN on 10/27/23	11/03/23

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R247	Continued From page 10 items included 2 containers of leftovers. The undated and unlabeled perishable food items listed above were confirmed by the Executive Director of the home during the facility tour on the morning of 9/25/23.	R247		
R258 SS=F	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.h All garbage shall be collected and stored to prevent the transmission of contagious diseases, creation of a nuisance, or the breeding of insects and rodents, and shall be disposed of at least weekly. Garbage or trash in the kitchen area must be placed in lined containers with covers. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure garbage cans in the main kitchen and two kitchenettes of the home were covered with lids. Findings include: During the facility tour on the morning of 9/25/23 both garbage cans in the main kitchen, and garbage cans in the first and second floor kitchenettes were observed to be without lids. This finding was confirmed by the Executive Director of the home during the facility tour on the morning of 9/25/23.	R258	New trash lids were ordered and placed on the trash cans in the kitchen, MC kitchenette, and the AL Country Kitchen. Education was provided to all staff that all trash cans must have a lid on the trash cans at all times. All residents are at potential risk for this alleged deficient practice. Weekly audits of trash can lids will be conducted by the ED X4 and then monthly X2. These audits will be conducted by the ED or designee. The results will be reviewed by the QAPI team for further interventions if necessary. R258 Plan of Correction accepted by Jo A Evans RN on 10/27/23	11/03/23
R266 SS=F	IX. PHYSICAL PLANT 9.1 Environment	R266	Elder safety gates have been ordered and installed in the entry way to the kitchentte of MC. Staff have been educated on the need to keep these gates closed at all times. Weekly audits X4 will be conducted by the ED or his designee and then monthly X2 to ensure compliance.	11/03/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0673	A. BUILDING: _____ B. WING _____	C 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT PLACE	430 BERLIN MALL ROAD BERLIN, VT 05602

(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
R266	Continued From page 11 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 there was a failure to ensure care in a safe sanitary environment. Findings include: 1. During the tour of the first floor of the home commencing at 9:28 AM on 9/25/23 the kitchenette and medication administration area of the Memory Care Center were observed to be accessible to be open and accessible to Memory Care residents due to lack of an entryway barrier on one side of the kitchenette. Upon entering the open entryway an unlocked drawer in the kitchenette was observed to contain a sharp knife, and cleaning chemicals were observed to be stored in an unlocked cabinet under the kitchenette sink. Residents of the Memory Care Center have limited abilities to safely manage access to knives and chemicals due to cognitive decline. 2. During the tour of the second floor of the home commencing at 9:49 AM on 9/25/23 the spa was observed to be unlocked and accessible to residents without supervision the ensure safety during use of the walk-in tub and to ensure the tub is sanitized after each use. Cleaning chemicals including Shout stain remover and Clorox bleach wipes were observed to be unsecured and accessible in the spa. Oxygen tanks were observed to be stored in the spa without cautionary signage posted at the spa doorway.	R266	A sharp knife that was observed in the drawer has been removed, so have the cleaning chemicals. All residents that reside in MC are at potential risk for this alleged deficient practice. Weekly audits of the MC kitchenette drawers will be conducted by the ED or designee X4 and then monthly X2. The results will be reviewed by the QAPI team for further interventions if necessary. Staff have been educated to keep the walk-in tub room locked when not in use. All chemicals have been removed from the room. A sign-off sheet has been placed in the walk-in tub room and staff have been educated on the need to sign and date the sign-off sheet immediately after they clean and disinfect the walk-in tub. All residents that use this room are at potential risk for this alleged deficient practice. Weekly audits X4 will be conducted by the ED or designee and then monthly X2. The results will be reviewed by the QAPI team for further interventions if necessary. The oxygen tanks have been removed from the walk-in tub room and moved to a secured storage room and a sign has been placed on the outside of the door stating oxygen storage. All staff have been educated on proper storage of oxygen cylinders. All residents are at potential risk for this alleged deficient practice. The results will be reviewed byt he QAPI team for further interventions if necessary. R266 Plan of Correction accepted by Jo A Evans RN on 10/27/23	11/03/23 11/03/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0573	A. BUILDING: _____ B. WING _____	C 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT PLACE	430 BERLIN MALL ROAD BERLIN, VT 05602

(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
R266	Continued From page 12 These findings were confirmed by the Executive Director during the facility tour on the morning of 9/25/23.	R266		
R303 SS=F	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.d There shall be an operable telephone on each floor of the home, at all times. A list of emergency telephone numbers shall be posted by each telephone. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure an operable phone on each floor of the home at all times with emergency number posted by each phone. Findings include: During the tour of the second floor of the home commencing at 9:49 AM on 9/25/23 the Executive Director confirmed phones with posted emergency numbers were not accessible at all times on both floors of the Assisted Living Residence.	R303	An operable phone will be made available to all AL residents to use. This phone will be placed in the AL activities room on the second floor. A list of all emergency numbers will be placed next to the phone. All AL residents are at potential risk for the alleged deficient practice. The results will be reviewed by the QAPI team for further interventions if necessary. R303 Plan of Correction accpeted by Jo A Evans RN on 10/27/23	11/03/23