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

August 7, 2023

Ms. Beatrice Birch, Manager
Inner Fire
26 Parker Road
Brookline, VT 05345

Dear Ms. Birch:

Enclosed is a copy of your acceptable plans of correction for the re-licensure survey conducted on **June 27, 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,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

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
	0662	A. BUILDING: _____ B. WING _____	C 06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNER FIRE	26 PARKER ROAD BROOKLINE, VT 05345

(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 on-site re-licensure survey, and a facility self-report investigation was conducted by the Division of Licensing and Protection on 6/27/23. The following regulatory violations are related to the re-licensure survey.	T 001		
T 022 SS=D	V.5.4.c Resident Care and Services 5.4 Discharge Requirements 5.4.c A summary of the resident ' s stay at the facility shall be added to the resident record within two weeks of his or her leaving. The summary shall include the reason for leaving, areas in which progress, no progress, or regression was observed, and the medication the resident was prescribed at the time of leaving. If a resident is receiving treatment for a serious mental illness, the facility shall follow up with that resident within seventy-two (72) hours of discharge from the facility. This shall be done using the most effective means possible, including email, text messaging, or phone. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, there was a failure of the TCR (Therapeutic Community Residence) to complete a required discharge summary within 2 weeks after a resident decided to leave the program and pursue alternative living arrangements. (Resident #4) Findings include: Resident #4 who had been at the TCR since 5/2/22 decided to terminate his/her relationship	T 022	T 022 Action: A Discharge Summary form will be created to record the reason for leaving, areas of progress and/or regression, medication being prescribed at the time of discharge and recommendation for future treatment if needed. Policy Change: A Discharge Summary will be completed for any departing Seeker. Each completed form will be secured in the individual seeker's file for use as appropriate. Monitored by: Seeker Care Coordinator Completion date: 8/4/2023 Tag T022 accepted on 8/7/23 - M. McIntosh RN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0662	A. BUILDING: _____ B. WING _____	C 06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNER FIRE	26 PARKER ROAD BROOKLINE, VT 05345

(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 022	Continued From page 1 with the TCR and the programs associated with his/her wellness programs on 4/10/23. Per review of Resident #4's record, there was no evidence a discharge summary was completed and signed by staff who would be responsible to complete the reason for leaving; areas of progress and/or regression; medications being prescribed at the time of discharge and future treatment if necessary. Per interview on the afternoon of 6/27/23, the RN who identified as the individual responsible for completing a discharge summary confirmed the document had not been completed.	T 022		
T 035 SS=E	V.5.8.a.1.2.3.4.5.6.7.8 Resident Care and Services 5.8 Medication Management 5.8.a Each therapeutic community residence must have written policies and procedures describing the residence ' s medication practices. The policies must cover at least the following: (1) If a therapeutic community residence provides medication management, it shall be done under the supervision of a registered nurse. (2) Who will provide the professional nursing delegation if the residence administers medications to residents unable to self-administer and how the process of delegation is to be carried out in the residence. (3) Qualifications of the staff who will be managing medications or administering medications and the	T 035	T 035 Action: 1) Inner Fire will use various commercially available forms of medication, along with the use of compounding pharmacies, to meet physician's written orders. 2) IF purchased a locked box for disposing of outdated or unused medications to be kept locked in the Meds Closet. The Seeker Care Coordinator will deliver the disposed medications to Messenger Valley Pharmacy monthly. Policy Change: 1) Medication administration will be consistent with the physician's written orders. 2) A written policy for disposal of medications will be presented to staff at a Monthly Retreat Training, emailed to all staff in the next Friday Week Review, added to the Inner Fire Policy & Procedure Handbook, and posted in the Meds Room. Monitored by: Executive Director Completion Date: 9/1/2023 Tag T035 accepted on 8/7/23 - M. McIntosh RN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0662	A. BUILDING: _____ B. WING _____	C 06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNER FIRE	26 PARKER ROAD BROOKLINE, VT 05345

(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 035	Continued From page 2 residence's process for nursing supervision of the staff. (4) How medications shall be obtained for residents including choices of pharmacies. (5) Procedures for documentation of medication administration. (6) Procedures for disposing of outdated or unused medication, including designation of a person or persons with responsibility for disposal. (7) Procedures for monitoring side effects of psychoactive medications. (8) Procedures for assessing a resident ' s ability to self-administer and documentation of the assessment in the medical record This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the TCR failed to develop written policies and procedures to include the process for the medication management practice for Micro Tapering (small daily microgram reduction) of specific medications. There was also a failure to develop a process for the disposing of outdated or unused medications. Findings include: 1. Per interview with the RN on the afternoon of 6/27/23, the medication management system was reviewed. Medications were observed in medication planners for Resident #1 and Residents #2. In each of the resident's planners unmarked capsules were observed. The RN identified the medications as the medications that	T 035		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0662	A. BUILDING: _____ B. WING _____	C 06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNER FIRE	26 PARKER ROAD BROOKLINE, VT 05345

(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 035	Continued From page 3	T 035		

were on a Micro taper per physician order. Resident #1 is prescribed Micro tapering for Escitalopram (antidepressant) and Resident #2 Lamotrigine (mood stabilizer). At the time of the observation, the RN confirmed that s/he prepares the medication from its original form into a remeasured amount. The RN explained after completing mathematical calculations to determine the precise micro dose, the pills are individually crushed, utilizing a small glass mortar and pestle; remeasures the powder utilizing a jeweler's scale for weight of dosage, then reconverting the weight into the prescribed physician dose. This extremely low and calculated powdered dose is then encapsulated for administration. The RN further confirmed the capsules used were procured from an on-line vendor and unsure of absorption rate when ingested. In addition, Resident #2's prescribed Lanotrigine was compounded into a Micro tapering dose from a chewable tablet form. Further evidence that Lanotrigine was potentially effective when crushed and ingested was not validated.

Per review of physician orders for both Resident #1 and Resident #2 noted the TCR had not been provided with prescribed instructions on how to create the specific Micro tapering dose, only the listing of the daily dose reduction. The RN had not consulted with contracted pharmacies to validate dosage calculations; whether Escitalopram and Lamotrigine were stable when crushed and placed in capsules for administration and if both medications were appropriate for Micro tapering. The RN confirmed presently s/he was the only nurse at the TCR. As a result, no other licensed staff is available to confirm mathematic conversions and accuracies of the complex Micro tapering process.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0662	A. BUILDING: _____ B. WING _____	C 06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNER FIRE	26 PARKER ROAD BROOKLINE, VT 05345

(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 035	Continued From page 4 In addition, when requested to demonstrate the TCR's policy and procedures of Medication Administration for Micro dosing, there was not an established policy and procedure for the management of the whole Micro tapering process, to include handling, preparation and re-packaging of medications. This was confirmed at 2:46 PM on 6/27/23 by the RN. 2. Per observation on the afternoon of 6/27/23 seven bottles of outdated and unused medications were noted to be stored in a wicker basket on a shelving unit located in the medication room. These medications include Escitalopram 5 mg (antidepressant), Lithium Carbonate 300 mg (mood stabilizer), Clozapine 2.5 mg (antipsychotic), Lithium Carbonate 150 mg (mood stabilizer), Rexulti 1 mg (atypical antipsychotic), and a bottle containing three unknown medication capsules. Per interview at 4:55 PM the RN confirmed the facility had not developed a written policy and procedure for the disposal of outdated and unused medication.	T 035		
T 036 SS=F	V.5.8.b Resident Care and Services 5.8 Medication Management 5.8.b The manager of the residence is responsible for ensuring that all medications are handled according to the residence's policies and that designated staff are fully trained in the policies and procedures. The manager shall assure that all medications and drugs are used only as prescribed by the resident's physician, properly labeled and kept in a locked cabinet at all times or, when a program of self-medication is in effect, otherwise safely secured.	T 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0662	A. BUILDING: _____ B. WING _____	C 06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNER FIRE	26 PARKER ROAD BROOKLINE, VT 05345

(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 036	Continued From page 5 This REQUIREMENT is not met as evidenced by: The manager, and registered nurse (RN) failed to assure that all medications are used only as prescribed by the resident's physician, properly labeled, and kept in a locked cabinet at all times. Findings include: Per observation on the afternoon of 6/27/23 seven bottles of outdated and unused medications were noted to be stored in a wicker basket on a shelving unit located in the unlocked medication room. These medications include Escitalopram 5 mg (antidepressant), Lithium Carbonate 300 mg (mood stabilizer), Clozapine 2.5 mg (antipsychotic), Lithium Carbonate 150 mg (mood stabilizer), Rexulti 1 mg (atypical antipsychotic), and a bottle containing three unknown, unlabeled medication capsules. This finding was confirmed by the RN at 2:46 PM on 6/27/23. Per observation it was noted that Resident # 1's medication container contained a prescription bottle with the original label covered by paper tape with a handwritten label of "Lexapro". This was confirmed by RN at time of finding.	T 036	T 036 Action: IF has purchased a locked box for disposing of outdated or unused medications to be kept in the locked Medication room. The medication disposal will be done monthly by the Seeker Care Coordinator. The Seeker Care Coordinator will assure that all medications and drugs are used only as prescribed by the resident's physician, properly labeled, kept in a locked cabinet at all times and disposed of when the medication has been discontinued or expired as according to the policy and procedure. Policy Change: The written policy for disposal of medications will be updated in the IF Medication Administration Procedures manual. It will be presented to staff at a Monthly Retreat Training, emailed to all staff in the next Friday Week Review, added to the general Inner Fire Policy & Procedure Handbook, and posted in the Medication Room. Monitored by: Executive Director Completion Date: 9/1/2023 Tag T036 accepted on 8/7/23 - M. McIntosh RN	
T 052 SS=D	V.5.9.b.1.2.3.4.5.6.7 Resident Care and Services 5.9 Staff Services 5.9.b. The residence 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	T 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0662	A. BUILDING: _____ B. WING _____	C 06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNER FIRE	26 PARKER ROAD BROOKLINE, VT 05345

(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 052	Continued From page 6 for each staff person providing direct care to residents. The training must include, but is not 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, hand washing, 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 the TCR Executive Director failed to ensure all staff received the required 12 hours of training each year. Findings include: Per record review on 6/27/23 the office manager was asked to demonstrate that staff had been provided the 12 hours of training required for staff employed at the TCR who provide direct care to residents. Per interview on the afternoon of 6/27/23 the Executive Director via telephone	T 052	T 052 Action: In the process of contracting with Relias LLC, a company providing “Healthcare Workforce Enablement Solutions”. Policy Change: Inner Fire will use online, multiplatform training and education to provide staff orientation, as well as the required 12 hrs. of annual training. Monitored by: Seeker Care Coordinator/RN & Office Manager Completion Date: 9/1/2023 Tag T052 accepted on 8/7/23 - M. McIntosh RN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0662	A. BUILDING: _____ B. WING _____	C 06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNER FIRE	26 PARKER ROAD BROOKLINE, VT 05345

(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 052	Continued From page 7 interview confirmed the present training program did not include the 12-hours of yearly training to include: Resident Rights; Fire Safety; Mandatory Reporting; Infection Control; Emergency Response; Respectful Interactions and General Supervision.	T 052		
T 063 SS=G	V.5.10.c Resident Care and Services 5.10 Records/ Reports 5.10.c The residence shall ensure that resident records are safeguarded and protected against loss, tampering or unauthorized disclosure of information, that the content and format of resident records are kept uniform and that all entries in resident records are signed and dated. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the TCR failed to ensure resident records are safeguarded and protected against loss, tampering and unauthorized disclosure of information. Findings include: During the process of survey, the RN had provided specific clinical information related to residents presently residing at the TCR. The information was stored on the RN's personal cell phone. The use of a personal cell phone by the RN for storage of resident's personal and clinical information fails to protect clinical record information from tampering and unauthorized disclosure. On the afternoon of 6/27/23 via telephone interview, the Executive Director confirmed a personal cell phone should not be used for containing resident's clinical and personal information.	T 063	T 063 Action: Obtain a dedicated company smartphone and a dedicated company digital voice recorder for use by the Seeker Care Coordinator/RN to ensure resident records are safeguarded and protected against loss, tampering and unauthorized disclosure of information. Policy Change: Only dedicated company smartphone and/or digital voice recorder will be used to record residents' personal/clinical data treatment in order to protect each resident's rights. Monitored by: Executive Director Completion date: 8/4/2023 Tag T063 accepted on 8/7/23 - M. McIntosh RN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0662	A. BUILDING: _____ B. WING _____	C 06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNER FIRE	26 PARKER ROAD BROOKLINE, VT 05345

(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 133 SS=E	VII.7.3.a Nutrition and Food Services 7.3 Food Storage and Equipment 7.3.a All food and drink shall be stored so as to protect from dust, insects, rodents, overhead leakage, unnecessary handling and all other sources of contamination. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the TCR failed to ensure food within the refrigerator and freezer were protected from sources of contamination. Findings include: Per observation of the kitchen refrigerator, rhubarb stalks were stored in an unsealed gallon sized Ziploc bag and leafy greens were stored in an unsealed quart size Ziploc bag. Both items exceeded the packaging limits, and were observed to touch other surfaces and/or items within the refrigerator. Also, on the storage door of the refrigerator a mason jar of cooked apple was partially covered. Within the freezer, a bucket style container which contained frozen meat compost was without a cover. Per interview on 6/27/23 at 10:45 AM, the chef confirmed the observation of the unsealed storage of rhubarb, prepared apples and frozen compost. The chef acknowledged the necessity for the proper storage of food items to protect from sources of contamination.	T 133	T 133 Action: IF Chef will adhere to VT's policies in storing food properly and be more aware of any items that are not sealed correctly or lack a proper lid. He will train all guides in this policy as well. Policy Change: A written clarification of the food storage policy was sent via two consecutive Friday Week Reviews to all staff. To maintain an ongoing orientation with all staff. Monitored by: Chef Completion date: 7/19/23 Tag T133 accepted on 8/7/23 - M. McIntosh RN	
T 174 SS=F	IX.9.6.d Physical Plant 9.6 Plumbing	T 174		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0662	A. BUILDING: _____ B. WING _____	C 06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNER FIRE	26 PARKER ROAD BROOKLINE, VT 05345

(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 174	Continued From page 9 9.6.d Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure water temperatures did not exceed 120 degrees Fahrenheit in resident areas. Findings include: Per observation on 6/27/23 at 10:55 AM water temperatures exceeded the recommended 120 degrees Fahrenheit in three resident areas. Upstairs resident restroom water temperature was noted to be 127.0 degrees Fahrenheit, downstairs restroom used by residents' staff and visitors water temperature was noted to be 127.6 degrees Fahrenheit, and the kitchen water temperature was noted to be 124.0 degrees Fahrenheit. This observation was confirmed by the kitchen manager at the time of findings. Per interview on 6/27/23 at 12:35 PM, the office manager stated " I am not sure who we have that can fix this, but I have a call out so that it is fixed by the end of the day". After an adjustment of the hot water heater by staff, a follow-up observation was conducted at 5:00 PM and water temperatures were confirmed to be under the required 120 degree Fahrenheit in all three resident areas.	T 174	T 174 Action: Hot water temperature was lowered so that it was below 120 degrees in all three residences on the afternoon of 6/27/2023. Policy Change: The hot water temperature will be maintained below 120 degrees through weekly inspections. Monitored by: Chef Completion date: 7/19/2023 Tag T174 accepted on 8/7/23 - M. McIntosh RN	
T 187 SS=F	IX.9.11.c Physical Plant 9.11 Disaster and Emergency Preparedness	T 187		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0662	A. BUILDING: _____ B. WING _____	C 06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNER FIRE	26 PARKER ROAD BROOKLINE, VT 05345

(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 187	Continued From page 10 9.11.c Each residence 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 record review and staff interview there was a failure to provide documentation of fire drills conducted during the previous 12 months. Findings include: On 6/27/23 staff were asked to demonstrate via documentation that they were conducting fire drills on a quarterly basis and rotating times among morning, afternoon, evening, and night. Based on record review the TCR failed to demonstrate fire drills on a quarterly basis with rotating times. Additionally, policies and procedure had not been developed regarding how and when to conduct quarterly fire dills. This was confirmed by the office manager on 6/27/23 at 1:48 PM.	T 187	T 187 Action: • A Fire Drill Policy and an Evacuation Chart with directions has been created and posted in all 3 buildings. It will be added to the Policy & Procedures Handbook as well as to the Seeker's Handbook. • Staff will be trained in the procedures at one of the biweekly Guides' Meetings in September 2023 (after all back from vacations). We will also offer additional training via the Relias platform. • The first fire drill was conducted while residents were still sleeping in the wee hours of July 4th, 2023. After the alarm company comes to do an inspection and answer any questions on 7/24/2023, we will finalize our plan for rotating, quarterly fire drills. Policy Change: An explicit Fire Drill Policy was created and will be published in appropriate manuals listed above. It will be incorporated into the orientation of new hires and covered annually at a monthly Retreat. Monitored by: Executive Director Completion date: 9/11/2023 Tag T187 accepted on 8/7/23 - M. McIntosh RN	