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

March 13, 2024

Sarah Rowan, Manager
Lincoln House
120 Hill Street
Barre, VT 05641-3915

Dear Ms. Rowan:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 5, 2024.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

If you have any questions, please feel free to contact me at (802) 585-0995.

Sincerely,

Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0175	A. BUILDING: _____ B. WING _____	02/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN HOUSE	120 HILL STREET BARRE, VT 05641

(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 2/5/24 the Division of Licensing and Protection conducted an unannounced on-site relicensure survey. The following regulatory deficiencies were identified:	R100		
R144 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c.(1) Complete an assessment of the resident in accordance with section 5.7; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to complete Resident Assessments in accordance with section 5.7 of the Vermont Residential Care Home Licensing Regulations effective 10/3/2000 for 2 applicable residents (Resident # 2 and Resident # 3) . Findings include: Per review, the facility's policies and procedures effective 1/30/2018 state, "Lincoln House abides by Vermont Residential Care Home Licensing Regulations 10/3/2000. Vermont Licensing Assessments are completed within 5 days of admission at Lincoln House. Reassessment are done when there is a significant change in resident status as well as yearly." Per record review Resident # 2 was admitted to the home on 8/10/21. Resident # 2's record did not include an annual assessment completed in 2022. Per record review Resident # 3 was admitted to the home on 12/11/23. Resident # 3's record did not include an admission assessment.	R144		

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R144	Continued From page 1 On the afternoon of 2/5/24 the Manager of the home confirmed there was no documentation of an annual reassessment completed for Resident # 2 in 2022 and an admission assessment completed for Resident #3 in the residents' records. The Manager confirmed policies and procedures for the completion of resident assessments as required had not been developed by the facility. In conclusion this deficient practice is a risk for more than minimal harm due to the failure to identify resident strengths, weaknesses, preferences, and needs which is the basis of resident care planning.	R144		
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 develop written plans of care describing the care and services necessary to maintain the independence and well-being of 2 applicable residents (Resident #1 and #3). Findings include:	R145		

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R145	Continued From page 2 1. Per review of the facility policy and procedure, a policy established on 1/30/2018, titled Assessment, states "Assessment and care plans are revised as the resident's status change." Per record review Resident # 1, has a diagnosis of Fluid retention identified from a medical appointment on 10/8/23, routine Torsemide 20 mg and daily weighs were to be obtained. On a follow-up appointment form dated 12/6/23, resident #1 was ordered to be administered an additional dose of as needed Torsemide weight daily greater then 180 lbs. The care plan does not include the identification of a problem of fluid retention with the necessary services identified to obtain daily weight, to aide in determining when the administration of as needed Torsemide is to be administered. In review of Resident #1 weight record since appointment date of 10/8/23, weights were not documented to be obtained on 11/24/23, 11/25/23, 12/12/23, 12/14/23, 12/16/23, 12/22/23, 12/27/23, 12/30/23, 12/31/23, 1/12/24, 1/14/24, 1/15/24, 1/19/24, 1/27/24, 1/28/24, 2/1/24 and 2/2/24. Per interview on 2/5/24, the Nurse confirmed the orders to obtain daily weights on 10/8/23 and the follow up appointment providing directions to administer Torsemide as needed with obtained weights of greater than 180 lbs. The acknowledged the care plan was not updated to reflect necessary care services prescribed to aide in the management of fluid retention. 2. The facility's policies and procedures states information from the Primary Physician "has input into developing the care plan for the resident".	R145		

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R145	Continued From page 3 Per review of Resident #3's signed physician's admission orders and Medication Administration Record, the anticoagulant medication Clopidogrel was prescribed by Resident #3's physician on admission and is administered by staff daily. Resident #3's Care Plan includes the question "Is Patient receiving anticoagulation?" with the follow up question "If yes what"; however the Care Plan does not indicate Resident #1 is receiving anticoagulant therapy or identify the prescribed medication. Additionally, pertinent information related to the administration of anticoagulant medications is not included in Resident #3's Care Plan including the risk of uncontrolled bleeding, the importance of injury prevention and avoidance of activities which increase the risk of bleeding, the signs of internal bleeding, and when to seek medical attention. On the afternoon of 2/5/24 the Manager acknowledged Resident #3's Care Plan did not address the use of anticoagulant medication. In conclusion this deficient practice is a risk for more than minimal harm to all residents resulting from unidentified residents needs and interventions. Per record review Resident #3's Care Plan includes the question "Is Patient receiving anticoagulation?" with the follow up question "If yes what". Per review of the February 2024 Medication Administration Record (MAR)	R145		

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R145	Continued From page 4 Resident #3's is prescribed the anticoagulant medication Clopidogrel, which was prescribed on admission and is administered daily. Resident #3's Care Plan does not indicate s/he is receiving anticoagulant therapy and identify the prescribed medication. Additionally, pertinent information related to the administration of anticoagulant medications is not included in Resident #3's Care Plan including the risk of uncontrolled bleeding, importance of injury prevention and avoidance of activities which increase the risk of bleeding, the signs of internal bleeding, and when to seek medical attention. On the afternoon of 2/5/24 the Manager acknowledged Resident #3's Care Plan did not address the use of anticoagulant medication. In conclusion this deficient practice is a risk for more than minimal harm to all residents resulting from unidentified residents needs and interventions. This deficit practices poses as more than minimal harm to all facility residents as the nurse developed care plans identify all necessary care needs to maintain well being of the residents and the management of disease processes or identified health related problem areas.	R145		
R147 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (4) Maintain a current list for review by staff and physician of all residents' medications. The list shall include: resident's name; medications; date	R147		

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R147	Continued From page 5 medication ordered; dosage and frequency of administration; and likely side effects to monitor; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure medication orders include a specific dose and frequency of administration for 4 applicable residents (Residents #2, #4, #5 and #6). Findings include: Per review of Medication Administration Records for February 2024 the following PRN (as needed) medication orders did not include specific doses and/or frequency of administration: 1. For Resident #2: a. "Diphenhydramine 1-2 tablet(s) (2.5 - 5 mg) by mouth every 4 hours as needed for Diarrhea", which does not include a specific dose b. "Nystatin Powder 100,000 Apply to affected area three times daily as needed (Yeast Infection)", which does not include the strength of the medication which defines the specific dose, and does not include the amount of time between doses 2. For Resident #4: a. "DSS CAPS 100 mg 1-2 capsule(s) (100-200 mg) by mouth at bedtime", which does not include a specific dose b. Loperamide Cap 2 mg 1-2 tablet(s) (2-4 mg) by mouth daily as needed for Diarrhea", which does not include a specific dose c. "Senna- S 1-2 tab PO daily for constipation", which does not include a specific dose d. Additionally, the tablet strength listed in a handwritten order in the MAR for Torsemide	R147		

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R147	Continued From page 6 scheduled daily includes a write over instead of a single line through the incorrect number of milligrams per tablet followed by the correct strength. The number 1 and the number 2 both appear in the same place before a zero indicating the tablet strength is either 10 mg or 20 mg, resulting in lack of clarity regarding the specific dose ordered. 3. For Resident #5: a. "Loperamide use per packet instructions by mouth as needed for Diarrhea" which does not include a specific dose or frequency of administration. b. "Methocarbam [Methocarbamol] Tab 50 mg 1-2 tablet(s) (500 - 1000 mg) by mouth every 6 hours as needed", which does not include a specific dose. This order also does not include an indication of the symptom or condition the medication is intended to treat. c. "Naproxen Tab 500 mg 1 tablet by mouth twice daily as needed", which does not include the amount of time between doses. This order also does not include an indication of the symptom or condition the medication is intended to treat. d. "Soothe XP DRO (IE Artificial Tear Ophth Solut) Instill 1 drop in each eye before starting puzzles", which does not include a specific frequency of administration. 4. For Resident #6 a handwritten order is listed in the MAR for "QVAR inhaler 1 puff BIP [BID] PRN for wheezing", which does not include the specific dose. This medication comes in strengths including 40 mcg per actuation and 80 microgram per actuation inhalers. The order does not include the amount of time between doses. On the afternoon of 2/5/24 the Manager acknowledged medication orders listed in the	R147		

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R147	Continued From page 7 February 2024 MARs did not include the specific dose and frequency of administration as required. In conclusion this deficient practice is a risk for more than minimal harm for all residents due to administration of PRN medications at a dose and/or frequency that is ineffective or in excess of the amount required to address the symptoms the medication is intended to treat.	R147		
R162 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.c. Staff will not assist with or administer any 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 staff interview and record review there was a failure to ensure a signed medication order was obtained for a medication change including the dose and administration time of the medication Paroxetine HCl for one applicable resident (Resident #3). Findings include: Per review, the facility's policies and procedures for Medication Management state, "Staff will not assist with or administer any 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. " Per review of Resident #3's signed admission	R162		

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R162	Continued From page 8 orders dated 12/4/23, the prescribing physician ordered "Paroxetine HCl Oral Tablet 20 mg Give 20 mg by mouth at bedtime for depression" and "Paroxetine HCl Oral Tablet 40 mg Give one table by mouth at bedtime for depression" for a prescribed total dose of 60 mg Paroxetine HCl to be administered at bedtime. Per review of Resident #3's February 2024 Medication Administration Record (MAR) orders were listed and documented as administered by staff indicating 40 mg of Paroxetine HCl was given twice daily in the morning and at bed time, for a combined total daily dose of 80 mg Paroxetine HCl. Orders for Paroxetine HCl appear in the MAR as follows : a. "Paroxetine Tab 20 mg 1 tablet my mouth daily" with an administration time listed as 8:00 AM b. "Paroxetine Tab 20 mg Take one tablet by mouth at bedtime for depression" with a line through the words "at bedtime" and an administration time listed as 8:00 AM c. "Paroxetine HCL Tab 40 mg Take one tablet by mouth at bedtime for depression" On the afternoon of 2/5/24 the Manager confirmed Resident #3's record did not include a signed order for a change to the dose and administration time for Paroxetine HCl. In conclusion this deficient practice is a risk for more than minimal harm to Residents because physician's written, signed orders ensure the medication, dose, route, and frequency of administration are communicated as the physician intended.	R162		

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R167	Continued From page 9	R167		
R167 SS=D	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 staff interview and record review there was a failure to ensure development of a written plan for the administration of PRN (as needed) psychoactive medications by staff other than a nurse for one applicable resident (Resident #2). Findings include: Per record review and confirmation of the Manager, policies and procedures related to the administration of PRN psychoactive medications by staff other than a nurse had not been developed by the facility. Per record review Resident #2 is prescribed the psychoactive medication Quetiapine 25 mg by mouth every 4 hours as needed for Paranoid	R167		

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R167	Continued From page 10 Ideations. Per interview on the afternoon of 2/5/24, the Manager of the home confirmed Resident #2 was the only current resident of the home who is prescribed PRN psychoactive medications, and stated s/he was not aware of the requirement of a written plan for the administration of this type of PRN medication by staff other than a nurse At 3:03 PM on 2/5/24 the Manager confirmed a written plan for the administration of PRN Quetiapine to Resident #2 by med delegated staff had not been developed. In conclusion this deficient practice is a risk for more than minimal harm for all applicable facility residents due to administration of PRN medications at a dose and/or frequency that is ineffective or in excess of the amount required to address the symptoms the medication is intended to treat.	R167		
R171 SS=F	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: (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, including the reason why and the actions taken by the home;	R171		

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R171	Continued From page 11 (3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect; (4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and (5) For residents receiving psychoactive medications, a record of monitoring for side effects. (6) All incidents of medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to establish procedures for monitoring and documenting potential side effects for facility residents who are receiving scheduled psychoactive medications. Findings include: Per review the home's policies and procedures state, "Each residential care home must have written policies and procedures describing the home's management practices. The policies must cover at least the following ... 7. (7) Procedures for monitoring side effects of psychoactive medications." A facility policy revision effective 2/16/18 further states "In reference to side effects of the psychoactive medications, there are specific care plans for residents, receiving psychoactive medication. If side effects are noted this is reported to the Medical administrator and the physician." Per review of documentation of facility residents prescribed psychoactive medications provided by the Manager for review on the afternoon of	R171		

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R171	Continued From page 12 2/5/24, 17 out of the 25 residents of the home are prescribed psychoactive medications including antidepressants, anxiolytics, and antipsychotic medications. Per interview with the Manager on the afternoon of 2/5/24, 16 facility residents are prescribed scheduled psychoactive medications and 1 resident is prescribed PRN and scheduled psychoactive medications. Per record review, Care Plans for Residents #2 and #3 state, "See psychoactive medication care plan for this resident". The Manager was unable to locate psychoactive medication plans for review on request. The Manager identified a process for monitoring and documenting the effects of PRN psychoactive medications, however a process for periodic assessments to monitor for potential side effects of psychoactive medications including scheduled psychoactive medications was not identified. At 3:03 PM 2/5/24 the Manager of the home confirmed a process for monitoring and documenting potential side effects resulting from the administration of prescribed scheduled psychoactive medications had not been developed and implemented. In conclusion this deficient practice is a potential risk for more than minimal harm to all applicable residents of the home resulting from unidentified and untreated side effects of psychoactive medications.	R171		
R173 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h.	R173		

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R173	Continued From page 13 (1) Resident medications that the home manages must be stored in locked compartments under proper temperature controls. Only authorized personnel shall have access to the keys This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure all medications the home manages are stored in locked compartments and are accessible only to authorized personnel. Findings include: Per review, the home's policies and procedures state, "Resident Medications that the home manages must be stored in locked compartments under proper temperature controls. Only authorized personnel shall have access to the keys." During a facility tour commencing at 10:15 AM on 2/5/24 medications were observed to be unsecured and accessible in resident rooms and common areas of the home as follows: 1. In Resident Rooms: Room #2- Nitroglycerin tablets Room # 5 - TUMS antacid tablets Room #7- Systane Eye Drops Room #9- Goldbond Medicated Powder, Muscle Rub, Hydrocortisone Cream, and Tinactin Antifungal Spray Room #16- Salonpas Pain Relieving Patches, Cortisone 10 Cream, Goldbond Medicated Powder Room #27- TUMS antacid tablets, Preparation H	R173		

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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
R173	Continued From page 14 ointment, Bacitracin ointment During an entrance interview commencing at 11:20 AM the Manager confirmed the only resident approved to keep medications in their room is the resident who resides in Room #2., where nitroglycerine was observed to be unsecured and accessible. Per review, the facility policies and procedures state, "Residents who are capable of self-administration may choose to store their own medications provided that the home is able to provide the resident with a secure storage space to prevent unauthorized access to the resident's medications." 2. In common areas of the home: a. First floor shared bathroom - Gold Bond Medicated Powder b. Second floor kitchenette wall cabinet- Hydrocortisone Cream and Triple Antibiotic Ointment 3. During lunch service an insulin pen was observed to be left unattended on a table beside the med cart in the dining area adjacent to the main dining room while the med tech and med tech in training served residents lunch. Additionally, the insulin was left unattended for a period of time when no staff were present in the main dining area as they were in the kitchen preparing to deliver trays to residents. This observation was confirmed by the med tech on duty at 12:16 PM on 2/5/24. At 1:03 PM on 2/5/24 the Manager confirmed medications were unsecured and accessible in resident rooms and common areas of the home. In conclusion these deficient practices are a potential risk for more than minimal harm for all	R173		

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R173	Continued From page 15 facility residents due to access to medications by residents with varying abilities to safely manage access to medications.	R173		
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 the RCH failed to ensure proper labeling and dating of stored food items to identify the items and dates of repackages and/or use by dates. Findings include: Based on observation of the food storage area of the kitchen, storage container were observed to store varying types of dry pastas. Of the nine storage bins three were not labeled to identity the stored item, indicate the packaged date or the use by dates. Also, within the pantry area, items received from bulk supply ordering were observed to not have the indicated use by dates individually labeling on each items, the observed items include (12) 6 lbs cans of tomato sauce, (10) 6 lbs. cans of salad sliced beets, (8) 6 lbs. cans of cut waxed beans, (9) 6 lbs. cans of sweet peas, (5) 6 lbs. cans yellow peaches and (3) 6lbs cans of fruit cocktail, and (4) 6 lbs. cans of mandarin oranges	R247		

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R247	Continued From page 16 Per review of the facility policy and procedures, a policy is not established by the facility for storage, labeling practices procedures for facility staff to utilize. The manager indicated, the regulations set forth is the referenced material for Food Handling and Storage practices within the facility. Per interview on 2/5/24 at 10: 45 AM the Kitchen Manager, confirmed the items identified did not have use by date printed on them by the supplier. The manager confirmed the items were delivered by a bulk food supplier. In additional interview with the facility Manager in the afternoon of 2/5/24, s/he confirmed to have observed all the items identified, and acknowledged the requirement of proper labeling including identifying the items, dates of packages and use by dates on all items. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents related to risk of food contamination and food born illnesses.	R247		
R250 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.e The use of outdated, unlabeled or damaged canned goods is prohibited and such goods shall not be maintained on the premises. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the RCH failed to ensure food items stored in the dry pantry of the kitchen were within there use by date. Findings include:	R250		

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R250	Continued From page 17 Per observation of the dry pantry storage area at 10:22 AM, varying food items were observed stored on the shelves exceeding there use by dated indicated on the times. Items observed were 2 cans of 6.5 lb slices apples dated 4/27/21, (5) 12 oz bottles of honey dated, 12/17/23, (2) 4 lb 6 ounce containers of Salsa expired on 11/6/23 and 12/9/23, 9 oz box of wheat crackers dated 11/22/23, (4) 5 lb containers of peanut butter dated 7/24/23, (5) 12 oz cans of evaporated milk expired on 2/3/21 and 12/29/21 (4) 16 oz rich and creamy cream cheese frosting, opened, and stored on shelf after use, label states to store in fridge for up to 30 days after use. Per interview with the Kitchen Manager at 10: 40 AM, s/he confirmed the dates on the items observed. When asked about policy in place to reference for procedures established for processes in the Kitchen, the manager conformed policies are not in place to reference, for storage practices. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents related to risk of food contamination and food born illnesses.	R250		
R266 SS=F	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment.	R266		

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R266	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure a safe environment related to the storage of poisonous compounds in areas of the home accessible to residents. Findings include: During the facility tour commencing at 10:15 AM on 2/5/24 Poisonous Compounds were observed to be stored in resident rooms, unlocked utility closets, and common areas of the home as follows: 1. In Resident Rooms: Room #5 - Febreeze and Glade Air Freshener sprays Room #9- Isopropyl alcohol, Armour All, glass cleaner. Tools and kitchen utensils including sharp knives were also observed to be stored in the bathroom of Room #9. Room #16- Isopropyl Alcohol, Miracle Grow, Oxiclean Spray Room #27 - Nail polish remover, jewelry cleaner 2. In common areas of the home a. First Floor Shared Bathroom- Lysol Spray b. Second floor kitchenette- Lysol Spray, Febreeze, and Scrubbing Bubbles Foaming Cleaner 3. In unlocked utility closets a. First floor utility closet- Bleach, Lysol, Super Duty Degreaser b. Storage closet beside first floor utility closet- Approximately 20 bottle of Germ -X hand sanitizer, bottles of Febreeze Air Freshener Spray c. Second floor utility/storage room- Gallons and quarts of paint filling multiple shelves and stacked on the floor	R266		

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R266	Continued From page 19 d. Third floor utility/storage room- isopropyl Alcohol, WD 40, Disinfectant wipes and Sprays, Lysol all purpose cleaner, hand sanitizer, Pledge furniture polish The Manager confirmed these findings at 1:03 PM on 2/5/24. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents due to access and exposure to poisonous compounds.	R266		
R302 SS=E	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, the facility failed to ensure fire drills were conducted on a quarterly basis. Findings include:	R302		

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R302	Continued From page 20 Per interview on 2/5/24 the Manager confirmed fire drills have not been conducted on a quarterly basis at rotating times, within the past year of review. This deficient practice is a potential risk for more than minimal harm for all facility residents due to missed opportunities to practice the facility's established emergency preparedness, related to fires for safe and timely evacuations.	R302		
R313 SS=E	XI. RESIDENT FUNDS AND PROPERTY 11.1 A resident's money and other valuables shall be in the control of the resident, except where there is a guardian, attorney in fact (power of attorney), or representative payee who requests otherwise. The home may manage the resident's finances only upon the written request of the resident. There shall be a written agreement stating the assistance requested, the terms of same, the funds or property and persons involved. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure written requests for facility management of resident's personal funds were obtained for 3 out of 4 sampled residents. Findings include: Per review of resident requests forms for facility management of personal funds included in the admission agreements for a sample of 4 residents on the afternoon of 2/5/24, the requests for management of personal funds in the resident records for Residents #1, #2, #3,	R313		

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R313	Continued From page 21 were not completed and signed by the residents or their guardians if applicable. On the afternoon of 2/5/24 the Manager of the home confirmed written requests for the management of personal funds were not obtained for 3 out of 4 sampled residents. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents due to the failure to ensure management of resident funds occurs only with consent and at the request of the resident or their guardian.	R313		
R314 SS=F	XI. RESIDENT FUNDS AND PROPERTY 11.2 If the home manages the resident's finances, the home must keep a record of all transactions, provide the resident with a quarterly statement, and keep all resident funds separate from the home or licensee's funds This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to provide a quarterly statement to the residents for whom the facility manages personal funds. Findings include: Per interview with the Manager of the home on the afternoon of 2/5/24, the facility manages personal funds for 16 of the facility's 25 residents. At 1:44 PM on 2/5/.24 the Manager confirmed for the 16 residents for whom the facility manages personal finances quarterly statements are not provided to the residents, or their guardians when applicable.	R314		

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R314	Continued From page 22 In closing this deficient practice is a potential risk for more than minimal harm for all facility residents due to the failure to ensure residents are provided the opportunity to review and confirm the accuracy of all transactions.	R314		

R144

How Corrected: Resident that was reviewed was the only resident that did not have and up to date assessment. This was corrected immediately. The other resident that was missing an assessment, was missing the 2022 assessment. [redacted] currently is up to date.

System Change: Spreadsheet created to identify the due date for each resident's annual assessment. Packets and checklist created for admission so the assessment will be completed within 5 days.

Who's Monitoring: LPN/RN use the spread sheet to monitor each month when an assessment is due.

Completion date: Has been completed 3/1/24

R 144 Accepted
Jenielle Shea, RN
3/13/24

R145

How Corrected: Spreadsheet will be created and all resident's care plans will be reviewed and updated to be more specified to resident's needs and diagnosis, as well as use of anticoagulants.

System Change: Resident care plan template will be changed to be more specific. Spread sheet will identify when annual assessment is due and the care plan will be reviewed at the same time.

Who's Monitoring: RN director will be responsible for creating a care plan on admission and updating the care plan as needed.

Completion date: Within 90 days May 31st 2024.

R 145 Accepted
Jenielle Shea, RN
3/13/24

R147

How Corrected: PRN medication list has been re-written and no longer includes ranges. The current MARS will be reviewed to assure that the orders are accurate and comply with the regulations. New PRN medication list will be sent to MD and pharmacy for signature and updating of the MARS.

System Change: RN will review all orders when coming in from MD office. Staff will be educated on appropriately written medication orders.

Who's Monitoring: RN will re-write PRN list and have changes signed by PCP and then sent to pharmacy for update and change of MARS. RN will review each order that is obtained by physician to ensure compliance.

Completion date: 90 days 5/31/24.

R 147 Accepted
Jenielle Shea, RN
3/13/24

R162

How Corrected: RN will review each medication order prior to being filed in the chart to ensure that the medication is transcribed appropriately and has a signature.

System Change: Clip board will be set up to put new orders on prior to being filed in the chart. Order will be reviewed by RN/LPN.

Who's Monitoring: RN/LPN will be responsible for monitoring.

Completion date: System change made immediately. Completed.

R 162 Accepted
Jenielle Shea, RN
3/13/24

R167

How Corrected: Spreadsheet created with a list of everyone that is taking psychotropic medications as well as everyone that is receiving PRN psychotropic medication. Care plans will be created for each of these individuals to include behaviors that would indicate the administration and side effects of the medication.

System Change: Care plans will be created for each individual taking psychotropic medications and PRN psychotropic medications.

Who's Monitoring: RN will monitor and create care plans.

Completion date: 30 days April 1st 2024

R 167 Accepted
Jenielle Shea, RN
3/13/24

R171

How Corrected: Spreadsheet created with a list of everyone that is taking psychotropic medications as well as everyone that is receiving PRN psychotropic medication. Care plans will be created for each of these individuals to include behaviors that would indicate the administration and side effects of the medication. Forms created by pharmacy in the MAR will be used to track frequency and reason that resident is being administered PRN psychotropic medications.

System Change: Care plans will be created for each individual taking psychotropic medications and PRN psychotropic medications.

Who's Monitoring: RN will monitor and create care plan.

Completion date: 30 days April 1st 2024

R171 Accepted
Jenielle Shea, RN
3/13/24

R173

How Corrected: Each resident's room will be assessed for medications. Medications will be locked in either a box in their room with orders to have medication at bedside or be locked in the medication cart/room.

System Change: Residents and families will be made aware that they are not to have medications in their rooms. Medications will be locked either in a locked compartment in the room, or be held in the med cart/med room.

Who's Monitoring: RN/LPN will assure that medication appropriately contained.

R 173 Accepted
Jenielle Shea, RN
3/13/24

Completion date: 30 days by 4/1/24

R247

How Corrected: All canned goods coming into the home will be marked with expiration dates. Pasta will be stored in a labeled bin and expiration date will be marked. All food in common area refrigerators will be checked every night to make sure that food is properly marked and disposed of by the expiration date.

System Change: Kitchen staff will mark food as it is delivered. Night staff will check each of the common area refrigerators to make sure that the food is properly marked and disposed of.

Who's Monitoring: Kitchen staff will monitor for dates and proper storage of food. Night staff will monitor refrigerators in the common areas. Administrator will meet with staff.

Completion date: Meetings have already been put in place for new plan and correction. This has been completed.

R 247 Accepted
Jenielle Shea, RN
3/13/24

R250

How Corrected: Policy will be created and followed by kitchen staff and pantry will be cleaned out.

System Change: Policy will be followed and food will be disposed of by expiration date.

Who's Monitoring: Kitchen manager and administer will be monitoring and policy will be written by administrator.

Completion date: Pantry has been cleaned out and food disposed of properly. Administrator has been with staff and developed a policy.

R 250 Accepted
Jenielle Shea, RN
3/13/24

R266

How Corrected: Poisonous compounds have been gathered and will be locked in closets that residents are not able to access. Rooms will need to be assessed for these compounds. They will then be stored appropriately.

System Change: List of items that the residents should not have will be provided to residents. Poisonous compounds will be stored in locked closets.

Who's Monitoring: Administrator will monitor for policy being followed.

Completion date: April 1st 2024.

R 266 Accepted
Jenielle Shea, RN
3/13/24

R302

How Corrected: Fire drills will be conducted quarterly.

System Change: Fire drills will be conducted quarterly and spreadsheet will be created to track dates.

Who's Monitoring: Administrator will monitor.

Completion date: Spreadsheet has been created and fire drill has been conducted.

R302 Accepted
Jenielle Shea, RN
3/13/24

R313

How Corrected: Spreadsheet created and petty cash will be tracked and families provided with statements quarterly. Charts have been reviewed to identify that consents are signed.

System Change: Tracking and quarterly statements will be performed. Assurrance of consent on admission and will be updated for those that currently have petty cash being handled by administrator.

Who's Monitoring: Administrator will monitor.

Completion date: April 1st 2024

R 313 Accepted
Jenielle Shea, RN
3/13/24

R314

How Corrected: Spreadsheet created and petty cash will be tracked and families provided with statements quarterly. Charts have been reviewed to identify that consents are signed.

System Change: Tracking and quarterly statements will be performed. Assurrance of consent on admission and will be updated for those that currently have petty cash being handled by administrator.

Who's Monitoring: Administrator will monitor.

Completion date: April 1st 2024

R 314 Accepted
Jenielle Shea, RN
3/13/24