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 19, 2023

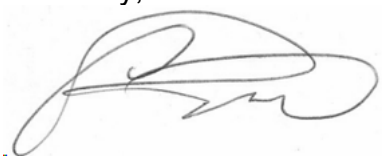
Mr. Michael Flournoy, Manager
Margaret Pratt Community
210 Plateau Acres
Bradford, VT 05033

Dear Mr. Flournoy:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 1, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0659	A. BUILDING: _____ B. WING _____	C 08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGARET PRATT COMMUNITY	210 PLATEAU ACRES BRADFORD, VT 05033

(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 8/1/23 the Division of Licensing and Protection conducted an unannounced on-site re-licensure survey and investigation of 6 facility reported incidents. The following regulatory deficiencies were identified:	R100		
R135 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 Assessment 5.7.b If a resident requires nursing overview or nursing care, the resident shall be assessed by a licensed nurse within fourteen days of admission to the home or the commencement of nursing services, using an assessment instrument provided by the licensing agency. This REQUIREMENT is not met as evidenced by: Per staff interview and record review, the Registered Nurse failed to complete admission assessment for 1 out 5 resident's of the applicable sample. Findings include: Per record review Resident # 6 was admitted to the facility on 11/16/2020, the admission assessment was initiated, however the assessment was not completed to identify all care needs of the resident. Per interview on 8/1/23 at 4:20 PM the Executive Director confirmed the initial assessment was incomplete for Resident # 6.	R135	1. Action to Correct Deficiency The 11/16/2020 admission assessment was missing some information. The annual assessment for this resident completed on 11/16/2021 was complete, and another full re-assessment was completed on 08/22/23. 2. Measures to Prevent Recurrence The completion of the admission assessment is on the move-in workflow, and all nurses are being trained on this. 3. Monitoring Practice Implemented The QA committee will review the completeness of all assessments in the month they move-in, as well as monitor PCC for completion of all that are due. 4. Date to be Completed R135. Accepted on 10/19/23. Sherry Ross, RN	
R146 SS=F	V. RESIDENT CARE AND HOME SERVICES	R146		

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R146	Continued From page 1 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 observation, staff interview and record review the Registered Nurse failed to ensure instruction and supervision was provided to all direct care personnel for 1 out 5 sampled residents. Findings include: Per observation of the Memory Care Unit at 2:40 PM, Resident #6 was in his/her room, the door to room was open for entry and a stop sign was hanging along the door frame and not posted across the doorway entrance. During the observation, another resident was freely ambulating the unit, and entered into Resident # 6 room. Staff did not immediately respond to redirect and/or assist the wandering resident to another location. At 2:43 PM the resident wandered out of the room and at 2:50 PM the door was observed to be closed with the stop sign hanging along the door frame and not posted across the doorway. Per record review Resident # 6 was involved in physical interactions with other residents on 6/9/23 and 6/15/23 requiring staff involvement particularly around other residents entering their room. The care plan was updated on 6/9/23 and 6/15/23 to include care and services to decrease behaviors identified as agitation and anger. One intervention states " Staff will ensure Resident #6 door is closed with the stop sign up while s/he is	R146	1. Action to Correct Deficiency All direct care staff are receiving additional training on the specific care needs of each resident, as well as appropriate behavioral interventions. Staff will also be required to attend additional training on Habilitation Therapy, the model of care used by MPC for dementia programming. 2. Measures to Prevent Recurrence Training record documentation is being updated and will be monitored to ensure that all staff receive both required and supplemental trainings. 3. Monitoring Practice Implemented The QA committee will review the employee training records monthly. 4. Date to be Completed 10/31/23 R146 Accepted on 10/19/23. Sherry Ross, RN	

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R146	Continued From page 2 in his/her room to prevent hostile exchanges." Per interview on 8/1/23 at 3:00 PM with staff who wish to remain anonymous, stated "The resident is to have his/her entry door closed while s/he is in the room, and the stop [sign] to be posted in the evening." The staff stated, the resident can become angered...we haven't been given any instruction on how to de-escalate behaviors for this specific resident." The staff continued "We let him/her walk away- s/he enjoys walking. Unless s/he is calm and approachable we just let him/her be." The staff discussed activities on the unit throughout the day and into the evening hours, and confirmed not many engagement activities occur in the evening, the activities are provided by the care staff, and usually are table activities, coloring, music, and television. Per interview on 8/1/23 at 4:10 PM the Executive Director (ED) confirmed the care plan was updated on 6/15/23 after an interaction occurred with another resident. The ED confirmed the intervention was to deter residents from entering the room while the resident was in the room. The ED stated the door is to be closed when resident is in the room and the stop sign is to be up at all times to deter entry. The ED was made aware of the observation at 2:40 PM on 8/1/23; and acknowledged the importance of providing a safe environment for all residents and staff receiving instruction to follow through on the care needs identified in the care plan.	R146		
R150 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (7)	R150		

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R150	Continued From page 3 Assure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the RN failed to ensure documentation for care and services was recorded for one applicable resident (Resident # 5). Findings include: Per record review, on 3/27/23 Resident #5 experienced a fall as a result of an interaction with another resident. The record did not include an account of the occurrence at the time it occurred, assessment by the RN, and follow up documentation of an assessment or monitoring for injury. The record did not include notification to family or primary physician at the time of the occurrence. The record indicated on 4/4/23, notifications were provided to the family, physician and reporting to the licensing agency. During an interview at 2:10 PM on 8/1/23 the Executive Director (ED) confirmed the incident and explained when falls occur assessments are done by the RN on duty or staff are to call the RN for guidance based on observations. A subsequent follow-up is performed and documentated to demonstrate continued monitoring of injury. The ED acknowledged the fall was a reportable resident to resident incident. The ED confirmed the Director of Health Services (DOHS) at the time did not follow the facility policies and procedures related to the incident, and the DOHS resigned immediately on 4/4/23 when the ED addressed his/her lack of timely reporting and follow up.	R150	1. Action to Correct Deficiency The Executive Director reported the incident to the Division of Licensing and Protection and APS on April 4th when she learned of the incident. Unfortunately, a turnover in the RN position made it impossible to retrain and educate the nurse who failed to make the timely report. All new nurses at MPC are trained on the correct policy and procedures and regulations for timely documentation and reporting. 2. Measures to Prevent Recurrence All current nurses and direct care staff will receive additional training on the importance of timely documentation. 3. Monitoring Practice Implemented All incident reports will be reviewed monthly by the QA Committee. 4. Date to be Completed 10/31/23 R150 Accepted on 10/19/23. Sherry Ross, RN	

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R162	Continued From page 4	R162		
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 observation and staff interview there was a failure to ensure signed orders for medications administered to one applicable resident (Resident #4). Findings include: At approximately 11:15 AM on 8/1/23 the Registered Nurse (RN) in the Memory Care Unit was requested to provide documentation of signed orders for medications administered to Resident #4. A subsequent request was made at approximately 3:20 PM when the RN confirmed signed medication orders were not routinely maintained in residents charts when s/he began working at the home as a contracted employee. The RN stated s/he was unsure if there were signed orders for Resident #4's medications. The surveyor requested copies of the signed orders, however signed physician's orders for Resident #4's medications were not received.	R162	1. Action to Correct Deficiency The Executive Director located the signed orders for resident #4 after the survey team finished. The agency RN was instructed how to locate them. 2. Measures to Prevent Recurrence Since the survey, a new team of nurses has been onboarded. They are each receiving thorough training on the medication administration program and associated documentation. A complete audit of all resident charts is being completed to ensure that all signed orders are filed appropriately in resident charts. 3. Monitoring Practice Implemented The clinical and administrative team is currently meeting weekly to conduct medication QA reviews. This will transition to being part of the monthly QA committee agenda. 4. Date to be Completed R162 Accept on 10/19/23. Sherry Ross, RN	
R167 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication	R167		

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R167	Continued From page 5 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 the Nurse failed to develop a written plan for the use of PRN (as needed) psychoactive medications for 4 out 5 residents. Findings include: Per record review Resident # 4, # 5, # 7, and # 8 have physician orders for PRN psychoative medications. 1. Resident #4 is prescribed Lorazepam 0.5 mg by mouth every 4 hours PRN for anxiety, restlessness; and Haloperidol Lactate Oral Concentrate 2 mg/ml 0.5 ml by mouth every 8 hours PRN for agitation, delirium, hallucinations. 2. Resident # 5 has an order for Risperidal 1mg tablet, Give 1 by mouth every 6 hours PRN for restlessness/agitation. 3. Resident # 7 Lorazepam 0.5 mg tablet, Give 1 tablet by mouth every 24 hours PRN for agitation.	R167	1. Action to Correct Deficiency The RN will complete a written plan for the use of PRN psychoactive medications specific to each resident, per the MPC policy. 2. Measures to Prevent Recurrence All nursing staff and medication aides will be trained/retrained on the importance of the written plan for the use of PRN psychoactive medications, and the appropriate interventions and documentation. 3. Monitoring Practice Implemented The QA committee will review a report of PRN orders at least quarterly, and confirm that written plans are in place for resident who is prescribed a PRN psychoactive medication. 4. Date to be Completed 10/20/23 R167 Accepted on 10/19/23. Sherry Ross, RN	

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R167	Continued From page 6 4. Resident # 8 has an order for Quetiapine 25 mg tablet, Give 12.5 mg (1/2 tablet) by mouth every 24 hours PRN for severe agitation; and Trazodone 50 mg tablet Give 25 mg (1/2 tablet) every 12 hours PRN for increased agitation/aggression. Per interview on 8/1/23 at 1:15 PM, the Registered Nurse confirmed Residents #4, # 5, # 7 and # 8 medication order lists include PRN psychoactive medications and confirmed written plans for the use of PRN psychoactive medication have not been developed for adminitration by unlicensed staff.	R167		
R177 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (5) Narcotics and other controlled drugs must be kept in a locked cabinet. Narcotics must be accounted for on a daily basis. Other controlled drugs shall be accounted for on at least a weekly basis. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview there was a failure in ensure narcotics were accounted for on a daily basis. Findings include: Per record review a facility report indicates the facilities narcotic count was incorrect on 3/26/23. During the narcotic count on 3/26/23 page # 76	R177	1. Action to Correct Deficiency Margaret Pratt Community has strict policies in place for nurses and medication aides regarding the controls for narcotics. This includes policies, training, and strict controls around documentation and shift to shift counts, and immediate reporting of any discrepancies. In this situation, the Executive Director was made aware of a potential discrepancy, began an immediate investigation, which resulted in a change in nursing staff. The Executive Director also made a timely report to the licensing agency, APS and the Board of Nursing of the findings. 2. Measures to Prevent Recurrence MPC will continue to follow its strict policies and procedures, and will continue to train all nurses and medication aides on these policies and procedures.	

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R177	Continued From page 7 was noted to have 20 Lorazepam 0.5 mg ½ tablets for Resident #2, however, the Lorazepam card was witnessed to contain 18 Lorazepam 0.5 mg ½ tablets. This discrepancy was reported by residential care staff to the Executive Director (ED) on 3/26/23. The ED followed up by reporting the occurrence to the Director of Health Services (DOHS) on 3/26/23. The DOHS verified the narcotic count was incorrect on 3/27/23. On 3/31/23 it was witnessed by the ED and the Health Services Coordinator that this occurrence had not been corrected in the narcotic book to account for the missing medication, leaving the narcotic count incorrect for 5 days. On 4/4/23 the Health Services Coordinator (HSC) was notified Staff #2 was refusing to pass medication because the DOHS had falsified the narcotic log to account for the missing Lorazepam by signing Staff #2 and Staff #4's initials. On review of narcotic sign out page #76 it was confirmed to state on 3/26/23 at 7:08 PM that 2 Lorazepam 0.5 mg ½ tablets were signed out with the initials of Staff #2 and witnessed with initials of Staff #4. Staff #2 stated in his/her written facility statement that s/he could not have signed for that entry because s/he was not working during that shift. Per record review of Staff #2's time sheet, s/he had clocked in on 3/26/23 at 05:45 AM and clocked out at 2:00 PM. Additionally Staff #4's time sheet indicated s/he clocked in at 7:00 PM on 3/25/23 and clocked out on 3/26/23 at 7:45 AM, and was therefore not present to witness the count. These findings were confirmed by the Executive Director on 8/1/23 at 3:05 PM.	R177	The Health Services Director/RN or their nurse designee will review the controlled drug log weekly. 3. Monitoring Practice Implemented The QA committee will review the weekly reports from the nursing administration team to ensure compliance. The Executive Director will also conduct random reviews of the controlled drug log for accuracy. R177 Accepted on 10/19/23. Sherry Ross, RN	

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R179	Continued From page 8	R179		
R179 SS=D	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: (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 ensure 5 out of 5 sampled staff completed the required yearly training's. Findings include: On the morning of 8/1/23 staff training records for the previous year for a sample of 5 staff were	R179	1. Action to Correct Deficiency Margaret Pratt Community has an annual training plan that identifies all of the required annual training for direct care staff. The Executive Director will ensure that these training records are maintained, and all staff participate in the trainings and that it is documented. 2. Measures to Prevent Recurrence The Business Office Director is receiving assistance to ensure that all staff receive any missed trainings, and that an on-going schedule is adhered to. 3. Monitoring Practice Implemented The Executive Director will review the staff training records at least monthly to ensure that all staff are current with their training. 4. Date to be Completed 10/31/23 R179 Accepted on 10/19/23. Sherry Ross, RN	

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R179	Continued From page 9 requested. Documented completion of all mandatory yearly training's was not on file and available for review for 5 out of 5 sampled staff. Per review of training's records the following training's were not completed: * Resident Rights training for 5 of 5 staff * Fire Safety and Emergency Evacuation training for 2 of 5 staff * Resident Emergency Response and First Aid training; and Infection Control training for 3 of 5 staff * Mandatory Reporting of Abuse, Neglect, and Exploitation training; and Respectful and Effective Interactions with Residents training for 2 of 5 staff * General Care and Supervision training's for 1of 5 staff * 1 staff who was a contracted employee, did not complete any of the required training's On the afternoon of 8/1/23 the Executive Director confirmed 5 out of 5 sampled staff did not complete all required yearly training's.	R179		
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	1. Action to Correct Deficiency MPC is now requiring any contracted agencies to provide copies of their criminal background checks on their staff to us, and we are also completing our own criminal record and adult abuse registry checks prior to the start of their work.	

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R190	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to complete criminal record and abuse registry checks for 1 out for 5 sampled staff. Per review of criminal record and abuse registry checks, documentation of completion of the required checks for 1 contracted staff in the sample was not provided on request. Per interview with the contracted staff the agency s/he works for did not complete the required checks when s/he began working at the home. On the afternoon of 8/1/23 the Executive Director confirmed the required criminal record and abuse registry checks were not completed on hire for the 1 applicable contracted staff .	R190	2. Measures to Prevent Recurrence The Business Office Director has been made aware of our policy requiring the checks on agency staff. 3. Monitoring Practice Implemented The QA committee will review the summary of employees with dates of hire and compliance with all required background checks monthly. 4. Date to be Completed 10/13/23 R190 Accepted on 10/19/23. Sherry Ross, RN	
R224 SS=G	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure the right to be free of abuse, neglect and exploitation for 4 applicable residents (Residents #1, #2 , #3 and #4). Findings include: 1. Per record review it was noted that on 7/2/23 at	R224	1. Action to Correct Deficiency Margaret Pratt Community has a complete set of documents, policies and procedures regarding Resident's Rights and the their right to be free form abuse, neglect or exploitation. All staff receive training on this as a part of orientation and annually. Residents also receive notice of their rights, our policy on Resident's Rights, and how to report suspected abuse. An internal investigation was completed of these incidents, and corrective action was taken resulting in termination of the employment of 2 employees. A report was also made by MPC to DAIL and APS of the incidents.	

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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
R224	Continued From page 11 approximately 6:30 AM three separate health services staff members reported witnessing mistreatment of Resident #1 by Staff #1. Per Staff #2's written facility statement after arriving on the memory care unit to start his/her shift on 7/2/23 s/he found staff #1 in Resident #1's room giving him/her a shower. It was witnessed that Resident #1 had been incontinent of stool and Staff #1 was yelling at Resident #1 stating, "This is disgusting, you're so gross". When Staff #2 entered the resident's bathroom, Staff #1 stated, "Good you are here, I've had it, s/he won't stop shitting". Additionally, approximately 10 minutes later Staff #2, and Staff #4 witnessed Staff #1 sitting at the unit desk openly discussing Resident #1's incontinence with other residents present. Per Staff #2's and Staff #4 's written statements, when they went to Resident #1's room they found s/he was left unattended, unclothed, and without towels in the shower. Staff #4 stated they were also concerned that Resident #1 could have fallen due to the bathroom floor being wet. On the afternoon of 8/1/23 the facility RN confirmed multiple consistent staff complaints regarding the incident that occurred on 7/2/23 were received; an immediate investigation was conducted; and Staff #1's employment at the ALR was terminated. 2. Per record review Resident #3 resided in the Memory Care Unit of the home and had diagnoses including advanced Parkinson's Disease, respiratory and cardiovascular conditions, and an overactive bladder. Resident #3 was on hospice and dependent on staff for all Activities of Daily Living (ADLs) including ambulation and toileting. S/he experienced chronic pain, recent falls, and was at high risk for subsequent falls. S/he passed away at the facility	R224	2. Measures to Prevent Recurrence All staff will receive additional training on Resident's Rights, Recognizing and Reporting Abuse or Mistreatment. The administrative staff will all receive this training plus additional training on the need to conduct immediate investigations, and report to DAIL and APS in a timely manner. 3. Monitoring Practice Implemented The Executive Director and QA committee will review all incident reports monthly. They will also review the records of staff training and education, to ensure that everyone has completed the mandatory training on Resident's Rights and Abuse each year. 4. Date to be Completed 10/20/23 R224 Accepted on 10/19/23. Sherry Ross, RN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0659	A. BUILDING: _____ B. WING _____	C 08/01/2023

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R224	Continued From page 12 on 6/7/23. Per review of the Executive Director's written reports regarding an incident occurring on the night of 5/26/23, a staff member (Staff #5) was witnessed mistreating Resident #3 after refusing to assist him/her to the bathroom. Staff #5 reportedly responded to Resident #3's request to use the bathroom by stating s/he could void in the disposable brief s/he was wearing. While other staff on duty assisted Resident #3 to the bathroom Staff #5 was informed the refusal to toilet is considered neglect and abuse. Staff #5 responded by joining the other staff in assisting Resident #3, and while assisting s/he was observed rushing Resident #3 by repeatedly telling him/her to hurry up and kicking at his/her heels to get him/her to move faster. Once Resident #3 was returned to his/her bed Staff #5 reportedly stated "[S/he] can stay right there, cause I am not going to get [him/her] up". Staff #5 was placed on leave, then terminated following the facility's internal investigation of the incident. On 5/31/23, five days after this incident occurred, a staff member (Staff #4) who witnessed the mistreatment of Resident #3 reported an additional incident of abuse and neglect of another resident in the Memory Care Unit by Staff #5. On the morning of 5/26/23. Staff #4 stated s/he witnessed Staff #5 yelling at Resident #4 when s/he was having difficulty standing up. Resident #4 has Cerebral Palsy, uses a walker, and requires one staff assist to stand. Staff #4 reported hearing Staff #5 yell "You need to stand up" and saying "If you want to have breakfast you will have to get up on your own". Resident #4 was reportedly crying and stated "I don't like to be yelled at" as Staff #4 assisted him/her following this incident.	R224		

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R224	Continued From page 13 On the afternoon of 8/1/23 the Executive Director confirmed the mistreatment of Resident #3 and Resident #4 by Staff #4.	R224		
R266 SS=E	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure care in a safe environment related to hazardous items stored in Resident's Rooms in the Memory Care Unit. Findings include: During the tour of the Memory Care Unit commencing at 10:10 AM the following environmental issues were observed: 1. A rack of filled Oxygen tanks was stored in room # 116 without signage on the door indicating oxygen was in use or stored in the room. The oxygen was in use in the room until the previous resident who lived in the room passed away. The Executive Director (ED) confirmed the Oxygen tanks were stored in the room without the appropriate signage, and stated the tanks were awaiting removal. 2. A disposable razor was observed to be stored on top of a cabinet in the bathroom in room #111.	R266	1. Action to Correct Deficiency Signs have been placed on any rooms that have Oxygen storage. Hazardous items found during the inspection were removed immediately. 08/01/23 2. Measures to Prevent Recurrence All staff will receive a training on the importance of keeping hazardous materials away from residents in the Memory Care neighborhood. Additionally, family members will receive a communication asking them to check with staff before providing their loved ones with any items that may be considered hazardous. 3. Monitoring Practice Implemented Staff who work in Memory Care will receive additional training on what can be considered hazardous to residents, and to look for these items each time they are in the room assisting residents or cleaning. The Management team will do Environmental Rounds at least every 2 weeks, looking for anything that may be unsafe. 4. Date to be Completed 10/20/23	

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R266	Continued From page 14 This hazardous item was removed immediately by the ED due to safety concerns, and was confirmed by the ED to be an item that is not permitted to be accessible to residents. 3. Hazardous chemicals including nail polish remover, alcohol based hand wipes, Polydent Antibacterial Denture cleaner; and medications including Prevident 0.2% Fluoride Rinse, alcohol based antiseptic mouth wash, and Gold Bond Medicated Powder were observed to be stored in residents rooms. These items were removed from the resident's rooms by the ED during the tour of the Memory Care Center, and confirmed to be items which were not permitted to be stored in the resident's rooms.	R266	R266 Accepted on 10/19/23. Sherry Ross, RN	
R291 SS=F	IX. PHYSICAL PLANT 9.6 Plumbing 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 of the Assisted Living Residences (ALR). Findings include: Per observation on 8/01/23 at 09:20 AM water temperatures exceeded the recommended 120 degrees Fahrenheit in nine resident areas as follows: * 127.5 degrees Fahrenheit in room #104 * 122.0 degrees Fahrenheit in room #103	R291	1. Action to Correct Deficiency The Facilities Director immediately adjusted the mixing valve in the boiler room. On 08/01/23 2. Measures to Prevent Recurrence Further inspection found a part that needed to be replaced. The repair work was completed on 8/14/23. 3. Monitoring Practice Implemented Facility Director will monitor and record temps weekly, taking a random sample in different locations of the building, at different times of the day. These reports will be reviewed by the QA Committee monthly. 4. Date to be Completed 10/06/23	

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R291	Continued From page 15 * 123.6 degrees Fahrenheit in room #105 * 123.6 degrees Fahrenheit in room #202 * 121.3 degrees Fahrenheit in room #204 * the second-floor resident restroom water temperature was noted to be 123.4 degrees Fahrenheit * the second floor resident kitchenette water temperature was noted to be 127.0 degrees Fahrenheit * in the memory care unit: 121.3 degrees Fahrenheit in room #111, and 123.1 degrees Fahrenheit in room #118. This observation was confirmed by the facilities Director of Nursing (DON) at the time of findings, and on 8/1/23 the water temperatures were observed to be corrected and noted to be below the required 120 degrees Fahrenheit.	R291	R291 Accepted on 10/19/23. Sherry Ross, RN	