

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 11, 2016

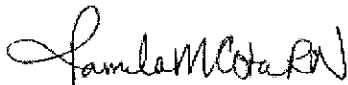
Mr. Robert Memmolo, Administrator
Arbors Nursing Home
687 Harbor Road
Shelburne, VT 05482

Dear Mr. Memmolo:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 12, 2016**. 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
Licensing Chief

PRINTED: 10/05/2016
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 47S001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2016
NAME OF PROVIDER OR SUPPLIER ARBORS NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 687 HARBOR ROAD SHELBURNE, VT 05482			
(X4) ID PREFIX TAG N 001 SS=D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG N 001	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	<p>Initial Comments</p> <p>An unannounced on site annual re-licensing survey was conducted by the Division of Licensing and Protection on 9/12/16. The findings include the following:</p> <p>8. PHYSICAL ENVIRONMENT</p> <p>8.3 Space and Equipment</p> <p>The facility must:</p> <p>(b) Maintain all essential mechanical, electrical and patient care equipment in a safe operating condition.</p> <p>This requirement was NOT MET as evidenced by:</p> <p>Based on observation and staff interview, the facility failed to ensure refrigeration equipment is operating properly and kept clean to ensure food safety. The findings include the following:</p> <p>Per facility tour at 11:45 AM in the presence of the Activity Coordinator and the Director of Dining Services, the refrigerator on the West Unit Kitchenette was observed with the following concerns:</p> <ol style="list-style-type: none"> 1. Small refrigerator located in the newly renovated dining room, storing nourishments and snacks for resident use, was found to have no recording that temperatures are reviewed/logged. 2. Large refrigerator located in a locked room adjacent to the dining room, storing nourishments for resident use, was found to have inconsistent temperature logs. 3. Large refrigerator located in a locked room adjacent to the dining room, storing nourishments 			<ol style="list-style-type: none"> 1. Dining staff responsible for checking refrigerator temperatures and maintaining a daily log. Dining staff was re-trained 9/12/16. 2. Daily logs will continue to be checked and recorded daily on all refrigerators by DSD/Designee. 3. All Refrigerators were cleaned by staff and retrained on 9/12/16 4. All Refrigerators be cleaned on a weekly basis schedule. DSD/Designee will do random audits to verify compliance. <p>8.3(b) POC accepted 10/10/16 mbertrand/RS/pw</p>	

Division of Licensing and Protection

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

STATE FORM

TITLE

(X5) DATE

UN4P11

If continuation sheet 1 of 2

PRINTED: 10/05/2016
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 47S001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/12/2016
NAME OF PROVIDER OR SUPPLIER ARBORS NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 687 HARBOR ROAD SHELburnE, VT 05482			
(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
N 001	Continued From page 1 for resident use, was found to have accumulated dried sticky liquid and food spills located throughout the refrigerator. Confirmation was made by the Director of Food Service at 11:54 AM that the refrigerator is very dirty and needs attention and the temperature logs are either inconsistent or absent therefore, the facility can't ensure that perishable food stored in these areas is safe for distribution to the resident population.	N 001			

Division of Licensing and Protection
STATE FORM

3599

UN4P11

If continuation sheet 2 of 2