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

January 22, 2024

Deanna Ryerson, Manager
Assist Program
851 Pine Street
Burlington, VT 05401

Dear Ms. Ryerson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 19, 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.

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

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
	0511	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSIST PROGRAM	851 PINE STREET BURLINGTON, VT 05401

(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 in conjunction with 1 facility reported incident was conducted by the Division of Licensing and Protection on 12/19/23 to determine compliance with the Vermont Therapeutic Community Residences (TCR) Licensing Regulations effective 3/1/22. The following regulatory violations were identified.	T 001		
T 049 SS=F	V.5.8.h.4 Resident Care and Services 5.8 Medication Management 5.8.h.4 Medications left after the death or discharge of a resident, or outdated medications, shall be promptly disposed of in accordance with the residence ' s policy and applicable standards of practice and regulations. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the Nurse failed to ensure medications belonging to previous resident's were disposed of according to facility policy and procedures. Findings include: Per observation of the medication storage cabinet, medications belonging to previous residents were within the medication cabinet. The medications observed were a remaining cycle package of Propranolol 10 mg tablet , a box of Nicotine patch 21mg, a sealed box of Nicotine gum 4 mg, 2 boxes of Nicorette 4 mg (mini lozenges) containing 81 lozenges each; 9 sealed intact boxes containing 5 patches each of Lidocaine 4% pain relief patches and Nicootrol inhaler including 168 cartridges. The facility Medication Administration Handbook	T 049	T-049 Accepted on 1/22/24. Sherry Ross, RN	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

1/17/24 Deanna L Ryerson PhD
Director of Crisis (interim program manager)

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T 049	Continued From page 1 and Procedure guide section titled, When a Client Discharges from Assist, indicates that "Medications that a client or resident leaves behind after discharge from the program will be considered for disposal if arrangements cannot be made for the client to retrieve the medications within a reasonable amount to time. (3 days)" Per interview on 12/19/23 at 11:25 AM with the Med Tech, confirmed the medications belonged to previous residents. The med tech explained when a resident discharges the Nurse will manage the remaining medications and coordinate with a case manager or waste the medications. Per interview on 12/19/23 at 11:50 AM the Nurse confirmed the medications observed belonged to previous resident. The nurse indicated the medications should be held for a "few" days per policy as the nurse will coordinate with the case manager to organize the medications belonging to the resident after discharge. The Nurse confirmed the medications are to be wasted if medications are still within the facility after a period time as indicated in the policy. This deficient practice presents a potential for more than minimal harm because of the high risk of outdated or another person's medications being improperly used.	T 049		
T 052 SS=F	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	T 052	T-052 Accepted on 1/22/24. Sherry Ross, RN	

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T 052	Continued From page 2 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, 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 Therapeutic Community Residence (TCR) failed to ensure all staff received the required 12 hours of training each year. Findings include: Per record review on 12/19/23 the 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	T 052		

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T 052	Continued From page 3 residents. Per interview in the afternoon of 12/19/23 the manager confirmed that staff providing direct care did not have the required yearly training to include Resident Rights; Fire Safety; Mandatory Reporting; Infection Control; Emergency Response; Respectful Interactions and General Supervision.	T 052		
T 066 SS=D	V.5.10.d.2 Resident Care and Services 5.10 Records/Reports 5.10.d.2 A written report of any reports or incidents of abuse, neglect or exploitation reported to the licensing agency. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that an allegation of abuse was reported to the licensing agency. Findings include: Per record review on 12/19/23 Resident #1 reported an incident of alleged abuse on 10/26/23 at approximately 2:00 PM. Although the facility manager was aware of this allegation and an internal investigation was conducted the facility failed to report the allegation of abuse to the licensing agency until 11/1/23. Per record review of written policies and procedures on 12/19/23 it was noted the facility has a policy entitled: Adult and Child Abuse Report last reviewed on 4/24/2023 states " All staff persons who has a reasonable suspicion	T 066	T-066 Accepted on 1/22/24. Sherry Ross, RN	

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T 066	Continued From page 4 that any vulnerable adult has been abused, neglected, or exploited must report the suspicion to Adult Protective Services (APS). APS is part of the Vermont Department of Disabilities, Aging & independent Living (DAIL) Division of Licensing and Protection (DLP)". Per interview conducted on the afternoon of 12/19/23 the manager confirmed that a written report was not submitted to the licensing agency until 11/1/23. This deficient practice poses a potential safety risk as facilities are required to report all incidents and allegations of abuse to the licensing agency to aid in the protection of the residents.	T 066		
T 174 SS=F	IX.9.6.d 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. Findings include: Per observation on 12/19/23 at 9:35 AM water temperatures exceeded the recommended 120 degrees Fahrenheit in two resident areas. Resident restroom #1 water temperature was noted to be 129.6 degrees Fahrenheit, and resident restroom #2 water temperature was noted to be 134.6 degrees Fahrenheit. This	T 174	T-174 Accepted on 1/22/24. Sherry Ross, RN	

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T 174	Continued From page 5 observation was confirmed by staff at the time of finding. Facility maintenance was notified and adjusted water temperature. At 1:30 PM resident restroom #1 water temperature was noted to be 127.6, and resident restroom #2 water temperature was noted to be 129.3. The facility manager notified surveyors that an outside company was called to address water temperatures. On the afternoon of 12/19/23 a Climate Systems technician was onsite and informed the surveyor that a new mixing valve was on order. Per record review of the facilities policies and procedure manual conducted on 12/19/23, the facility failed to develop a written policies and procedure to monitor the facility water temperatures. This deficient practice poses potential safety risk for more than minimal harm due to increased risk of scolding or burns.	T 174		
T 187 SS=D	IX.9.11.c Physical Plant 9.11 Disaster and Emergency Preparedness 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.	T 187	T-187 Accepted on 1/22/24. Sherry Ross, RN	

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T 187	Continued From page 6 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 12/19/23 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. This was confirmed by the manager on 12/19/23 at 1:30 PM.	T 187		
T999 SS=C	Final Comments This REQUIREMENT is not met as evidenced by: 4.13.f The home shall make written reports resulting from inspections readily available to residents and to the public in a place readily accessible to residents where individuals wishing to examine the results do not have to ask to see them. The home must post a notice of the availability of such written reports. If a copy is requested and the home does not have a copy machine, the home must inform the resident or member of the public that they may request a copy from the licensing agency and provide the address and telephone number of the licensing agency. This requirement was NOT MET as evidenced	T999		

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T999	Continued From page 7 by: Based on observation and staff interview there was a failure to ensure a current written report with results of inspection was readily available to residents. The residence shall make current written report results from inspection readily available to residents and to the public in a place readily accessible to residents where individuals wishing to examine the results do not have to ask to see them. Findings include: On the afternoon of 12/19/23, when asked to show surveyor where the written reports with inspection results that should be available to the public and residents was posted the facility supervisor was unable to locate the reports. A license shall be issued only for the applicant(s) and premises named in the application and is not transferable or assignable. This requirement was NOT MET as evidenced by: During the facility tour commencing at 9:15 AM, the license posted within the facility indicated a name of a previous manager. The license was issued on 1/1/23 with an expiration of 12/31/23. Per record review of application history, the facility applied for a renewal license on 12/8/23, indicating the current manager. Per interview on 12/19/23 at 10:00 AM the current	T999	T-999 Accepted on 1/22/24. Sherry Ross, RN	

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T999	Continued From page 8 Manager confirmed the license posted was with the previous Manager with an expiration date of 12/31/23. S/he stated to have assumed the role of Manager in May 2023, and confirmed the licensing agency was not notified at that time of a change in manager to the facility. In further interview, the current manager submitted a new application for a "renewal" license with his/her name as the manager. The application was submitted on on 12/8/23. The manager acknowledged the failure to notify the licensing agency of a change in manager for the facility in May 2023, when s/he assumed the role.	T999		

January 17, 2024

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

Deanna Ryerson
Director of Crisis (Interim Program Manager)
Howard Center
ASSIST Program

Re: DAIL: Re-licensing Survey Plan of Correction for site visit 12/19/23

1) **Regulation T049:**
V.5.8.h.4 Resident Care and Services
5.8 Medication Management
5.8.h.4 Medications left after the death or discharge of a resident, or outdated medications, shall be promptly disposed of in accordance with the residence ' s policy and applicable standards of practice and regulations.

Findings from Site Visit:
Based on observation and staff interview the Nurse failed to ensure medications belonging to previous resident's were disposed of according to facility policy and procedures. Findings include: Per observation of the medication storage cabinet, medications belonging to previous residents were within the medication cabinet. The medications observed were a remaining cycle package of Propranolol 10 mg tablet , a box of Nicotine patch 21mg, a sealed box of Nicotine gum 4 mg, 2 boxes of Nicorette 4 mg (mini lozenges) containing 81 lozenges each; 9 sealed intact boxes containing 5 patches each of Lidocaine 4% pain relief patches and Nicootrol inhaler including 168 cartridges. The facility Medication Administration Handbook and Procedure guide section titled, When a Client Discharges from Assist, indicates that "Medications that a client or resident leaves behind after discharge from the program will be considered for disposal if arrangements cannot be made for the client to retrieve the medications within a reasonable amount to time. (3 days)". Per interview on 12/19/23 at 11:25 AM with the Med Tech, confirmed the medications belonged to previous residents. The med tech explained when a resident discharges the Nurse will manage the remaining medications and coordinate with a case manager or waste the medications. Per interview on 12/19/23 at 11:50 AM the Nurse confirmed the

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Member Agency of United Way of Chittenden County

medications observed belonged to previous resident. The nurse indicated the medications should be held for a "few" days per policy as the nurse will coordinate with the case manager to organize the medications belonging to the resident after discharge. The Nurse confirmed the medications are to be wasted if medications are still within the facility after a period time as indicated in the policy. This deficient practice presents a potential for more than minimal harm because of the high risk of outdated or another person's medications being improperly used.

Plan of Correction:
When a resident is discharged from the program, ASSIST staff will return any of the individual's prescribed or personal over-the-counter medications or supplements to the person directly prior to their leaving the unit. If returning medications to the individual is unsafe or not advised due to safety concerns of the individual, the staff will place the medications in a bag or other container labeled with the individual's name, date of discharge, and use signage to indicate that these medications are for a client who is no longer on the unit and must not be administered. Staff shall notify the Nurse at the time of discharge, and the nurse will return the medications (either to the client with a safety plan or deliver them to a designated caregiver who is responsible for the individual's medication oversight when the client is not admitted to a residential program). If medications cannot be returned to the client or designated caregiver, the medications will be disposed of per agency protocol after 2 business days. The corresponding medication administration handbook will be updated to reflect this change.

Nursing checks all medications for expiration dates when an individual is admitted to ASSIST. If an individual brings their medications into the program, and it is found that there is an expired medication, the Nurse will explain to the client that staff are unable to administer that medication during the course of their admission. If the individual would like the medication to be destroyed, the Nurse or program staff will dispose of that medication per the agency's Disposal of Unused Client Medication policy. If the individual does not consent to disposal of the expired medication, the Nurse will place the medications in a bag or other container labeled with the individual's name, date of admission, and use signage to indicate that these medications are expired and must not be administered, but may be returned to the client upon discharge if that is their preference along with their other belongings.

Over-the-counter (OTC) medications that are stocked by the ASSIST program are kept in a locked cabinet separate from the residents' personal medications. Nursing will monitor the stock of OTC medications to ensure there are no expired OTC medications stored in this cabinet.

Accountability measures to ensure the deficient practice of T 049 does not recur:
The Nurse will provide training to program staff and leadership of the change in practice when a client is no longer admitted to the program and does not take all of their medications with them at the time of discharge.

The Nurse will do a monthly check of all non-prescribed stock over-the-counter medications to ensure that only non-expired medications are kept in stock. Any medications that are expired will be disposed of per agency protocol.

Monitoring corrective actions so the deficient practice of finding T 049 does not recur:
The Nurse will check resident medication storage areas when a client is discharged to ensure that no medications are left behind, and if medications are found, will follow process outlined in the plan of correction.

The Nurse will do a monthly survey of the OTC medication cabinet to look for expired medications. This check will be documented in a log that will be kept in the cabinet where stocked OTC medications are stored.

Date this corrective action will be completed:
Staff training will take place in staff meeting before 1/31/24, and the ongoing monitoring for expired medications or medications that belong to a resident who is no longer admitted to the program will commence immediately after the training. Substitute or staff who are on CTO during this meeting will receive written notification of these changes and confirm receipt of these changes with their supervisor by 2/15/24.

T-049 Accepted on 1/22/24. Sherry Ross, RN

2) **Regulation T052:**
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 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

Findings from Site Visit:
Based on staff interview the Therapeutic Community Residence (TCR) failed to ensure all staff received the required 12 hours of training each year. Findings include:
Per record review on 12/19/23 the 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 in the afternoon of 12/19/23 the manager confirmed that staff providing direct care did not have the required yearly training to include Resident Rights; Fire Safety; Mandatory Reporting; Infection Control; Emergency Response; Respectful Interactions and General Supervision.

Plan of Correction:
Accountability measures to ensure the deficient practice of T 052 does not recur:
Trainings are completed in onboarding schedule and through staff meetings or via an online learning platform. A schedule for the annual training plan and corresponding training calendar is being developed. This will outline which trainings are done as part of onboarding, and which are done on an annual cycle as refresher trainings for all staff in staff meeting to ensure that all trainings are covered annually with all staff to maintain compliance.

Monitoring corrective actions so the deficient practice of finding T 052 does not recur:
All necessary trainings will be tracked in our HC system (Mastery Institute) with quarterly reports aggregating compliance and distributed to staff supervisors for monitoring. This system tracks when trainings are due with reminders and also includes supervisors in reminders when overdue for real-time tracking but summary reports quarterly will ensure that all program leadership are able to understand this on a program-level and follow up accordingly to ensure compliance. Substitute or staff who are new and missed regularly scheduled trainings conducted within staff meeting will have an alternative online platform training identified so they can maintain compliance.

Date this corrective action will be completed:
A review of trainings and corresponding training online alternative will occur before 2/28/24, with onboarding schedule and first quarterly report created by 3/31/24.

T-052 Accepted on 1/22/24.
Sherry Ross, RN

3) **Regulation T066:**
5.10 Records/Reports
5.10.d.2 A written report of any reports or incidents of abuse, neglect or exploitation reported to the licensing agency.

Findings from Site Visit:
Based on staff interview and record review, the facility failed to ensure that an allegation of abuse was reported to the licensing agency. Findings include:
Per record review on 12/19/23 Resident #1 reported an incident of alleged abuse on 10/26/23 at approximately 2:00 PM. Although the facility manager was aware of this allegation and an internal investigation was conducted the facility failed to report the allegation of abuse to the licensing agency until 11/1/23.
Per record review of written policies and procedures on 12/19/23 it was noted the facility has a policy entitled: Adult and Child Abuse Report last reviewed on 4/24/2023 states " All staff persons who has a reasonable suspicion that any vulnerable adult has been abused, neglected, or exploited must report the suspicion to Adult Protective Services (APS). APS is part of the Vermont Department of Disabilities, Aging & independent Living (DAIL) Division of Licensing and Protection (DLP)".
Per interview conducted on the afternoon of 12/19/23 the manager confirmed that a written report was not submitted to the licensing agency until 11/1/23.
This deficient practice poses a potential safety risk as facilities are required to report all incidents and allegations of abuse to the licensing agency to aid in the protection of the residents.

Plan of Correction:
While the APS incident was reported in writing on the same day to APS and to DAIL on 10/26 (date of alleged incident), the report to DAIL was by email and was not on the form requested to be used. This has been clarified and the incident form will be used in any report in future. There is no further action needed on this item. T-066 Accepted on 1/22/24. Sherry Ross, RN

4) **Regulation T174:**
IX.9.6.d Physical Plant
9.6 Plumbing
9.6.d Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas

Findings from Site Visit:
Per observation on 12/19/23 at 9:35 AM water temperatures exceeded the recommended 120 degrees Fahrenheit in two resident areas.
Resident restroom #1 water temperature was noted to be 129.6 degrees Fahrenheit, and resident restroom #2 water temperature was noted to be 134.6 degrees Fahrenheit. This observation was confirmed by staff at the time of finding. Facility maintenance was notified and adjusted water temperature. At 1:30 PM resident restroom #1 water temperature was noted to be 127.6, and resident restroom #2 water temperature was noted to be 129.3. The facility manager notified surveyors that an

outside company was called to address water temperatures. On the afternoon of 12/19/23 a Climate Systems technician was onsite and informed the surveyor that a new mixing valve was on order. Per record review of the facilities policies and procedure manual conducted on 12/19/23, the facility failed to develop a written policies and procedure to monitor the facility water temperatures. This deficient practice poses potential safety risk for more than minimal harm due to increased risk of scolding or burns.

Plan of Correction:

Accountability measures to ensure the deficient practice of T 174 does not recur:

Residential leadership is connecting to HC Facilities to ensure that staff are trained in checking water temperature and have necessary equipment to do this. Then, this will be incorporated into our monthly Safety Checks that to ensure that water temperature is checked at each faucet and documented to ensure it is within range and safe for residents. If falling outside parameters indicated, Facilities can be contacted immediately to remedy the situation and has a number to be contacted after-hours 24/7 in case of emergency. This phone number is posted in the front office and also available if staff reach out to supervisors/supervisors on-call after hours for support.

Monitoring corrective actions so the deficient practice of finding T 174 does not recur:

The monthly Safety Checklist process for monitoring building safety will be used as the ongoing monitoring tool to ensure compliance.

Date this corrective action will be completed:

Facilities and Leadership will ensure proper training is done by 1/31/24 and this process will be incorporated into our Monthly Safety Checklist process by 2/28/24.

T-174 Accepted on 1/22/24.
Sherry Ross, RN

5) **Regulation T187:**

IX.9.11.c Physical Plant

9.11 Disaster and Emergency Preparedness

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.

Findings from Site Visit:

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 12/19/23 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. This was confirmed by the manager on 12/19/23 at 1:30 PM

Plan of Correction:

Accountability measures to ensure the deficient practice of T 174 does not recur:
Fire Drill schedules will alternate time of day quarterly across Day, Evening, Night and then repeat. A schedule will be made up in advance and staff person identified to run the drill on each corresponding timeframe.

Monitoring corrective actions so the deficient practice of finding T 174 does not recur:
Date and Time of Fire Drills will be tracked on Monthly Safety Checklists.

Date this corrective action will be completed:
A schedule will be made up date and time with identified staff for fire drills by 1/31/24.
T-187 Accepted on 1/22/24. Sherry Ross, RN

6) **Regulation T999: Final Comments**
4.13.f The home shall make written reports resulting from inspections readily available to residents and to the public in a place readily accessible to residents where individuals wishing to examine the results do not have to ask to see them. The home must post a notice of the availability of such written reports. If a copy is requested and the home does not have a copy machine, the home must inform the resident or member of the public that they may request a copy from the licensing agency and provide the address and telephone number of the licensing agency.

Findings from Site Visit:
Based on observation and staff interview there was a failure to ensure a current written report with results of inspection was readily available to residents. The residence shall make current written report results from inspection readily available to residents and to the public in a place readily accessible to residents where individuals wishing to examine the results do not have to ask to see them. Findings include:
On the afternoon of 12/19/23, when asked to show surveyor where the written reports with inspection results that should be available to the public and residents was posted the facility supervisor was unable to locate the reports.

And

A license shall be issued only for the applicant (s) and premises named in the application and is not transferable or assignable. During the facility tour commencing at 9:15 AM, the license posted within the facility indicated a name of a previous manager. The license was issued on 1/1/23 with an expiration of 12/31/23. Per record review of application history, the facility applied for a renewal license on 12/8/23, indicating the current manager. Per interview on 12/19/23 at 10:00 AM the current Manager confirmed the license posted was with the previous Manager with an expiration date of 12/31/23. S/he stated to have assumed the role of Manager in May 2023, and confirmed the licensing agency was not notified at that time of a change in manager to the facility. In further interview, the current manager submitted a new application for a "renewal" license with his/her name as the manager. The application was submitted on on 12/8/23. The manager acknowledged the failure to notify the licensing agency of a change in manager for the facility in May 2023, when s/he assumed the role.

Plan of Correction:

The most current site visit report (from 12/19/23) and the new license with the current manager are currently posted at the front office in visible location. The program manager (interim) has reviewed the requirements of transfer and will submit new application when a new manager is hired immediately to notify of the change in management when this position is hired. No further action is needed.

T-999 Accepted on 1/22/24. Sherry Ross, RN