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

February 8, 2023

Ms. Stacey Johnson
Ave Maria Community Care Home
19 School Street
Richford, VT 05476-1130

Dear Ms. Johnson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 13, 2022.** Please post this document in a prominent place in your facility.

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

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0005	A. BUILDING: _____ B. WING _____	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA COMMUNITY CARE HOME	19 SCHOOL STREET RICHFORD, VT 05476

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R100	Initial Comments: On 12/12/22 the Division of Licensing and Protection conducted an unannounced on-site relicensure survey. Additional information was provided by the Administrative Manager in training for the organization that manages the facility on 12/13/22. The following regulatory deficiencies were identified:	R100		
R128 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the nurse failed to ensure medication administration consistent with physician's orders for one applicable resident. (Resident # 2) Findings include: On 8/23/22 Resident #2's physician ordered Kaopectate 525 mg/15 ml 1-2 Tablespoons by mouth once daily as needed daily for Diarrhea. Resident #2's December 2022 Medication Administration Record (MAR) includes an order for Kaopectate 262 mg/15 ml with instructions to administer 1-2 Tablespoons by mouth as needed for Diarrhea. The order entered in the MAR does not include the administration schedule and lists a dose that is not consistent with the physcian's orders. Resident #2's December 2022 MAR includes	R128	(PLEASE SEE ATTACHED)	

R128 - R302 POC accepted 2/3/23 JEvans RN/PMC

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R128	Continued From page 1 orders for Folic Acid 3 mg by mouth once daily. On 8/23/22 Resident #2's physician ordered Folic Acid 5 mg by mouth once daily On the afternoon of 8/23/22 the Staff on duty confirmed Resident #2's MAR orders for Kaopectate and Folic Acid were not consistent with physician's orders, and on the evening of 12/12/22 the Administrative Manager in training acknowledged this finding.	R128		
R145 SS=E	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 record review and staff interview the Registered Nurse failed to ensure the written plan of care for 3 applicable residents (Residents #1, #2, and #3) describes the care and services necessary to assist the resident to maintain independence and wellbeing. Findings include: 1. Resident #1 was admitted to the facility in 2006. His /her diagnoses include Dementia, Bipolar Disorder, medication induced tremors, Morbid Obesity, Peripheral Vascular Disease, and back and neck pain.. S/he is receiving end of life	R145	PLEASE SEE ATTACHED	

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R145	Continued From page 2 care, with hospice medication orders initiated on 6/27/22. The Care Plan on file for Resident #1, dated 5/20/21, does not address chronic pain and has not been updated to include hospice care interventions including instructions for the use of comfort medications during the end of life process. 2. Resident #2 was admitted to the facility in September of 2021. His/her diagnoses include Ataxic Cerebral Palsy (developmental disorder that affects balance, coordination, and motor skills); Adjustment Disorder (poor response to stress and changes), and Moderate Intellectual Disabilities. Staff notes for Resident #2 document declining health with increased frequency and severity of signs and symptoms of Cerebral Palsy including falls, injuries, difficulty swallowing, inability to hold his/her head up, as well as head, neck, and leg pain. The Care Plan on file for Resident #2, dated and signed by a Registered Nurse on 9/14/21, fails to address risk for falls and injuries, pain, loss of motor control; and risks for imbalanced nutrition, dehydration and choking due to impaired ability to swallow and hold his/her head up. Additionally, his/her Care Plan does not include the swallowing guidelines provided on 6/7/22 by the Speech-Language Pathology Department of the Home Health Agency providing care for Resident #2. 3. Resident #3 was admitted to the facility in 2015. His/her diagnoses include Adult Failure to Thrive, Abnormal Weight Loss, General Weakness, history of nerve damage due to shingles and hemiplegia (one sided	R145		

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R145	Continued From page 3 weakness/partial paralysis) subsequent to a cardiovascular event, low blood pressure, Osteoarthritis, upper back pain, and chest pain. Resident #3's most recent Care Plan on file, dated 12/30/2020, fails to address pain; and risks for imbalanced nutrition and inadequate intake of calories associated with Adult Failure to Thrive. On the evening of 12/12/22 the Administrative Manager in training acknowledged the Care Plans for Residents #1, #2, and #3 did not include care and services necessary to maintain resident wellbeing.	R145		
R162 SS=E	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 record review and staff interview there was a failure to ensure medication orders were signed by a physician for 6 applicable residents. (Residents #2, #3, #4, #5, #6. and #7) Findings include: 1. On the afternoon of 12/12/22 the Med Delegated Staff confirmed there were no signed orders maintained on file and available for review on request for the following medications in the Medication Administration for Residents #2 and #3:	R162	(PLEASE SEE ATTACHED)	

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R162	Continued From page 4 * Isopto Atropine 1% Eye Drop instill 2-4 drops sublingually every 2-4 hours for excessive secretions for Resident #2 * Docusate Sodium 100 mg softgel, 1 capsule by mouth twice daily; Nystop 100,000 units/gram powder apply under breasts twice daily; Clotrimazole 1% cream apply topically to abdomen and legs twice daily; and Zinc Oxide 20% ointment apply topically to sacral area every shift for redness for Resident #3. On the evening of 12/12/22 the Administrative Manager in Training for the organization that manages the Residential Care Home acknowledged the lack of signed medication orders for Resident's #2 and Resident #3. 2. Over the counter medications were observed stored in the bathrooms and bedrooms of residents during the facility tour commencing at 10:28 AM on 12/12/22 including Analgesic Gel for Resident #3; Aspercreme topical pain reliever and Systane Lubricating Eye Drops for Resident's #4 and #5; Systane Lubricating Eye Drops, Vitamin B 12, Vitamin C for Resident #6; and Systane Lubricating Eye Drops for Resident #7. At 12:45 PM on 12/12/22 the Registered Nurse confirmed there were no signed orders for Residents #3, #4, #5, #6, and #7 to self administer medications, and the Residents Assessments the 5 applicable residents self administering medications indicated the residents require medication administration and did not control their own medications.	R162		

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R172	Continued From page 5	R172		
R172 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h All medicines and chemicals used in the home must be labeled in accordance with currently accepted professional standards of practice. Medication shall be used only for the resident identified on the pharmacy label. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview unlabeled medications were observed stored in the medication cart. Findings include: During examination of the medication administration system conducted with the Manager and commencing at 12:56 PM on 12/12/22 an albuterol inhaler; bottles of diabetic testing strips; a bottle of Lion's Mane Mushroom capsules; boxes of Duo Derm Wound Dressing; a bottle of Loratadine 10 mg tablets; a small box containing white pills that appear to be Loratadine 10 mg tablets; and a bottle of Tylenol 500 mg tablets were confirmed by the Manager to be stored in the medication care without labels identifying the name of the resident the medications belonged to and/or prescriber's instructions for use.	R172	(PLEASE SEE ATTACHED)	
R173 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h.	R173	(PLEASE SEE ATTACHED)	

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R173	Continued From page 6 (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, record review, and staff interview there was a failure to store all medications the home manages in a locked compartment. Findings include: During the course of the facility tour commencing at 10:28 Am on 12/12/22 medications were observed in resident bathrooms and rooms to include Systane Eye Lubricant Drops and Aspercreme topical pain reliever in the bathroom shared by Resident #4 and #5; Analgesic Gel stored in a shared bathroom for Resident #3; Systane Eye Drops, Vitamin B 12, and Vitamin C gummies in Resident #6's room; and Systane Lubricating Eye Drops in Resident #7's room. During the course of the facility tour commencing at 10:28 AM on 12/12/22 the Manager confirmed medications belonging to Residents #3, #4, #5, #6, and #7 were not stored in a locked compartment . At 12:45 PM on 12/12/22 the Registered Nurse confirmed the Resident Assessments for Residents #3, #4, #5, #6, and #7 all indicate the residents require medication administration, and there are no signed orders to self administer medications the residents.	R173		
R176 SS=E	V. RESIDENT CARE AND HOME SERVICES	R176	(PLEASE SEE ATTACHED)	

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R176	Continued From page 7 5.10 Medication Management 5.10.h (4) Medications left after the death or discharge of a resident, or outdated medications, shall be promptly disposed of in accordance with the home's policy and applicable standards of practice. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure prompt disposal of outdated medications. Findings include: During examination of the medication administration system conducted with the Manager and commencing at 12:56 PM on 12/12/22 expired medications and medical supplies including diabetic testing strips expired as of 10/25/20; Lumigan Eye Drops expired as of 5/31/2022; Cough Drops expired as of 12/5/2022; Ben Gay Cream expired as of 4/30/22; Benadryl 25 mg tablets expired as of 8/31/22; Loratadine 10 mg tablets expired as of 3/31/19; Acetaminophen 500 mg tablets expired as of 3/31/22; and DuoDerm wound dressing expired as of 5/1/22 were observed and confirmed by the Manager to be stored in the medication cart.	R176		
R179 SS=E	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	R179	(PLEASE SEE ATTACHED)	

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R179	Continued From page 8 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 record review and staff interview there was a failure to ensure all staff received all required yearly trainings. Findings include: Per record review 2 out of 5 sampled staff failed to complete all of the required yearly trainings to include trainings in Resident Rights; Fire Safety and Emergency Evacuation; Resident Emergency Response Procedures; Mandatory Reports of Abuse, Neglect and Exploitation; Respectful and Effective Interaction with Residents; Infection Control Measures; and General Supervision and Care of Residents.	R179		

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R179	Continued From page 9 On the afternoon of 12/12/22 the Manager confirmed Staff #1 did not complete training in Mandatory Reporting of Abuse, Neglect, and Exploitation; and Staff #2 did not complete trainings in Resident's Rights, Mandatory Reports of Abuse, Neglect and Exploitation; and Respectful and Effective Interaction with Residents.	R179		
R221 SS=E	VI. RESIDENTS' RIGHTS 6.9 Residents may manage their own personal finances. The home or licensee shall not manage a resident's finances unless requested in writing by the resident and then in accordance with the resident's wishes. The home or licensee shall keep a record of all transactions and make the record available, upon request, to the resident or legal representative, and shall provide the resident with an accounting of all transactions at least quarterly. Resident funds must be kept separate from other accounts or funds of the home. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview the facility failed to ensure written requests were submitted for the management of funds for 4 applicable residents (Residents#1, #2, #3, and #6), a written record of all transactions was maintained for 2 applicable residents (Resident #6 and #8) , and quarterly accounting of all transactions was provided to the 8 residents for whom the home manages funds (Residents #1, #2, #3, #6, #7, #8, #9, and #10). Findings	R221	(PLEASE SEE ATTACHED)	

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R221	Continued From page 10 include: During the process of confirming the accurate accounting of resident funds managed at the home on the afternoon of 12/12/22, the absence of a written record of transactions for Residents #6 and #8 was observed and confirmed by the Manager. Additionally, the Manager confirmed the accounting of funds for Residents #1, #2, #3, #6, #7, #8, #9, and #10 is conducted only when a resident requests money and stated a process is not in place to provide the residents with quarterly accounting of all transactions. At 4:40 PM 12/12/22 the Finance Manager for the organization that manages the home confirmed the absence of a written request to manage funds for Residents #1, #2, #3, and #6.	R221		
R247 SS=F	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 there was a failure to ensure kitchen staff consistently labeled, dated and covered all perishable food items. Findings include: During the course of the facility kitchen observation, commencing at 10:28 AM on 12/12/22, the Manager confirmed the observation	R247	(PLEASE SEE ATTACHED)	

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R247	Continued From page 11 of the following perishable food items stored without dates indicating when the items were opened or prepared. * In refrigerator #1: A gallon of milk; pitcher of orange juice; bottles of apple, grape, cranberry, prune and tomato juice; container of half and half; three 2 liter bottles of soda; French toast, English muffins, tortillas, chopped lettuce, salad mix, and pepperoni in Ziploc bags; a plastic tub of cooked sausage; and seven packages of sliced cheese wrapped in saran wrap stacked in an disorganized fashion of the door of the refrigerator. Some of the packages were loosely wrapped allowing exposure to air, and contained sliced cheese with dried edges. * In freezer #1: Unsealed bags of battered fish and hash browns, a Ziploc bag of hamburger, and sliced American cheese wrapped in a single layer of plastic wrap with ice crystals accumulating inside the packaging. * In refrigerator #2: Two containers of cool whip, one recycled plastic tub containing corn chowder and another containing food scraps which the Manager reported are stored in the refrigerator for a staff member's animals at home. * Additionally there were large recycled plastic tubs containing outdated foods including BBQ sauce dated 11/10/22; dill pickles dated 4/3/22; Italian dressing dated 7/6/22; Caesar dressing dated 9/12/22; and what appeared to be Thousand Island dressing in a tub with a handwritten label identifying the contents as "crab cakes 9/6/22" stored in refrigerator #2.	R247		

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R258 SS=D	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.h All garbage shall be collected and stored to prevent the transmission of contagious diseases, creation of a nuisance, or the breeding of insects and rodents, and shall be disposed of at least weekly. Garbage or trash in the kitchen area must be placed in lined containers with covers. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was failure to ensure garbage in the kitchen area is stored in a container with a cover to prevent the transmission of contagious diseases, creation of a nuisance, and the breeding of insects.. Findings include: During the course of kitchen tour commencing at 10:28 AM on 12/12/22 the Manager confirmed the observation of the kitchen garbage can without a cover.	R258	(PLEASE SEE ATTACHED)	
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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews there was a failure to ensure a safe, functional,	R266	(PLEASE SEE ATTACHED)	

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R266	Continued From page 13 homelike, comfortable environment related to the storage of cleaning supplies and medications, and windows without screens. Findings include: During the facility tour commencing at 10:28 AM on 12/12/22 the following environmental issues were observed. 1. Cleaning supplies were stored in unlocked areas accessible to residents throughout the home including: a) In the facility kitchen, which is open and accessible to Residents, a gallon of bleach, Comet disinfecting powder, dishwashing detergents, and disinfectant spray were stored in an unlocked cabinet under the sink. b) In the unlocked laundry room adjacent to the kitchen, cleaning supplies and other poisonous substances were observed on open shelves above the counter and laundry equipment. These items included bleach; detergents; bottles of floor cleaner and a tub of unlabeled floor cleaner; Febreeze deodorizing sprays; stain removal sprays; bottles of carpet and upholstery cleaners, hospital disinfectants, dust-off spray; unlabeled containers and spray bottles containing unidentified green and clear liquids; Clorox disinfectant wipes and sprays; Comet disinfecting powder; WD 40 lubricating spray; Terro Ant Baits; and Raid Insect spray. c) An unlocked linen closet on the second floor of the facility contained cleaning supplies accessible to residents including floor cleaners, Pledge furniture polish, Clorox spray, and Comet disinfecting powder.	R266		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0005	A. BUILDING: _____ B. WING _____	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA COMMUNITY CARE HOME	19 SCHOOL STREET RICHFORD, VT 05476

(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
R266	Continued From page 14 d) An unlocked staff bathroom on first floor with the door left open except when in use contained Clorox bleach wipes and disinfecting spray; the bathroom between rooms #2 & #3 contained Clorox wipes; an unlabeled disinfectant spray; and the bathroom between rooms #4 & #5 contained an unlabeled bottle of disinfectant spray; Clorox wipes; and a clear disposable plastic drinking cup containing bleach placed beside the bathroom sink. The disposable drinking cup of bleach posed a significant risk for accidental bleach ingestion and was disposed of immediately by the Manager. 2. Medications and over the counter treatments were observed in resident bathrooms and rooms to include Systane Eye Lubricant Drops and Aspercreme topical pain reliever in the bathroom shared by Resident #4 and #5; Analgesic Gel, Gold Bond Powder, and Listerine antiseptic mouthwash stored in a shared bathroom for Resident #3; Systane Eye Drops, Vitamin B 12, and Vitamin C gummies in Resident #6's room; and Systane Lubricating Eye Drops in Resident #7's room. Please refer to tag 173. 3. Rooms #1, #7, and #8 were each missing one window screen. Resident rooms #9, #10, and the Living Room were each missing 2 window screens. During the course of the facility tour commencing at 10:28 AM on 12/12/22 the Manager confirmed the observations of cleaning chemicals and other poisons accessible to residents, medications stored in bathrooms and rooms, and missing window screens. At 12:45 PM on 12/12/22 the Registered Nurse confirmed there are no physician's orders to self administer medications	R266		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0005	A. BUILDING: _____ B. WING _____	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA COMMUNITY CARE HOME	19 SCHOOL STREET RICHFORD, VT 05476

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R266	Continued From page 15 for Residents #3, #4, #5, #6, and #7, and the Resident Assessments for the applicable residents indicated medication administration is required.	R266		
R299 SS=F	IX. PHYSICAL PLANT 9.10 Life Safety/Building Construction All homes shall meet all of the applicable fire safety and building requirements of the Department of Labor and Industry, Division of Fire Prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview there was a failure to ensure fire drills conducted included evacuation of residents from the home. Findings include: During the course of the survey on 12/12/22 the designated Fire Marshall for the company that manages the facility explained the drills conducted at the Residential Care Home (RCH) do not include evacuation of residents from the facility. During drills residents are instructed to congregate in a designated room within the facility. The designated room is a different location each time a drill is conducted. The facility's designated Fire Marshall stated the facility has not been evaluated and approved as a shelter in place facility to ensure specific standards that minimize the risk of remaining in the facility while awaiting emergency response are met. Several of the Resident's living in the home require walkers, one resident is blind, and one resident has cerebral palsy with a significant decline in physical abilities in recent months. The	R299	(Please See Attached)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0005	A. BUILDING: _____ B. WING _____	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA COMMUNITY CARE HOME	19 SCHOOL STREET RICHFORD, VT 05476

(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
R299	Continued From page 16 overnight shift is single staffed, and the facility's emergency plan is to evacuate to a church located across the street from the RCH. The facility designated Fire Marshall acknowledged evacuation of the RCH's residents would be difficult to implement in a safe and timely manner considering the physical needs of the residents, especially if an emergency were to occur at night. At 2:32 PM on 12/12/22 the facility's designated Fire Marshall confirmed residents are not evacuated during drills.	R299		
R302 SS=F	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 record review and staff interview there was a failure to conduct fire drills on at least a quarterly basis and to rotate times of day among morning, afternoon, evening, and night. Findings	R302	(PLEASE SEE ATTACHED)	

JAD

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
	0005	A. BUILDING: _____ B. WING _____	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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R302	Continued From page 17 include: Per record review fire drills were not conducted during the first and third quarters of the year, and there were no evening drills conducted during the year. This was confirmed by the Manager on the afternoon of 12/12/22.	R302		

SAB

Ave Maria Home
Plan of Correction
Residential Care Home State Survey
December 13, 2022

R128

5.5.c

Action:

Kaopectate dose for Resident #2 was e-linked from the pharmacy with a different strength. The Nurse Manager has corrected Resident #2's Electronic Medical Record as of 1/12/23 to reflect physician order. (Please see **Attachment A)**

Folic Acid order for Resident #2 was clarified on 10/14/22 to 3mg by mouth daily. (Please see **Attachment B)**

Measures:

The Nurse Manager met with the nursing team to review the requirement that each resident's medication, treatment, and dietary services shall be consistent with the physician's order.

Monitors:

The Nurse Manager and the entire Nursing Staff will monitor this practice to ensure that this deficiency does not reoccur.

Date Completed:

1/11/23

R145

5.9.c (2)

Actions:

The Nurse Manager updated Resident #1's Care Plan on 1/11/23 (Please see **Attachment C**). Please note that Resident #1 was admitted to Hospice on 7/1/22. Then on 9/29/22, Hospice was revoked as the resident no longer qualified. There

was no End-of-Life Care. Comfort medications were added to the EMR and instructions were given to staff who would administer these PRN on 7/1/22.

The Nurse Manager updated Resident #2's Care Plan on 1/12/23 to address; falls, injuries, safety risks, nutritional challenges and feeding issues. Speech-Language Pathologist guidelines have been provided with the updated Care Plan and instructions were given to direct care staff on 10/12/22 when received. Resident #2 was admitted to the Hospice Program on 1/10/23 and Hospice is included on the Care Plan. (Please see **Attachment D**)

The Nurse Manager has updated Resident #3's Care Plan to address pain, PO intake and nutritional status. (Please see **Attachment E**)

Measures:

The Nurse Manager and entire nursing team will ensure that all residents will have a written plan of care that is based on abilities and needs as identified in the resident assessment and will describe the care and services necessary to assist the resident to maintain independence and well-being.

Monitors:

The Nurse Manger and entire nursing team will monitor this practice to ensure that this deficiency will not reoccur.

Date Completed:

1/12/23

R162

5.10.c

Actions:

The Nurse Manager has located physicians order for Isopto Atropine for Resident #2 (Please see **Attachments F**) Eye drops are to be used as a drying agent used orally. Instructions were given to staff by Nursing for use.

The Nurse Manager has located physicians order for Docusate Sodium, Nystatin, Clotrimazole, and Zinc Oxide for Resident #3 from thinned chart. (Please see **Attachment G**)

The Nurse Manager has clarified medications with Resident #3's physician and has obtained written orders (Please see **Attachment H**). These medications have been moved to locked medication cart.

The Nurse Manager has clarified medications with Resident #4's physician and has obtained written orders (Please see **Attachment I**). These medications have been moved to locked medication cart.

The Nurse Manager has clarified medications with Resident #5's physician and has obtained written orders (Please see **Attachment J**). These medications have been moved to locked medication cart.

The Nurse Manager has clarified medications with Resident #6's physician and has obtained written orders (Please see **Attachment K**). These medications have been moved to locked medication cart.

The Nurse Manager has clarified medications with Resident #7's physician and has obtained written orders (Please see **Attachment L**). These medications have been moved to locked medication cart.

Measures:

The Nurse Manager and entire nursing team will ensure that 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. The Nurse Manager will also ensure to obtain signed orders for any residents to self-administer medications as needed. Additionally, in January 2023, a notification will be sent to the legal representatives of each resident to remind them that all medications brought into the facility, must be given to the nursing staff for review.

Monitors:

The Nurse Manger and entire nursing team will monitor this practice to ensure that this deficiency will not reoccur.

Date Completed:

1/12/23

R172

5.10.h

Action:

As of 1/4/23 the Nurse Manager has destroyed all old or expired medications

Measures:

The Nurse Manager met with the Manager of Ave Maria Home to review the requirement that all medications and chemicals used in the home shall be labeled in accordance with currently accepted professional standards of practice and that medication shall be used only for the resident identified on the pharmacy label.

Monitors:

The Nurse Manager and Manager will monitor this practice to ensure that this deficiency does not reoccur.

Date Completed:

1/4/23

R173

5.10.h

Actions:

The Nurse Manager has moved the Analgesic Gel for Resident #3 to locked medication cart.

The Nurse Manager has moved the Systane Eye Lubricant Drops and Asper Creme topical pain reliever from Resident #4 and Resident #5's bathroom to the locked medication cart.

The Nurse Manager has moved Systane Eye Drops, Vitamin B 12, and Vitamin C gummies from Resident #6's room to the locked medication cart.

The Nurse Manager has moved the Systane Lubricating Eye Drops in Resident #7's room to the locked medication cart.

Measures:

The Nurse Manager and entire nursing team will ensure that all resident medications that are managed by the home are stored in locked compartments under proper temperature controls and that only authorized personnel shall have access to the keys.

Monitors:

The Nurse Manger and entire nursing team will monitor this practice to ensure that this deficiency will not reoccur.

Date Completed:

1/12/23

R176

5.10.h (4)

Actions:

The Nurse Manager has disposed of any and all expired or outdated medications on 1/4/23. The Nurse Manager has also disposed of any medications or treatments belonging to a deceased or discharged resident on 1/4/23.

Measures:

The Nurse Manager and the Manager of Ave Maria Home will ensure that all outdated medications will be promptly disposed of in accordance with applicable standards of practice.

Monitors:

The Nurse Manger and the Manager of Ave Maria Home will monitor this practice to ensure that this deficiency will not reoccur.

Date Completed:

1/4/23

R179

5.11.b

Action:

As of 01/16/2023, the 2 cited employees have completed a minimum of 12 hours of training and meet the requirement of mandatory topics (Please see **Attachments M, N, O, P, Q, and R**).

Measures:

The Manager will review the training progress of each staff member at Ave Maria Home on no less than a quarterly basis to ensure that each staff person providing direct care to residents have received at least twelve (12) hours of training each

year as identified in Regulation 5.11.b in the Vermont Residential Care Home Regulations.

Monitors:

The Manager will monitor this practice to ensure that this deficiency will not reoccur.

Date Completed:

01/16/2023

R221

6.9

Action:

Written requests by Resident #1, Resident #2 and Resident #3 and Resident #6 have been obtained to allow Ave Maria Home to manage the resident's finances. (Please see **Attachments S, T, U, and V**) Additionally, a written record of transaction has been updated for Resident #6 and Resident #8 and an accounting of funds has been provided to Resident #1, #2, #3, #6, #7, #8, #9 and #10 as of 01/12/2023

Measures:

The Finance Manager and Manager of Ave Maria Home will ensure that Ave Maria will not manage a resident's finances unless requested to do so in writing by the resident and in accordance with the resident's wishes. The Finance Manger will keep a record of all transactions and provide the resident with an accounting of all transactions on a quarterly basis.

Monitors:

The Finance Manager and Manager of Ave Maria Home will monitor this practice to ensure that this deficiency does not reoccur.

Date Completed:

01/12/2023

R247

7.2.b

Action:

On December 14, 2022, all perishable food and drink were correctly labeled and dated in refrigerator #1, freezer #1 and refrigerator #2 and all outdated or expired items were discarded.

Measures:

The Manager and staff at Ave Maria Home will ensure that all perishable food and drink shall be labeled and dated. Additionally, all outdated or expired food items will be promptly discarded as needed.

Monitors:

The Manager and staff at Ave Maria Home will monitor this practice to ensure that this deficiency does not reoccur.

Date Completed:

12/14/2022

R258

7.3.h

Action:

A cover has been installed on the kitchen garbage can on 12/14/22

Measures:

The Manager and staff at Ave Maria Home will ensure that the garbage in the kitchen area will be placed in lined containers with covers.

Monitors:

The Manager and staff at Ave Maria Home will monitor this practice to ensure that this deficiency does not reoccur.

Date Completed:

12/14/22

R266

9.1.a

Action:

On December 14, 2022, all harmful/poisonous substances and cleaning supplies have been stored in locked cabinets and/or in locked storage areas. Additionally, a new lock has been installed on the laundry room door and medications/over the counter treatments have been stored in locked cabinets. All bedroom screens have been replaced other than those in bedrooms where air conditioning units will be installed in the Spring. The living room window screens were removed during the winter months to install the storm windows. These screens will be reinstalled in the Spring when the storm windows are removed.

Measures:

The Manager has reminded all staff that Ave Maria Home must provide and maintain a safe, functional, sanitary, homelike, and comfortable environment. To that end, all harmful cleaning products and medications/over the counter treatments must be stored in a locked area when not in use. The Manager will also ensure that screens are on all bedroom windows that do not have air conditioner units in them.

Monitors:

The Manager and staff will monitor this practice to ensure that this deficiency will not reoccur.

Date Completed:

January 11, 2023

R299

9.10

Action:

Please find attached a memo dated March 13, 2013, from the Department of Public Safety – Division of Fire Safety which states:

> *"Facilities protected by an automatic sprinkler system, having impractical residents must demonstrate that evacuation can be conducted in 13 minutes or less, or at least two (2) or more staff based on number of residents requiring personal assistance, shall be on duty at all times regardless of facility size (small or large)."*

Ave Maria Home is protected by an automatic sprinkler system and upon review of the Ave Maria Home Fire Drill Logbook the last six (6) fire drills have been conducted with the average internal evacuation time of 10 minutes. Therefore, according to the above stated memo, Ave Maria Home is not required to always have at least two or more staff on duty.

In the 34 years that Ave Maria Home has been a licensed Level III Residential Care Home, fire drills have consisted of completing a Stage 2/Lateral Evacuation to a location nearest an exit and furthest away from the proposed area of immediate danger. We have not conducted an external evacuation from the facility during a Fire Drill due to the safety concerns of having the residents walk in the dark in snow, ice, and frigid temperatures during the winter months in northern Vermont.

On 1/14/23, Ave Maria Home's designated Fire Drill Coordinator has asked the Division of Fire Safety to assist in evaluating the current Fire Drill procedures to provide guidance on how to best keep the residents safe during all Fire Drill exercises.

Measures:

The Manager and designated Fire Drill Coordinator will work with the Division of Fire Safety to develop a plan of action that will keep the residents safe during all Fire Drill exercises.

Monitors:

The Manager and designated Fire Drill Coordinator will implement and monitor the revised Division of Fire Safety's approved process for conducting Fire Drills at Ave Maria Home that are safe for the residents and ensure that this deficiency does not reoccur.

Date Completed:

1/17/23

R302

9.11.c

Action:

A fire drill was conducted on 1/14/2023 and are scheduled to be conducted at least six (6) times a year and shall rotate times of day among morning, afternoon, evening and night.

Measures:

The Manager will ensure that fire drills are conducted accordance to the Vermont Residential Care Home Regulations.

Monitors:

The Manager will monitor this practice to ensure that this deficiency does not reoccur.

Date Completed:

January 17, 2023