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 15, 2024

Abigail Schramm, Manager
Averte - Gray House
2122 Lower Plain
Bradford, VT 05033

Dear Ms. Schramm:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 10, 2024.** Please post this document in a prominent place in your facility.

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

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

Sincerely,

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

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
	0521	A. BUILDING: _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERTE - GRAY HOUSE	2122 LOWER PLAIN 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
T 001	Initial Comments On 9/10/24 the Division of Licensing and Protection conducted an unannounced on-site annual relicensure survey and investigation of one facility reported incident and one complaint. The following regulatory deficiencies were identified related to the relicensure survey and investigations:	T 001		
T 032 SS=F	V.5.7.b Resident Care and Services 5.7 Treatment Plan 5.7.b The residence shall ensure that the treatment plan reflects steps to be taken to solve identified problems, either by direct service at the residence or indirectly by referral to a community resource. The treatment plan shall be completed within fourteen (14) days of admission. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to develop treatment plans which reflect the steps to be taken to address physical and psychological problems identified for 3 out of 3 sampled residents (Residents #1, #2, and #3). Findings include: The organization that manages the home has created policies and procedures for the development of treatment plans. 1. Per record review Resident #1's Treatment Plan does not address the following identified problems which require monitoring and support including:	T 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0521	A. BUILDING: _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERTE - GRAY HOUSE	2122 LOWER PLAIN 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
T 032	Continued From page 1 a. Cardiovascular conditions including orthostatic hypotension (sudden blood pressure drop when standing up). b. Urinary system conditions including Chronic Kidney Disease with a history of hyponatremia (insufficient blood sodium levels); and history of urinary retention with current use of an indwelling catheter changed monthly by a Visiting Nurse, and emptying of the urinary drainage bag completed by the resident. c. A recent diagnosis of anemia, atrophy of leg muscles, and loss of ability to walk. Physical therapy was recently started to improve strength and endurance, and transition to use of a walker as an assistive device which requires staff assistance and support. d. Toileting needs which require frequent monitoring and assistance with bathroom cleaning to ensure care in a safe and sanitary environment. Please refer to tag 0146. 2. Per record review Resident #2 is prescribed the anticoagulant medication Eliquis which is a risk for bleeding and requires monitoring for internal bleeding and uncontrolled bleeding. S/he has a history of smoking in his/her room which poses a risk of fire in the home which requires Staff monitoring to ensure the safety of all residents. Resident #2's Treatment Plan does not address these identified problems including the steps to be taken by staff to ensure adequate monitoring and support. 3. Per record review Resident #3 has a history of Hyponatremia and Diabetes Insipidus, and requires scheduled laboratory testing for medication monitoring which are not addressed in	T 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0521	A. BUILDING: _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERTE - GRAY HOUSE	2122 LOWER PLAIN 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
T 032	Continued From page 2 his/her Treatment Plan. At 5:00 PM on 9/10/24 the home's Interim Manger confirmed the Treatment Plans on file for Residents #1, #2, and #3 do not address all issues identified for each individual resident, and list steps to be taken related to the residents' identified problems.	T 032		
T 036 SS=D	V.5.8.b Resident Care and Services 5.8 Medication Management 5.8.b The manager of the residence is responsible for ensuring that all medications are handled according to the residence's policies and that designated staff are fully trained in the policies and procedures. The manager shall assure that all medications and drugs are used only as prescribed by the resident's physician, properly labeled and kept in a locked cabinet at all times or, when a program of self-medication is in effect, otherwise safely secured. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure all medications are kept in a locked compartment related to the storage of unsecured medications in the bedroom and bathroom of one applicable resident (Resident #1). Findings include: The facility's Medication Management policies and procedures are consistent with regulatory requirements for storage of medications in a locked compartment.	T 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0521	A. BUILDING: _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERTE - GRAY HOUSE	2122 LOWER PLAIN 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
T 036	Continued From page 3 During a facility tour commencing at 10:10 AM on 9/10/24 unsecured medications were observed in Resident #1's bedroom and bathroom. Tubes of topical medications including Preparation H were observed to be stored in an unlocked bathroom vanity, and the topical antiseptic medication Povidone/Iodine solution was observed to be stored on the desk in Resident #1's bedroom. During the tour on the morning of 9/10/24 the Interim Manager confirmed unsecured medications were stored in Resident #1's bedroom and bathroom; and at 3:35 PM on 9/10/24 the Interim Manager confirmed a current assessment was not on file indicating Resident #1 is capable of self-administration without staff supervision.	T 036		
T 052 SS=D	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;	T 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0521	A. BUILDING: _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERTE - GRAY HOUSE	2122 LOWER PLAIN 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
T 052	Continued From page 4 (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 and record review there was a failure to ensure 1 out of 5 sampled staff completed all required yearly trainings. Findings include: Policies and procedures provided for review on 9/10/24 do not include procedures for completion of the required yearly trainings by staff. On the morning of 9/10/24 the Interim Manager was requested to provide documentation of trainings completed for a sample of 5 staff. Per review of the documentation of trainings provided for review, one out of 5 sampled staff did not complete all required yearly trainings. This findings was confirmed by the Interim Manager at 11:56 AM on 9/10/24.	T 052		
T 054 SS=D	V.5.9.d Resident Care and Services 5.9 Staff Services	T 054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0521	A. BUILDING: _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERTE - GRAY HOUSE	2122 LOWER PLAIN 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
T 054	Continued From page 5 5.9.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the residence as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection and the Department for Children and Families in accordance with 33 V.S.A. §6911 and 33 V.S.A. §4919 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the licensee failed to ensure a person with substantiated Child Abuse Registry charges was not employed by the home. Findings include: The policies and procedures related to completion of background checks for employees developed by the organization that manages the home are consistent with licensing regulations. Per record review, a Vermont Child Abuse Registry check conducted prior to hire for a Staff member on 10/16/23 was returned with no findings. A subsequent yearly Vermont Child	T 054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0521	A. BUILDING: _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERTE - GRAY HOUSE	2122 LOWER PLAIN 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
T 054	Continued From page 6 Protection Registry check conducted on 7/3/24 was returned with two Child Abuse Registry findings substantiated on 10/22/98 and 2/14/2000. Per record review, an incorrect date of birth was entered by the organization that manages the home on the information provided to the Agency of Human Services for the Staff's Child Abuse Registry and Adult Protective Services checks completed prior to hire. The applicable Staff had provided the home his/her correct date of birth on the Agency of Human Services consent form, and on legal documents provided during the hiring process including a birth certificate and driver's license. As a result of this clerical error, the applicable Staff member was hired, and employed by the home from 10/24/23 until 7/17/24 when the Staff's employment was terminated following receipt of substantiated abuse findings which prohibit employment at the home. On the afternoon of 9/10/24, the Market Director for the organization that manages the home confirmed an incorrect date of birth was entered in the information submitted for completion of the applicable Staff's initial Child Abuse Registry background check on 10/16/23, resulting in the employment of the Staff member with substantiated child abuse findings that prohibit employment at the home.	T 054		
T 062 SS=E	V.5.10.b.4 Resident Care and Services 5.10 Records/Reports 5.10.b.4 The results of the criminal record and abuse registry checks for all staff. This REQUIREMENT is not met as evidenced	T 062		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0521	A. BUILDING: _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERTE - GRAY HOUSE	2122 LOWER PLAIN 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
T 062	Continued From page 7 by: Based on staff interview and record review there was a failure to ensure completion of the required national criminal record check for 2 out of 5 applicable staff. Findings include: The background check policies and procedures on file for the organization that manages the home are consistent with regulatory requirements. On the morning of 9/10/24 the Market Director was requested to provide documentation of criminal record and abuse registry background checks completed for a sample of 5 staff. Per review of the documentation provided for review, all required background checks were not completed for 2 out of 5 sampled staff . On the afternoon of 9/10/24 the Market Director confirmed national criminal background checks were not completed as required for the 2 applicable staff.	T 062	[redacted]	
T 146 SS=F	IX.9.1.a Physical Plant 9.1 Environment 9.1.a The residence must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced	T 146		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0521	A. BUILDING: _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERTE - GRAY HOUSE	2122 LOWER PLAIN 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
T 146	Continued From page 8 by: Based on observation and staff interview there was a failure to ensure the home is maintained as a safe, functional, sanitary environment related to the storage of cleaning chemicals, the frequency of bathroom cleaning , and use of the bathroom for food storage in one applicable resident's room (Resident #1). Findings include: The home's policies and procedures provided for review related to community expectations for maintaining a safe and therapeutic environment; and related to control of hazardous materials, cleaning supplies/ chemicals, and waste do not address the environmental regulatory deficiencies identified in this citation. 1. Per observation on the morning of 9/10/24 Resident #1's bathroom was observed with unsecured cleaning chemicals accessible to the residents including Clorox bleach spray. 2. The bathroom was also observed to be used for food storage, with a container of Slimfast and a small refrigerator stored on the bathroom counter, and a bag of nutritional supplement beverages stored on the floor between the counter and the toilet. 3. During an interview on the afternoon of 9/10/24, the home's Interim Manager confirmed Resident #1 has personal preferences for toileting which the facility permits in order to provide care to meet the resident's individual preferences and needs. This personal practice creates a need for frequent monitoring and cleaning of the bathroom including the shower and the resident's toileting accessory to ensure a safe and sanitary living environment. This need is not met by the home. During an interview	T 146		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0521	A. BUILDING: _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERTE - GRAY HOUSE	2122 LOWER PLAIN 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
T 146	Continued From page 9 commencing at 2:40 PM on 9/10/24 the Interim Manager confirmed Resident #1's shower and toileting accessory become soiled as a result of his/her toileting method, and confirmed the established frequency for monitoring and cleaning of his/her shower and accessory by Staff is limited to twice a month. Please refer to tag 0032.	T 146		
T 167 SS=F	IX.9.4.d Physical Plant 9.4 Recreation and Dining Rooms 9.4.d Smoking shall not be permitted inside the building. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure a smoke free environment in the home related to evidence of smoking observed in the room of one applicable resident (Resident #2). Findings include: The home's Community Expectations policy states smoking is not permitted in the home. At approximately 10:40 AM on 9/10/24 Resident #2's room was observed with an odor of cigarette smoke. The sheets on the resident's bed were observed with numerous holes in the fabric with burned edges; small areas of what appeared to be smeared ash were observed on the sheets; and debris observed on the sheets appeared to be small pieces of burned tobacco. During the tour of Resident #2's room on the morning of 9/10/24 the Interim Manager	T 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0521	A. BUILDING: _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERTE - GRAY HOUSE	2122 LOWER PLAIN 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
T 167	Continued From page 10 confirmed Resident #2's sheets are washed weekly with staff supervision; and stated Resident #2's sheets are replaced whenever holes, tears, staining or other evidence of wear or damage are observed. During the tour of Resident #2's room on the morning of 9/10/24 the Interim Manager stated Resident #2 has a history of smoking in the home; however staff were not aware Resident #2 was still smoking in his/her room. Following the observation of the odor of smoke in Resident #2's room and burn holes in his/her bed sheets, the Interim Manager confirmed Resident #2 has continued to smoke in his/her room. Smoking in the home is a risk for more than minimal harm to all residents due to the risk of fires, and exposure to smoke.	T 167		

Averte-Gray House

Plan of Correction

T 032

A Medical Care Plan was developed and completed on October 1, 2024, for Resident #1 addressing the following: Cardiovascular conditions, Urinary System conditions, Anemia, and toileting needs.

A Medical Care Plan was developed and completed on September 29, 2024, for Resident #2 addressing the monitoring required when prescribed the anticoagulant medication Eliquis. Resident #2 Treatment Plan was updated on October 2, 2024, and includes staff monitoring and support in relation to the resident smoking in their room.

A Medical Care Plan was developed and completed on October 1, 2024, for Resident #3 addressing the following: Hypernatremia and Diabetes Insipidus.

Averte's Nurse will review Resident records upon admission, annually in conjunction with the Vermont State Assessment, and as needed following significant diagnoses or hospitalizations, to ensure Medical Care Plans are developed when necessary. This will ensure that as new needs arise, they will be addressed.

T 032 Plan of Correction accepted by Jo A Evans RN on 10/14/24.

T 036

The unsecured medications were removed on September 11, 2024 and a signed medication order was requested from the Primary Care Provider. The signed order was received on September 17, 2024. This order allows Resident #1 to store the medications in [redacted] room. Medications are now stored in a locked box as per regulations. Staff will complete routine room checks to ensure the medications are secure.

T 036 Plan of Correction accepted by Jo A Evans RN on 10/14/24

T 052

Staff 1 completed all required annual training as of September 29, 2024.

A revision of the policy on Training and Education was released on September 9, 2024, and has now been disseminated to staff. This revision includes procedures for completion of required yearly trainings by staff.

We utilize Relias LMS for management of staff training. Our managers get a weekly notification regarding both upcoming and overdue trainings for their staff, and staff now

Pronouns removed by DLP 10-8-2024

get a weekly reminder email as well. This allows for closer monitoring of due dates and will allow managers and staff to review the timeline for training completion and create a plan if needed. If a mandatory annual training is past due, the staff will be expected to complete it on or before their next scheduled shift.

T 052 Plan of Correction accepted by Jo A Evans RN on 10/14/24

T 054

As of September 16, 2024, we have implemented a procedure for both HR and the hiring manager to review background check results for accuracy and findings before onboarding and upon annual review.

T 054 Plan of Correction accepted by Jo A Evans RN on 10/14/24

T 062

The national background checks were completed for the two staff on September 16, 2024, and September 18, 2024.

The Human Resource Department updated the file system, and created a checklist to ensure all required background checks are completed upon hire and annually thereafter. The department also completed an audit to ensure all background checks have been completed.

T 062 Plan of Correction accepted by Jo A Evans RN on 10/14/24

T 146

Resident #1 participated in creating a plan to address concerns regarding [redacted] room and bathroom. The cleaning chemicals were removed from the room on September 11, 2024. Cleaning supplies are available upon request. The refrigerator and nutritional supplements were removed from the bathroom on September 11, 2024. A new refrigerator has been set up in the Resident's bedroom for [redacted] personal needs.

The bathroom was deep cleaned on September 11, and regular deep cleaning of the bathroom is now taking place twice per week or more frequently as needed. Staff will conduct daily room checks and encourage the Resident to participate in the daily maintenance of [redacted] space. Staff will conduct additional cleanings as needed based on the results of the daily room checks.

T 146 Plan of Correction accepted by Jo A Evans RN on 10/14/24

T 167

Resident #2's bedroom conditions have been addressed. The bed sheets were replaced on September 10, 2024. The room has been thoroughly cleaned and aired out. Randomized daily room checks have been implemented to look for signs of smoking, including smell, burn holes, ashes, or cigarette butts. The resident has agreed to leave [redacted] cigarettes and lighter with staff to help [redacted] resist the urge to smoke in [redacted] room.

Pronouns removed by DLP 10-8-2024

They are available upon request, with staff monitoring to ensure the resident goes outside to smoke. A meeting was held with the resident, [redacted] responsible party, the Program Manager, and Market Director to review the community expectations and address the related safety concerns.

T 167 Plan of Correction accepted by Jo A Evans RN on 10/14/24

Pronouns removed by DLP 10-8-2024