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

July 10, 2024

Kellie Decicco, Manager
Converse Home
272 Church Street
Burlington, VT 05401-4695

Dear Ms. Decicco:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 6, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1010	A. BUILDING: ______ B. WING ______	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONVERSE HOME	272 CHURCH 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
R100	Initial Comments: The Division of Licensig and Protection conducted an unannounced on-site relicensure survey on 6/5/24- 6/6/24, with addiitonal information provided by the home for review on 6/7/24. Findings include:	R100		
R144 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c.(1) Complete an assessment of the resident in accordance with section 5.7; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the Registered Nurse failed to complete resident assessments for 2 out of 3 sampled residents (Residents #1, and #2) in accordance with section 5.7 of the Vermont Residential Care Home Licensing Regulations effective 10/3/2000 to include completion of an assessment consistent with the physician's diagnoses and orders within 14 days of admission to the home; and completion of a reassessment annually and at any point in which there is a change in the resident's physical or mental condition. Findings include: Page #3 of the home's Resident Agreement includes Section H. Nursing Oversight which states "A resident assessment is done within two weeks of when a resident moves in, at least annually and any time there is a significant change in condition that is expected to last more than a couple of weeks."	R144	Please see Plan of Correction following this survey. KD	

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R144	Continued From page 1 1. Per record review Resident #1 was admitted to the home on 10/17/23. Resident #1's Admission Assessment was not completed in 14 days after admission as required. His/her Admission Assessment reference date indicates this assessment was initiated on 11/9/24, 23 days after admission; and Section N. Signatures of his/her Admission Assessment form was not signed and dated as completed by a Registered Nurse. 2. Per record review Resident #3 was admitted to the home on 6/9/22, and admitted to hospice services on 1/31/24. A significant change resident assessment was not completed for Resident #3 on admission to hospice. On the afternoon of 6/6/24 the Managers of the home confirmed Resident Assessments were not completed as required for Resident #1 and Resident #3. In conclusion this deficient practice is a risk for more than minimal harm to all facility residents due to the failure to identify resident needs through the required resident assessment process, which is the basis of resident care planning.	R144		
R145 SS=D	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	R145	Please see POC KD	

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R145	Continued From page 2	R145		

necessary to assist the resident to maintain independence and well-being;

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review there was a failure to develop plans of care which address care and services required to assist 1 applicable resident (Resident #1) in maintaining well-being and independence. Findings include:

The home's Resident Agreement states," A Registered Nurse oversees ... the development, implementation, and the evaluation of a written individualized Life Enhancement Plan designed to meet the resident's health and psychosocial needs."

Per record review Resident #1 has diagnoses including Anxiety Disorder, Recurrent Major Depressive Disorder, and Acute Pain. S/he is prescribed scheduled medications for anxiety, depression, and pain; and PRN (as needed) medications to treat symptoms associated with his/her diagnoses of Anxiety and Acute Pain. Resident #1's plan of care does not include goals and interventions related to pain management, and psychosocial needs related to the management signs and symptoms of anxiety and depression.

On the afternoon of 6/6/24 the Managers confirmed Resident #1's Plan of Care did not include care and services related to pain management, anxiety, and depression.

In conclusion this deficient practice is a potential risk for more than minimal harm to all residents

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R145	Continued From page 3 resulting from unidentified residents needs and interventions.	R145		
R175 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (3) Residents who are capable of self-administration may choose to store their own medications provided that the home is able to provide the resident with a secure storage space to prevent unauthorized access to the resident's medications. Whether or not the home is able to provide such a secured space must be explained to the resident on or before admission. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review there was a failure to ensure medications belonging to 2 applicable residents who self administer medications are consistently stored in a secured storage space to prevent unauthorized access (Residents #1 and #2) . Findings include: The home's Storage of Medications policy effective 3/16/23 states, "All medications, including over the counter medications, will be kept in a locked cabinet in the residents apartment or room. " During a tour of the home commencing at 11:00 AM on 6/5/24 the medication cabinets in Resident #1's and Resident #2's apartments were observed to be left unlocked. The self administered medications stored in the unlocked	R175	Please see POC. KD	

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R175	Continued From page 4 cabinets were unsecured and accessible to all residents, staff, and visitors who enter these resident's apartments. Self administered medications were also observed to left unsecured and accessible in a dish on the counter in Resident #2's kitchenette. During the tour of the home on the morning of 6/5/24 a Manager of the home confirmed medications stored in Resident #1 and Resident #2's apartments were not secured in locked compartments. In conclusion these deficient practices are a potential risk for more than minimal harm for all facility residents due to the failure to ensure all medications are securely stored to prevent access by unauthorized individuals.	R175		
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 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	R179	Please see POC. KD	

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R179	Continued From page 5 reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure 2 out of 5 sampled staff completed all required yearly trainings. Findings include: The home's Required Education Hours policy effective 2/2/23 states, "All RCA and LNA (Resident Care Assistant and Licensed Nursing Assistant) staff is required to obtain 12 hours of education /training each calendar year."; and includes a procedure which states, "Education hours are comprised of both mandatory and non-mandatory sessions." The Required Education Hours policy provided for review did not include the requirement for all direct care staff to complete the yearly trainings identified in the licensing regulations. Per record review 2 out of 5 sampled staff did not complete all required yearly trainings. On the afternoon of 6/6/24 the Managers of the home acknowledged the 2 applicable staff had not completed all required trainings. Additional training information provided by the home for review on 6/7/24 did not include documentation indicating all required trainings were completed	R179		

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R179	Continued From page 6 by the 2 applicable staff. This deficient practice is a potential risk for more than minimal harm for all facility residents due to inadequate staff education and training to safely and effectively provide resident care.	R179		
R200 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure development of policies and procedures which govern all areas of service provided by the home. Findings include: Per review of the home's policies and procedures on 6/5/24 and 6/6/24, policies and procedures governing all areas of service provided by the home were not on file and available for review. During the relicensure survey conducted at the home on 6/5/24 and 6/6/24 the Managers of the home confirmed policies and procedures governing the following areas of service had not been developed by the home: a. Completion of all required yearly trainings by all direct care staff b. Mandatory reporting of suspected or reported abuse , neglect, and exploitation of facility	R200	Please see POC. KD	

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R200	Continued From page 7 residents; and patterns of abusive behaviors by residents to the licensing agency c. Resident access to potentially hazardous items in the Memory Care Center including sharp objects d. Maintaining water temperatures at or below 120 degrees Fahrenheit in resident accessible areas of the home In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents due to failure to provide accessible information and clear instructions related to tasks staff are required to perform.	R200		
R208 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.c Incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse, or if an injury requiring physician intervention results, or if there is a pattern of abusive behavior. All resident-to-resident incidents, even minor ones, must be recorded in the resident's record. Families or legal representatives must be notified and a plan must be developed to deal with the behaviors This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to report to the licensing agency regarding one applicable resident's (Resident #4's) pattern of abusive behaviors including multiple incidents of aggressive and abusive behaviors towards another resident (Resident #5)	R208	Please see POC KD	

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R208	Continued From page 8	R208		

and facility Staff. Findings include:

The home's Mandated Reporting policy effective 3/16/23 states, "All [the home's] Staff , as Assisted Living Facility care employees, are mandated by State Law to report to Adult Protective Services (APS) within 48 hours if they witness, suspect or have reason to suspect abuse, neglect, or exploitation had occurred with a vulnerable adult."

The home's Mandated Reporting policy on file during the relicensure survey on 6/5/24- 6/6/24 does not include procedures for notifying the licensing agency regarding suspected or reported incidents of abuse, neglect, and exploitation including resident patterns of abusive behaviors.

Per record review Resident #4 was observed with aggressive and assaultive behaviors towards Resident #5 including pinching Resident #5 on the upper back on 5/14/24 and throwing the contents of a glass of juice at Resident #5 on 5/29/24; which occurred as part of a pattern of aggressive and abusive behaviors demonstrated by Resident #4 towards Resident #5 and Staff including:

a. 5/29/24 - Resident #4 repeatedly approaching Resident #5 "as if to put [his/her] hands on [him/her]; and grabbing at the hands and clothing of Staff who intervened.

b. 5/21/24 - Resident#4 attempted to grab Resident #5; then grabbed and squeezed the arm of the Staff who intervened to prevent Resident #4 from harming Resident #5.

c. 5/16/24 - Resident #4 grabbed a Staff's hands and attempted to twist them and attempted to bite

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R208	Continued From page 9	R208		

the Staff during incontinence care; then kicked the Staff as they exited the room.

d. 4/15/24 - Resident #4 grabbed, pinched, pulled at clothing, and scratched the arms of Staff providing incontinence care, resulting in Resident #4 breaking the skin on both arms of the Staff and drawing blood.

e. 1/24/24 - As 2 Staff intervened during an incident between Resident #4 and another resident, Resident #4 grabbed the hands, arms, and shoulder on one Staff leaving discolored skin in these areas; then grabbed the arm and hand of another Staff and attempted to bite this Staff's and his/her own fingers.

f. 10/4/23 - Resident #4 scratched the arms of a staff member attempting to provide incontinence care, which the incident report described at Resident #4 "raking down" the staff's arms, leaving reddened and scratched areas on the Staff's arms.

g. 10/1/23 - Resident #4 grabbed and scratched the arm of Staff, and pushed the Staff who was attempting to assist Resident #4 in changing his/her clothing.

At 11:32 AM on 6/6/24 a Manager of the home confirmed the facility failed to report Resident #4's pattern of abusive behaviors towards Resident 5 and Staff.

In conclusion this deficient practice is a risk for more than minimal harm to all facility residents due to the failure to report a resident's pattern of abusive behaviors to the Division of Licensing and Protection as required, which is required in

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R208	Continued From page 10 order to ensure residents are protected from harm, and to ensure allegations are investigated when deemed appropriated by State Agencies.	R208		
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 label and date perishable food items with the date the items were opened or prepared; and a failure to store and dispense perishable beverages at or below 40 degrees Fahrenheit. Findings include: 1. The home's Storage of Products policy effective 6/1/23 states: a. "All foods are stored at appropriate temperatures to prevent food borne diseases and bacteria growth" b. "Prepared foods are wrapped , covered, or sealed and labeled with the preparation date before putting into the refrigerator or freezer." c. "All opened manufactured items need to be labeled with an expiration date." 2. During a tour of the home commencing at	R247	Please see POC. KD	

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R247	Continued From page 11 11:00 AM on 6/5.24 the following perishable foods and beverages were observed without labels indicating the dates the items were opened or prepared: a. A chest freezer in the dry goods food storage area contained six opened 3 gallon containers of ice cream without the dates the containers were opened. b. The Chef's reach-in fridge in the kitchen contained multiple opened containers of cheese, condiments, and sauces without labels indicating the dates these perishable items were opened. 3. During the tour of the kitchen on the morning of 6/5.24 the beverages in the drink dispenser were observed to be stored and dispensed at temperatures higher than 40 degrees Fahrenheit as follows: a. Orange Juice 44.4 degrees b. Lemonade 41.2 degrees c. Citrus Punch 43.0 degrees d. Cranberry Juice Cocktail 41.4 degrees These findings were confirmed by the Dining Services Director during the tour of the kitchen and dining areas on the morning of 6/5/24. In conclusion, this deficient practice is a potential risk for more than minimal harm due to food borne illness for all facility residents.	R247		
R266 SS=F	IX. PHYSICAL PLANT 9.1 Environment	R266	Please see POC. KD	

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R266	Continued From page 12 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure care in a safe environment in the home's Gardenview Memory Care Center. Findings include: On the afternoon of 6/5/24 the Managers of the home confirmed policies and procedures governing resident access to potentially hazardous items in the Gardenview Memory Care Center including access to sharp objects had not been developed by the home. During a tour of the home's Gardenview Memory Care Center during lunch service on 6/5/24 sharp objects were stored in unsecured areas of the kitchen including scissors stored in an unlocked kitchen drawer and small appliances with sharp blades in an unlocked kitchen cabinet. The Memory Care Center is home to residents with varying abilities to safely manage access to potentially hazardous items. During the tour of the Memory Care Center of the home on the afternoon of 6/5/24 the home's Managers confirmed sharp objects including scissors and small appliances with sharp blades. In closing this deficient practice is a potential risk for more then minimal harm for all memory care residents of the home due to accessibility of potentially hazardous items.	R266		

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R291	Continued From page 13	R291		
R291 SS=F	IX. PHYSICAL PLANT 9.6 Plumbing 9.6.d Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to maintain water temperatures at or below 120 degrees Fahrenheit in resident accessible areas of the home. Findings include: On 6/5/24 the Mangers of the home confirmed policies and procedures for maintaining water temperatures at or below 120 degrees Fahrenheit had not been developed by the home. During a tour of the home commencing at 11:00 AM on 6/5/24 water temperatures were observed to be above 120 degrees Fahrenheit in the following areas accessible to residents: a. Shared bathroom by the dining room 123.6 degrees b. Resident Room #304 125.1 degrees c. Residents Room #307 125.4 degrees d. Gardenview Memory Care kitchenette sink 124.0 degrees e. Gardenview Resident Room #S 08 128.5 degrees These findings were confirmed by the Managers during the tour of the home on 6/5/24. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility	R291	Please see POC. KD	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONVERSE HOME	272 CHURCH 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
R291	Continued From page 14 residents due to the risk for burns associated with water temperatures above 120 degrees Fahrenheit and increased risk for burns with injuries resulting for vulnerable adults.	R291		

Plan of Correction Response to Division of Licensing and Protection

Plan of Correction Response 7/1/2024

R144
5.9.c.(1)
Action to correct deficiency:

1. All new residents will have an admission assessment completed within the regulated 14-day time frame.
2. The Converse Home Assessment policy has been updated to reflect the addition of Hospice admission, move to memory care community, and Weight Loss or Gain of 5% to qualifications of a Significant Change. These will trigger a Significant Change Assessment to be completed.

Measure/Systemic Change to ensure to recurrence:

1. A reminder will be scheduled on the Leadership calendar to trigger an initial assessment by the DON, ADON or GV Manager within 10 days of move-in date.
2. The DON, ADON, and GV Manager will begin a new assessment for a resident upon admission to the hospice program. This will be triggered by the hospice admission paperwork.
3. The leadership team meets weekly and does a full house resident review. During this meeting, any noticeable changes or concerns are discussed. This opportunity supports identifying a resident needing a significant change assessment.

Monitor:

1. The Co-Executive Director maintains a spreadsheet with all resident assessment due dates and will notify the DON, ADON and GV Manager via email when a resident assessment due date is approaching. This is checked daily.
2. The DON will review the monthly vitals to monitor any unreported weight loss or gain of 5% and initiate a significant change assessment.

Completion:

The clinical nursing team- Director of Nursing, Assistant Director of Nursing, Gardenview Nurse Manager, and Co-Executive Director met on 6/25/2024, came up with a POC and implemented effective immediately. The DON, ADON and GV Manager will be the staff completing or assigning assessments.

Tag 144-Accepted 7-10-24-LTCM

R145
5.9.c.(2)
Action to correct deficiency:

1. Prior to move in, Resident Service Plan will be created to include goals and interventions based on information from the Health Questionnaire, “Getting to Know You” form, Providers orders and diagnosis list with attention to acute and chronic pain management and recurrent signs and symptoms of anxiety and depression.

Measure/Systemic Change to ensure no reoccurrence:

1. Upon resident move in the DON/ADON/GV Manager will review and update the service plan after medication reconciliation is completed and based on nursing observations of resident needs.
2. Service plans will be reviewed and updated quarterly and as needed when any significant change is noted to include but not limited to falls, wound care, infections, acute illnesses, exacerbations of chronic illness, changes in mobility, discharges from ED and inpatient hospitalization, discharges from LTC/rehabilitation facility hospice admissions, a discharge from Converse Home traditional assisted

living and admission not Converse Home memory care community, 5% weight gain or weight loss and initiation of new pharmacological therapies for pain and psychosis.

Monitor:

1. The DON, ADON and GV Manager will discuss changes in residents' condition, medication orders and/or diagnosis during the leadership weekly resident review meeting as an additional opportunity to discuss potential changes then initiate service plan updates if necessary.
2. Service plans will be reviewed quarterly.

Completion:

All resident service plans, prescribed medications, and diagnosis will be reviewed, and any corrections or updates will be made. A plan has been established for the DON, ADON, and GV Manager to review and complete all by July 15, 2024.

Tag 145-Accepted 7-10-24-LTCM

R175
5.10.h (3)

Action to correct deficiency:

1. The Self-Administering policy and Assessment & Informed Consent of Self Administration of Medications has been updated to reflect the state regulation requirements.
2. The DON and ADON will visit with 6 residents currently self-administering medications and update them on our misunderstanding in regulation. These residents will be educated on the standard and reassessed.
3. New locks will be installed on the medication cabinets for self-administering residents, The resident will receive their own key, the nursing department will receive a copy of the key, labeled, and locked in the medication cart stored in the locked nurse's office for monthly counts and support,

Measure/Systemic Change to ensure to recurrence:

Nursing staff will periodically monitor self-administering residents to ensure they are properly storing medications. Any resident who fails to or has trouble adhering to this regulation may risk the ability to self-administer.

Monitor:

The DON and ADON will check in with staff periodically during change of shift reports to discuss how things are going with the new process.

Completion:

The implementation process for resident discussions began Thursday, June 27, 2024. The completion date for education and new locks to be installed will be Monday, July 15.

Tag 175-Accepted 7-10-24-LTCM

R179
5.11.b

Action to correct deficiency:

1. The Co-Executive Director's worked with the leadership team, which includes clinical leadership DON/ADON/GV Manager, to create an education template for non-nursing staff to be trained as appropriate on First Aid/Emergency Response and General Care and Supervision. This education will be reviewed during orientation as well as in addition to yearly mandatory all staff Infection Control.

Measure/Systemic Change to ensure to recurrence:

1. The HR Manager will continue to send quarterly updates on staff education to all leadership. Supervisors will notify staff of their current hours and what remains to be completed for the current year.
2. Mandatory education is offered throughout the year for staff to attend and opportunities are created for those who have challenges with content of the timing of offered educations.

Monitor:

The additional trainings will be tracked and monitored with all other mandatory trainings, as is our current process, through the HR Manager.

Completion:

The implementation process for mandatory education for all staff is effective July 5, 2024 and the completion date for the additional training is September 10, 2024.

Tag 179-Accepted 7-10-24-LTCM

R200
5.18
Action to correct deficiency:

1. A policy has been written and implemented to reflect the Mandatory Education for all staff.
2. A policy has been written and implemented to give a more comprehensive explanation on how to document and report resident to resident contact.
3. A policy has been created to address the need to lock up any sharp objects in our memory care community.
4. A policy has been created and implemented to address the regulation around water temperature ranges in the building.

Measure/Systemic Change to ensure to recurrence:

1. These policies have been written by the Co-Executive Directors and the department director that each deficiency falls under.
2. The department director has notified and will continually monitor as self or with employees the implemented policy is working and being adhered to properly.

Completion:

These policies are effective immediately and currently in use by all employees.

Tag 200-Accepted 7-10-24-LTCM

R208
5.18
Action to correct deficiency:

1. A more detailed and comprehensive policy has been implemented for staff to better understand when it is appropriate to report to the state when there is a resident-to-resident conflict.
2. We have updated the current Mandated Reporter policy and created a Resident-to Resident procedure to reflect the need to notify Adult Protective Services (APS) as well as Department of Licensing and Protection when sending a report regarding a resident-to-resident conflict.
3. Staff will have continuous education to understand a “Pattern of Abuse” and it is reportable to APS and DLP even if there is no physical contact.

Measure/Systemic Change to ensure no reoccurrence:

1. The clinical nursing team will routinely discuss scenarios where patterns of abuse are questionable.
2. The additional detailed and comprehensive education around mandatory reporting will be part of the mandatory education for all staff.

Monitor:

The clinical nursing team will monitor notes and incident reports to detect signs of a pattern of abuse.

Completion:

This education will roll out to staff over the next month through nurse’s meetings, care staff meetings, and all staff education. All Charge of Shifts and leadership members will be educated on this addition by July 5, 2024.

Tag 208-Accepted
7-10-24-LTCM

R247
7.2.b
Action to correct deficiency:

All perishable food and drink shall be labeled, dated and held at proper temperatures.

Measure/Systemic Change to ensure to recurrence:

1. The Director of Dining will purchase additional food date labels which indicate the date opened to be utilized on freezer items and commonly used items.
2. Twice daily checks of the internal juice thermometer for the appropriate temperature.

Monitor:

1. The shift supervisor and/or the generalist on duty will complete a check of all products ensuring everything is properly date labeled during each shift.
2. The morning and afternoon supervisor will verify and record in the log the temperature of the juice machine and dispensed juice. If temperatures are found above 40 degrees Fahrenheit, a service call to the third-party vendor will be placed.
3. The chefs will label all products when they are opened with the proper labels.
4. The Director of Dining will include the monitoring of food date labeling and juice temperatures in their monthly department audits. They will re-educate and retrain as necessary.

Completion:

The Co-Executive Director and Director of Dining met on 6/27/24 to review the Food Handling Policy. New labels have been purchased and are now utilized on all products. A service call was placed for the juice machine, and the vendor came on July 2, 2024 and reduced the temp to 39 degrees.

Tag 247-Accepted 7-10-24-LTCM

R266
9.1
Action to correct deficiency:

All sharp objects in any common areas of the memory care community have been placed behind locked doors where residents do not have access. Butter knives, plastic ware, and safety scissors have been deemed acceptable by clinical nursing leadership.

Measure/Systemic Change to ensure to recurrence:

The Gardenview Manager and memory care staff will regularly check to make sure there are no sharp objects on the open community and the pantry door that stores the blender remains locked.

Completion:

The policy went into effect on June 8 following a discussion with the state surveyor.

Tag 266-Accepted 7-10-24-LTCM

R291
9.6.d
Action to correct deficiency:

Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas.

Measure/Systemic Change to ensure to recurrence:

1. Establish a policy to address adherence to the regulation governing water temperatures.
2. Perform and maintain log of monthly random sampling of water temperatures in resident areas.
3. Prior to the move-in of a new resident, the water temperature will be checked.
4. Any temperatures found to be greater than 120 degrees Fahrenheit will be corrected immediately and investigated for the cause.

Monitor:

The Director of Maintenance will review the monthly checks to ensure compliance and trends.

Completion:

The Co-Executive Director and Director of Maintenance met on 6/7/24 to develop and adopt the Water Temperature Policy, the procedures and was implemented effective immediately.

Tag 291-Accepted 7-10-24-LTCM