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

March 4, 2024

Lyndsay Patrone, Manager
Copley House Community Care Home
379 Washington Highway
Morrisville, VT 05661-8968

Dear Ms. Patrone:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 22, 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
	0139	A. BUILDING: _____ B. WING _____	01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPLEY HOUSE COMMUNITY CARE HOME	379 WASHINGTON HIGHWAY MORRISVILLE, VT 05661

(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: On 1/22/24 the Division of Licensing and Protection conducted an unannounced on-site relicensure survey. The following regulatory deficienies were identified:	R100	Please see attached reply.	
R128 SS=E	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 staff interview and record review there was a failure to administer medications as ordered for 3 applicable residents. Findings include: Per review of the facility's Policies and Procedures provided by the Director of Residential Services for review on request on 1/22/24, there was a failure to develop policies and procedures for medication administration. 1. Per record Resident #1's physician ordered Victoza 18 mg/3 ml inject 1.2 mg subcutaneously daily at dinner time for Diabetes Mellitus. Per review of the January 2024 Medication Administration Record (MAR), 3 doses of Resident #1's Victoza injection were not administered between 1/15/24 and 1/17/24. The MAR indicated the medication was "not available", however on the afternoon of 1/22/24 the Mediation Specialist and the Director of Residential Services were not aware the	R128		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0139	A. BUILDING: _____ B. WING _____	01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPLEY HOUSE COMMUNITY CARE HOME	379 WASHINGTON HIGHWAY MORRISVILLE, VT 05661

(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
R128	Continued From page 1 medication was missed and were unable to identify the reason the medication was not available. Additionally, it is unclear if this medication was administered on 1/5/24 due to the staff signature being circled (indicating the medication was not given) then crossed out, with what appeared to be another signature below. A note on the back of the MAR indicated a staff member initialed the wrong area, howeve,r the note indicated this occurred on 1/4/24 and the note is also crossed out. 2. Per record review Resident #3 was prescribed Trulicity 3 mg/0.5 ml, injected once weekly for Diabetes Mellitus. Per review of the facility's medication error reports, the prescribed Trulicity injections were not administered to Resident #3 on 6/10/23 and 6/17/23. The Registered Nurse noted Resident #3 was hyperglycemic (blood glucose levels above normal range), and was observed with agitation and paranoia as a result of the missed doses of Trulicity. 3. Per review of the facility's medication error reports Resident #4 was not administered Clonazepam (anti-anxiety medication) as ordered on 6/24/23. On the afternoon of 1/22/23 the Director of Residential Services acknowledged medication errors had occurred at the facility. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents due to failure to administer medications according to the physican orders ensuring the medication is administered with correct resident, medication, dose, route, time and documentation.	R128		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0139	A. BUILDING: _____ B. WING _____	01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPLEY HOUSE COMMUNITY CARE HOME	379 WASHINGTON HIGHWAY MORRISVILLE, VT 05661

(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
R179	Continued From page 2	R179		
R179 SS=F	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 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 4 out of 5 sampled staff completed all required trainings. Findings include: Per review of the facility's Policies and Procedures provided by the Director of	R179		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0139	A. BUILDING: _____ B. WING _____	01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPLEY HOUSE COMMUNITY CARE HOME	379 WASHINGTON HIGHWAY MORRISVILLE, VT 05661

(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
R179	Continued From page 3 Residential Services for review on request on 1/22/24, there was a failure to develop policies and procedures for staff completion of required trainings. Per review of staff training documentation for a sample of 5 staff, 4 out of 5 staff did not complete all required trainings. At 2:50 PM on 1/22/24 the Director of Residential Services confirmed this finding. This deficient practice is a risk for more than minimal harm for all resident due to inadequate staff education and training to safely and effectively provide resident care.	R179		
R190 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure criminal background and abuse registry checks were completed as required for 1 out of 5 sampled staff. Findings include: Per review of the facility's Policies and Procedures provided by the Director of Residential Services for review on request on 1/22/24, there was a failure to develop policies and procedures for completion and documentation of required criminal record and abuse registry checks for all staff.	R190		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0139	A. BUILDING: _____ B. WING _____	01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPLEY HOUSE COMMUNITY CARE HOME	379 WASHINGTON HIGHWAY MORRISVILLE, VT 05661

(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
R190	Continued From page 4 Per review of criminal record and abuse registry check records for a sample of 5 staff, the required checks were not completed for 1 out of 5 applicable staff. This finding was confirmed by the Director of Residential Services at 3:12 PM on 1/22/24. In conclusion this deficient practice is potential risk for more than minimal harm for all residents, as the requirement for criminal background and abuse checks is intended to ensure all residents are free from harm.	R190		
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 written policies and procedures governing all services provided by the home are developed, and maintained on file and available for review. Findings include: On the morning of 1/22/24 the Director of Residential Services was requested to provide access to the home's policies and procedures for review during the relicensure survey. Per review of the manual provided for review on request, policies and procedures related to staff training, staff criminal record and abuse registry checks,	R200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0139	A. BUILDING: _____ B. WING _____	01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPLEY HOUSE COMMUNITY CARE HOME	379 WASHINGTON HIGHWAY MORRISVILLE, VT 05661

(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
R200	Continued From page 5 management of resident personal funds, and the home's medication administration system were not on file and available for review. On the afternoon of 1/22/24 the Director of Residential Services confirmed the organization that manages the home was in the process of developing policies and procedures that govern services provided by the home, as the policies and procedures which had previously been developed were no longer accessible. 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		
R221 SS=F	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 staff interview and record review there	R221		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0139	A. BUILDING: _____ B. WING _____	01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPLEY HOUSE COMMUNITY CARE HOME	379 WASHINGTON HIGHWAY MORRISVILLE, VT 05661

(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
R221	Continued From page 6 was a failure to ensure written requests are obtained for management of resident funds and quarterly accounting of funds are provided on at least a quarterly basis for all applicable facility residents. Findings include: Per review of the facility's Policies and Procedures provided by the Director of Residential Services for review on request on 1/22/24, there was a failure to develop policies for management of resident funds. During the course of the survey on 1/22/24 the Director of Residential Service was asked to provide documentation of written resident requests for management of personal funds for all residents for whom the facility manages personal funds, and accounting of resident transactions provided to residents and their responsible parties on at least a quarterly basis. On the afternoon of 1/22/24 the Director of Residential Services confirmed the facility had not obtained written requests to manage personal funds from the applicable residents, and did not provide the required quarterly accounting of all transactions to the applicable residents In conclusion this deficient practice is potential risk for more than minimal harm for all residents, as the required written requests for management of personal funds and quarterly accounting of transactions are intended to ensure each resident's right to manage their own funds, the management of personal funds is provided in accordance with each individual resident's wishes, and the resident is informed regarding their personal funds.	R221		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0139	A. BUILDING: _____ B. WING _____	01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPLEY HOUSE COMMUNITY CARE HOME	379 WASHINGTON HIGHWAY MORRISVILLE, VT 05661

(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 7	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 ensure water temperature in areas accessible to residents do not exceed 120 degrees Fahrenheit. Findings include: The recently implemented facility procedure for routine testing of water temperatures includes the statement " ... water temperature must range from 110 degrees F to no more than 120 degrees F" as referenced from The U.S. Federal Regulations on Hot Water Scald Protection. During the facility tour commencing at 11:05 AM on 1/22/24 water temperatures in excess of 120 degrees Fahrenheit were observed in resident rooms including 126.7 degrees Fahrenheit in Resident #1's room and 122.9 degrees Fahrenheit in Resident #5's room. These findings were confirmed by the Director of Residential Services during the facility tour on the morning of 1/22/24. The facility's maintenance staff was notified and immediate corrective action was taken. Following an adjustment to the facility's boiler, the water temperatures in Resident #1's and Resident #5's rooms were observed to be sustained between 114-115 degrees Fahrenheit on recheck by the surveyor.	R291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0139	A. BUILDING: _____ B. WING _____	01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPLEY HOUSE COMMUNITY CARE HOME	379 WASHINGTON HIGHWAY MORRISVILLE, VT 05661

(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 8 In conclusion this deficient practice is a potential risk for more than minimal harm for all facility 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 for Correction Copley house 2/13/24

R128 SS=E V. RESIDENT CARE AND HOME SERVICES

The Copley House has a thorough medication training program in place, which all staff must complete before being delegated by the RN to pass medications to residents.

For the 3 incidents involving med errors described in this report, the following procedures are in place to address the causes and prevent similar incidents in the future.

This plan will be implemented immediately under the direction of [redacted], APRN

1. **Issue:** A Resident did not receive a weekly Trulicity injection as scheduled x 2 weeks
2. **Response:** Staff will review the MAR carefully at the start of each shift, noting all clients who receive meds and ensuring that the medication is in the med cart
    i. If a med is missing, staff will immediately notify the med tech/RN
    ii. Staff now use a checklist at each med pass to ensure that all clients receive their meds as scheduled
    b. Staff will review the MAR q shift to catch any potential med errors immediately and alert the med tech/RN
3. **Issue:** A Resident did not receive 3 Victoza injections as scheduled/medication was not available/unclear documentation
4. **Response:** The med tech will inventory/order medications at least weekly to ensure that all medications are in stock in the med room
    a. Staff will review the MAR carefully at the start of each shift, noting all Residents who receive meds and ensuring that all medications are in the med cart
        i. If a med is missing, staff will immediately notify the med tech/RN

ii. Staff will use a checklist at each med pass to ensure that all Residents receive their meds as scheduled

b. Staff will review the MAR at the beginning of each shift to catch any potential med errors immediately and alert the med tech/RN

5. **Issue:** A resident did not receive a scheduled controlled medication
6. **Response:** Staff will review the MAR carefully at the start of each shift, noting all Residents who receive meds and ensuring that the medication is in the med cart

    i. Staff will use a checklist at each med pass to ensure that all Residents receive their meds as scheduled

    b. Staff will review the MAR q shift to catch any potential med errors immediately and alert the med tech/RN

7. If a med error occurs, the RN will follow up ASAP with staff to identify the issue, how the Resident was affected, identify contributing factors and create a proactive plan to prevent similar future errors.

    a. The response includes a structured review/retraining of the staff, based on the RN's judgement.

    b. There is a clear series of responses (3) to repeated med errors which may result in a staff being dismissed from the agency.

Medication Delegation training is provided by the med tech under the supervision of the Residential RN. All staff must complete the training which consists of a PowerPoint presentation followed by an exam, hands on training and a final med pass observed by the RN. All staff repeat the training as part of being annually re delegated by the RN.

This training emphasizes the importance of ensuring resident safety and well-being by carefully following a specific med pass procedure. The procedural steps for responding to med errors, including; reporting any errors, documentation and staff retraining, are covered in detail.

The Residential Medication & Treatment administration Procedure; **2-24** has be added to Copley house PNP and is included for reference

Implemented and completed by Director of Nursing/nurse Practitioner by 2/13/2024.

R 128 Plan of Correction accepted by Jo A Evans RN on 3/3/24.

R 179

Training –

The Copley House will ensure that staff demonstrates competency in skills and techniques that they are expected to perform before providing direct services to residents. There are twelve hours minimum training that will need to be completed by all staff. The training includes:

1. Resident rights.
2. Fire safety and emergency evacuation.
3. Resident emergency response procedures, accidents, police, or ambulance contact and basic first aid.
4. Policies and procedures regarding mandatory reports of abuse, neglect, or 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.

All new hires must finish training before starting shift as well as current employees.

Staff will complete training and note training a training log. Staff will also complete required online trainings and will attach certificates in training log.

Management will review training log monthly to ensure assignments have been completed.

All staff trainings will be up to date and Copley house Staff will be in compliance with all mandated trainings.

Implemented and completed by Manager [redacted] by 3/1/2024.

R 190

Background Checks -

Reviewing existing policy with HR and have started the process of clearing the change to yearly Background checks for facility staff through the union once complete we will updated to PNP book. In the interim we are using the background protocol in our PNP book with the protocol received from Dail that took effect 1/1/24 as an addendum to our current PNP Book.

Copley House will keep background checks on file for all employees. Background checks will be checked yearly for adherence to state policy.

Manager [redacted] will review quarterly to ensure compliance

Implemented and completed by Manager [redacted] by 2/6/2024.

R179 Plan of Correction accepted by Jo A Evans RN on 3/3/24.

R 200

Policies and Procedures –

The policy and procedure book has been updated with the following missing policies:

The water temperature monitoring.

The training policy.

Resident finance policy.

Background check policy with state rule change as addendum

The Residential Medication & Treatment administration Procedure; **2-24**

All have been added to our Policy and Procedure book.

Policies will be reviewed yearly to ensure that they are in adherence to Residential Care Home Licensing Regulations. We have included a copy of each of these policies that have already been added to our Policies and Procedures Book.

Implemented and completed by Manager [redacted] by 2/9/2024.

R200 Plan of Correction accepted by Jo A Evans RN on 3/3/24.

R 221

Finances for residents –

Copley House will manage resident finances only upon written request. We will keep copies of the requests on file. We shall keep a record of all transactions. This record will be available upon request to the resident or their legal representative. The client will receive an account of all transactions on a quarterly basis. Management will keep a copy on file in their record. Management will also keep a copy of any request resident makes for fund distribution. Clients must request these funds in writing.

This has been implemented on 3/1/2024. Please find attached our policy and procedure for financial management.

Manager [redacted] will be responsible for implementation and oversight of this policy.

Accounts will be audited quarterly and reviewed by house Manager, [redacted]

R221 Plan of Correction accepted by Jo A Evans RN on 3/3/24.

R 291

Water Temps –

As per regulation, water temperatures need to be between 110- and 120-degrees Fahrenheit. Management is monitoring temperatures monthly. We have divided up all sinks in the house so that they will be checked monthly on a rotating basis. Management will be receiving copies of water temperatures on a monthly basis.

Upon this situation occurring, maintenance has set water temperatures to 115 degrees so this should not reoccur. Manager will be responsible for the oversight of the temperature log.

As of the date of inspection (1/31/2024) this implementation occurred.

Manager [redacted] will be responsible for implementation. Manager will be maintaining a file with water temperature records.

R291 Plan of Correctionaccepted by Jo A Evans RNon 3/3/24