

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 <u>http://www.dail.vermont.gov</u> 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

September 4, 2024

Sarah Jane Alexander, Manager Eagle Eye Farm Po Box 247, 3014 Abbott Hill Road West Burke, VT 05871-0247

Dear Ms. Alexander:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 24, 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

	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED
		0513	B. WING	C 07/24/2024	
NAME OF PR	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STATE	, ZIP CODE	
EAGLE EY	E FARM		247, 3014 ABBOT JRKE, VT 05871	T HILL ROAD	
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T 001	Initial Comments		T 001		
	annual relicensure su complaints. There we identified related to the The following regulated	on of Licensing and I an unannounced on-site urvey and investigation of 2 ere no regulatory deficiencies ne complaint investigations. ory deficiencies were ne annual relicensure survey:		Please Sce Attache	ð
T 006 SS=F	V.5.2.a Resident Car 5.2 Admission Agree		T 006		
	resident, and the resi any, shall be provid agreement which dee monthly rate to be ch covered in the rate, a financial issues, inclu residence's policy resi when a resident's fina privately paying to pa			بی بی این استقلیم برای میرید کر بی این این استقلیم کرد این میرید کر این این این کرد کرد بی این این این این این این این این این ای	
	by: Based on Staff interv was a failure to ensu Therapeutic Commu #1 and #2) were prov	T is not met as evidenced riew and record review there re both residents of the nity Residence (Residents vided with a written			
BORATORY	ensing and Protection DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE	(X6) DATE
T ATE FORM	Sauch	Janc R (for an and the second s	okin (er, Di 9/2/2024	If continuation shee

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		3) DATE SURVEY COMPLETED	
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		0513	B. WING		07/24/2024	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
EAGLE E	E FARM		247, 3014 ABBOT URKE, VT 05871	T HILL ROAD		
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T 006	Continued From pag	e 1	T 006			
	admission agreemen to the home. Finding	t as required on admission s include:				
	procedures governin residents of the Ther Residence (TCR).			φ/ .		
	TCR was requested admission agreemen who are the current r review. At 3:17 PM o the Registered Nurse agreements had not	7/24/24 the Director of the to provide copies of the its for Residents #1 and #2 residents of the home for in 7/24/24 the Director and e confirmed admission been provided to and signed icable residents or their is required.		plans scended		
T 016 SS=F	V.5.3.c Resident Car	re and Services	T 016			
	5.3 Intake					
		nary of the basic data shall sidence for the record.				
	by: Based on Staff interv was a failure to ensu summaries of resider	T is not met as evidenced riew and record review there re completion of written nt intake data for both e (Residents #1 and #2).				
		ires governing the itten intake summary for all e not been developed by the				

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If continuation sheet 2 of 12

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		0513	B. WING		07/24/2024	
AME OF PR	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
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T 016	Continued From page	e 2	T 016			
	home.					
	and the Director were copies of the intake s residents of the home review. The Register summaries of the ap assessment data had stated s/he was not a requirement to comp summaries.			No Hulle		
T 022 SS=F	V.5.4.c Resident Car 5.4 Discharge Requ		T 022	ha Ka		
	facility shall be addee within two weeks of h summary shall includ areas in which progra regression was obse resident was prescrift resident is receiving mental illness, the fa resident within sever discharge from the fa using the most effect	rved, and the medication the bed at the time of leaving. If a treatment for a serious cility shall follow up with that hty-two (72) hours of acility. This shall be done				
	by: Based on Staff interv	T is not met as evidenced view and record review there plete discharge summaries				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		0513	B. WING		C 07/24/2024	
				I	0112412024	
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
AGLE E	E FARM		247, 3014 ABBOT URKE, VT 05871			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
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T 022	Continued From pag	e 3	T 022			
	discharged from the Residence (TCR) to	ents of the home who were Therapeutic Community the independent living y the organization that owns ne.				
		res governing the discharge en developed by the home.		0/ \		
TOFA	Registered Nurse we copy of the discharge completed following Therapeutic Commu independent living pr same organization. A Registered Nurse and discharge summary Resident #3. The Dir aware of the requirer discharge summaries discharge to include the organization's TO program operated by	nity Residence to the ogram managed by the At 3:17 PM on 7/24/24 the d Director confirmed a had not been completed for ector confirmed s/he was not ment to complete written s for all residents following residents transferring from CR to the independent living the organization.	T 054	pros stan		
T 054 SS=F	V.5.9.d Resident Car 5.9 Staff Services	re and Services	T 054			
	person who has had or exploitation substa as defined in 33 V.S. one who has been co actions related to bo funds or property, or public welfare, in any or outside of the Stat	shall not have on staff a a charge of abuse, neglect antiated against him or her, A. Chapters 49 and 69, or onvicted of an offense for dily injury, theft or misuse of other crimes inimical to the <i>y</i> jurisdiction whether within the of Vermont. This provision nager of the residence as				

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		0513	B. WING		07	/24/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
EAGLE E	E FARM		247, 3014 ABBOT URKE, VT 05871	T HILL ROAD		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLET DATE
T 054	Continued From pag	e 4	T 054			
	well regardless of w	hether the manager is the				
	-	licensee shall take all				
		comply with this requirement,				
	including, but not lim					
	checking personal ar	nd work references and				
	contacting the Divisio					
		epartment for Children and		0/	<i>,</i>	
		ce with 33 V.S.A. §6911 and		CV -		
		ee if prospective employees istry or have a record of		ð		
	convictions.	istry of have a record of				
	convictions.			\mathcal{N}	4	
				n D n	N	
	This REQUIREMEN	T is not met as evidenced		please while	/	
	by:					
		iew and record review there		N NU.		
		re written documentation		· Ko		
		able for review indicating the		UK,		
	decision to hire 2 app	nt Center for Criminal		$\langle \mathcal{V} \rangle$		
		riminal record findings did		9		
	not pose a risk to fac	-				
	Division of Licensing					
	•	d "Background Check				
	Process" sent to all F	Residential Care Home				
	facilities on June 25,	2015. Findings include:				
	Policies and procedu	re governing the hiring of				
	staff with substantiate	ed findings on criminal				
	record background c					
	developed by the hor	me				
		7/24/24 the Director was				
		written documentation				
		ted findings on 2 applicable				
		background checks did not				
	PM on 7/24/24 the D	sidents of the home. At 5:25				
		ation was not on file and				
		n the personnel files of the 2				

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If continuation sheet 5 of 12

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		0513	B. WING		C 07/24/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		PO BOX	247, 3014 ABBOT	T HILL ROAD		
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T 054	Continued From pa	ige 5	T 054			
	applicable Staff.					
T 060 SS=F		v.v.vi.vii.viii.i Resident Care and	Т 060			
	5.10 Records/Reports5.10.b The following records shall be maintained and kept on file:			0		
				SV		
	(1) A resident regi and discharges out	ister including all admissions to of the residence.		a state		
	(2) A record for ea	(2) A record for each resident which includes:		My Do 1		
	 The resident's name, emergency notification numbers, the name, address and telephone number of 			610 De		
		epresentative or, if there is				
	ii. The health address and teleph	care provider ' s name, none number;				
	iii. Instructions	s in case of resident's death;				
		nt ' s intake assessment ation of problems and areas of m:				
		other agencies;				
	progress notes; su conclusions, afterc plan and	discharge summary, al information, and a resident				

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If continuation sheet 6 of 12

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED C
	0513 B. WING			07	//24/2024
OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
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	WEST B	URKE, VT 05871			
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Continued From page	e 6	T 060			
form;					
vii. A signed ac	Imission agreement;				
•					
directives, if any were			(1 X	
	giving legal authority to		4	Ď \	
			(/.	Q.	
				p	
	is not met as evidenced		a) all a	У°	
Based on Staff interv			UN Ke	5	
the home is maintaine transfer between diffe	ed to include residents who erent levels of care provided				
and discharges includ complete resident ros	ling maintenance of a ster have not been				
	· · · · · · · · · · · · · · · · · · ·				
	F CORRECTION COVIDER OR SUPPLIER E FARM SUMMARY ST (EACH DEFICIENC REGULATORY OR I Continued From page form; vii. A signed ac viii. A recent ph a resident may decline taken. any such r in the resident 's reco ix. A copy of th directives, if any were the document g another, if any. This REQUIREMENT by: Based on Staff interv was a failure to ensur register of all admissi the home is maintained transfer between diffet the organization that Community Residence Policies and procedur and discharges includ complete resident ros developed by the hom On the morning of 7/2 requested to provide for review. At 3:17 PM resident roster on file include a record of ac	F CORRECTION IDENTIFICATION NUMBER: 0513 COVIDER OR SUPPLIER E FARM SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 form; vii. A signed admission agreement; viii. A recent photograph of the resident (but a resident may decline to have his or her picture taken. any such refusal shall be documented in the resident 's record); ix. A copy of the resident 's advance directives, if any were completed, and a copy of the document giving legal authority to another, if any. This REQUIREMENT is not met as evidenced	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 0513 B. WING DOVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE E FARM PO BOX 247, 3014 ABBOT WEST BURKE, VT 05871 ID SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 6 form; vii. A signed admission agreement; viii. A recent photograph of the resident (but a resident may decline to have his or her picture taken. T 060 in the resident 's record); ix. A copy of the resident 's advance directives, if any were completed, and a copy of the document giving legal authority to another, if any. This REQUIREMENT is not met as evidenced by: Based on Staff interview and record review there was a failure to ensure a complete resident register of all admissions to and discharges from the home is maintained to include residents who transfer between different levels of care provided the organization that operates the Therapeutic Community Residence (TCR). Policies and procedures governing admissions and discharges including maintenance of a complete resident roster have not been developed by the home. On the morning of 7/24/24 the Director was requested to provide the home's resident roster for review. At 3:17 PM the Director confirmed the resident roster on file was incomplete and did not include a record of admissions and discharges of <td>F CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 0513 B. WING CONDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 247, 3914 ABEOTT HILL ROAD WEST BURKE, VT 05871 SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST REPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX Continued From page 6 form; T 060 To iii A resent photograph of the resident (but a resident may decline to have his or her picture taken. T 060 IX. A copy of the resident 's advance directives, if any were completed, and a copy of the document giving legal authority to another, if any. To the resident 's advance directives, if any were completed, and a copy of the document giving legal authority to another, if any. This REQUIREMENT is not met as evidenced by: Based on Staff interview and record review there was a failure to ensure a complete resident the home is maintained to include resident swho transfer between different levels of care provided the organization that operates the Therapeutic Community Residence (TCR). Folicies and procedures governing admissions and discharges including maintenance of a complete resident roster have not been developed by the home. On the morning of 7/24/24 the Director was requested to provide the home's resident roster for review. At 3:17 PM the Director confirmed the resident roster on of admissions and discharges of</td> <td>F CORRECTION DENTIFICATION NUMBER: A BUILDING: 07 0513 B. WING 07 0000ER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZP CODE E FARM PO BOX 247, 3014 ABBOTT HILL ROAD WEST BURKE, VT 05871 E CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) CONTINUE OF DESIDENT PRIVE OF DEFICIENCIES I D PREFX CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) CONTINUE OF DESIDENT PRIVE OF DEFICIENCIES I D PREFX CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) CONTINUE OF USE DENTIFYING INFORMATION CONTINUE OF USED DENTIFYING INFORMATION CONTINUE OF DESIDENT OF DEFICIENCIES I D PREFX VII. A signed admission agreement; VII. A signed admission agreement; VII. A signed admission agreement; VII. A recent photograph of the resident (but a resident may decline to have his or her picture taken. any such refusal shall be documented in the resident's record); IX. A copy of the resident 's advance directives, if any were completed, and a copy of the adocument giving legal authority to another, if any. This RECULIREMENT is not met as evidenced by; Based on Staff interview and record review three was a failure to ensure a complete resident teres who transfer between different levels of care provided the forme is maintand to include a record review there was a failure to that operates the Therapeutic Community Residence (TCR). Policies and procedures governing admissions and discharges from the toperates the Therapeutic Community Residence (TCR). Policies and procedures governing admissions and discharges of the home's resident roster for review. AT: 71 PM the Director confirmed the resident roster on file was incomplete resident roster and or and been developed by the home. On the morning of 7/24/24 the Director confirmed the resident roster on file was incomplete and did not include a record of admissions and discharges of the resident roster on file was incompleter and of admissions and discharges of the teadmined to fadmissions</td>	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 0513 B. WING CONDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 247, 3914 ABEOTT HILL ROAD WEST BURKE, VT 05871 SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST REPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX Continued From page 6 form; T 060 To iii A resent photograph of the resident (but a resident may decline to have his or her picture taken. T 060 IX. A copy of the resident 's advance directives, if any were completed, and a copy of the document giving legal authority to another, if any. To the resident 's advance directives, if any were completed, and a copy of the document giving legal authority to another, if any. This REQUIREMENT is not met as evidenced by: Based on Staff interview and record review there was a failure to ensure a complete resident the home is maintained to include resident swho transfer between different levels of care provided the organization that operates the Therapeutic Community Residence (TCR). 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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
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0513		0513	B. WING		C 07/24/2024	
IAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	ZIP CODE		
	/E FARM		247, 3014 ABBOT URKE, VT 05871	T HILL ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMP	
T 060	Continued From pa	age 7	T 060			
	operates the TCR f residents who were 7/24/24 (Residents and #2 were admit organization's inde Resident #3 was d independent living s/he was not aware maintain a record of discharges betwee	haged by the organization that to include 3 out of 3 sampled a chosen for record review on s #1, #2, and #3). Residents #1 ted to the TCR from the pendent living program; and ischarged from the TCR to the program. The Director stated a of the requirement to of resident admissions and an the organization's TCR and ring program in the resident				
T 062 SS=F	5.10 Records/Rep	ilts of the criminal record and	T 062	Not toke		
	by: Based on staff inte was a failure to co	NT is not met as evidenced rview and record review there mplete all required background 5 sampled Staff. Findings		1.0		
	criminal record and employees of the	dures governing completion of d abuse registry checks for Fherapeutic Community ot been developed by the				
	requested to provie criminal record and checks completed	of 7/24/24 the Director was de records of the required d adult and child abuse registry for a sample of 5 Staff. Per rds provided, the required				

Division of Licensing and Protection STATE FORM

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If continuation sheet 8 of 12

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED
		0512	B. WING	с	
		0513	ADDRESS, CITY, STATE		07/24/2024
			247, 3014 ABBOT		
EAGLE E	/E FARM		URKE, VT 05871		in the strength of the second s
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMP
T 062	Continued From pag	je 8	T 062	kande en men de kommen men konstanten men en en en sek konstanten en konstanten en konstanten en med konstanten	
	not completed for 4 of the required national not completed for 1 of	abuse registry checks were out of 5 sampled Staff; and I criminal record check was out of 5 sampled Staff. confirmed by the Director at			
T 071 SS=F	V.5.13 Resident Car	e and Services	T 071	~~ V	
	5.13 Policies and Pr	rocedures		50	
	procedures that gove	t have written policies and ern all services provided by by shall be available for review n request.		Olar Kring	
	by: Based on staff interv was a failure to deve	T is not met as evidenced riew and record review there alop policies and procedures ces provided by the home.		·	
	requested to provide policies and procedu individual policies an requested for review Registered Nurse re practices identified d	from the Director and the lated to specific deficient luring the survey and			
	7/24/24 the Director policies and procedu				

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STATEMENT	of Licensing and Prote OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE COMF	SURVEY	
			A. BUILDING:				
		0513	B. WING	C 07/24/2024			
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
EAGLE E	F FARM		247, 3014 ABBOT	T HILL ROAD			
		WEST B	URKE, VT 05871				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE	
T 105	Continued From page	ge 9	T 105				
T 105 SS=F	VI.6.21 Residents' F	Rights	T 105				
	VI. Residents' Right	S					
	residents shall be w print, given to reside in an accessible, pri- each floor of the reside and directions for co- Vermont protection This REQUIREMEN by: Based on observati was a failure to pos residence's Grievan for contacting the de	hs of the residence to its rritten in clear language, large ents on admission, and posted ominent and public place on sidence. Such notice shall ence's grievance procedure ontacting the designated and advocacy organization. IT is not met as evidenced on and Staff interview, there t the Resident's Rights, the nee Procedures, and directions esignated Vermont protection hization in prominent and		per tor			
	accessible areas in property as required	the buildings on the TCR d. Findings include:					
	procedures governi	developed policies and ng the posting of the required lentify the residence's ents of the home.					
	accessible to reside Community Reside that the Resident's procedures, and dir Vermont State Long Program, which is t protection and advo	organization's buildings ents of the Therapeutic nce (TCR) it was observed Rights, the facility's grievance rections for contacting the g Term Care Ombudsman he designated Vermont bocacy organization, were not of the home accessible to the					

Division of Licensing and Protection STATE FORM

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If continuation sheet 10 of 12

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ((X3) DATE SURVEY COMPLETED	
			A. BUILDING:		С	
		0513	B. WING		07/24/2024	
AME OF PF	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STAT	E, ZIP CODE		
AGLE EY	E FARM		247, 3014 ABBO ⁻ URKE, VT 05871	TT HILL ROAD		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
T 105	Continued From page	e 10	T 105			
	This finding was conf Nurse at 12:10 PM o	îrmed by the Registered n 7/24/24,				
T 174 SS=F	IX.9.6.d Physical Pla	nt	T 174	cul/		
	9.6 Plumbing9.6.d Hot water temperatures shall not exceed120 degrees Fahrenheit in resident areasThis REQUIREMENT is not met as evidencedby:			3		
				4.1		
				please hel		
	was a failure to main	n and staff interview there tain water temperatures at or ahrenheit in both facility . Findings include:		Offer		
		eveloped policies and g water temperatures in reas of the home.				
	home to the organiza Community Residence temperatures in the b	ce (TCR) residents, water pathrooms of both facility				
	residents were observed to be above 120 degrees Fahrenheit. Resident #1's bathroom water temperature was 128.8 degrees at 11:22 AM on 7/24/24; and Resident #2's bathroom					
	PM on 7/24/24. These by the Registered Nu	as 121.1 degrees at 12:05 se findings were confirmed irse during the Farmhouse or confirmed these findings				
	on the afternoon of 7					
	boilers by the Admini	ts made to the Farmhouse strator water temperatures sustained at or below 120				

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Division of	of Licensing and Prote	ction			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					С
		0513	B. WING		07/24/2024
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT		경기방법은 직망했지 않는데
EAGLE E	E FARM		247, 3014 ABBO	TT HILL ROAD	
		WEST B	URKE, VT 05871		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
140		,	inte	DEFICIENCY)	
T 474	0	44	T 474		
T 174	Continued From pag	e 11	T 174		
	degrees Fahrenheit i	n both resident's bathrooms.			
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Division of Lic	ensing and Protection				

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If continuation sheet 12 of 12

Eagle Eye Farm Rehabilitation Center

Plan of Correction

- T 006
 - 5.2 Admissions Agreements
 - . Action
 - We will have the completed admissions agreements for each Resident completed by no later than 09/15/2024.

T006 Plan of Correction accepted by Jo A Evans RN on 9/3/24

- Measures
 - We will have the admissions agreement template available for when a Resident is moved within EEFRC, or we admit a new Resident. This will also go on an admissions checklist.
- Monitoring
 - The director will periodically check Resident files to be certain they are complete per regulations.
- T 016
 - 5.3 Intake 0
 - . Action
 - We will get the intake data completed no later than • 9/15/2024.
 - . Measures
 - The Case Manager will have an admissions check list to • ensure that all required information is obtained prior to admission.
 - Monitorina
 - The director will periodically check Resident files to make sure that they are all complete per regulations.
- T 022 •
 - **Discharge Requirements** 0
 - Action
 - We will have a discharge summary for Resident #3 no later than 9/15/2024.
 - Measures
 - The Case Manager will complete a discharge summary before the Resident is moved to a different location. The discharge summary will be included on the checklist.
 - Monitoring
 - The director will periodically check Resident files to make sure that they are complete per regulations.
- T 054
 - Staff Services 0
 - Action .
- T054 Plan of Correction accepted by Jo A Evans RN on 9/3/24
- We will have completed personnel files no later than 7/29/2024 as well as the hiring policies and procedures for hiring staff with substantiated findings on criminal record. It will have our written decision to hire the two employees with criminal background checks.

T016 Plan of Correction accepted by Jo A Evans RN on 9/3/24

- T022 Plan of Correction accepted by Jo A Evans RN
 - on 9/3/24

- Measures
 - If a criminal background check comes back substantiated, we will have written documentation to reflect our decision to hire.
- Monitoring
 - Director will review personnel files twice a year to ensure that they are complete.
- T 060
 - Records/Reports
 - Action
 - The director and Case Manager will complete the Resident register no later than 9/15/2024.
 - Measures
 - New admissions will be added to the Resident register immediately and will include:
 - Resident's name, emergency notification numbers, name, address and telephone number of any legal representative, or, if there is none, the next of kin.
 - The health care provider's name, address and telephone number.
 - Instructions in case of death.
 - The Resident's intake assessment summary, identification of problems and areas of successful life function.
 - Data from other agencies.
 - Treatment plans and goals, regular progress notes, supervisory and review conclusions, aftercare plan and discharge summary, appropriate medical information and a resident information release.
 - o Signed admissions agreement
 - A recent photograph of Resident- Resident may decline. Refusal will be documented.
 - Copy of Advance Directive.
 - Monitoring
 - The director and Case Manager will add this to the admissions checklist to ensure all requirements are met.
- T 062

T062 Plan of Correction

on 9/3/24

accepted by Jo A Evans RN

- Records/Reports
 - Action
 - Background checks were completed 7/29/2024 for all staff to include the surveyed staff.
 - Measures
 - A checklist was created for background checks for new hires.
 - Monitoring
 - The director will periodically check personnel files to ensure they are complete.
- T 071
 - Policies and Procedures

T060 Plan of Correction accepted by Jo A Evans RN on 9/3/24 T071 Plan of Correction accepted by Jo A Evans RN on 9/3/24

- Action
 - The Policies and Procedures manual will be completed no later than 9/30/2024.
- Measures
 - We will make sure the Policies and Procedures manual is kept up to date with regulations.
- Monitoring
 - The director will make sure that the Policies and Procedures manual is updated to reflect any changes from L & P.
- T105
 - Residents' Rights

- Action
 - Residents' Rights, Grievance procedures and directions for contacting the designated Vermont protection and advocacy organization in a prominent and accessible area will be completed no later than 9/15/2024.
- T105 Plan of Correction accepted by Jo A Evans RN on 9/3/24
- Measures
 - We will make certain staff and Residents have an understanding that these documents need to stay in the accessible area.
- Monitor
 - The director will periodically check to make sure the abovementioned documents are kept in the appropriate area.
- T 174

0

- Plumbing
 - Action
 - The hot water temperature was lowered on the day of survey.
- T174 Plan of Correction accepted by Jo A Evans RN on 9/3/24
- Measures
 - We will be checking the water temperature monthly to make sure it is at an acceptable temperature.
- Monitor
 - We will be checking the water temperature regularly.