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

December 27, 2023

Ms. Constance Leach, Administrator
Eastview At Middlebury
100 Eastview Terrace
Middlebury, VT 05753-9327

Dear Ms. Leach:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 21, 2023.** 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
	0603	A. BUILDING: _____ B. WING _____	11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTVIEW AT MIDDLEBURY	100 EASTVIEW TERRACE MIDDLEBURY, VT 05753

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R100	Initial Comments: An unannounced On-site re-licensure survey was conducted on 11/21/23 by the Division of Licensing and Protection. The following regulatory violations were identified:	R100		
R162 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to obtain signed physician's orders for one applicable resident's medications (Residents #2). Findings include: Per review of Resident #2's November 2023 Medication Administration Record (MAR) the following medications listed on the MAR did not have corresponding signed orders on file in his/her resident record: a. Acetaminophen 325 mg table Take 2 tablets by mouth every 4 hours as needed for pain of fever. b. Artificial Tears 0.5 -0.6 % eye drops Instill 2 drops into affect eye(s) three times daily as needed for dry eyes. c. Biscodyl 10 mg rectal suppository Unwrap and insert one suppository rectally once daily as needed for constipation.	R162	Deficiency: R162 Failure to obtain signed Physician's orders. Action to correct deficiency: The Senior Nurse has requested High Mountain Home Care Pharmacy (HMHC) to have all electronic prescriptions sent directly to the nurse for verification by nursing in the EMAR, with the physical copies placed in the resident's chart. If HMHC is unable to provide the electronic prescription prior to when the resident's next scheduled dose is to be given, the medication will be held, and the PCP contacted by EastView nursing to expedite the signed order being sent to HMHC. EastView nursing will solicit support from HMHC with this endeavor when needed. Medications, including OTC items and supplements will not be administered by EastView staff without a signed order. Systemic Changes to ensure no reoccurrence: The EastView nursing staff have been educated on this deficiency and the action items above to prevent reoccurrence.	

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R162	Continued From page 1 d. Clearcanal Earwax Softener (carbamide peroxide) Instill 4 drops into ear daily for 5 days as directed, irrigate with warm water on 6th day. e. Geri-lanta (alum-mag-hydroxide-simeth) suspension 200-200-20/5 ml oral solution Take 15 ml by mouth every 4 hours as needed for GI distress. f. GS Enema 4.5 oz Single Pac Insert one fleet enema rectally once daily as needed for constipation. g. Loperamide 2 mg capsule Take 1 cap by mouth every 6 hours as needed for repeated loose stools. On the afternoon of 11/21/23 the Senior Nurse and Licensed Practical Nurse confirmed there were medications listed on Resident #2's MAR without signed physician's orders.	R162	EastView nursing staff will audit medication orders prior to the end of each business day. If a signed, electronic, (or written) order is not on-file, the order will be suspended, and the PCP office notified. An on-site visit with EastView nursing is being arranged with HMHC to gain a better understanding of processes on the pharmacy end. HMHC has been informed of this deficiency and is aware of EastView's plan of correction to prevent reoccurrence. The policy and procedure pertaining to handling of orders will be updated to reflect current practices. How corrective action will be monitored: The EastView nursing staff will audit all new orders in the EMAR daily and verify that a physical order is on-hand. Date of corrective action: The process outlined above was put in place on December 7, 2023 and will continue going forward.	
R173 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h. (1) Resident medications that the home manages must be stored in locked compartments under proper temperature controls. Only authorized personnel shall have access to the keys This REQUIREMENT is not met as evidenced	R173	R-162 POC accepted 12/26/23 M. McIntosh,RN Deficiency: R173 Failure to ensure medications retained by residents are stored in a locked compartment and accessible to authorized personnel. Action to correct deficiency: On 12/7/2023, the Senior Nurse met with Resident #1, and explained the importance of all medications, supplements, and OTC items being stored securely to ensure compliance with regulatory requirements. Resident #1 willingly surrendered all medications to the Senior Nurse for proper storage.	

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R173	Continued From page 2 by: Based on observation and confirmed by staff interview, the RCH (Residential Care Home) failed to ensure medications retained by residents are stored in a locked compartment and accessible only to authorized personnel for 1 applicable resident (Resident #1). Findings include: Per review of the RCH's Policies and Procedures for Medication Delivery and Storage (effective date not listed) provided by the Director for review, the RCH's policy for storage of medications states, "It is Eastview's policy to store medications the resident's apartment when possible. Medications stored in apartments must be in a locked container or cabinet." During a tour of the RCH commencing at 10:40 AM on 11/21/23 medications and nutritional supplements were observed to be stored in an unlocked drawer and on the counter in the kitchenette of Resident #1's apartment including various types of Vitamin B supplements; Vitamin D; Vitamin C; mineral supplements including Zinc, Copper, and Magnesium; Omega -3 Fatty Acids, bags of unlabeled capsules, Ashwaganda (herbal medication), and 2 types of antihistamine eye drops. A bottle of Miralax was observed on the bathroom counter. Resident #1's apartment door was observed to be unlocked, leaving the unsecured medications and supplements accessible to other residents of the home. During the facility tour commencing at 10:40 AM on 11/21/23 the Director confirmed unsecured medications were stored in unlocked areas of Resident #1's apartment.	R173	The Senior Nurse has communicated this deficiency with Resident #1's support person who is committed to ensuring the resident does not return from outings with medications moving forward. The Senior Nurse informed the Resident that in the event the Resident needs a certain medication, the Resident will need to communicate the request with the nursing staff. Nursing will facilitate an order from the PCP if appropriate and will properly store and administer the medication. Resident stated understanding. Systemic changes to ensure no reoccurrence: A form letter will be provided to all new and prospective MeadowSweet and Floating License residents outlining the regulatory requirement for a ll medications, including supplements and OTC preparations, to be stored under lock and key. EastView nursing staff have been educated on this deficiency and the action items above to prevent reoccurrence. How corrective action will be monitored: The Evening Supervisor, Medical Assistant, Med Technicians and the Administrative Assistant will audit resident apartments at least once per month to identify issues with medication storage and take the appropriate steps to rectify the problem. Date of corrective action: December 7, 2023 and will continue going forward. R173 POC Accepted 12/26/23 M.McIntosh,RN	

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R179	Continued From page 3	R179	Deficiency: R179 Failure to ensure that staff who are providing direct care to residents demonstrated competency and have completed at least twelve hours of training annually.	
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 that staff who are providing direct care to residents demonstrated competency and have completed at least twelve (12) hours of training each year. Findings include: Per review of training records on 11/21/23 several	R179	Action to correct deficiency: An audit is underway to determine which Health Services staff are not in compliance with the annual training requirement. The Health Services Evening Supervisor, Health Services Administrative Assistant, Medical Assistant, and Nursing staff will assist and support these employees with completing the necessary training. The Senior Nurse will create an annual monthly training calendar, which will incorporate the 7 Mandatory trainings, along with additional educational offerings specific to current resident census needs. The Senior Nurse will collaborate with Home Health and the Alzheimer's Association, who have provided additional supplemental training in the past, to coordinate biannual training specific to each agency's area of expertise. Since many informal, "spot" trainings can occur throughout the employee's shift, participation will be documented for capture in the employee's training record. Training sign-in sheets have been placed at the two staff stations for ease of access. The Senior Nurse will collaborate with Human Resources to determine what training can be provided and tracked electronically. Systemic changes to ensure no reoccurrence: The creation of and adherence to a training calendar will reduce the likelihood that the 7 Mandatory training topics are missed.	

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R179	Continued From page 4 training's had not been provided to include: Resident Rights; Fire Safety; Emergency Response/First Aid. Two of the staff identified for review were found to lack evidence of compliance with any of the required 12 hours of training's. The lack of training was confirmed by the RCH Director on the afternoon of 11/21/23.	R179	The addition of two extra Health Services team members who are monitoring employee training attendance and assisting with training will enhance compliance. Employees who successfully complete training courses on schedule will be entered into a drawing for an incentive. R-179 POC Accepted 12/26/23 M.McIntosh,RN	
R189 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b. (3) For residents requiring nursing care, including nursing overview or medication management, the record shall also contain: initial assessment; annual reassessment; significant change assessment; physician's admission statement and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of physician visits, signed telephone orders and treatment documentation; and resident plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, there was a failure to complete an admission assessment and to obtain a physician's admission statement with current orders for one applicable resident who was reassigned from Independent Living to Residential Care after experiencing significant health issues post surgery. (Resident #2) Findings include: Resident #2 was admitted to the Residential Care Home (RCH) from the Independent Living area of the facility on 11/2/23 following a femur fracture requiring surgical repair and treatment in an	R189	The EastView nursing staff have been educated on this deficiency and the action items above to prevent reoccurrence. Training attendance will be monitored by the entities noted above. If an employee fails to comply, the Senior Nurse will be notified, and will meet with the employee to devise a plan to get the employee back on track. Date of corrective action: Auditing and development of tracking materials will be completed by February 1, 2024; training will be ongoing going forward and will prioritize the seven mandatory trainings first. Deficiency: R189 Failure to complete an initial assessment and obtain current orders for Resident #2. Action to correct deficiency: EastView Health Services has begun utilizing MatrixCare, an online, integrated, documentation platform. The EMAR functionality began 8/31/2023. Assessment functionality began as of 12/8/2023. The ability to complete all assessments online, and track assessment due dates electronically, will support compliance with timely completion of all necessary admission and annual assessment components.	

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R189	Continued From page 5 orthopedic rehabilitation facility. Resident #2's admission occurred with use of the RCH's Floating License, which allows transfer of an independent living resident into the care of the RCH without a change in the location of the resident's apartment. When a Floating License is utilized to transfer a resident into the care of the RCH, all licensing regulations for Residential Care Homes are applicable for the transferred resident while in the care of the RCH. 1. Per record review an admission assessment was not on file and available for review for Resident #2. At 2:22 PM on 11/21/23 the Senior Nurse and Licensed Practical Nurse confirmed an admission assessment had not been completed for Resident #2. Per RCH regulations completion of an admission assessment within 14 days of admission is required. 2. Per record review, a physician's admission statement with current signed physician's orders was not on file and available for review for Resident #2. Documentation of communications with Resident #2's Primary Care Provider (PCP) to clarify Resident #2's medication orders following admission were on file, however signed medication orders for all medications listed on Resident #2's November 2023 Medication Administration Record (MAR) were not obtained. At 2:23 PM on 11/21/23 the Senior Nurse and Licensed Practical Nurse confirmed a physician's admission statement with signed physician's orders for Resident #2's current medications was not obtained and on file for review. Please refer to tag 162.	R189	As an added measure, the Senior Nurse will work with MatrixCare to establish functionality which will provide an alert if admission items are incomplete at day ten to facilitate completion by day 14 at the latest. The Senior Nurse has requested of High Mountain Home Care Pharmacy (HMHC) that all electronic prescriptions be sent directly to the Senior Nurse for verification by nursing in the EMAR, with the physical copies placed in the Resident's chart. Systemic Changes to ensure no reoccurrence: The full implementation and usage of MatrixCare to complete and track assessments due will prevent items from being missed. The EastView nursing staff have been educated on this deficiency and the actions items above to prevent reoccurrence. How corrective action will be monitored: The "Actionable" dashboard in MatrixCare will keep the Nursing staff apprised of upcoming assessments and their due dates. Until all assessments have been entered into MatrixCare, the nursing staff will continue to track via Excel spreadsheet. When there are two nurses on duty, one nurse will review the spreadsheet to determine if anything is due or approaching due date. Two nurses are on-site together once per week. The Senior Nurse will review the dashboard in MatrixCare daily. Date of corrective action: Record review to ensure compliance occurred on December 7, 2023 for current Residential Care Home residents; all future admissions will be reviewed by the nursing team going forward. R-189 POC Accepted 12/26/23 MMcIntosh,RN	

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R190	Continued From page 6	R190	Deficiency: R190 - Failure to ensure criminal record checks are completed	
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 by the Administration to ensure criminal record checks were completed for 3 of 5 individuals hired by the RCH. Findings include: During the course of survey a request was made of the Administration on 11/21/23 to demonstrate compliance with criminal and abuse registry checks which are required to be conducted for all RCH individuals hired to work at the facility. Per review of 5 randomly chosen employees found only 2 of the 5 individuals were screened for a criminal record. This failure to complete required screening was confirmed by the Director on the afternoon of 11/21/23.	R190	Action to correct deficiency: During the onboarding process, the HR/Business Support Administrator will run criminal background checks for all new employees through the Vermont Crime Information Center's Criminal Conviction Record Request Service. Systemic Changes to ensure no reoccurrence: Director of Operations will review records of new employees on a quarterly basis to ensure criminal record checks have been run and recorded in HRIS. How corrective action will be monitored: Director of Operations will review records of new employees in HRIS on a quarterly basis to verify all checks are run, a favorable result was received, and the documentation is appropriately recorded. Date of corrective action: EastView's HR Admin began running employee criminal background checks for all new, and missed, employees as of November 21, 2023. All staff criminal record checks will be up-to-date by February 1, 2024. R-190 POC accepted 12/26/23 M.Mcintosh, RN	
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	R200	Deficiency: R200 Failure of the RCH staff to develop policies and procedures for discontinuation of medications, admission process, and infection control. Action to correct deficiency: The current Nursing P&P manual does not accurately reflect current processes, which have changed over time. The Senior Nurse has begun revision of the P&P manual to reflect current practices.	

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R200	Continued From page 7 was a failure of the RCH staff to develop policies and procedures for the following: Discontinuation of medications; monitoring of hot water temperatures; Admission process; safe storage of chemicals and hazardous materials and Infection Control. Findings include: On the afternoon of 11/21/23 the Director was requested to provide the RCH's policies and procedures for discontinuation of medications, the home's admission process, safe storage of chemicals and hazardous materials, monitoring of water temperatures, and infection control. Following additional requests for the policies and procedures listed above throughout the afternoon of 11/21/23, at approximately 5:30 PM on 11/21/23 Director of the home confirmed the requested policies and procedures were not on file and available for review, and stated s/he was not aware of facility policies and procedures related to these aspects of care.	R200	Systemic Changes to ensure no reoccurrence: The Senior Nurse will review the updated P&P manual biannually and make necessary revisions at that time. How corrective action will be monitored: Twice yearly review of P&P manual to ensure accurate reflection of current processes. Date of corrective action: Policies and procedures for discontinuation of medications, monitoring of hot water temperatures, admission process, safe storage of chemicals and hazardous materials, and infection control will be complete by February 1, 2024. R-200 poc Accepted 12/26/23 M.McIntosh,RN	
R266 SS=F	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review there was a failure to maintain a safe environment within the RCH due to the following: 1. During the tour of RCH commencing at 10:40	R266	Deficiency: R266 - The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. Action to correct deficiency: (1) The lock core for the janitorial closet in the Memory Care unit will be checked/replaced to ensure the door locks properly. (2) The unlocked storage closet in MeadowSweet with bleach will be locked when not being accessed by staff. (3) The sliding barn door to the Maintenance Area will be locked when staff is not using the space. (4) The door handle to the MeadowSweet laundry room will be changed to a push-button coded handle and the door will no longer be left propped open.	

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R266	Continued From page 8 AM on 11/21/23 the following environmental concerns were observed: a. In the Memory Care Unit a janitorial closet was observed to be unlocked leaving chemicals including bleach, disinfectants; enzymatic cleaner; # 83 floor cleaner; and toilet bowl cleaner which were accessible to residents with limited ability to safely manage access to hazardous chemicals. An unlocked cabinet in the activities room of the Memory Care Unit was observed to contain Lysol wipes, antibacterial dishwashing soap and antimicrobial "lotion soap". The doors of the activity room were observed to remain open throughout the survey, including times when the area was not monitored by staff. b. An unlocked storage closet in Meadowsweet area was observed to contain bleach which was accessible to all residents in the Meadowsweet area of the home. These findings were confirmed by the Director during the facility tour commencing at 10:40 AM on 11/21/23. 2. On the afternoon of 11/21/23 the Maintenance area of the home with a sign on the door stating "Restricted Area Maintenance Personnel Only" was observed with an unlocked door leaving the area accessible to residents. Upon entry to the area hazardous items including power tools, WD 40 lubricating spray, Lysol wipes and generic disinfecting wipes, and disinfectant spray were observed. The Laundry Room located on the same hallway was also observed to be unlocked and accessible to residents. Hazardous chemicals including a multipurpose disinfectant spray with bleach, bio-enzyme odor spray, floor cleaner, Comet with bleach, Spray and Wash,	R266	Systemic changes to ensure no reoccurrence: All staff will be trained about the importance of keeping dangerous and hazardous materials and chemicals out of reach of residents and visitors to EastView. Training will include instruction about keeping all storage space doors closed and secure, and will be recorded so the training will be available to all staff who aren't able to attend. A sign-in sheet and quiz will be a part of each training to reinforce the material. How corrective action will be monitored: All locations where hazardous chemicals and/or materials are stored will be monitored by the Facilities Manager or designee on a regular basis to ensure areas are not accessible to residents. Date of corrective action: Changes to access doors will be completed by January 1, 2024; all staff will be trained by February 1, 2024. R-266 POC Accepted 12/26/23 M.Mcintosh, RN	

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R266	Continued From page 9 and Hydrogen Peroxide Multipurpose Cleaner were observed to be stored on the shelves in the Laundry Room. At 3:10 PM on 11/21/23 the Director confirmed the Maintenance Room and Laundry Room were for staff use only; and confirmed hazardous items including cleaning chemicals and power tools were left accessible to residents in the unlocked rooms.	R266		
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 hot water temperatures were monitored and maintained at or below the required 120 degrees Fahrenheit (F). Findings include: 1. During the tour of the Residential Care Home (RCH) commencing at 10:40 AM on 11/21/23 water temperatures in resident areas were observed to be higher than 120 degrees Fahrenheit as follows: 1. In Room #144 the water temperature in the kitchenette sink was 124.9 degrees F. 2. In Room #150 the kitchenette sink water temperature was 123.6 degrees F and the bathroom sink water temperature was 123.8	R291	Deficiency: R291 - Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas. Action to correct deficiency: On the day of the survey, the water temperature was lowered to 120 degrees using the mixing valve found in the mechanical room. Systemic changes to ensure no reoccurrence: Water temperatures will be checked weekly by Facilities. How corrective action will be monitored: Through the Facilities monthly checklist, with temperatures recorded from water taps in both GardenSong and MeadowSweet resident apartments Date of corrective action: November 21, 2023 and ongoing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0603	A. BUILDING: _____ B. WING _____	11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTVIEW AT MIDDLEBURY	100 EASTVIEW TERRACE MIDDLEBURY, VT 05753

(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 10 degrees F. 3. In Room # 159 the water temperature in the kitchenette sink was 121.8 degrees F. 4.. In Room #168 the water temperature in the kitchenette sink was 120.4 degrees F. These findings were confirmed by the Director during the RCH Tour on the morning of 11/21/23. At 3:02 PM on 11/21/23 the Director confirmed policies and procedures had not been developed for monitoring of water temperatures in resident areas to ensure temperatures are maintained within the required limit. On return to Room #144 at 4:27 PM and 5:02 PM on 11/21/23 an increase in water temperature to 125.4 degrees was observed following adjustments to the boiler made by staff on duty. At approximately 6:20 PM 11/21/23 water temperatures were observed to be maintained within the required limits at 113 degrees F following further adjustment. These findings were confirmed by the Director on the evening of 11/21/23.	R291	R-291 POC Accepted 12/26/23 M.Mc intosh	
R302 SS=F	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on	R302	Deficiency: R302 – Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. Action to correct deficiency: EastView will hold fire drills quarterly, at a minimum, or as required in current Residential Care Home regulations, alternating times of day and participants.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0603	A. BUILDING: _____ B. WING _____	11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTVIEW AT MIDDLEBURY	100 EASTVIEW TERRACE MIDDLEBURY, VT 05753

(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
R302	Continued From page 11 at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, there was a failure to conduct fire drills at least quarterly rotating times of day among morning, afternoon, evening and nights. Findings include: Per review of fire drill records, identified the RCH failed to conduct the required facility fire drills on a quarterly basis. Only 2 fire drills were conducted in 2023 to include one performed on 1/6/23 and a second on 9/12/23. The Director confirmed on the afternoon of 11/21/23, there was a failure to meet the requirement.	R302	Systemic changes to ensure no reoccurrence: Following the completion of each drill, documentation including a list of all staff participating in the drill, the location of the "fire" and any particular scenarios or highlights from the debrief connected with the drill will be provided to senior leadership for review and filing to ensure all materials are available for review. How corrective action will be monitored: Leadership will monitor the location of the written policies to ensure the reports are always available and up-to-date. Date of corrective action: A fire drill occurred on December 7, 2023; additional fire drills will be scheduled, performed, and documented at a minimum of each quarter. R-302 POC accepted M. mcintosh, RN 12/26/23	