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 19, 2024

Tammy Zalubski, Manager
Elm Street Group Home
C/o Csac, 109 Catamount Park
Middlebury, VT 05753

Dear Ms. Zalubski:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 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
	0500	A. BUILDING: _____ B. WING _____	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM STREET GROUP HOME	C/O CSAC, 109 CATAMOUNT PARK MIDDLEBURY, VT 05753

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T 001	Initial Comments On 10/22/24 the Division of Licensing and Protection conducted on unannounced on-site annual relicensure survey. The following regulatory deficiencies were identified:	T 001		
T 038 SS=F	V.5.8.d.1.2.3.i.ii.iii.iv. Resident Care and Services 5.8 Medication Management d) If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (1) A registered nurse must conduct an assessment of the resident's careneeds consistent with the physician's or other health care provider ' s diagnosis and orders. (2) A registered nurse must delegate the responsibility for the administration ofspecific medications to designated staff for designated residents . (3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for: i. Teaching designated staff propertechniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects; ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as	T 038		

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T 038	Continued From page 1 well as changes in medications; iii. Assessing the resident's condition and the need for any changes in medications; and iv. Monitoring and evaluating thedesignated staff performance in carrying out the nurse 's instructions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure 2 applicable staff who are responsible for administering medications to residents of the home were delegated to administer specific medications to specific residents by the current Registered Nurse. Findings include: On the afternoon of 10/22/24 the Manager confirmed policies and procedures governing medication delegation by the home's registered nurse had not been developed by the home. Per review of the home's staff medication delegation training records, documented completion of medication delegation training by the home's current Registered Nurse for 2 staff responsible for administering medications to residents of the home was not on file and available for review on the afternoon of 10/22/24. This finding was confirmed by the Manager at approximately 2:25 PM on 10/22/24.	T 038	All regular residential staff are delegated appropriately. 2 substitute staff, who are not hired for shifts where meds are needed, have not yet completed their training. In these situations there is always a delegated staff person available to come in and administer a PRN is the resident is in need. The Elm Street home is covered by the DS (Community Associates) Medication Procedures. This procedure was available in the home in a red 3-ring binder. This procedure does need updating to reflect the use of an Electronic Medication Administration Record. Updating will occur by 12/13/24. T038 Plan of Correction accepted by Jo A Evans RN on 12/18/24	12-13-24
T 052 SS=F	V.5.9.b.1.2.3.4.5.6.7 Resident Care and Services 5.9 Staff Services	T 052		

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T 052	Continued From page 2 5.9.b. The residence must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure completion of all required yearly trainings for 5 out of 5 sampled staff. Findings include:	T 052	On 12-16-24 the 4 current staff (we have one vacancy, and one substitute has been terminated) will have completed the 7 required trainings and have enough additional trainings documented this calendar year through the agencies on-line training system RELIAS to meet the required 12 hours	12-16-24

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T 052	Continued From page 3 The home's Training policy and procedures do not identify the required yearly trainings. Per review of staff training records provided by the Manager for review on request, 5 out of 5 sampled staff did not complete all required yearly trainings. This finding was confirmed by the Manager at 2:23 PM on 10/22/24.	T 052	A training policy has been developed. T052 Plan of Correction accepted by Jo A Evans RN on 12/18/24	12-13-24
T 054 SS=D	V.5.9.d Resident Care and Services 5.9 Staff Services 5.9.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the residence as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection and the Department for Children and Families in accordance with 33 V.S.A. §6911 and 33 V.S.A. §4919 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there	T 054		

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T 054	Continued From page 4 was a failure to ensure written documentation is maintained on file and available for review indicating the decision to hire 1 applicable staff with a substantiated Vermont Criminal Information Center (VCIC) criminal record finding does not pose a risk to facility residents per the Division of Licensing and Protection's memorandum entitled "Background Check Process" sent to all Therapeutic Care Residences on June 25, 2015. Findings include: Per review of the home's Background Checks policy and procedures state, " In the case of adverse findings, appropriate actions will be taken after consideration of all relevant facts." Per review of the criminal record checks on file for a sample of 5 staff, one applicable staff's Vermont Criminal Information Center criminal record check included a substantiated finding which does not exclude the staff from employment. At 4:00 PM on 10/22/24 the Recruitment and Training Specialist confirmed a letter indicating the decision to hire the applicable staff was not on file and available for review on request.	T 054	One staff person has a charge which the agency reviewed and it was agreed that a variance was acceptable with the remedy that s/he was relieved of his/her driving duties. This occurred on 7/19/22 when the background check was received. The CSAC HR dept. has documented a verification of the variance to the background check policy which was reviewed and agreed upon in July of 2022. T 054 Plan of Correction accepted by Jo A Evans RN on 12/18/24	11-15-24
T 062 SS=F	V.5.10.b.4 Resident Care and Services 5.10 Records/Reports 5.10.b.4 The results of the criminal record and abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to complete all required criminal record and abuse registry checks for 1 out of 5	T 062		

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T 062	Continued From page 5 sampled residents. Findings include: The home's policies and procedures governing staff background checks are consistent with the regulatory requirements. Per record review, all required criminal record and abuse registry checks were not completed as required for 1 out of 5 sampled staff. This finding was confirmed by the Recruitment and Training Specialist for the organization that manages the home at 3:33 PM on 10/22/24.	T 062	The staff person is question is a college student and abroad for the spring semester. The student's employment has been terminated and when they return they will reapply if they are interested in resuming work and have their background checks run at that time. It is now the practice of CSAC to run background checks on all residential staff as part of their hiring process AND annually in March so that all staff are on the same cycle and no one will exceed 12 months between checks. The CSAC HR Manager is responsible for assuring it is completed.	12-18-24
T 071 SS=F	V.5.13 Resident Care and Services 5.13 Policies and Procedures Each residence must have written policies and procedures that govern all services provided by the residence. A copy shall be available for review at the residence 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 governing services provided by the home. Findings include: During the annual relicensure survey conducted on 10/22/24 the Manager was requested to provide policies and procedures governing the following services provided by the home for review: a. Secure storage of poisonous compounds including cleaning chemicals	T 071	T062 Plan of Correction accepted by Jo A Evans RN on 12/18/24	

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T 071	Continued From page 6 b. Labeling of perishable foods and beverages c. Maintenance of the home's physical environment d. Delegation of Staff to administer resident medications by the Registered Nurse On the afternoon of 10/22/24 the Manager confirm policies and procedures governing these areas of service had not been developed by the home/	T 071	Much of client care is directed by the guidelines issued by DAIL, DDSD which mesh with or go beyond those in the TCR Regulations such as Positive Behavior Supports, Health and Wellness Guidelines, Critical Incident Reporting etc…. We will author policies to detail the areas described in this report and include such in a comprehensive book of policies which pertain to the home.	12/13/24
T 127 SS=F	VII.7.2.b 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 temperature. Hot foods shall be kept hot at 135 degrees F and cold foods shall be kept at 41 degrees F or cooler. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure perishable items stored in the kitchen refrigerator and pantry were labeled and dated with the dates the items were opened. Findings include: On the afternoon of 10/22/24 the Manager confirmed policies and procedures governing storage and labeling of perishable items have not been developed by the home. During a tour of the home commencing at 10:45 AM on 10/22/24 the following perishable items stored in the kitchen refrigerator and pantry were observed to be without labels indication the dates the items were opened:	T 127	T 071 Plan of Correction accepted by Jo A Evans RN on 12/18/24	

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T 127	Continued From page 7 1. In the kitchen refrigerator containers of cow's milk and almond milk, bottles of juice, cottage cheese, deli meats, and slices cheeses were observed to be without labels indicating the dates the items were opened. 2. In the kitchen pantry perishable items including containers of nuts, cereals, and oils were observed to be stored without labels indicating the dates the items were opened. These findings were confirmed by the Manager of the home during the tour of the kitchen on the morning of 10/22/24.	T 127	It has long been the practice to label and date food in the fridge, mainly foods prepared in the home or leftovers. We have immediately expanded this practice to all food which have been opened, refrigerated or dry and in the pantry. T 127 Plan of Correction accepted by Jo A Evans RN on 12/18/24	11/15/24
T 146 SS=F	IX.9.1.a Physical Plant 9.1 Environment 9.1.a The residence must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure care in a safe, sanitary, functional, homelike and comfortable environment. Findings include: On the afternoon of 10/22/24 the Manager confirmed policies and procedures governing	T 146		

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T 146	Continued From page 8 Maintenance of the living environment have not been developed by the home. During the tour of the home commencing at 10:45 AM the following environmental concerns were observed: 1. The laundry room door was observed to be open leaving poisonous compounds including miracle grow plant food, insecticide spray, Lysol Spray, Endust Spray, toilet cleaner, disinfectants, sanitizers, multi-purpose cleaners, and hydrogen peroxide observed to unsecured on the countertop and in unlocked cabinets. The Manager of the home confirmed this finding during the tour of the home on the morning of 10/22/24, and confirmed the laundry room is routinely left open and accessible to residents. 2. The Downstairs bathroom was observed with mildew on the exterior wall and the curtain covering the window. The ceiling showed signs of water damage evidenced by bubbling, cracking, and peeling paint, and the exhaust vent around the ceiling light was covered with dust. A section of floor trim adjacent to the tub was observed to be blackened and broken. These findings were confirmed by the Manager during the tour of the downstairs bathroom.	T 146	All cleaning supplies and others chemical substances have been transferred to a locking closet. The bathroom curtain has been replaced, dust cleared from the vent, and mold/mildew removed. CSAC facilities department has repaired the ceiling and fixed the floor trim. Photos are available upon request. T 146 Plan of Correction accepted by Jo A Evans RN on 12/18/24	11-15-24 11/29/24