

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 9, 2022

Ms. Shannon Robtoy, Manager Ethan Allen Residence 1200 North Avenue Burlington, VT 05408-2777

Dear Ms. Robtoy:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 9**, **2022.** 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.

Sincerely,

Pamela M. Cota, RN

Lamela MCotaRN

Licensing Chief

Division of Licensing and Protection (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: 11/09/2022 0128 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1200 NORTH AVENUE **ETHAN ALLEN RESIDENCE** BURLINGTON, VT 05408 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R100 R100 Initial Comments: On 10/31/22 the Division of Licensing and R128 Protection conducted an unannounced on-site investigation of a complaint with additional information provided by the Director of Nursing 5.5.c Rights of medication Services on 11/9/22 . There were no regulatory administration and medication deficiencies identified related to the complaint pass competencies are investigation, however regulatory deficiencies being done for all MedTechs and 10-19-22 were identified during the course of the nurses on staff. A new narcotic book investigation. Findings include: and documentation system was put in place on 10-19-22. Ensures the person R128 R128 V. RESIDENT CARE AND HOME SERVICES giving medication to visualize more thoroughly all information prior to SS=E administration and more thorough documentation. This process will 5.5 General Care be ongoing and the DNS or delegated 5.5.c Each resident's medication, treatment, and nurse is responsible for oversight. dietary services shall be consistent with the Re-education has been provided physician's orders. to the nurses on ensuring the correct medication is being given and them, resources available, and This REQUIREMENT is not met as evidenced a new medication guide has been by: ordered, awaiting arrival. Oversight Based on record review and staff interview there ongoing was a failure to ensure medications were of this is the responsibility of the administered according to physician's orders for 4 DNS or delegated representative applicable residents (Resident # 2, #3, #4, and and is ongoing. New admission #5). Findings include: medication will be ordered upon admission, or a doctor's order will 1. Resident #2 is diagnosed with attention and be obtained to hold until they are concentration deficits and is prescribed available, this is situational, and Methylphenidate (central nervous system ongoing. DNS or delegated nurse stimulant) 5 mg twice daily to treat these is responsible. conditions. Per record review, on the morning of 10/13/22 Resident #2 received Lorazepam (used to treat anxiety) 0.5 mg belonging to Resident #5 instead of his/her prescribed dose of Methylphenidate. On the afternoon of 10/31/22 the Director of Nursing Services confirmed Resident #2 was given the wrong medication in Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

(X6) DATE

12-2-2022 If continuation sheet 1 of 7

NAME OF PROVIDER OR SUPPLIER STHEET ADDRESS, CLIT., STATE, ZIP CODE 1200 NORTH AVENUE ETHAN ALLEN RESIDENCE ETHAN ALLEN RESIDENCE SUMMARY STATEMENT OF DEFICIENCY BOULATORY OR LSC IDENTIFYING INFORMATION) RECOLATORY OR LSC IDENTIFYING INFORMATION) R128 Continued From page 1 orror on the morning of 10/13/22. Por record review Resident #2 did not receive Dilitazern (for high blood pressure) 120 mg on 10/11/22, 10/12/22, 10/27/22 - 10/30/22; Metoprolal ER (for high blood pressure) 100 mg on 10/11/22, and 10/12/22, Atorvastatin (for high cholesteroil) 10 mg on 10/10/22 and 10/12/22, thoreore in a tries on 10/12/22 and a Multivitamin with minerals on 10/12/22 and a Multivitamin with minerals on 11/9/22 the Director of Nursing Services confirmed the medications were not available because they were not received from 11/9/22 the Director of Nursing Services confirmed the medications of Ability (antipsychotic medication) for this condition. Per record review Resident #2 was admitted to the facility on 10/10/22. 2. Resident #3 is diagnosed with Schizoaffoctive disorder and is prescribed injections of Ability (antipsychotic medication) for this condition. Per record review Resident #3 was bedded to received from the family when Resident #2 was admitted to the facility on 10/10/22. 2. Resident #3 is diagnosed with Schizoaffoctive disorder and is prescribed injections of Ability (antipsychotic medication) for this condition. Per record review Resident #3 was bedded to received from the family when Resident #3 was bedded to received from the family when Resident #2 the Director of Norsing Services confirmed Resident #3 was abchided to received from the family process is congoging and is the responsibility of the DNS or delegated representative.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	JMBER: A. BUILDING:			
THAN ALLEN RESIDENCE SUMMARY STATEMENT OF DEFICIENCES BURLINGTON, VT 05408 PROVIDENS FLAN OF CORRECTION GRAPH TAG R128 Continued From page 1 error on the morning of 10/13/22. Per record review Resident #2 did not raceive Dilitazem (for high blood pressure) 120 mg on 10/14/122, 10/12/22, 10/13/02. Metophole ER (for high blood pressure) 100 mg on 10/14/22, Citalopram (amit-depressant) 10 mg on 10/14/24, Citalopram (amit-depressant) 10 mg on 10/14/24, C			IDENTIFICATION NUMBER.				
ETHAN ALLEN RESIDENCE DOI D	å\'	0128		B. WING		11/09/2022	
PREFIX (Inch Derivo of Use Destrity) in Given the American of the medication as ordered to Resident #2 was admitted to the family when Resident #3 was scheduled to 10/31/22, however nursing staff failed to administer the medication on 10/10/22. however nursing staff failed to administer the medication on 10/10/22. however nursing staff failed to administer the medication on 10/10/22. however nursing staff failed to administer the medication on 10/10/22. however nursing staff failed to administered to scheduled on 10/10/22. however nursing staff failed to administer the medication on 10/10/22. however nursing staff failed to administered to scheduled on 10/10/22. however nursing staff failed to administer the medication on 10/10/22. however nursing staff failed to administered to scheduled on 10/10/22. however nursing staff failed to administer the medication on 10/10/22. however nursing staff failed to administer the medication on 10/10/22. however nursing staff failed to administer the medication on 10/10/22. however nursing staff failed to administer the medication on 10/10/22. however nursing staff failed to administer the medication on 10/10/24/2. however nursing staff failed to administer the medication on 10/10/24/2. however nursing staff failed to administer the medication on 10/10/24/2. however nursing staff failed to administer the medication until 10/24/2. A both the process to the 3 of the process to 3 of the process and added to the medication as well and the process and the medication as well and the process and the process and the process and the medication as well and the process and			1200 NOF	RTH AVENUE			
error on the morning of 10/13/22. Per record review Resident #2 did not receive Dilitazem (for high blood pressure) 120 mg on 10/11/22, 10/12/22, 10/27/22 - 10/30/22; Metoprolol ER (for high blood pressure) 100 mg on 10/24/22, (clalopram (anti-depressant) 10 mg on 10/11/22 and 10/12/22; Atorvastatin (for high cholesterol) 10 mg on 10/10/22 and 10/11/22; (bandronate (for bone density) 150 mg on 10/15/22; Cranberry tablets (to prevent and treat urinary tract infection) 900 mg on 10/11/22; Docusate Sodium (for constipation) 100 mg on 10/12/22; and a Multivitamin with minerals on 10/12/22 and a Multivitamin with minerals on 11/12/22 due to the medications wore not administration as ordered. During a phone interview commencing at 10.37 AM on 11/19/22 the Director of Nursing Services confirmed the medications were not available because they were not received from the familty when Resident #2. The Director of Nursing Services stated the medications were not available because they were not received from the familty when Resident #2 was admitted to the facility on 10/10/22. 2. Resident #3 is diagnosed with Schizoaffective disorder and is prescribed injections of Abilify (antipsychotic medication) for this condition. Per record review Resident #3 was scheduled to receive an Abilify injection on 10/19/2022, however nursing staff failed to administer the medication until 10/24/22. On the afternoon of 10/31/22 the Director of Nursing Services confirmed Resident #3 shillify injection scheduled on 10/19/22 was not administered until scheduled o	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	BE COMPLETE	
Per record review Resident #4 was prescribed Cephalexin (antibiotic) 500 mg to twice daily for 7	R128	error on the morning Per record review Re Diltiazem (for high bl 10/11/22, 10/12/22, 1 Metoprolol ER (for hi on 10/24/22; Citalopi on 10/11/22 and 10/1 cholesterol) 10 mg of Ibandronate (for bon 10/15/22; Cranberry urinary tract infection Docusate Sodium (fo 10/12/22; and a Mult 10/12/22 due to the available for adminis phone interview com 11/9/22 the Director confirmed the medic as ordered to Reside Nursing Services sta available because the family when Res facility on 10/10/22. 2. Resident #3 is dia disorder and is pres (antipsychotic medic record review Resid receive an Abilify inj however nursing sta medication until 10/1 10/31/22 the Director confirmed Resident scheduled on 10/19 10/24/22. 3. Per record review	esident #2 did not receive ood pressure) 120 mg on 10/27/22 - 10/30/22; gigh blood pressure) 100 mg ram (anti-depressant) 10 mg 12/22; Atorvastatin (for high in 10/10/22 and 10/11/22; e density) 150 mg on tablets (to prevent and treat in) 900 mg on 10/11/22; or constipation) 100 mg on tivitamin with minerals on medications not being stration as ordered. During a intending at 10:37 AM on of Nursing Services rations were not administered ent #2. The Director of lated the medications were not ney were not received from sident #2 was admitted to the large of the stration of this condition. Per ent #3 was scheduled to ection on 10/19/2022, aff failed to administer the 24/22. On the afternoon of or of Nursing Services #3's Abilify injection /22 was not administered until	R128	ongoing ordering and follow up concerns will be charted and r in the 24- hour report. Access the pharmacy page and ability to see what has been ordered directly, and ensure thorough up is now available. Education the MedTech's on this is to be provided in the meeting sched 11-7-2022 so they can also ha information to follow up on. Needucation on how to access the pharmacy was provided and a to the main computer. Access 24 hour report on Point Click will be available for the MedTellow them to know as well. One to one re-education prov to the staff nurse about the new to document and communicate the team. Email nurse to nurse available for direct communic well. This process is ongoing the responsibility of the DNS	noted to , order follow n to duled on eve the urse ne added to the Care ech's to ided te with te now ation as and is	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A BUILDING:	A. BUILDING:			
		D MING			C 11/09/2022	
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NAME OF PR	ROVIDER OR SUPPLIER	STREETAL	DDRESS, CITY, STATE	E, ZIP CODE		
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ETHAN AL	LEN RESIDENCE	BURLING	STON, VT 05408			
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INO		W. C.		DEFICIENCY)		
R128	Continued From page	e 2	R128			
11120						
	infection. The facility	maintains a supply of stock g Cephalexin 250 mg tablets				
	which were utilized to	begin administration of this			150	
		er in the MAR included				
	instructions to admin	ister two 250 mg capsules at				
	8 AM and 8 PM, how	rever at 8 PM on 10/16/22				
	and 8 AM on 10/17/2	2 med delegated staff failed				
		dication as ordered and psule in error. On the				
	afternoon of 10/31/2	2 the Director of Nursing				
		Resident #4 received the	1			
	wrong dose of Cepha	alexin on 10/16/22 and	- 2			
	10/17/22.					
	4.5. 11. 145	and Anithromypia	1 1			
	4. Resident #5 was p	orescribed Azithromycin ng tabs on 9/8/22 followed by				
	one 250 mg tab daily	on 9/9/22-9/12/22 for a	1			
	respiratory infection.	The facility maintains a				
	supply of stock medi	cations including				
	Ciprofloxacin (antibio	otic) 250 mg tablets. The				
		rofloxacin 250 mg tablets Resident #5 instead of	į			
		g tablets, and the error was				
	not discovered until	9/12/22 when the pharmacy				1
	noticed the facility's	request for replacement of				
		dication did not match the				
		Resident #5's respiratory				
		solved until the correct was administered. The				
	Director of Nursing	Services confirmed the wrong				
	medication was adm	ninistered to Resident #5 on				
	the afternoon of 10/3				ā	
11	I.I.	E AND HOME SERVICES	R135			
SS=E				9.		
	5.5 Assessment					
	J.J ASSESSITER					
	5.7 b. If a resident r	equires nursing overview or				

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Division o	of Licensing and Protect				(V2) DATE SI	IDVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (IDENTIFICATION NUMBER:		A. BUILDING:		i	
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	LEN DECIDENCE	1200 NO	RTH AVENUE			
ETHAN A	LEN RESIDENCE	BURLING	STON, VT 05408			
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R135	Continued From page	e 3	R135			
	licensed nurse within to the home or the co	ident shall be assessed by a fourteen days of admission ommencement of nursing assessment instrument sing agency.		R135		
				1(155)		
	by: Based on record revi Registered Nurse fai assessment within 1- applicable residents #2). Findings include 1. Resident # 1 was 7/15/2020 with diagr Pulmonary Edema, h history of Subdural F rupture between the record review the ini Resident #1 was sig Registered Nurse or 10/31/33 the facility Resident #1's Resident	iew and staff interview the led to complete an initial 4 days of admission for 2 (Resident #1 and Resident etc.) admitted to the facility on loses including Dementia, high blood pressure, and a demorrhage (blood vessel brain and the skull). Per tial Resident Assessment for lose as complete by the lose 18/26/2020. At 12:54 on Administrator confirmed lent Assessment was not legistered Nurse within 14		The director of nursing re-edulation as we the administrator. This is correand the administrator and DNs continue to hold each other accountable to ensure thorough.	ell as ected S will	11-4-2022
	9/27/2022 with diagr impairments, urinary suprapubic Foley ca Syndrome (blood rel Obstructive Pulmona review an initial Res completed for Resid 10/31/22 the Director	admitted to the facility on noses including cognitive vetention with use of a theter, Myelodysplastic lated cancer), and Chronic ary Disease. Per record ident Assessment was not tent #2. At 4:58 PM on or of Nursing confirmed an issment had not been lent #2.		G		

RTWY11

Division of Licensing and Protection (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:__ C 11/09/2022 B. WING 0128 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1200 NORTH AVENUE **ETHAN ALLEN RESIDENCE BURLINGTON, VT 05408** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R136 R136 Continued From page 4 R136 V. RESIDENT CARE AND HOME SERVICES R136 R136 SS=D 11-15-2022 5.7. Assessment The director of nursing re-educated herself on the regulation as well as 5.7.c Each resident shall also be reassessed the administrator. This is corrected annually and at any point in which there is a and the administrator and DNS will change in the resident's physical or mental continue to hold each other condition. accountable to ensure thorough follow through. This REQUIREMENT is not met as evidenced Based on record review and staff interview the nurse failed to complete an annual reassessment for one applicable resident (Resident #1). Findings include: Resident # 1 was admitted to the facility on 7/15/2020 with diagnoses including Dementia, Pulmonary Edema, high blood pressure, and a history of Subdural Hemorrhage (blood vessel rupture between the brain and the skull). Per record review Resident #1's annual reassessment for 2021 did not include the date the Registered Nurse signed the document as complete. At 12:54 PM on 10/31/22 the Administrator confirmed the Registered Nurse failed to document the date the reassessment was completed. R247 R247 VII, NUTRITION AND FOOD SERVICES SS=E 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be

Division of Licensing and Protection

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Division of Licensing and Protection								
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED				
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	0128		B. WING		11/09/2	2022		
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ETHAN AL	LEN RESIDENCE					1		
				TON, VT 05408				
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				DEFICIENCY)				
R247	Continued From page	5	R247	2047				
				R247		- 1		
		eld at proper temperatures: egrees Fahrenheit. (2) At or			į			
		ahrenheit when served or						
	heated prior to service			7.2 Food safety and Sanitation	items	l		
2	D			All perishable food and drink it				
	This REQUIREMENT	is not met as evidenced		shall be labeled, dated, and he				
	by:			proper temperatures. On 11-1-	2022			
		and staff interview there		the administrator and dietary n went through the refrigerator in		i		
		re all perishable food items		dietary department and checke				
		refrigeration unit were		labeled, and dated all items, in				
	labeled with dates. F	indings include:		checking for expiration dates.	oldaling			
	During the course of	the facility tour on the		Dietary staff have been educate				
		perishable food items stored						
		ation unit were observed		on the expectation and regulatory guidelines of proper food/beverage				
		ing the dates the items were		dating and storage. This will be				
		taken out of the freezer to		task when checking the tempe				
		items that did not have		of the fridge. The dietary mana				
	labels indicating when			delegated staff person will con				
		andwiches, ham salad, a		weekly compliance checks for				
		g, cups of pudding, and		4 weeks and then monthly; a least All powerteff will be tr				
		d tomatoes and cucumbers. bels indicating the dates		be kept. All new staff will be tra in the process, education will	he on			
		cluded salad dressings,		going as will the monitoring. P	rovided			
		e, pickles, barbeque sauce,		to all kitchen/dietary/and appro	poriate			
		and a tub of muffin batter.		staff with the guidelines for the				
		f chicken, and a container of		mandatory processes.				
	hamburger without la	bels indicating the dates						
	they were removed fr	rom the freezer to thaw.						
	AL 40-E0 ALL 40/0	1/22 the Food Comics	-					
		1/22 the Food Service e storage of unlabeled	i					
		e storage of unlabeled s in the kitchen refrigerators	1					
	perioriable rood items	, and known remgerators						
R258	VII. NUTRITION AND	FOOD SERVICES	R258					
SS=D	THE RESTRICT AND	, , 5 50 02.00.00						
	7.3 Food Storage ar	nd Equipment						
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Division of Licensing and Protection (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING: C B. WING 11/09/2022 0128 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1200 NORTH AVENUE **ETHAN ALLEN RESIDENCE** BURLINGTON, VT 05408 (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R258 R258 Continued From page 6 R258 7.3.h All garbage shall be collected and stored to prevent the transmission of contagious diseases, creation of a nuisance, or the breeding of insects and rodents, and shall be disposed of at least weekly. Garbage or trash in the kitchen area 7.3 Food Storage and Equipment must be placed in lined containers with covers. On 10/31/2022 lids for the trash cans 10/31/2022 and compost cover were purchased This REQUIREMENT is not met as evidenced and placed on the correct bins. Staff by: were educated on the regulatory Based on observation and staff interview there guidelines for covering the bins and was a failure to ensure 2 trash cans and a expectation to utilize the covers/lids. compost bucket in the facility kitchen were The dietary manager will conduct covered with lids to prevent the transmission of weekly checks for the next 4 weeks contagious diseases, creation of a nuisance, or and remain responsible for ensuring the breeding of insects and rodents. Findings the process is continued to meet include: compliance. During a tour of the facility kitchen on the morning of 10/31/22 two trash cans and a compost bucket were observed to be uncovered and without lids. At 10:50 AM on 10/31/22 the Food Service Director confirmed the two trash cans and a compost basket without lids in the facility kitchen.

RTWY11