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

November 27, 2023

Ms. Peggy Degoosh, Manager
Frances Atkinson Residence For The Retired
4717 Main Street
Newbury, VT 05051

Dear Ms. Degoosh:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 13, 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
	0004	A. BUILDING: _____ B. WING _____	10/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCES ATKINSON RESIDENCE FOR THE RETIREE	4717 MAIN STREET NEWBURY, VT 05051

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: On 10/9/23 the Division of Licensing and Protection conducted an unannounced on-site relicensure survey and investigation of 2 complaints with additional staff interviews conducted on 10/13/23. There were no regulatory deficiencies identified related to the complaint investigation. The following regulatory deficiencies were identified related to the relicensure survey:	R100	See attached document for the corrective actions submitted for each individual tag	
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the Registered Nurse failed to develop a written plan of care describing the care and services necessary to maintain the well-being of 1 applicable resident (Resident #1). Findings include: During the course of the survey the Assistant Manager was requested to provide copies of written plans of care for Resident's #1 who was admitted to the home on 8/17/23. On the afternoon of 10/9/23 the Assistant Manager confirmed a written plan of care had not yet been	R145	R145 Plan of Correction Accepted by Jo A Evans RN on 11/22/23	

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R145	Continued From page 1 developed for Resident #1.	R145		
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 5 out of 5 sampled staff failed to complete the required yearly trainings. Findings include:	R179	R179 Plan of Correction accepted by Jo A Evans RN 11/22/23	

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R179	Continued From page 2 Per review of training documentation for the previous year 5 out of 5 staff had not complete Resident's Rights trainings; 3 out of 5 staff did not complete Respectful and Effective Interactions with Residents training; 2 out of 5 did not complete Fire Safety, Mandatory Reporting of Abuse Neglect and Exploitation, and General Care and Supervision trainings; and 1 out of 5 staff did not complete Infection Control training. At 3:03 PM on 10/9/23 the Assistant Manager and Manager confirmed 5 out of 5 sampled staff had failed to complete the required yearly trainings.	R179		
R190 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to complete the required criminal background and abuse registry checks . Findings include: Per record review the Manager and Assistant Manager were unable to provide documentation of completion of the required criminal background checks for 5 out of 5 sampled staff, and completion of the required abuse registry checks for 1 out of 5 applicable staff. At 3:05 PM on 10/9/23 the Manager and Assistant Manager confirmed these findings.	R190	R190 Plan of Correction accepted by Jo A Evans RN on 11/22/23	

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R247	Continued From page 3	R247		
R247 SS=F	VII. NUTRITION AND FOOD SERVICES	R247		

7.2 Food Safety and Sanitation

7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview there was a failure to ensure refrigerated stored at the required temperatures and all perishable foods were labeled and dated. Findings include:

During the facility tour commencing at 10:58 AM on 10/9/23 perishable food items in the kitchen refrigerator were observed to be stored without labels indicating the date the items were prepared or opened including:

1. In the kitchen refrigerator opened undated items included lime juice, pesto, chocolate syrup, pancake syrup, relish, yogurt, cheese, minced garlic, pasta sauce, containers of juice, apple sauce, jelly. A second fridge in the kitchen was observed to contain opened undated apple butter, olives, condiments and dressings, sliced cheese, and sliced ham.

2. On the kitchen shelves a undated uncovered container of butter and several opened undated boxes of cereal were observed.

3. In the pantry room adjacent to the dining room the freezer contained 2 opened undated containers of ice cream; and the pantry room

R247 Plan of Correction accepted by Jo A Evans RN on 11/22/23

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R247	Continued From page 4 fridge contained unlabeled undated prepared beets, an undated unlabeled sandwich, and a large opened undated jar of pickles. 4. On the pantry shelves an opened jar of jelly was observed, which was immediately discarded by the Manager. During the facility tour on the morning of 10/9/23 the Manager of the home confirmed the unlabeled undated perishable food items listed above were stored in the facility kitchen and pantry room.	R247		
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, and staff interview there was a failure to ensure care in a safe, functional, sanitary and comfortable homelike environment. Findings include: During the environmental tour of the home commencing at 10:58 AM on 10/9/23 the following environmental concerns were observed: 1. The internal door of the home's elevator has an open scissor style collapsing framework requiring the operator's hands to be positioned on the edge of the door frame where the door articulates with	R266	R266 Plan of Correction accepted by Jo A Evans RN on 11/22/23	

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R266	Continued From page 5	R266		

the elevator car. Positioning of the hand anywhere other than the edge of the door results in pinching as the internal door is closed. The open framework of the interior door leaves the elevator shaft exposed during use, which is a risk for injury should any objects or body parts move through the open framework with the elevator in motion. The internal door is weighted to ensure it closes after use, and was observed to rapidly slam shut when not held open. During the facility tour on the morning of 10/9/23 the Manager confirmed the elevator poses a risk for injury, confirmed the elevator is used by many of the residents to travel between the first and second floor of the home.

2. The floor of a shared shower room across the hall from the elevator was observed to have water damage along the tub which felt soft and spongy as the surveyor walked in the area. The Manager of the home was unable to confirm when the water damage occurred and the extent of the damage. Per discussion with the Contractor hired for repairs to the home, the damaged area had not been evaluated to determine the extent of the damage and the structural integrity of the floor had not been confirmed. The Manager of the home closed the shower room and provided a plan to evaluate and repair the floor on 10/12/23 following the environmental tour on the morning of 10/9/23.

3. A gate was observed across the top of the stairs along the second floor hallway which was constructed with two pieces of wood in an X across an open frame. The gate is locked with hook and eye closures on the top and bottom of the side of the gate facing the staircase which require a resident to reach over the gate to unlock the top closure, and bend down and reach

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R266	Continued From page 6 through the gate's open framework to unlock the bottom closure when standing in the hallway. Opening the gate to exit the stairs requires a resident to maintain balance on the stairs while bending or stretching to open the bottom lock, and to balance and reach while standing at the top of the staircase to open the top lock. At approximately 4:20 PM on 10/9/23 the Assistant Manager and Manager of the home acknowledged the placement of the locked gate is a barrier to use of the stairs and it a potential risk for falls and injury. 4. Additional concerns observed in the home during the environmental tour commencing at 10: 58 AM on 10/9/23 included the observation of kitchen items including trays and tools stacked on top shelf within 3-5 inches of a sprinkler head potentially preventing proper dispersing of water if the sprinkler system was activated; the placement of a juice bottle belonging to a staff member directly into the kitchen freezer ice container containing ice for use by residents; the storage of a spray bottle of diluted bleach, bleach wipes, and E3000 industrial strength adhesive glue in an unlocked cabinet in the dining room. These findings were confirmed by the Manager during the tour on the morning of 10/9/23.	R266		
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	R302	R302 Plan of Correction accepted by Jo A Evans RN on 11/22/23	

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R302	Continued From page 7 periodically and kept informed of their duties under the plan. 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. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to complete fire drills on at least a quarterly basis and to complete at least one drill during all designated times during the previous year. Findings include: Per record review the home failed to complete fire drills during the second and fourth yearly quarters, and fire drills were not performed in the afternoon, evening , and night during the previous year. These findings were confirmed by the Manager of the home at 1:08 PM on 10/9/23.	R302		
R314 SS=F	XI. RESIDENT FUNDS AND PROPERTY 11.2 If the home manages the resident's finances, the home must keep a record of all transactions, provide the resident with a quarterly statement, and keep all resident funds separate from the home or licensee's funds This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to provide quarterly accounting for resident funds managed by the home for 6 out of	R314	R314 Plan of Correction accepted by Jo A Evans RN on 11/22/23	

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R314	Continued From page 8 6 applicable residents (Residents #2, #3, #4, #5, #6, #7). Findings include: At 4:04 PM on 10/9/23 the Assistant Manager confirmed quarterly accounting of resident funds managed by the home were not provided to 6 out of 6 applicable residents and stated s/he was not aware of this requirement.	R314		

A great place to call home!

Frances Atkinson Residence
for the Retired
4717 Main Street
Newbury, Vermont 05051
(802) 866-5582 phone
(802) 866-5585 fax
director.atkinson@gmail.com

November 7, 2023

Carolyn Scott, LMHC, M.S.
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

Dear Ms. Scott:

Enclosed is our Plan of Correction you requested.

1. R145 5.9c (2) Written Care plans
    a. Action taken: A.R Nurse went through all residents and made sure that a care plan was in all resident's files through EHR database. Our Assistant director went through as well and verified this.
    b. Measures it won't happen again: Added to the check list on the admission to check off for both Assistant Director and Nurse to initial.
    c. How will it be monitored: The Assistant Director put an email into a representative at our EHR to see if we can flag a new admission so that if it hasn't been done within 24 hours after admission it will alert us to complete the assessment. This EHR is working on putting this into the system.
    d. Dates Corrective Action was complete: 10/12/2023 by Atkinson Residence Nurse.
2. R179 5.11.b Competency in skills with 12 hours of training.

    a. Action taken: The Assistant Director has uploaded all training courses on our training site. The Assistant Director has gone through all the employees that are lacking and has completed a memo to all with the expectation that these need to be completed in the next 30 days. This letter will be going out in their paychecks on 11/8/2023. The Assistant Director has also created training to be put into place annually with our

nurse or our director observing and checking off that they are successfully able to perform tasks. If they aren't, a retraining will be scheduled.

b. Measures it won't happen again: This is added to the new employee checklist and will need to be checked off before filing chart. Also, a verbal warning, then a written warning, then termination of employment to any employee who doesn't adhere to this rule. A person has been hired part-time to assist in the Administrators office.
c. How will it be monitored: Online on our training software by our assistant director.
d. Dates of Corrective Action: All employees will have all their training completed by 12/7/2023. Director and nurse will have their observations done by 12/20/2023.

3. R190 5.12.b. (4) Criminal record and abuse records
    a. Action taken: We have completed the abuse registry on all our employees. We have completed the criminal background check on all our employees. We have completed the federal check on all our employees.
    b. Measures it won't happen again: This has been added to the new employee check list. Annually, all employees will be checked through the federal criminal site and the Vermont registry.
    c. How it will be monitored: Every employee upon hire will have all three. Any re-hires will have all three as well. Annually the registry and federal criminal check will be done on all employees.
    d. Dates of Corrective Action: This was done on 10/31/2023
4. R247 7.2 Food Safety (undated items that were opened)
    a. Action taken: A full time cook has been hired on 11/3/2023. The cook has an extensive history of commercial kitchen management and is certified in SAFESERV. The kitchen refrigerators and freezers have been cleaned and food and condiments are labeled at the time of being opened 10/20/2023. The new cook is in the process of organizing the kitchen so it can be more functional. Expected completion 11/17/2023.
    b. Measure it won't happen again: AR have just hired a new day cook and the Director is training her about labeling and putting dates on the items in the refrigerator. Once a week, the cooks will go through the food and throw out anything that is outdated.
    c. How it will be monitored: A checklist will be checked off weekly for the kitchen staff, signed and dated and returned to the Director to sign off on as well that it has been done.
    d. Dates of Corrective Action: 10/14/2023 for labeling. Checklist will be put into effect by 11/15/2023.
5. R266.1 Physical Plant
   A. Elevator internal door
6. Action Taken: We have been working diligently with an architectural company and elevator company to find a solution that is not going to get caught in the existing cables. A call was made to see if the elevator company

could design a fully enclosed door. Our hope is to get a new elevator, but the cost is more than we can bare. We have reached out to several State Representatives to help and the private sector to look for grants and have not been successful. To ensure that nobody's unsafe in the elevator, we can provide staff to transport people up and down. This isn't a viable solution because of the weight restriction of the elevator's occupants. Expected completion is undetermined at this time due to the complexity as discussed with our elevator company, Fire safety, Contractors, and The Department of Licensing and Protection. We need to find a way to slow the gate down to avoid fingers getting pinched. The facilities Registered nurse will conduct a Mini-Cog on all the residents who will be using the elevator to ensure they can safely operate it. The assessments will be completed by December 4, 2023. If a resident is not capable of operating the elevator safely, then they will be accompanied by a staff member. We will put the assessment tool into the admission policies and procedures.

7. R266.2 Shower Floor
    a. Contractor was contacted to evaluate the extent of the structural damage in the shower room on 10/9/2023. The Contractor replaced the subflooring and laid new linoleum. Completion was 10/14/2023.
    b. Measures it won't happen again: Contractor put caulking around the edges of the shower lip where it meets the new floor, preventing water sprayed on the floor from seeping under the linoleum and tub.
8. R66.3 Gate at the top of the back stairway
    a. The Contractor built a completely enclosed half door with a fastened turntable doorknob that locks in place when it's closed.
    b. Completed 11/4/2023
9. R266.4

A. Top shelf near sprinkler
    a. Action Taken: Removed all the items from the top shelf near sprinkler.
    b. Measure it won't happen: A new kitchen manager was hired and will sign off on the checklist given to [redacted] weekly and signed by the Director as well.
    c. Completion of the clearing of the shelf was done 10/10/2023. Check list will be put into effect on 11/15/2023.

Pronoun removed by DLP 11-22-23

B. Employee juice bottle in the ice tray
    a. Action taken: Removed the juice bottle. Spoke and issued a verbal warning to the employee responsible. Hired a new Cook to oversee that this won't happen as [redacted] has SAFESERV experience.
    b. Measures it won't happen again: Staff who bring in food from home will follow policies and procedures expected by SAFESERV and Licensing and Protection. This will be added to the checklist and signed off weekly by the cook and the Director. This will also be added to the employee handbook on expectations.
    c. Corrective Action was done on 10/09/2023. The handbook will be updated by 11/15/2023.

Pronoun removed by DLP 11-22-23

C. Storage of Spray bottle, bleach wipes, and industrial strength adhesive glue

a. Action taken: Removed on 10/9/2023. Informed staff and housekeeping that cleaning supplies and construction materials need to be put into a locked cabinet which was done.
b. Measure it won't happen again: This will be put in the employee's handbook as well, and on the checklist for housekeeping and cooks and signed of by them and The Director.
c. Completion was on 10/9/2023. Check list will be completed by 11/15/2023.

10.R302 Fire drills

a. Action taken: Fire drills will be conducted quarterly and will rotate between morning, afternoon, evening, and night.
b. Measure if won't happen again: Post on the EHR website main calendar to flag that a fire drill is to be conducted on that day at least one week prior. Hire more staff for the overnight drill. Hired another office person to come help with office so The Assistant Director can do more of the compliance issues.
c. Completed by 11/15/2023 (drill will be put on the calendar and monitored by the Director and Assistant Director).

11.R314 Petty cash funds for residents

a. Action taken: Sent out with Novembers Statements a copy of all resident personal funds. Put on Calendar quarterly to send with Statements. Also, the Assistant Director will contact resident families when funds are near depletion.
b. Measure it won't happen again: The Assistant Director has entered it into her personal calendar for completion. The Assistant Director will also notify families if personal funds are near depletion and send a copy of the residents' expenditures. This was completed 10/15/2023. The next one will be sent on 1/1/2024.

Plan of Correction accepted by Jo A Evans RN on 11/22/23.
Please refer to the Statement of Deficiency for acceptance
of individual tags.