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

September 5, 2023

Ms. Tina Fede, Manager
Gatling House Group Home
United Counseling Service, Po Box 588
Bennington, VT 05201

Dear Ms. Fede:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 10, 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.

Sincerely,

Carolyn Scott, LMHC, M.S.
State long Term Care Manager

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
	0535	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATLING HOUSE GROUP HOME	UNITED COUNSELING SERVICE, PO BOX 588 BENNINGTON, VT 05201

(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 2/27/23 the Division of Licensing and Protection conducted on unannounced on-site relicesnure survey with further information received from the facility on 3/10/23. The following regulatory deficiencies were identified:	R100		
R128 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review there was a failure to ensure medication administration consistent with physician's signed orders for one applicable resident (Resident #1). Findings include: Per record review the following medications for Resident #1 are not entered into his/her February 2023 paper and/or electronic Medication Administration Records (MARs) as ordered: 1. Resident #1's order for Chloroseptic Spray dated 11/8/22 states "2 sprays to throat every 2 hours PRN sore throat". His/her electronic MAR does not include the frequency of administration and states "2 sprays PRN as needed". 2. The facility's Bowel Protocol signed by Resident #1's provider on 11/8/22 includes orders as follows: *No BM (bowel movement) for 3 days MILK OF	R128	See attachment	4/10/23

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tina Fede	Group Home Manager	4/10/23

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R128	Continued From page 1 MAGNESIA 30 ml po (by mouth) in AM or PM *No BM for 4 days REPEAT MILK OF MAGNESIA DOSE *No BM for 5 days DULCOLAX SUPP (suppository) 1 pr (per rectal route) in AM IF NO RESULTS, FLEET ENEMA X 1 IN AFTERNOON/EVENING *No BM for 6 days REPEAT FLEET ENEMA NO RESULTS FROM FLEET ENEMA #2 CALL MD Prolonged constipation causes discomfort and increasing risk of health complications the longer constipation persists. Resident #1's paper and electronic MARs do not list instructions for when to take action, the appropriate medication to administer depending on the number of days without bowel movement, and when to seek medical attention. The MARs read "PRN per bowel protocol" and do not provide instructions to give the least invasive medication first after 3 days, a schedule to administer the appropriate medication, and prevent the use of multiple medications at the same time. The electronic MAR does not include the order for Milk of Magnesia, which is the least invasive first action defined in the protocol. 3. Resident #1's signed order for Glucose 4 gm tablets dated 11/8/22 reads "chew and swallow 4 tablets by mouth one time for low blood sugar". Resident #1's paper MAR does not include this medication, which is prescribed for rapid response to hypoglycemia which can quickly progress to a medical emergency. His/her orders and MAR do not identify the blood glucose level at which intervention is needed, what to do if the resident becomes unconscious, and when to seek emergency medical help. While the facility primarily uses an electronic MAR, paper MARs	R128	See attachment	

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R128	Continued From page 2 are required to be maintained with all medication orders in case the electronic MAR becomes inaccessible. 4. Resident #1's order for Ibuprofen signed on 11/8/22 reads "200-400 mg every 6 hours pain/temp 101 or greater" and does not include a specific dose. His/her paper and electronic MARs both order 400 mg every 6 hours, however there is no evidence of a signed order clarifying the specific dose range for Ibuprofen in Resident #1's record. The electronic MAR indicates Ibuprofen is indicated for "Pain >0-5", and does not list temperature 101 or greater as an indication for administration. 5. Resident #1's signed order for Pantoprazole Sodium 20 mg tablets dated 11/8/22 reads "1 tablet by mouth daily 30 minutes before a meal as needed for heartburn, reflux, or trouble". Orders in the paper and electronic MARs indicate Pantoprazole Sodium 20 mg tab is to be given three times a day for gerd/gastritis. The frequency of administration and instructions for use in the MARs are not consistent with the signed orders. The MARs do not include instructions to administer 30 minutes before a meal, and the symptom the medication is intended to treat differ. While gastritis (inflammation of the stomach lining) and heartburn (dyspepsia) have similar symptoms, they are not the same condition. 6. A signed order for Trazodone HCl mg tab reads: "take one tablet at bedtime routinely; plus 1 or 2 more as needed during the night for insomnia". The order does not include a specific dose and the frequency of administration to include the amount of time between the schedule	R128	See attachment	

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R128	Continued From page 3 dose and PRN doses, as well as the time between PRN doses. The paper MAR reads "Up to 2 times as PRN after HS (bedtime) dose for insomnia" and the electronic MAR reads "1 tablet PRN Q-HS At Bedtime as necessary". There is no evidence of a signed order clarifying the dose and frequency of administration in Resident #1's record.	R128		
R145 SS=E	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 record review and staff interview the Registered Nurse failed to oversee development of a written plan of care based on individual abilities and needs for 3 applicable residents. (Residents #1,#2, and #3). Findings include: 1. Per record review Resident #1 was admitted on 1/27/21, and requires supportive care and monitoring for multiple medical and psychological conditions. Per record review on the afternoon of 2/27/23, and confirmed by the Manager on the afternoon of 3/10/23, a plan of care had not been developed for Resident #1 by the Registered Nurse.	R145	See attachment 3/10/23	

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R145	Continued From page 4 2. Per record review Resident #2 was admitted to the facility on 6/23/2010 and has care needs related to medical conditions and a mood disorder. S/he requires foods prepared with chopped consistency and moistened textures, and assistance with avoiding refined sugars. Resident #2's plan of care was last updated in July 2020 and does not reflect his/her current needs. 3. Per record review Resident #3 was admitted to the facility on 5/12/2008. In addition to neurological conditions, hearing loss and high blood pressure s/he has a recent diagnosis of Multiple Sclerosis, increased episodes of incontinence, and requires pureed foods. Resident #3's plan of care was last updated in July 2020 and does not reflect his/her current needs. On 3/10/23 at 12:58 PM the Manager confirmed the care plans for Resident #2 and Resident #3's have not been updated since July of 2020 and do not address each resident's current individual abilities and needs. The Manager stated the Registered Nurse "didn't realize [the residents] had to have a plan of care".	R145	See attachment	
R147 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (4) Maintain a current list for review by staff and physician of all residents' medications. The list shall include: resident's name; medications; date medication ordered; dosage and frequency of administration; and likely side effects to monitor;	R147		

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R147	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure all medication orders included specific dose and frequency of administration for one applicable resident (Resident #1). Findings include: Per review of Resident #1's signed orders, and February 2023 paper and electronic Medication Administration Records (MARs), the following mediation orders do not include the specific dose and frequency of administration: 1. Resident #1 has an order signed in August of 2022 for Ben Gay 10-15% to be administered "PRN- as needed" for sore muscles and joints signed which is entered on his/her electronic MAR and does not include a specific dose and frequency of administration. A signed order dated 11/8/22 for "Analgesic Cream PRN to minor muscles aches" is entered on his/her paper MAR and does not include a specific dose and frequency of administration. 2. Signed orders for Calamine Lotion, Hydrocortisone Cream, Cough Drops, First Aid Cream, Bactine Antiseptic Spray, Bacitracin Ointment, and A and D ointment dated 11/8/22 do not include specific doses and frequencies of administration. 3. A signed order for Depakote 250 mg tablets reads "take 1 tablet twice daily as needed agitation" and does not include the frequency of administration to include the amount of time between doses and instructions indicating if this	R147	See attachment	

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R147	Continued From page 6 PRN medication can be given at the same time as Resident #1's twice daily 500 mg scheduled doses of Depakote. 4. A signed order for Glucose 4 gm tablets dated 11/8/22 states "chew and swallow 4 tablets by mouth one time for low blood sugar". The order does not provide instructions for administration including the blood glucose level at which the tablets are to be administered; and what actions staff should take after administration the medication including when to recheck blood glucose level, administer a second dose, and seek help from a medical provider. Resident #1's paper MAR does not include this medication. His/her electronic MAR lists "hypoglycemia" as the reason for giving this medication, however does not include information about signs and symptoms of hypoglycemia including the blood glucose level at which someone is considered hypoglycemic, what to do if the resident becomes unconscious, and when to seek emergency medical help. 5. A signed order for Ibuprofen dated 11/8/22 reads "200-400 mg every 6 hours pain/temp 101 or greater" and does not include a specific dose. His/her paper and electronic MARs both order 400 mg every 6 hours, however there is no evidence of a signed order clarifying the specific dose range for Ibuprofen in Resident #1's record. The electronic MAR indicates Ibuprofen is indicated for "Pain >0-5", and does not list temperature 101 or greater as an indication for administration. 6. A signed order for Seroquel dated 11/8/22 reads "1 tablet 4 times daily as needed for agitation". The signed order, paper and electronic MARs do not include the frequency of	R147	See attachment	

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R147	Continued From page 7 administration to include the amount of time between doses. 7. A signed order for Trazodone HCl mg tab reads: "take one tablet at bedtime routinely; plus 1 or 2 more as needed during the night for insomnia". The order does not include a specific dose and the frequency of administration to include the amount of time between the schedule dose and PRN doses, as well as the time between PRN doses. The paper MAR reads "Up to 2 times as PRN after HS (bedtime) dose for insomnia" and the electronic MAR reads "1 tablet PRN Q-HS At Bedtime as necessary". There is no evidence of a signed order clarifying the dose and frequency of administration in Resident #1's record.	R147		
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;	R179	See attachment	4-5-23

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R179	Continued From page 8 (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 record review and staff interview there was a failure to ensure 5 out of 5 applicable staff completed all required yearly trrainings, Findings include: Based on review of staff trainings records 5 out of 5 staff (Staff #1, #2, #3, #4, and #5) failed to complete all required yearly trainings during the previous 12 months. All five staff had not completed Fire Safety and Emergency Evacuation Training. Staff #3 also did not complete trainings in Resident's Rights; Mandatory Reporting of Abuse, Neglect, and Exploitation; and Respectful and Effective interactions with residents. At 5:16 PM on 2/27/23 the Manager confirmed 5 out of 5 staff had not completed all required yearly trainings.	R179		
R190 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff.	R190	See attachment	2-27-23

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R190	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure an adult abuse registry check was completed for one applicable staff (Staff #6); and to ensure the personal file of one staff with a criminal record contained documentation indicating the applicable staff (Staff #3) does not pose a threat to residents. Findings include: On the afternoon of 2/27/23 the Manager confirmed there was no documentation of an adult abuse registry check completed for Staff #6 when hired in 2004; and the personnel file of Staff #3 does not contain documentation indicating a review was conducted and it was determined his/her criminal history of simple assault and driving without a license does not pose a risk to residents.	R190		
R230 SS=C	VI. RESIDENTS' RIGHTS 6.18 The enumeration of residents' rights shall not be construed to limit, modify, abridge or reduce in any way any rights that a resident otherwise enjoys as a human being or citizen. A summary of the obligations of the residential care home to its residents shall be written in clear language, large print, given to residents on admission, and posted conspicuously in a public place in the home. Such notice shall also summarize the home's grievance procedure and directions for contacting the Ombudsman Program and Vermont Protection and Advocacy, Inc.	R230	See attachment	2/27/23

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R230	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure a summary of the home's grievance procedure is posted in a conspicuously in a public place in the home. Findings include: During the course of the facility tour commencing at 8:48 AM on 2/27/23 the Manager confirmed the home's grievance procedure was not posted in a public place in the home.	R230		
R247 SS=F	VII. 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 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 perishable refrigerated foods are held at proper temperatures. Findings include: During the facility tour commencing at 8:48 AM on 2/27/23 the kitchen refrigerator temperature was observed to be 56 degrees Fahrenheit. On recheck at then end of the facility tour the temperature was observed to be 52 degrees Fahrenheit. The Manager stated the fridge usually takes about a half hour to return to proper temps after the fridge is opened during meal time.	R247	See attachment	2/28/23

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R247	Continued From page 11 Per review of the facility Fridge/ Freezer Temp Logs between 1/5/23 and 2/26/23 staff documented 31 out of 84 fridge temperatures higher than 40 degrees. At 11:53 AM on 2/27/23 the Manager confirmed the documentation of fridge temps above 40 degrees.	R247		
R266 SS=E	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, sanitary, homelike environment. Findings include: During the course of the facility tour commencing at 8:48 AM on 2/27/23 the following environmental issues were observed: * In the basement bathroom, glue traps with dead insects stuck to the traps were observed protruding from the bottom of the trash can. During the tour of the basement on the morning of 2/27/23 the Manager confirmed the presence of dead bugs on the glue traps placed under the edge of the bathroom trash can; stated the schedule for pest control services was changed from every 3 months to every 6 months. * Hazardous cleaning products were observed stored in unlocked cabinets under the basement	R266	See attachment	2/27/23 2/27/23

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R266	Continued From page 12 bathroom sinks including Lysol wipes, Lysol disinfecting spray, and floor wipes. Additionally Lysol disinfection wipes were observed on the dresser in the resident room located beside the basement bathroom. The facility is home to residents living with cognitive and developmental conditions, each with individual abilities and needs. * An uncovered bowl of bacon grease was observed beside the kitchen sink, during meal time when staff and residents utilize the kitchen sink and counters. Staff confirmed the bacon grease was poured into the bowl from a frying pan during breakfast preparation and placed beside the sink to cool. During the course of the facility tour commencing at 8:48 AM on 2/27/23 the Manager acknowledged the bacon grease left to cool beside the sink in the busy kitchen was a potential risk for burns. * Per review of documentation of twice daily water temperature checks in resident areas of the home between 1/1/23 and 2/27/23 water temperatures exceeded 120 degrees Fahrenheit on all except for the morning temperature check on 1/3/23, with 149 out of 150 checks conducted during this time frame indicating the water temperatures were over 120 degrees (in resident areas??). Water temperatures reached as high as 129 degrees Fahrenheit in the bathroom hand sink on the main floor of the home on the evening of 2/6/23. At 11:53 AM on 2/27/23 the Manager confirmed the documentation of water temperatures in the resident areas higher than 120 degrees Fahrenheit. Please refer to 291. * Per review of the facility Fridge/ Freezer Temp Logs between 1/5/23 and 2/26/23 staff documented 31 out of 84 fridge temperatures	R266	See attachment 3/4/23 See attachment 2/27/23	

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R266	Continued From page 13 higher than 40 degrees. At 11:53 AM on 2/27/23 the Manager confirmed the documentation of fridge temps above 40 degrees. Please refer to tag 247.	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 record review and staff interview there was a failure to ensure water temps do not exceed 120 degrees Fahrenheit in resident areas of the home. Findings include: Per review of documentation of twice daily water temperature checks in resident areas of the home between 1/1/23 and 2/27/23 water temperatures exceeded 120 degrees Fahrenheit on all except for the morning temperature check on 1/3/23; with 149 out of 150 checks conducted during this time frame indicating the water temperatures were over 120 degrees. Water temperatures reached as high as 129 degrees Fahrenheit, which was the temperature of the water in the bathroom hand sink on the main floor of the home on the evening of 2/6/23. At 11:53 AM on 2/27/23 the Manager confirmed the documentation of water temperatures in the resident areas higher than 120 degrees Fahrenheit.	R291	See attachment	2/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0535	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATLING HOUSE GROUP HOME	UNITED COUNSELING SERVICE, PO BOX 588 BENNINGTON, VT 05201

(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 14	R302		
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 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 record review and staff interview there was a failure to rotate fire drill times to include at least one evening and night drill yearly, and a failure to document the names of staff participating in fire drills. Findings include: At 11:05 AM on 2/27/23 the Manager confirmed evening and night fire drills were not conducted during the previous 12 months; and the names of staff participating in fire drills were not documented.	R302	See attachment	~~3/27/23~~ 4/10/23
R303 SS=D	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness	R303		3/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R303	Continued From page 15 9.11.d There shall be an operable telephone on each floor of the home, at all times. A list of emergency telephone numbers shall be posted by each telephone. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure emergency numbers were posted by the first floor telephone. Findings include: During the course of the facility tour commencing at 8:48 AM on 2/27/23 the Manager confirmed there were no emergency numbers posted by the first floor telephone.	R303	See attachment	3/27/23
R310 SS=D	X. PETS 10.2.d Pets must be free from disease including leukemia, heartworm, hepititis, leptos psorisos, parvo, worms, fleas, ticks, ear mites, and skin disorders, and must be current at all times with rabies and distemper vaccinations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure the facility cat was free from leukemia, parasites and worms. Findings include: Based on record review the facility cat was due for a feline leukemia vaccination on 11/11/2022, and Fecal Ova and Parasite screening on 11/17/2022. On the afternoon of 2/27/23 the Manager confirmed the Feline Leukemia	R310	See attachment	2/28/23 4/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R310	Continued From page 16 vaccination and fecal parasite testing had not been completed for the facility cat as of 2/2/7/23.	R310		
R999 SS=F	MISCELLANEOUS Gatling House Group Home is currently licensed as a level 3 Residential Care Home. Level 3 Residential Care Homes are required to provide nursing overview as defined by these regulations. The definition states: 2.3.cc. "Nursing overview" means a process in which a nurse assures that the health and psychosocial needs of the resident are met. The process includes observation, assessment, goal setting, education of staff, and the development, implementation, and evaluation of a written, individualized treatment plan to maintain the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there is a failure to ensure nursing overview to include observation of residents, education of staff, goal setting, and the development, implementation, and evaluation of a written, individualized treatment plans to maintain the resident's well-being. 1. At 1:42 PM on 2/27/23 the RN stated s/he is scheduled to be on site at the facility one hour every two weeks and as needed. The RN further stated "we try to be available", however records of the hours spent on site are not maintained and there are no policies for nursing on site visits to the facility. The Registered Nurse's Position Description effective 6/30/21 states the RN is responsible for organizing, planning, and supervising the medical component for assigned	R999		

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R999	Continued From page 17	R999		

programs and individuals including performing nursing assessments, identifying goals, identifying changes in resident's well-being, and overseeing medical care and medication delegation to the home; however the Position Description does not include visits to the home to perform these duties.

On 2/27/23 facility staff, and managerial staff for the organization that manages the facility indicated the RN has performed the majority of his/her duties remotely since 2020, and recently there have been months when a nurse has not been on site at the facility. The Manager confirmed the Registered Nurse had not been on site since December of 2022, with the exception of possibly being on site to med delegate staff. Managerial Staff for the organization that manages the facility indicated there has been significant discussion related to the lack of nursing on site presence and availability; and difficulty getting nursing support when assessments, staff education, and communication with medical providers are needed for significant medical issues. At approximately 1:00 PM on 2/27/23 the Manager confirmed an additional RN was hired to provide onsite nursing at the facility, however this RN has not been on site since October of 2022.

2. Per record review the Plans of Care for 3 applicable residents (Residents #1,#2, and #3) do not evidence nursing oversight to include:

Per record review 2 out of 3 sampled resident's care plans had not been updated since July of 2020 and did not address the resident's current needs. A care plan had not been developed for the third sampled resident who was admitted to the facility in January of 2021. On 3/10/23 at

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R999	Continued From page 18 12:58 PM the Manager confirmed the care plans for Resident #2 and Resident #3's have not been updated since July of 2020 and a care plan had not been developed for Resident #1. The Manager stated the Registered Nurse "didn't realize [the residents] had to have a plan of care". Please refer to tag 145 3. At 12:33 Med Delegated Staff confirmed the Registered Nurse reviews the Medication Administration Records (MARs) at the end of each month rather than at the beginning of the month, which creates a risk for medication errors to go unnoticed for weeks. Med Delegated Staff also stated short term medications such as antibiotics are only entered on paper MARs by staff and are not recorded or documented on the Electronic MARs, which was confirmed by the Manager at 12:40 PM on 2/27/23. The practice of entering short term medications on the paper MARs maintained by the facility in case the electronic MAR is not accessible requires staff to manage and monitor two separate documents for medication administration, and creates increased risk for overlooked medication changes and med errors. During an interview commencing at 1:42 PM, when asked why all prescribed medications are not entered on the electronic MAR the Registered Nurse stated, "it depends on the time of day ...only nursing can enter orders into the electronic MAR ...[there are] only 2 nurses for the whole agency".	R999	See attachment	

R179 5.11b… The home must ensure that staff demonstrate competency in the skills and techniques they are expected to preform before providing and direct care to residents. There shall be at least twelve 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: resident rights, fire safety and emergency evacuation, resident emergency response procedures and policies and procedures regarding mandatory reports of abuse, neglect, and exploitation. Based on records reviewed 5 applicable staff failed to complete all required yearly trainings during the previous 12 months. All five had not completed fire safety and emergency evacuation training. Staff #3 did not complete trainings in resident rights, mandatory reporting of abuse, neglect and exploitation, and respectful and effective interactions with residents.

Plan of correction: All applicable staff will attend fire safety and evacuation training, staff #3 will also attend residents' rights, mandatory reporting of abuse, neglect, and exploitation, and respectful interactions with residents.

Completion date of correction: 4/5/23 all five applicable staff attended fire safety and evacuation training. Staff #3 completed resident's rights, mandatory reporting of abuse, neglect, and exploitation and respectful and effective interactions with residents on 3/22/23. Her original date of the included trainings was 10/23/22 listed on the On-the-Job training document that HR keeps for all staff but was not given on the day of review.

Monitoring Plan: All required trainings documentation of completion will be on sight and kept in HR before working with residents. This will include the On-the-Job document. Required trainings are being added to the Relias training data base and will allow for all completed trainings to give reminder and flag to employee and supervisor when it is due.

R179 accepted on 9/5/23 by J. Evans/C. Scott

R190 5.12.b. (4) …The results of the criminal record and adult abuse registry checks for all staff. Based on record review and staff interview there was a failure to ensure an adult abuse registry check was completed for one applicable staff (#6) also to ensure the personal file of one staff with a criminal record contained documentation indicating the applicable staff does not pose threat to residents (staff #3)

Plan of Correction: a variance was obtained and included in that employees file Staff #3, data from the 2004 adult abuse registry check was entered in data base.

Date of correction: Both the variance and adult abuse registry check data was entered immediately on 2/27/23.

Monitoring Plan: All background and DMV checks will be completed and entered before employee starts employment. If a finding on a check that requires a variance, a variance form will be completed, signed, and recorded before the employee starts work at UCS.

R190 accepted on 9/5/23 by J. Evans/C. Scott

R230 6.18… The enumeration of resident rights shall not be construed to limit, modify, abridge, or reduce in any way any rights that a resident otherwise enjoys as a human being or citizen. A summary of the obligations of the residential care home to its residents shall

be written in clear language, large print, given to residents on admission, and posted conspicuously in a public place in the home. Such notice shall also summarize the homes grievance procedure and directions for contacting the ombudsman program and Vermont protection and advocacy Inc. Based on observation and staff interview there was a failure to ensure a summary of the home's grievance procedure is posted in a conspicuously public place in home.

Plan of Correction: Grievance procedure posted by license in dining room.

Date of correction: Grievance procedure posted immediately on 2/27/23 by license in dining room.

Monitoring Plan: Grievance procedure will not be taken down except to be replaced if it is updated and remain in same location next to posted license in dining room. Addition copies can be made from UCS data base and/or posting from office.

R230 accepted on 9/5/23 by J. Evans/C. Scott

R247 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. During the facility tour on 2/27/23 the kitchen refrigerator temperature was observed to be 56 degrees Fahrenheit. On recheck at the end of tour the temp was observed to be 52 degrees. Per review the fridge/freezer temp logs between 1/5/23 and 2/26/23 staff documented 31 out of 84 fridge temps higher than 40 degrees.

Plan of Correction: refrigerator was turned up to meet under 40 degrees and replacement of thermometer was obtained. Purchase of a digital thermometer occurred and waiting for delivery.

Date of Correction: immediately on 2/27/23 the refrigerator was turned up to bring temperature to acceptable level. A replacement thermometer was needed and obtained on 2/28/23 and continually fridge is under 40 degrees.

Monitoring Plan: The log that staff documents on was changed to include now an intervention if equal to or above 40 degrees and documentation that it was reported to manager and facilities department. The use of a digital thermometer will help accurate temperature.

R247 accepted on 9/5/23 by J. Evans/C. Scott

R266 9.1.a… The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. In the basement bathroom, glue traps with dead insects stuck to trap were observed protruding from the bottom of the can. It was stated that pest control services was changed from every 3 months to every 6 months.

1. **Plan of correction:** Bug trap was immediately removed and disposed of. Pest Control service was made aware of the disposal.

Date of Correction: 2/27/23 removal of glue trap

Monitoring Plan: Pest control will be at Group Home every other month and log when they come and what they do. When disposal of trap needs to occur before the next pest control visit it

will be reported to facilities department. If needed pest control occurs between scheduled visits group home will notify facilities department that will notify pest control for additional services.

2. Hazardous cleaning products were observed in unlocked cabinet under the basement sink including Lysol wipe, Lysol disinfecting spray, and floor wipes. Lysol wipes ere observed on dresser of resident room.

Plan of correction: immediately removal of cleaning products and placed in locked cabinet.

Date of Correction: 2/27/23

Monitoring Plan: All staff and residents were reminded to place all cleaning products back to locked cabinet when done cleaning. All staff have a key for locked cabinet. The independent resident that purchases cleaning supplies was reminded that she can use them but supply and when not in use must be locked in cabinet that staff can unlock when needed.

3. An uncovered bowl of bacon grease was observed beside the kitchen sink, during mealtime when staff and residents utilize the kitchen sink and counters.

Plan of Correction: Grease will be kept in a grease container with a cover until cooled.

Date of Correction: 3/4/23 new grease containers with covers were purchased and available in kitchen.

Monitoring Plan: Use of proper utensils and appliances training has been added to new staff orientation to the home. The grease container will remain on kitchen counter for easy accessibility.

R266 accepted on 9/5/23 by J. Evans/C. Scott

R291 9.6.d… Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas. based on review there was failure to ensure water temps do not exceed 120 degrees Fahrenheit in resident area of the home.

Plan of Correction: water heater was turned down to be below 120 degrees in every area of the home.

Date of Correction: Turned down heater 2/27/23, new valve and meter added to heater on 3/4/23 for easy adjusting. Change to log for documentation on 3/4/23 to add intervention and notify manager and facilities.

Monitoring Plan: Each shift will monitor water temperatures and document on log that has additional step of an intervention if water every reach 120 or above, and spot to document that facilities and manager have been notified.

R291 accepted on 9/5/23 by J. Evans/C. Scott

R302 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 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 shall be documented. failure to rotate fire drill time to include at least one evening and night drill yearly, and failure to document the names of staff participating in fire drills.

Date of Correction: 4/10/23 new schedule logs for fire drills identify day, afternoon, evening and overnight yearly.

Monitoring Plan: Updated schedule to include identified need for day, afternoon, evening, and overnight fire drill yearly. All Fire drill logs will be signed by group home manager, sent to Health and Safety and in description of the drill report will add name of staff that participated.

R302 accepted on 9/5/23 by J. Evans/C. Scott

R303 9.11.d… There shall be an operatable telephone on each floor of the home, at all times. A list of emergency numbers shall be posted by each telephone. Failure to ensure emergency numbers were posted by the first-floor telephone.

Plan of Correction: All phones have poison control number posted, additional emergency number for each phone will be posted to follow our 911 procedures.

Date of Correction: 3/27/23 all phones have emergency numbers, 911 and poison control to follow our protocols.

Monitoring Plan: Health and safety is looking into stickers for emergency numbers to post on each phone, during emergency drills we will ensure the numbers are still posted.

R303 accepted on 9/5/23 by J. Evans/C. Scott

R310 10.2.d… Pets must be free from disease including leukemia, heartworm, hepatitis , leptos psoriasis, parvo worms, fleas, ticks, ear mites, and skin disorders, must be current at all times with rabies and distemper vaccinations. Based on review the facility cat was due for feline leukemia vaccination on 11/11/2022, and Fecal Ova and parasite screening on 11/17/2022 which had not been completed by 2/27/23.

Plan of Correction: Facility cat received Feline leukemia vaccination and Fecal Ova and parasite screening.

Date of Correction: Facility cat appointment for vet was set on 2/28/23 and received feline leukemia and the Fecal Ova and parasite screening was done on 4/6/23.

Monitoring Plan: Facility cats wellness visit, flea and tick prevention, and vaccinations are all on an schedule and documented on a facility calendar, vet has an automatic reminder system via mail, and if the vet is unable again to allow cat to be vaccinated due to COVID positive household or any other reason that prevents the vet to administer before the due date the option to go to a vaccination clinic in the area will occur.

R310 accepted on 9/5/23 by J. Evans/C. Scott

R128 5.5C… Each Resident's medication, treatment, and dietary services shall be consistent with the physician's orders.

Requirement not met AEB: Per record review the following medication for Resident #1 are not entered into their February 2023 paper and/or electron Medication Administration Records (MARs) as ordered.

Plan of Correction for each:

1. Chloroseptic Spray. Order was updated on 04/07/23 to include instructions of Q2hrs PRN as ordered in the "additional information" free text box in order entry. Work order submitted to add the option of "Q2hrs PRN" to eMAR order entry system used by UCS on 04/07/23. Currently the most frequent option is "Q4hrs PRN".

2. Bowel Protocol orders on paper and electronic MAR do not include order directions and state "see bowel protocol" in instructions. Milk of Magnesia order not listed in eMAR.

Milk of Magnesia order had expired off of the eMAR, a functionality of current eMAR system nursing has previously requested be removed, and order had been renewed. Order required "acknowledgement" in eMAR, another function we have requested be removed, so did not show on eMAR until it had been acknowledged. Acknowledgment completed on 03/10/23 and is not visible. Nurse team has taken action to prevent this prior to Gatling survey and item is still on agendas and work order tickets in place.

New more specific Bowel Protocol and Standing Orders will be developed by RN team by 04/13/23 and sent out for PCP review and signature for all group home clients. RN team will review current Bowel Protocol and Standing Orders on paper and eMAR for all group home clients for completeness and accuracy by 04/14/23.

3. Order for Glucose 4gm tablets. RN team to consult with PCP regarding order and parameters for administration by 04/13/23. RN team to develop Special Care Procedure for hypoglycemia and interventions by 04/13/23.

4. Ibuprofen order for 200-400mg Q6 hours for pain/temp 101 or greater. Clarification on specific, non-ranged directions, will be included in redevelopment of Standing orders and sent out for PCP review and signature by 04/13/23. Additional indication of elevated temperature added in eMAR order under additional order information. Current order entry system allows for "pain/fever greater than 100" but not "101". Work order placed to add 101 as order entry indication option 04/10/23.

5. Pantoprazole order. Order was on paper and eMAR as "TID PRN" and did not include the instructions to take 30 mins before meals as indicated in order. This was corrected on 04/03/23 by adding the additional instructions to give 30 mins before meals in the additional instructions free text section of the order entry. Work order placed on 04/07/23 to add option of "Before meals PRN" direction to order entry system. Indication corrected in eMAR on 04/10/23 to match order and paper MAR.

6. Trazodone order. More recent order prescribed by UCS prescribers in November 2022 that discontinued routine dose and only had as 1 PRN dose option at HS for insomnia. Order printed and added to Residents paper chart 04/10/23. Existed in Electronic chart since ordered and on eMAR accurately. Nurse Team will no longer accept any ranged orders and clarify exact time between routine and PRN doses of the same medication.

R128 5.5C continued…

Monitoring Plan: Nurse Team is actively working with the configuration team of the current eMAR and Electronic Medical Records system on developing a report option for printing and obtaining complete signed Physician's orders at least annually and more frequently as needed. Nurse Team routine visits will include audit and comparing of paper MAR to eMAR and current order list for accuracy and completeness a minimum of monthly. More effective fax based communication method developed for requesting order changes, updates, and clarification of orders to ensure no miscommunication of orders and indications.

R128 accepted on 9/5/23 by J. Evans/C. Scott

R145 5.9.c (2)… [Nurse will] oversee development of a written plan of care for each resident that is based on abilities and needs 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.

Requirement not met AEB: Nurse failed to oversee development of written plan of care for 3 applicable residents.

Plan of Correction for each:

1. Resident #1 admitted 01/27/2021. Plan had not been developed for this Resident by Nurse. This is completed as of 03/13/2023.

2. Resident #2 plan of care updated last July 2020 and does not reflect current diet orders. This was updated and corrected on 03/10/23.

3. Resident #3 plan of care updated last July 2020 and does not reflect current diet orders and current care needs. This was updated and corrected on 03/10/23.

Monitoring Plan: RN Team is working with the configuration team of the current eMAR and Electronic Medical Records system on developing Nursing Care Plan form in operating system. This would pull from current diagnosis and orders in EMR and would be updated yearly and as needed with change of conditions and monitored through shared Care Plan tracking system.

R145 accepted on 9/5/23 by J. Evans/C. Scott

R147 5.9c (4)…Maintain a current list for review by staff and physician of all residents' medications. The list shall include: Resident's name, medications, date medication ordered, dosage and frequency of administration, and likely side effects to monitor.

Requirement not met AEB: Failure to ensure all medication orders included specific dose and frequency of administration for one applicable Resident.

Plan of Correction for each:

1.Ben Gay 10-15%. Signed order does not include amount and frequency of administration. New Standing Orders with more specific directions will be developed by 04/13/23 and sent to PCPs for review and signature.

2. Other Standing Orders. Signed orders for calamine lotion, hydrocortisone cream, cough drops, "first aide" cream, Bactine antiseptic spray, Bacitracin ointment, and A and D ointment do not include doses or frequencies of administration. New Standing Orders with more specific directions will be developed by 04/13/23 and sent to PCPs for review and signature.

3. Depakote 250mg BID PRN. Order does not include the frequency of administration to include the amount of time between doses or instructions if can be given at the same time as routine Depakote 500mg BID. Prescriber reviewed use of this medication and has discontinued the PRN on 04/10/23.

4. Glucose 4 gm. RN team to consult with PCP regarding order and parameters for administration by 04/13/23. RN team to develop Special Care Procedure for hypoglycemia and interventions by 04/13/23.

5. Ibuprofen order for 200-400mg Q6 hours for pain/temp 101 or greater.
Clarification on specific, non-ranged directions, will be included in redevelopment of Standing orders and sent out for PCP review and signature by 04/13/23. Additional indication of elevated temperature added in eMAR order under additional order information. Current order entry system allows for "pain/fever greater than 100" but not "101". Work order placed to add 101 as order entry indication option 04/10/23.

6. Seroquel order. Order is for 25mg QID PRN but does not include amount of time between doses. Clarified required time between doses with UCS prescriber and updated paper and eMAR with the new order of Q6hrs PRN 04/10/23.

7. Trazodone order. More recent order prescribed by UCS prescribers in November 2022 that discontinued routine dose and only had as 1 PRN dose option at HS for insomnia. Order printed and added to Residents paper chart 04/10/23. Existed in Electronic chart since ordered and on eMAR accurately. Nurse Team will no longer accept any ranged orders and clarify exact time between routine and PRN doses of the same medication.

Monitoring Plan: Nurse Team is actively working with the configuration team of the current eMAR and Electronic Medical Records system on developing a report option for printing and obtaining complete signed Physician's orders at least annually and more frequently as needed. Nurse Team routine visits will include audit and comparing of paper MAR to eMAR and current order list for accuracy and completeness a minimum of monthly. More effective fax-based

communication method developed for requesting order changes, updates, and clarification of orders to ensure no miscommunication of orders and indications.

R147 accepted on 9/5/23 by J. Evans/C. Scott

R999 2.3.cc… "Nursing overview" means a process in which a nurse assures that the health and psychosocial needs of the resident are met. The process includes observation, assessment, goal setting, education of staff, and the development, implementation, and evaluation of a written, individualized treatment plan to maintain the resident's well-being.

Requirement not met AEB: Inadequate documented in-person visits by RN on license and lack of minimum required group home in-person visits in "Nurse Consultant" job description.

Plan of Correction for each:

1. UCS has a "Nurse Team" model that involves both in-person and remote work options, current team consists of 2 Registered Nurses, Nurse #1 being listed on license at facility and is primarily a remote position. Nurse #2 makes regular visits which is documented in Nurse's timesheet as well as in nurse's notes.

To make this information more available to all staff, Nurse communication and visit logs will be on-site at each group home. Each Nurse will document in this log whenever they make an in-person visit and a short description of the reason for the visit; routine or as needed. The "Nurse Consultant" job description is also being reviewed by the RNs and Medical Director to ensure it matches current needs of the aging population in group homes and clearly defines duties between Group Homes and other RN responsibilities across the UCS Agency.

2. Resident #1 Plan of Care not complete and Residents #2 and #3 Plan of Care not up to date.

a) Resident #1 admitted 01/27/2021. Plan had not been developed for this Resident by Nurse. This is completed as of 03/13/2023.
b) Resident #2 plan of care updated last July 2020 and does not reflect current diet orders. This was updated and corrected on 03/10/23.
c) Resident #3 plan of care updated last July 2020 and does not reflect current diet orders and current care needs. This was updated and corrected on 03/10/23.

3. RN review paper MARs at end of month and not beginning increasing risk for medication error. Some short-term orders are added on paper MAR only and not eMAR increasing risk for medication error. RN will type and review Group home paper MARs assuring accuracy before the 1st of each month.

Monitoring Plan: RN Team is working with the configuration team of the current eMAR and Electronic Medical Records system on developing Nursing Care Plan form in operating system. This would pull from current diagnosis and orders in EMR and would be updated yearly and as needed with change of conditions and monitored through shared

Care Plan tracking system. The "Nurse Consultant" job description is also being reviewed by the RNs and Medical Director to ensure it matches current needs of the aging population in group homes and clearly defines duties between Group Homes and other RN responsibilities across the UCS Agency and specifying RN "on-call" duties for quick order entry including during off hours.

R999 accepted on 9/5/23 by J. Evans/C. Scott