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

May 6, 2024

Jaime Walker, Manager
Heartbeet Lifesharing
218 Town Farm Road
Hardwick, VT 05843-9885

Dear Ms. Walker:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 25, 2024.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

If you have any questions, please feel free to contact me at (802) 585-0995.

Sincerely,

Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0599	A. BUILDING: _____ B. WING _____	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTBEET LIFESHARING	218 TOWN FARM ROAD HARDWICK, VT 05843

(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
T 001	Initial Comments On 3/25/24 the Division of Licensing and Protection conducted an unannounced on-site relicensure survey. The following regulatory deficiencies were identified:	T 001	Plans of Correction for all tags accepted by Jo A Evans RN on 5/4/24. Please see attached document to review the corrective actions accepted for individual tags.	
T 035 SS=F	V.5.8.a.1.2.3.4.5.6.7.8 Resident Care and Services 5.8 Medication Management 5.8.a Each therapeutic community residence must have written policies and procedures describing the residence ' s medication practices. The policies must cover at least the following: (1) If a therapeutic community residence provides medication management, it shall be done under the supervision of a registered nurse. (2) Who will provide the professional nursing delegation if the residence administers medications to residents unable to self-administer and how the process of delegation is to be carried out in the residence. (3) Qualifications of the staff who will be managing medications or administering medications and the residence's process for nursing supervision of the staff. (4) How medications shall be obtained for residents including choices of pharmacies. (5) Procedures for documentation of medication administration.	T 035		

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T 035	Continued From page 1 (6) Procedures for disposing of outdated or unused medication, including designation of a person or persons with responsibility for disposal. (7) Procedures for monitoring side effects of psychoactive medications. (8) Procedures for assessing a resident ' s ability to self-administer and documentation of the assessment in the medical record This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure prompt disposal of outdated medications. Findings include: The facility's Disposal of Medications policy effective 7/24/23 states, "At times it may be necessary to dispose of medications. This may occur when... medications have passed their expiration date. ". While this policy describes who is responsible for disposal of expired medications and how disposal of medications is documented, the policy does not identify the requirement to dispose of expired/outdated medications promptly. 1. During the main kitchen tour commencing at 10:05 AM on 3/25/24 expired medications were observed in the kitchen first aid kit to include: a. tubes of antibiotic ointment expired in 2018 and 2019 b. Aspirin expired in 2022 c. Homeopathic Arnica tablets expired in 2019 d. boxes of over the counter Pain Reliever containing Acetaminophen, Aspirin, and Caffeine	T 035		

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T 035	Continued From page 2 expired in 2022. The kitchen area where the first aid kit is stored is accessible to residents who frequently participate in preparation of meals and production of prepared food items in the main kitchen. The Manager confirmed these findings at 10:50 AM on 3/25/24. 2. During the tour of the facility's Kasper House commencing at 9:50 AM on 3/25/24, two expired bottles of Ibuprofen 200 mg softgels which expired on 2/2024 were observed. This finding was confirmed by the Kasper House Holder [House Manager]. In conclusion this deficient practice is a potential risk for more than minimal harm to all facility residents due to use of medications which are expired and ineffective.	T 035		
T 038 SS=F	V.5.8.d.1.2.3.i.ii.iii.iv. Resident Care and Services 5.8 Medication Management d) If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (1) A registered nurse must conduct an assessment of the resident's care needs consistent with the physician's or other health care provider ' s diagnosis and orders. (2) A registered nurse must delegate the responsibility for the administration of specific medications to designated staff for designated residents.	T 038		

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T 038	Continued From page 3 (3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for: i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects; ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications; iii. Assessing the resident's condition and the need for any changes in medications; and iv. Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure the Registered Nurse (RN) responsible for delegation of medication administration and nursing tasks delegates the responsibility for the administration of specific medications to designated staff for designated residents. Per record review, the facility's Medication Delegation & Nursing Policy effective 7/24/23 states, "Medication administration will be carried	T 038		

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T 038	Continued From page 4 out by licensed nursing staff or non-licensed staff delegated by an RN. Non-licensed staff delegated to administer medication by the RN will have reviewed medication administration policies and procedures, documentation, side effects and medication administration protocol." The policy does not identify the responsibility of the RN to delegate the administration of specific medications for designated residents to designated staff. During an interview commencing at 11:12 AM on 3/25/24 the facility Manager described the process for initiating new medications and stated the RN is notified of changes, however the RN is not directly involved in how the new med is communicated to the staff". At 11:17 AM on 3/25/24 the Manager confirmed the RN does not delegate the administration of specific medications to specific residents by designated staff. In closing this deficient practice is a potential risk for more than minimal harm for all facility residents resulting from the failure to ensure staff who administer medications are informed regarding each individual resident's specific needs related to their specific medications.	T 038		
T 040 SS=E	V.5.8.5 Resident Care and Services 5.8 Medication Management 5.8.5 Staff other than a nurse may administer PRN psychoactive medications only when the residence has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or	T 040		

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T 040	Continued From page 5	T 040		

address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review there was a failure to ensure development of written plans for the administration of PRN (as needed) psychoactive medications for 2 applicable residents (Residents #1 and #2). Findings include:

Per review of the facility's Medication Delegation and Nursing Policy effective 7/24/23 does not include policies and procedures for the development of written plans for the administration of PRN psychoactive medications by staff other than a nurse.

Per record review Resident #1 is prescribed the antipsychotic medication Thioridiazine as needed; and Resident #2 is prescribed the antipsychotic medication Olanzapine and the anxiolytic medication Lorazepam as needed.

At 1:50 PM on 3/25/24 the Manager confirmed written plans for the administration of PRN psychoactive medications to Residents #1 and Resident #2 by staff other than a nurse had not been developed by the Registered Nurse responsible for nursing supervision and oversight at the facility.

In conclusion this deficient practice is a potential risk for more than minimal harm for all facility

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T 040	Continued From page 6 residents due to administration of PRN psychoactive medications without monitoring the medication's effect, and potential medication errors including misuse.	T 040		
T 052 SS=F	V.5.9.b.1.2.3.4.5.6.7 Resident Care and Services 5.9 Staff Services 5.9.b. The residence must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents	T 052		

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T 052	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure 5 out of 5 sampled staff were provided all required trainings. Findings include: Per review of the Employee Training List document provided by the facility on 3/25/24, the training list does not include infection control training as required by the licensing agency. Per record review 5 out of 5 sampled staff did not complete training in infection control. Additionally 1 out of 5 staff did not complete training in emergency response and first aid, which is included in the facility's Employee Training List. These findings were confirmed by the Manager at 1:46 PM on 3/25/24. This deficient practice is a potential risk for more than minimal harm for all facility residents due to inadequate staff education and training to safely and effectively provide resident care. In particular, this deficient practice poses an increased risk of more than minimal harm to all facility residents due to the spread of communicable diseases.	T 052		
T 062 SS=F	V.5.10.b.4 Resident Care and Services 5.10 Records/Reports 5.10.b.4 The results of the criminal record and abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by:	T 062		

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T 062	Continued From page 8 Based on staff interview and record review there was a failure to complete all required criminal record checks for 5 out of 5 sampled staff, and all required abuse registry checks for 1 out of 5 sampled staff. Findings include: The facility's Background Check Policy effective 9/26/23 states the facility "currently conducts four separate checks to comply with Vermont and federal regulations." The policy lists 5 separate types of checks which include Vermont Criminal Information Center (VCIC) criminal background checks, National Criminal Background Checks, and Agency of Human Services Adult Abuse and Child Protection Registries (AHS) checks. Per review of the criminal record and abuse registry checks for a sample of 5 staff provided for review on request, Vermont Criminal Information Center criminal background checks were not completed for 5 out of 5 sampled staff. Additionally, the required National Criminal background check and adult and child abuse registry checks were not completed as required for 1 out of 5 sampled staff. These findings were confirmed by the HR Coordinator at 1:21 PM on 3/25/24. In conclusion this deficient practice is a potential risk for more than minimal harm for all residents, as the requirement for criminal background and abuse checks is intended to ensure all residents are free from the risk of harm.	T 062		
T 071 SS=F	V.5.13 Resident Care and Services 5.13 Policies and Procedures	T 071		

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T 071	Continued From page 9	T 071		

Each residence must have written policies and procedures that govern all services provided by the residence. A copy shall be available for review at the residence upon request.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review there was a failure to develop and/or maintain on file and available for review policies and procedures that govern all services provided by the facility.

During the course of the relicensure survey on 3/25/24 the Administrative Team including the facility Manager, HR Coordinator, and Licensing and Compliance Coordinator were requested to provide policies and procedures related to all potential deficient practices identified through observation, staff interview, and record review during the survey process. The Administrative team were unable to provide policies and procedures related to the following areas of service for review on request:

a. development of written plans for the administration of PRN psychoactive medications by staff other than a nurse

b. monitoring for and prevention of food spoilage and contamination, and disposal of expired perishable food items

c .storage and labeling of perishable food items

d. facility policies and procedures for production of yogurt and kraut

e. maintaining accessibility to telephones on each

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T 071	Continued From page 10 floor of the facility at all times, and positing emergency phone numbers by the phones f. posting directions for contacting the Ombudsman's office, which is the designated advocacy organization, in accessible areas on all floors of the facility The Manager was requested to provide the facility's written procedures for making yogurt and kraut for review during the tour on the morning of 3/25/24 and on the afternoon of 3/25/24. An additional request was made via phone call to the facility on the afternoon of 4/5/24. Written procedures for producing facility made yogurt and kraut were not provided by the Manager for review in response to these requests. On the afternoon of 3/25/24 the Manager of the home confirmed policies and procedures listed above had not been developed by the facility and were not on file and available for review on request. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents due to failure to provide accessible information and clear instructions related to tasks staff are required to perform.	T 071		
T 105 SS=F	VI.6.21 Residents' Rights VI. Residents' Rights 6.21 The obligations of the residence to its residents shall be written in clear language, large print, given to residents on admission, and posted in an accessible, prominent and public place on each floor of the residence. Such notice shall	T 105		

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T 105	Continued From page 11 also state the residence's grievance procedure and directions for contacting the designated Vermont protection and advocacy organization. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure all required items were posted including Resident Rights and the facility's Grievance procedures in the main building; and directions for contacting the designated Vermont protection and advocacy organization in the main building and all resident houses. Findings include: The facility's Household File and Bulletin Checklist includes a section entitled Keep Posted- House Bulletin Boards which indicates documents including the facility's Resident Rights policy and Grievance Policy are to be posted on house bulletin boards. The requirement to post directions for contacting the designated Vermont protection and advocacy organization is not included in the Household File and Bulletin Checklist . On the afternoon of 3/25/24 Resident Rights posters and the facility Grievance policy including information on how to contact the Ombudsman's office, which is the designated Vermont protection and advocacy organization, were not observed to be posted in the facility's main building. The main building serves as a community hub where facility residents congregate for meals, and participate in group meetings and activities. The facility's administrative offices, library, community meeting and dining hall, and main kitchen are located in this building. At approximately 1:00 PM on 3/25/24 the office	T 105		

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T 105	Continued From page 12 Administrative Staff confirmed Resident Rights and the facility's Grievance policies and procedures were not posted in the main building, and confirmed directions for contacting the Ombudsman's office were not posted in the main building or residential homes. In closing this deficient practice is a potential risk for more than minimal harm to all facility residents due to the failure to ensure all residents and other interested parties are informed of Resident Rights, how to file a Grievance, and how to reach the Ombudsman's office.	T 105		
T 126 SS=F	VII. 7.2.a Nutrition and Food Services 7.2 Food Safety and Sanitation 7.2.a Each residence must procure food from sources that comply with all laws relating to food and food labeling. Food must be safe for human consumption, free of spoilage, filth or other contamination. All milk products served and used in food preparation must be pasteurized. Cans with dents, swelling, rust, missing labels or leaks shall be rejected and kept separate until returned to the supplier. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure food is free of spoilage and contamination. Findings include: On the afternoon of 3/25/24 the Manager confirmed policies and procedures to ensure food remains free of spoilage and contamination had	T 126		

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T 126	Continued From page 13 not been developed by the facility. The Manager was requested to provide the facility's written procedures for making yogurt and kraut for review during the tour on the morning of 3/25/24 and on the afternoon of 3/25/24. An additional request was made via phone call to the facility on the afternoon of 4/5/24. Written procedures for producing facility made yogurt and kraut were not provided by the Manager for review in response to these requests. (See T0071) 1. During the tour of the kitchen and food storage areas commencing at 10:05 AM on 3/25/25 spoiled and contaminated foods were observed in the food storage areas as follows: a. In the kitchen reach-in fridge the following expired or spoiled perishable food items were observed: a gallon container of Dijon mustard with stains and dried spills on the outside and an opened date of 12/2022, a bag containing spoiled celeriac with softened and brown areas dated as expired on 3/20/24, containers of beef lard and yogurt dated as expired on 3/8/24, and a gallon of ketchup dated as expired on 3/8/24. b. In the walk-in fridge a half gallon jar of red cabbage sour kraut in the process of fermentation contained cabbage not fully submerged in the brine solution which was covered with a white substance. Containers of facility made yogurt and kraut were observed without clear consistent labeling which lists the common food name, the start date and the expiration or end date which the facility's Food Storage Safety Protocol states all homemade food containers must have. Additionally, unlabeled and undated pints of brine and jam were observed.	T 126		

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T 126	Continued From page 14 2. During the tour of the Amber Rose House commencing at 9:15 AM on 3/25/25 expired food observed to be stored in the home included: a. 12 oz Hot Cocoa powder expired on 8/11/22 b. 3 oz Masala Chai expired on 12/2/22 and 3 oz Golden Masala Chai expired on 10/29/22 c. 3 oz Rooibos Masala Chai expired on 10/24/22 d. 19 oz Real Kefir expired 3/2020 These findings were confirmed by the Amber Rose House Holder [House Manager] during the tour of the home on the morning of 3/25/24. 3. During the tour of the Kasper House commencing at 9:50 AM on 3/25/25 expired food observed to be stored in the home included: a. 13 oz Plain bread crumbs expired on 2/28/22 b. 12 oz Real Panko expired on 2/28/22 c. 16 oz Gelatin supplement mix expired on 6/2021 d. 32 oz Molasses expired on 9/2023 e. 6 lbs yeast flakes expired on 9/10/23 f. 9 lbs peanut butter expired on 10/28/23. These findings were confirmed by the Kasper House Holder [House Manager] during the tour of the home on the morning of 3/25/24. In conclusion, this deficient practice is a potential risk for more than minimal harm due to food borne illness for all facility residents.	T 126		
T 127 SS=F	VII.7.2.b Nutrition and Food Services 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperature. Hot foods shall be kept hot at 135 degrees F and	T 127		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0599	A. BUILDING: _____ B. WING _____	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTBEET LIFESHARING	218 TOWN FARM ROAD HARDWICK, VT 05843

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T 127	Continued From page 15 cold foods shall be kept at 41 degrees F or cooler. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure all perishable food items in the main kitchen and resident homes were labeled and dated. Findings include: The facility's Food Storage Safety Protocol states, "All foods, prepackaged, homemade, or otherwise must have clear and consistent labeling at all times." This procedure contains a Food Storage Label Template which includes the Food /Item Name, Open/Start Date, and Expiration/End Date, and states containers must be labeled with this information. 1. Per observation during the tour of the main kitchen commencing at 10:05 AM on 3/25/24 perishable foods were observed to be stored without labels indicating the dates the foods were opened or prepared including: a. In the reach-in refrigerator the following open undated perishable items were observed: earth balance margarine; 2 containers of cream cheese; 2 containers of oat milk; a bottle of lemon juice; 2 large bottles of fruit juices; half of a lime placed directly on the shelf without a cover or packaging; bottles of fish sauce, oyster sauce, ketchup, raspberry jam, ume plum vinegar; and chicken stock. b. In the dry goods storage areas the following opened undated perishable items were observed: storage bins, 5 gallon buckets, and bags of beans, legumes, rice and other grains, flax seeds, nutritional yeast, various types of flour,	T 127		

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T 127	Continued From page 16 panko, sugars, raisins, and chocolate. In the kitchen additional perishable items observed without the dates opened included large containers of vinegar, sauces, cooking oils, honey, tamari, and sunflower butter. c. In the walk-in refrigerator located outdoors behind the main kitchen opened unsealed 5 gallon dried apple rings and cranberries were placed directly on the floor. d. In the walk-in freezer located outdoors behind the main kitchen boxes of fruits and nuts left open and unsealed, which exposed these items to the open air and is a risk for contamination. 2. During a tour of the Amber Rose House commencing at 9:15 AM on 3/25/24 a large cup of smoothie was observed to be undated and placed in the refrigerator without a cover; and 6 jars of food were observed in the fridge without identifying labels and the dates the food contained within the jars was prepared. These findings were confirmed by the Amber Rose House Holder [House Manager] during the tour of the home on the morning of 3/25/24. In conclusion, this deficient practice is a potential risk for more than minimal harm due to food borne illness for all facility residents.	T 127		
T 187 SS=F	IX.9.11.c Physical Plant 9.11 Disaster and Emergency Preparedness 9.11.c Each residence shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the	T 187		

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T 187	Continued From page 17	T 187		

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 staff interview and record review there was a failure to conduct fire drills on at least a quarterly basis in 1 out of 4 applicable homes, and to conduct drills at least once yearly during all required times in 3 out of 4 applicable homes. Findings include:

The facility's Fire Safety and Emergency Preparedness Plan includes a Fire Drills section that states, "Drills will be conducted for coworkers and residents on a quarterly basis"; and the Household File and Bulletin Checklist includes instructions to submit Fire Drill forms quarterly with check off boxes for drills in all 4 quarters and times frames including Morning, Afternoon, Evening, and Night.

Per review of fire drill records for the 4 TCR resident houses on the facility property, the White Pine House did not conduct a fire drill during the second quarter of the previous year. Drills were not conducted during all required times to include: Amber Rose House did not conduct a night drill, Konig House did not conduct drills during the evening and night times, and White Pine House did not conduct drills in the morning

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T 187	Continued From page 18 and at night. The Licensing and Compliance Coordinator confirmed these findings at 12:25 PM on 3/25/24. This deficient practice is a potential risk for more than minimal harm for all facility residents due to missed opportunities for staff and residents to practice the evacuation process, and identify effective procedures for safe and timely evacuation.	T 187		
T 188 SS=F	IX.9.11.d Physical Plant 9.11 Disaster and Emergency Preparedness 9.11.d There shall be an operable telephone on each floor of the residence, 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 an operable telephone with emergency numbers posted by the telephone is accessible at all times in the facility's main building. Findings include: On the afternoon of 3/25/24 the Manager confirmed policies and procedures for ensuring accessibility of a telephone with emergency numbers posted by the phone on each floor of the facility. Following lunch service on 3/25/24 it was observed a telephone with emergency numbers posted by the phone is not available in the	T 188		

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T 188	Continued From page 19 common areas of the main building. A phone with emergency numbers located in the administrative office is not accessible at all times, as the office is locked during when the administrative staff are not in the office. On the afternoon of 3/25/24 the HR Coordinator, Licensing and Compliance Coordinator, and Manager acknowledged a telephone with emergency numbers is not accessible in the common areas of the main building at all times. In conclusion this deficient practice is a potential risk for more than minimal harm to all facility residents due to the failure to ensure a telephone with emergency numbers is accessible at all times in case of emergency.	T 188		

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HBLS Corrective Action Plan 2024

COLOR KEY:

DEFICIENCY STATEMENTS	POLICY CREATION/CHANGES	ACTIONS	TRAINING	RN INVOLVEMENT

ID PREFIX TAG	REGULATION PREFIX	DEFICIENCY STATEMENT	ID PREFIX TAG	REGULATION PREFIX	PLAN OF CORRECTION	DATE OF CORRECTION
T 035	V.58.a .6	**V.5.8.a.1.2.3.4.5.6.7.8 Resident Care and Services** **5.8 Medication Management** (6) Procedures for disposing of outdated or unused medication, including designation of a person or persons with responsibility for disposal. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure prompt disposal of outdated medications. Findings include: The facility's Disposal of Medications policy effective 7/24/23 states, "At times it may be necessary to dispose of medications. This	T 035	V.58.a .6	**CORRECTIVE ACTION PLAN (CAP):** **1.) POLICY CHANGE:** Heartbeet Policies #020 and #023 will adapt the specific language outlining the necessity of promptly disposing of expired, unused, or discontinued medication. These policies will also clearly outline the areas where prescribed, OTC, homeopathic, or other medications reside on the premises to ensure the awareness of what shall be stocked at all times. To include: All contents of House Medicine Cabinets and all First Aid kits. Policies will also outline the frequency of medication collections. **2.) ACTIONS:** In addition to policy modifications, Heartbeet direct care staff, in cooperation with the L&C Department, will remove all current expired and discontinued medications. The L&C Department and/or Heartbeet RN will dispose	Policy Change: No later than 30 days upon acceptance and/or approval of HBLS CAP Actions: No later than 30 days upon acceptance and/or approval of HBLS CAP Training:

		may occur when... medications have passed their expiration date." While this policy describes who is responsible for disposal of expired medications and how disposal of medications is documented, the policy does not identify the requirement to dispose of expired/outdated medications promptly.			of these medications. Any necessary replacement medications will be restocked. Following the initial collection, Heartbeet will implement a rhythm for regular collection of expired, discontinued, or unused medications. **3.) TRAINING:** An initial review of this policy will be conducted by the RN and/or Licensing and Compliance department. Following initial review of new material, this information will be included in the Onboarding, Annual Training Renewal task lists, and/or during *Medication Delegation Training for Non-Licensed Personnel* for all staff. ***Heartbeet Policy #020*** ***Medication Delegation and Nursing Policy*** ***est. 07/24/2023*** *Currently outlines the following:* ***Discontinued and Expired Medication:*** *"Will be returned by the house manager to the Director of L&C or the L&C Coordinator." … "Non-controlled medications will be disposed of (returned to an approved accepting facility) by* ***the Nurse,*** *the Director of L&C or the L&C Coordinator.The disposal shall be documented." … "Discontinued and expired controlled medications will be returned to the Director of L&C or the L&C Coordinator.: … "Controlled medications will be disposed of (returned to an approved accepting facility) by* ***the Nurse,*** *the Director of L&C or the L&C Coordinator. The disposal shall be documented."*	No later than 30 days upon acceptance and or approval of HLBS CAP

					Heartbeet Policy #023 ***Disposal of Medications*** ***est. 07/24/2023*** *Currently outlines the following:* *"Non-controlled medication– Will be disposed of (returned to an approved accepting facility) by* ***the Nurse,*** *the Director of L&C or the L&C Coordinator. The disposal shall be documented" … "Controlled medication– All controlled drugs will be disposed of (returned to an approved accepting facility) by* ***the Nurse,*** *the Director of L&C or the L&C Coordinator. The disposal shall be documented."*	T035 Plan of Correcrion accepted by Jo Evans RN on 5/4/24
T 038	V.5.8. d.2	**V.5.8.d.1.2.3.i.ii.iii.iv. Resident Care and Services** **5.8 Medication Management** (2) A registered nurse must delegate the responsibility for the administration of specific medications to designated staff for designated residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure the Registered Nurse (RN) responsible for delegation of medication administration and nursing tasks delegates the responsibility for the administration of specific medications to designated staff for designated residents.	T 038	V.5.8. d.2	**CORRECTIVE ACTION PLAN:** **1.) POLICY CHANGE:** Heartbeet Policy #020 will adopt clear language outlining that the RN must **educate and delegate to all** non-licensed staff the responsibilities of medication administration, **including new medication and treatment orders or any changes to existing orders which would change the actions and interventions that the delegated staff are responsible for implementing.** The policy will clearly state that non-licensed staff will carry out medication administration as a delegated function and will outline the process for following all assessment plans created by the RN. • **As a condition of this change in policy, the Heartbeet RN will be responsible for the creation, implementation, and revision of these plans.** • **The RN will be responsible for the oversight**	Policy Change: No later than 30 days upon acceptance and/or approval of HBLS CAP Actions: No later than 30 days upon acceptance and/or approval of HBLS CAP Training: No later than

		Per record review, the facility's Medication Delegation & Nursing Policy effective 7/24/23 states, "Medication administration will be carried out by licensed nursing staff or non-licensed staff delegated by an RN. Non-licensed staff delegated to administer medication by the RN will have reviewed medication administration policies and procedures, documentation, side effects and medication administration protocol." The policy does not identify the responsibility of the RN to delegate the administration of specific medications for designated residents to designated staff.			**and designation of tasks surrounding assessment plans and medication management for each staff member delegating medications.** • **There will be direct oversight of the RN from the Licensing and Compliance Director, as well as the Licensing and Compliance Coordinator.** **2.) ACTIONS:** Development of individual assessment plans for each resident based on baseline, current condition, medication regime, monitoring plan and needs, etc. • **Heartbeet's new RN is currently in the process of familiarizing [redacted] with the orders, condition, and medical histories of each Friend.** • **Upon orientation with these materials, [redacted] will begin creating individual assessment plans for each Friend based on their current medication regime and overall condition.** • **These assessment plans will be kept on file for each Friend and available in each Friend's MAR binder materials within each house. Once these plans have been created, the RN will orient and delegate specific staff to administer medications, as well as the process for communications around changes in medication or condition.** • **The RN will also outline the process for adhering to each plan, to include steps that must be taken each time there is a change, to**	30 days upon acceptance and or approval of HLBS CAP

ensure proper nurse involvement.

- **In addition to the creation and implementation of each assessment plan, there will be an overall process outlining the steps to take each time there is a change in condition or a change in medication for any given Friend, to ensure the RN is delegating tasks each time. This will include the understanding that staff are not to begin administering a new medication or change in medication until the RN has delegated them to do so.**

3.) TRAINING:

Effective 04/01/2024 Heartbeet Lifesharing will welcome a new RN. The Licensing and Compliance office and the Registered Nurse will work together to establish necessary changes to policy in regard to Medication Management, and in doing so, refocus and expand upon current training and continued education practices.
An initial review will be conducted once the policy has been updated. Following initial review, this policy will continue to be on the Onboarding and Annual Training Renewal task lists for all staff.

- **The Heartbeet RN will orient and educate staff to the newly created assessment plans and will orient and educate any new staff once they have been through the overall medication delegation for non-licensed personnel training by the RN.**
- **The RN will only delegate staff who are in direct care of any particular Friend. Staff who are not specifically delegated for**

					administering medication for a specific Friend will not do so. This will be a measure upheld by the RN to ensure compliance. • **Education for staff will be conducted by the RN upon completion of the assessment plans, which will include:** ○ **Overall process change** ○ **Orientation of assessment plans for staff the RN has delegated to** ○ **Overall process for adhering to each plan** ○ **Steps to take for each change in medication to ensure staff are only administering medications after prescriber information has been reviewed and delegated by the RN** ***Medication Delegation for Non-Licensed Personnel Handbook (2020)*** ***Module 1*** ***Legal Issues, Policies and Procedures*** *Currently outlines the following:* *"**Role of Non-Licensed Personnel in Medication Administration:*** *Where delegation is required the non-licensed personnel will perform medication administration as a delegated function under nursing supervision in accordance with Vermont standards and requirements."* ***Heartbeet Policy #020*** ***Medication Delegation and Nursing Policy*** *Currently outlines the following:*	

					"Who is Responsible for Delegation: *Medication administration will be carried out by licensed nursing staff or non-licensed staff* *delegated by an RN. Non-licensed staff delegated to administer medication by the RN will have reviewed medication administration policies and procedures, documentation, side effects and medication administration protocol."* ***"Procedures That Direct Care Staff Are Expected To Carry Out Related To Nursing Services:*** *1. Observing residents for changes in behavioral and physical health status, reporting changes in a timely fashion to nursing staff.* *2. Assisting licensed nursing staff and following the direction of nursing staff or designee in managing medical and behavioral health emergencies.* *3. Accompanying residents to appointments with physicians and for diagnostic tests; reporting information from the appointment back to nursing staff or designee.* *4. Following the direction of nursing staff or designee in implementing the treatment plan.* *5. Documenting administration of medication on the Medication Administration Record (MAR).* *6. Monitoring and documenting side effects of psychoactive medication* *7. Following the direction of licensed nursing staff or designee in providing first aid measures.* *8. Following the direction of nursing staff or designee in performing other duties as assigned.* *Medication management shall be done under the supervision of a registered nurse (RN). This*	

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					nurse shall provide medication delegation training to non-licensed staff at Heartbeet using the Heartbeet Medication Administration Training for Non-Licensed Personnel syllabus, followed by a 25 question evaluation and subsequent observation by the RN."	T038 Plan of Corrections accepted by Jo A Evans RN on 5/4/24
T 040	V.5.8.5	**V.5.8.d.1.2.3.i.ii.iii.iv. Resident Care and Services** **5.8 Medication Management** 5.8.5 Staff other than a nurse may administer PRN psychoactive medications only when the residence has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure development of written plans for the administration of PRN (as needed) psychoactive medications.	T 040	V.5.8.5	**CORRECTIVE ACTION PLAN:** **1.) POLICY CHANGE:** *The Medication Delegation and Nursing Policy* will be adapted to include an expansion of Heartbeet's current Medication Delegation Training process. This change will outline proper techniques and administration procedures for specific Psychoactive PRN medications to specific residents. This will be separate from the initial training on the overall administration of medications, and will provide education on the written plan(s) and procedure(s) for monitoring each resident's condition in relation to Psychoactive PRN medication. Additionally, Heartbeet will amend the *Medication Administration Procedures* policy to include a section reflecting the specific requirements and process for RN and for staff delegated to administer Psychoactive PRN medications. • **Change in policy will be done by the Licensing and Compliance Coordinator with oversight from the Licensing and Compliance Director** • **RN adherence to the policy will be monitored by the Licensing and Compliance Office.** • **Staff adherence to the policy will be monitored**	Policy Change: No later than 30 days upon acceptance and/or approval of HBLS CAP Actions: No later than 30 days upon acceptance and/or approval of HBLS CAP Training: No later than 30 days upon acceptance and or approval of HLBS CAP

					by the RN. • **The policy changes will include the need for education specific to each plan created by the RN for each staff member delegated.** • **The policy will also outline that only staff classified as Householders will be delegated to administer psychoactive PRNs** **2.) ACTIONS:** RN will develop PRN administration assessment plans for residents currently prescribed Psychoactive PRNs **within 30 days of CAP approval.** • **Plans will include:** ○ **The intended use of the ordered psychoactive PRN: the specific behaviors that the medication is intended to correct or address** ○ **Specific behavior or circumstance that indicate the use of the medication** ○ **Specific behavior, desired effects and/or undesired side effects to monitor for after administration** ○ **Current procedure for documentation: the time of, reason for and specific results of the medication use.** ○ **Responsibility of staff to record notes pertaining to any of the above** • **The Heartbeet RN will be the only one to create these plans and will be in charge of monitoring the adherence to each plan** • **RN will create the psychoactive PRN plans in addition to, but separate from, assessment**	

					plans of overall condition and medication regime. • **After the creation of these plans, the RN will then designate specific staff (Householders) for the administration of these PRNs. The plans will be implemented within 30 days of CAP approval.** • **Staff designated will receive education by the RN on the contents of the plan as well as education on how to follow each plan** **3.) TRAINING:** Effective 04/01/2024 Heartbeet Lifesharing will welcome a new RN. The Licensing and Compliance office and the Registered Nurse will work together to establish necessary changes to policy in regard to Medication Management, and in doing so, refocus and expand upon current training and continued education. • **Upon creation of these plans, the RN will designate specific staff (Householders) to be the only ones to administer these medications** • **Staff designated to administer these PRNs will be educated on the details of the plans specific to the Friends they have been delegated to by the RN** • **RN will educate staff on how to carryout PRN plans and how and where to record information** • **RN will be responsible for the oversight of staff designated to administer these medications** • **Licensing and Compliance Office will be**	

					responsible for oversight of the RN ***Heartbeet Policy #020*** ***Medication Delegation and Nursing Policy*** ***Est. 07/24/2023*** *"Psychoactive Medication Addressed:* *All direct care staff will receive training in the purpose, actions, side effects and adverse effects of psychoactive medications commonly prescribed for people with severe and prolonged mental illness. Training will be done by an RN.* *Residents will be observed by the nurse or non-licensed designee for changes in health or mental status, and vital signs will be taken as ordered.* *Nurses or their designee will respond to changes in resident status by documentation, communication with nurses (on call) or designees, or by notifying the physician."* ***Medication Delegation for Non-Licensed Personnel Handbook (2020)*** ***Module 1*** ***Legal Issues, Policies and Procedures*** *Currently outlines the following:* *"Role of Non-Licensed Personnel in Medication Administration:* *"The following cannot be delegated:* *Nursing judgment regarding the administration of PRN (medications given as ordered) medications* *Non-licensed personnel will be permitted to follow a specific physician protocol for PRN medication and document effectiveness or ineffectiveness of the*	

					medication." **Heartbeet Policy #021** **Medication Administration Procedures** **Est 07/24/2023** ***X*** *Amendment to include procedure for:* - *RN review of, and written plans for the administration of Psychoactive PRN (as needed) medications, monitoring of condition and changes, communicating and documenting observations, etc.* - *RN delegation to *specific* staff to administer Psychoactive PRN(s) and training specific to the written plan for administration*	T040 Plan of Correction accepted by Jo A Evans RN on 5/4/34.
T 052	V.5.9. b.2	**V.5.9.b.1.2.3.4.5.6.7 Resident Care and Services** **5.9 Staff Services** **"The training must include, but is not limited to, the following:** (6) Infection control measures, including but not limited to, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions" This REQUIREMENT is not met as evidenced by: Per review of the Employee Training List document provided by the facility on 3/25/24, the training list does not include infection	T 052	V.5.9. b.2	**CORRECTIVE ACTION PLAN:** **1.) POLICY CREATION:** Licensing and Compliance, in cooperation with the RN will develop a new policy regarding our infection control practices and training requirements. **2.) ACTIONS:** Distribution and/or posting of materials including: - Handing washing posters for all kitchens and bathrooms - Blood Borne Pathogen Spill Kits for each building - Universal PPE for each building including gloves and face masks (*upon request* gowns, goggles/face shields, booties, etc.) **3.) TRAINING:**	Policy Change: No later than 30 days upon acceptance and/or approval of HBLS CAP Actions: No later than 30 days upon acceptance and/or approval of HBLS CAP

		control training as required by the licensing agency. Per record review 5 out of 5 sampled staff did not complete training in infection control. Additionally 1 out of 5 staff did not complete training in Emergency Response and First Aid, which is included in the facility's Employee Training List. These findings were confirmed by the Manager at 1:46pm on 03/25/24.			Heartbeet's new RN will carry out necessary training on infection control techniques pertaining to nursing and personal care. This training will be provided upon Hire and reviewed Annually thereafter. **4.) TRAINING:** A new training to cover Emergency Response and First Aid will be created to cover basic understanding and will be conducted upon Hire and reviewed Annually thereafter. Further training of Emergency Response and First Aid will be offered after Hire through CPR, AED, and First Aid training provided by Heartbeet in coordination with local EMT services and American Red Cross. ***Medication Delegation for Non-Licensed Personnel Handbook (2020)*** ***Module 3*** ***Medication Preparation, Administration, and Storage*** *P.52* *Currently outlines the following:* ***"Proper Hand Washing*** *Good hand washing techniques include washing your hands with soap and water or using an alcohol-based hand sanitizer.* *Hand washing steps:* *• Remove rings* *• Wet your hands with warm, running water and apply liquid soap* *• Lather well* *• Scrub all surfaces, including the backs of your hands,*	Training: No later than 30 days upon acceptance and or approval of HLBS CAPP Training: No later than 30 days upon acceptance and or approval of HLBS CAPP

					wrists, between your fingers and under your fingernails *• Rub hands together for 20 seconds (sing "Happy Birthday" twice)* *• With water running, dry hands with a paper towel* *• Use paper towel to turn off the faucet* *• Dispose of paper towel."*	T052 Plan of Corrections accepted by Jo A Evans RN on 5/4/24
T 062	V.5.10 .b.4	**V.5.10.b.4 Resident Care and Services** **5.10 Records/Reports** 5.10.b.4 The results of the criminal record and abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to complete all required criminal record checks for 5 out of 5 sampled staff, and all required abuse registry checks for 1 out of 5 sampled staff. Per review of the criminal record and abuse registry checks for a sample of 5 staff provided for review on request, Vermont Criminal Information Center criminal background checks were not completed for 5 out of 5 sampled staff. Additionally, the required National Criminal background check and adult and child abuse registry checks were not completed as required for 1 out of 5 sampled staff.	T 062	V.5.10 .b.4	**CORRECTIVE ACTION PLAN:** **1.) POLICY CHANGES:** HR & Admissions has adjusted the Background Check Policy to include the following: National Criminal History Record Checks are required to be obtained Prior to Hire and Annually for the duration of employment ONLY if an employee continues to reside in another state. Vermont State Criminal History Record Checks are required to be obtained Prior to Hire and Annually for the duration of employment in order to be in accordance with Vermont State Regulations. This adjustment to the Background Check Policy ensures that Heartbeet's policies match Vermont State Regulations. **2.) ACTIONS:** HR & Admissions has created separate Background Check Consent Forms for National Checks and Vermont State Checks. The Vermont State Consent Form states the following:	Policy Change: **Completed as of 04/18/2024** Action: 2.) Completed as of 04/18/2024 Action: 3.) No later than 30 days upon acceptance and/or approval of HBLS CAP

					Vermont State Criminal History Record Checks are required to be obtained Prior to Hire and Annually for the duration of employment in order to be in accordance with Vermont State Regulations. The Authorization for Consent also now states: I do hereby authorize Heartbeet Lifesharing to conduct Vermont State Criminal History Record Checks required to be considered for a service position and annually thereafter for the duration of my employment. This adjustment to the Background Check Consent Forms ensures that Consent is given to perform Vermont State Checks annually so that Heartbeet is in compliance with Vermont State Regulations. **3.) ACTIONS:** HR & Admissions will be collecting updated Consent Forms from every employee and will be running the required VCIC Check to ensure compliance for all current employees. Moving forward, VCIC and AHS Adult and Child Abuse Registry Checks will be ran for every incoming employee Prior to Hire and Annually matching the date of their Hire. ***Background Check Policy (2024)*** *Heartbeet is required to conduct Criminal History Record Checks for all incoming or returning co-workers, volunteers, and employees. Criminal History Record*	

					Checks are also required for visitors who are staying on Heartbeet property for two weeks or more. *Heartbeet currently conducts the following five separate checks to comply with Vermont and Federal regulations:* *National Criminal Background Check (Asurint)* *Vermont Crime Information Center Criminal Conviction Records (VCIC)* *Agency of Human Services Vermont's Adult Abuse and Child Protection Registries (AHS)* *Department of Justice National Sex Offender Public Website (NSOPW)* *U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (LEIE)*	T062 Plan of Corrections accepted by Jo A Evans RN on 5/4/24
T 071	V.5.13 .a.b.c. d.e.f	**V.5.13 Resident Care and Services** **5.13 Policies and Procedures** Each residence must have written policies and procedures that govern all services provided by the residence. A copy shall be available for review at the residence upon request. This REQUIREMENT is not met as evidenced	T 071	V.5.13 .a.b.c. d.e.f	a. development of written plans for the administration of PRN psychoactive medications by staff other than a nurse. • **Licensing and Compliance Coordinator will adopt language into pre-existing policy outlining the responsibilities of RN and Staff for PRN procedures** • **The Heartbeet RN will create specific assessments plans for each psychoactive PRN prescribed to Friends**	**a. To be completed within 30 days upon approval of CAP**

		by:
		Based on staff interview and record review there was a failure to develop and/or maintain on file and available for review policies and procedures that govern all services provided by the facility.
		
		a. development of written plans for the administration of PRN psychoactive medications by staff other than a nurse
		
		b. monitoring for and prevention of food spoilage and contamination, and disposal of expired perishable food items
					• **Plans will be reviewed with staff RN delegates to administer PRNs**
					• **RN will only delegate staff titled as Householders**
					• **Plans will include:**
					  ○ **What must be occurring prior to administration**
					  ○ **Desired effects of the PRN**
					  ○ **What to look for after administration**
					  ○ **How and where to record all aspects of administration including notes of effects**
					
					Refer to deficiency T 040 for CAP
					
					b. monitoring for and prevention of food spoilage and contamination, and disposal of expired perishable food items
					• **Policy will be created for Food Production standards and procedures by the Licensing and Compliance Office**
					• **Policy for Food Spoilage Prevention will be created by the Licensing and Compliance Office**
					
					Refer to deficiency T 126 for CAP
						b. To be completed within 30 daysof CAP approval

		c. storage and labeling of perishable food items			c .storage and labeling of perishable food items • **A policy for Food Labeling and Storage has been created and will be implemented within 30 days** Refer to deficiency T 127 for CAP	**c. Completed as of 04/16/2024**
		d. facility policies and procedures for production of yogurt and kraut			d. facility policies and procedures for production of yogurt and kraut • **Policy will be created by the Licensing and Compliance office for Food Production Standards** • **Procedures for both kraut and yogurt production will be created** • **Creation and implementation of the policies will be complete within 30 days of CAP approval** Refer to deficiency T 126 for CAP	**d. To be completed within 30 days of CAP approval**
		e. maintaining accessibility to telephones on each floor of the facility at all times, and positing emergency phone numbers by the phones			e. maintaining accessibility to telephones on each floor of the facility at all times, and posting emergency phone numbers by the phones • **A policy will be created outlining the items listed on the Required Postings Checklist which will include materials that must be posted. The policy will outline the importance**	**e. To be completed within 30 days of CAP approval**

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		f. posting directions for contacting the Ombudsman's office, which is the designated advocacy organization, in accessible areas on all floors of the facility			**of accessible and working phones on all floors in all buildings** Refer to deficiency T 188 for CAP f. posting directions for contacting the Ombudsman's office, which is the designated advocacy organization, in accessible areas on all floors of the facility • **A policy will be created outlining the items listed on the Required Postings Checklist which will include materials that must be posted. The policy will outline the importance of accessible and working phones on all floors in all buildings** Refer to deficiency T 105 for CAP	**f. Completed as of 04/18/2024** T071 Plan of Corrections accpeted by Jo A Evans RN on 5/4/24.
T 105	VI.6.21	**VI.6.21 Residents' Rights** **VI. Residents' Rights** 6.21 The obligations of the residence to its residents shall be written in clear language, large print, given to residents on admission, and posted in an accessible, prominent and public place on each floor of the residence. Such notice shall also state the residence's grievance procedure and directions for contacting the designated Vermont protection	T 105	VI.6.21	**CORRECTIVE ACTION PLAN:** **1.) ACTIONS:** Heartbeet will place a bulletin in Sophia Hall (Main Hall space) with the following required postings: • Fire Escape Plan • Disaster Preparedness Plan • Resident Rights Policy + Resident Rights Posting • Grievance Policy • Monthly Menu • IN CASE OF EMERGENCY - Posting	Actions: **Completed as of 04/18/2024**

		and advocacy organization. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure all required items were posted including Resident Rights and the facility's Grievance procedures in the main building; and directions for contacting the designated Vermont protection and advocacy organization in the main building and all resident houses.			Heartbeet will also place the following Contact Sheets next to all phones in Sophia Hall and next to all phones in the Houses: • Internal Contact Sheet (All phones) • Local and Emergency Numbers Contact Sheet (All phones) • IN CASE OF EMERGENCY - Posting A new Contact Sheet has been created (Local and Emergency Numbers) that has been posted by every phone in the community and includes the information on how to contact the designated Vermont Protection and Advocacy organization. This new Contact Sheet has also been added to the Required Postings list. Heartbeet will also post the following next to all Fire Extinguishers in Sophia Hall and the Houses: • P.A.S.S (All extinguishers) • R.A.C.E (All extinguishers) Heartbeet will replenish any of the above listed postings currently missing from House Bulletins, designated posting areas, Fire Extinguishers, and Phones.	T105 Plan of Corrections accepted by Jo A Evans RN on 5/4/24
T 126	VII. 7.2.a	**VII. 7.2.a Nutrition and Food Services** **7.2 Food Safety and Sanitation** 7.2.a Each residence must procure food from sources that comply with all laws relating to food and food labeling. Food must be safe for	T 126	VII. 7.2.a	**CORRECTIVE ACTION PLAN:** **1.) POLICY CREATION:** Heartbeet's Licensing and Compliance Department in cooperation with Hall Kitchen and/or staff and residents participating in community-wide Food Production, will develop and implement a new policy outlining in clear	Policy Change: No later than 30 days upon acceptance and/or approval of

		human consumption, free of spoilage, filth or other contamination. All milk products served and used in food preparation must be pasteurized. Cans with dents, swelling, rust, missing labels or leaks shall be rejected and kept separate until returned to the supplier. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure food is free of spoilage and contamination. Findings include: "On the afternoon of 3/25/24 the Manager confirmed policies and procedures to ensure food remains free of spoilage and contamination had not been developed by the facility. 1. During the tour of the kitchen and food storage areas commencing at 10:05 AM on 3/25/25 spoiled and contaminated foods were observed in the food storage areas as follows: a. In the kitchen reach-in fridge b. In the walk-in fridge 2. During the tour of the Amber Rose House commencing at 9:15 AM on 3/25/25 expired food observed to be stored in the home 3. During the tour of the Kasper House commencing at 9:50 AM on 3/25/25 expired food observed to be stored in the home.			language the requirements and procedures of general practices for food preparation. **2.) POLICY CREATION:** Heartbeet's licensing and Compliance Department will also create a policy for general practices and outlining the procedures to follow for Food Spoilage Prevention when producing/handling food for the community. **3.) ACTIONS:** Community-wide effort to remove all expired, spoiled, contaminated or otherwise, food and drink from all kitchens, freezers, refrigerators, and pantries. **4.) TRAINING:** Following the creation of the above policies, Heartbeet will review the new materials with all staff and residents involved with the handling and/or production of food.	HBLS CAP <u>Actions:</u> No later than 30 days upon acceptance and/or approval of HBLS CAP <u>Training:</u> No later than 30 days upon acceptance and or approval of HLBS CAPP T126 Plan of Corrections accepted by Jo A Evans RN on 5/4/24.

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T 127	VII.7.2 .b	**VII.7.2.b Nutrition and Food Services** **7.2 Food Safety and Sanitation** 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperature.. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure all perishable food items in the main kitchen and resident homes were labeled and dated… The facility's Food Storage Safety Protocol states, "All foods, prepackaged, homemade, or otherwise must have clear and consistent labeling at all times." This procedure contains a Food Storage Label Template which includes the Food /Item Name, Open/Start Date, and Expiration/End Date, and states containers must be labeled with this information. 1. Per observation during the tour of the main kitchen commencing at 10:05 AM on 3/25/24 perishable foods were observed to be stored without labels indicating the dates the foods were opened or prepared including: a. In the reach-in refrigerator b. In the dry goods storage areas c. In the walk-in refrigerator located outdoors	T 127	VII.7.2 .b	**CORRECTIVE ACTION PLAN:** **1.) POLICY CREATION:** Heartbeet's Licensing and Compliance Department will adopt the current *Food Storage Safety Protocol, Food Storage Labels, and Cold Food Storage Chart* materials into a new policy. This policy will outline in clear language the procedure and responsibility of staff to correctly label all perishable foods including: pantry, freezer, and refrigerator items, in addition to storage practices for Food Spoilage Prevention. **2.) ACTIONS:** - Community-wide effort to remove unlabeled, expired, improperly contained, and otherwise food/drink from all food storage areas in all buildings. - Followed by an organized effort to bring all current food item labeling and storage up to compliance standards. - Redistribution of labeling criteria, postings, and various labels. **3.) TRAINING:** Following the creation of the above outlined policy, Heartbeet Administrative Staff will review the material with the community. After initial review, the policy will be added to the required postings and will be reviewed periodically or when necessary.	Policy Change: **Completed as of 04/16/2024** Actions: No later than 30 days upon acceptance and/or approval of HBLS CAP Training: No later than 30 days upon acceptance and or approval of HBLS CAP T127 Plan of Corrections accepted by Jo A Evans RN on 5/4/24

		behind the main kitchen d. In the walk-in freezer located outdoors behind the main kitchen 2. During a tour of the Amber Rose House commencing at 9:15 AM on 3/25/24 a large cup of smoothie was observed to be undated and placed in the refrigerator without a cover; and 6 jars of food were observed in the fridge without identifying labels and the dates the food contained within the jars was prepared.				
T 187	IX.9.11.c	**IX.9.11.c Physical Plant** **9.11 Disaster and Emergency Preparedness** 9.11.c Each residence 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:	T 187	IX.9.11.c	**CORRECTIVE ACTION PLAN:** **1.) POLICY CREATION:** Heartbeet's Licensing and Compliance Office will create a new policy for Fire Safety Procedures. This policy will be separate from the below details outlined in the current *Fire Safety and Emergency Preparedness Plan Policy* and will include procedures for carrying out quarterly Fire Drills and the responsibility of staff to conduct and take seriously the task and timeline of drills. **2.) TRAINING:** Following the creation of the above outlined policy, Heartbeet's Administrative Staff will review the new material with the community. After initial review, the policy will be added to the onboarding and annual retaining task lists for all staff. ***POLICY #012*** ***Fire Safety and Emergency Preparedness Plan est.07/24/2023***	Change: No **Completed as of 04/26/2024** Training: No later than 30 days upon acceptance and or approval of HLBS CAPP

		Based on staff interview and record review there was a failure to conduct fire drills on at least a quarterly basis in 1 out of 4 applicable homes, and to conduct drills at least once yearly during all required times in 3 out of 4 applicable homes. Per review of fire drill records for the 4 TCR resident houses on the facility property, the White Pine House did not conduct a fire drill during the second quarter of the previous year. Drills were not conducted during all required times to include: - Amber Rose House did not conduct a night drill, - Konig House did not conduct drills during the evening and night times, and - White Pine House did not conduct drills in the morning and at night.			***FIRE*** *"In case of fire, evacuate all people with whom you are working at that moment and close all doors behind you. DO NOT LOCK DOORS.* *Do not attempt to extinguish big fires. Sound the alarm – call the fire department – call 9-1-1.* *Small Fires: Sound the alarm – call the fire department – call 9-1-1. Consider extinguishing the fire only if you are properly equipped and, if in your judgment, you can do so safely.* *If fire cannot be extinguished by using a portable fire extinguisher, or if smoke presents a hazard, leave the area immediately. Close the door behind you to confine and contain the fire.* *If You Discover a Fire: R A C E* *RESCUE: Remove all persons who are in immediate danger to safety.* *ALERT/ALARM: Activate the alarm system and call or have someone call 9-1-1.* *CONFINE: Close doors and windows to contain fire and smoke.* *EXTINGUISH: Extinguish the fire if possible.* *Fire Extinguisher Procedure: P A S S* *PULL the pin located in the fire extinguisher's handle.* *AIM the nozzle, hose, or horn at the base of the fire.* *SQUEEZE or press the handle.* *SWEEP from side to side at the base of the fire.* *If You Hear the Fire Alarms* *1. Leave the building immediately, using the closest exit.* *2. Be aware that the closest exit may be blocked so know the location of secondary exits from your location.*	

					3. Meet at the designated evacuation site. *Emergency Exit Procedures* *Upon hearing the alarm:* *1. Before opening the door, feel the door bottom to top and knob with back of hand for heat.* *2. If not hot, brace yourself against the door and open slightly. If you feel air pressure or hot draft, close the door immediately.* *3. If you find no fire or smoke in the corridor, close the door behind you as you exit and leave by the nearest exit.* *4. If you encounter smoke in the corridor, consider taking the corridor to another exit that may be clear.* *Fire Drills* *● Drills will be conducted for coworkers and residents on a quarterly basis.* *● Drills will be unannounced.* *● When the alarm sounds, proceed with emergency procedures and orderly evacuation to the designated evacuation site.* *● After all persons have been evacuated and communications made with all designated staff members, the fire drill will be declared over. Documentation must be completed.* *● Records will be kept on all fire drills held."*	T187 Plan of Corrections accepted by Jo Evans RN on 5/4/24
T 188	IX.9.11.d	**IX.9.11.d Physical Plant** **9.11 Disaster and Emergency Preparedness**	T 188	IX.9.11.d	**CORRECTIVE ACTION PLAN:** **1.) ACTIONS:** A new Contact Sheet has been created (Local and	Action: 1.) **Completed as of

		9.11.d There shall be an operable telephone on each floor of the residence, 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 an operable telephone with emergency numbers posted by the telephone is accessible at all times in the facility's main building.. - telephone with emergency numbers posted by the phone is not available in the common areas of the main building. - A phone with emergency numbers located in the administrative office is not accessible at all times, as the office is locked when the administrative staff are not in the office. - telephone with emergency numbers is not accessible in the common areas of the main building at all times			Emergency Numbers) that has been posted by every phone in the community and includes the information on how to contact the designated Vermont Protection and Advocacy organization. This new Contact Sheet has also been added to the Required Postings list. **2.) ACTIONS:** The Hall/Community Kitchen landline phone will be brought back to working order by the administrative staff and/or the phone company, if needed. This will provide a phone in Sophia Hall that will be operable and accessible to anyone and everyone at any time.	04/18/2024** Action: 2.) No later than 30 days upon acceptance and/or approval of HBLS CAP T188 Plan of Corrections accepted by Jo A Evans RN on 5/4/24,

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

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