

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

January 18, 2024

Alonzo Tapley, Manager Historic Homes Of Runnemede-Evarts House 40 Maxwell Perkins Lane Windsor, VT 05089

Dear Mr. Tapley:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 20, 2023.** Please post this document in a prominent place in your facility.

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

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

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		0374	B. WNG		1	12/20/2023	
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
HISTORIC	HOMES OF RUNNEMED	E-EVARTS HOUSE	WELL PERKINS L DR, VT 05089	ANE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
R100	Initial Comments:		R100				
		an unannounced on-site ne following regulatory		Plans of Correction individual tags ac Jo A Evans RN 1	cepted by		
R147 SS=E	V. RESIDENT CARE	AND HOME SERVICES	R147				
	5.9.c (4)						
	physician of all reside shall include: resident medication ordered; of	for review by staff and nts' medications. The list 's name; medications; date losage and frequency of sely side effects to monitor;					
	by: Based on staff interviewas a failure to ensur include the specific do administration for 3 or (Residents #1, #3, an Page 13 of the facility Manual states, "The [maintain a list of all re review by staff and ph medications will include	at of 3 sampled residents d #6). Findings include: 's Policies and Procedure Registered Nurse] will esident medications for sysician. The list of de; the resident name, edication ordered, dosage					
	medications did not in	ers for the following PRN clude the specific dose dministration to include the en doses.					
	nsing and Protection IRECTOR'S OR PROVIDER/S	UPPLIER REPRESENTATIVE'S SIGNATUR	RE AM	h TITLE TA	tum inistrator	(X6) DATE	

Division of	of Licensing and Protect	otion			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X2) MULTIPLE CONSTRUCTION		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
			B. WING		401001000
		0374	D. 74110		12/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	
		40 MAY	NELL PERKINS LA	NF	
HISTORIC	HOMES OF RUNNEMED	DE-EVARTS HOUSE	R, VT 05089		
				270 TOTAL DI 11 OF 0000 5070	
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION SHOULD (EACH CORRECTIVE ACTION SHOULD)	
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP	
,,,,,		·		DEFICIENCY)	
	<u> </u>				
R147	Continued From page	9 1	R147		
	1. For Resident #1				
		One Tablet every other day.			
		two tablets every other day			
	with Ferrous Glucona	· ·			
		ne. e 12% Apply topically twice a			
		s 12% Apply topically twice a skin, scalp, face and body.			
	The signed order for t				
		is a scheduled medication,			
	not a PRN. Please re	•			
	-	mouth as needed for upset			
	stomach.				
		ment Apply to skin sores			
	·	eeded * May self administer			
		edication Administration			
		ude the areas for application			
		riber's order dated 10/16/23.			
		6 Spray One spray in each			
		ly as needed for nose			
	bleeds. ** Not to exce				
		aspoons (10 ml) by mouth			
		as needed for cough -			
	followed with a full gla	ass of water.			
	2. For Resident #3	ITA OO Indeed O Week			
	1	FA 90 mcg Inhale 2 puffs by			
		y as needed for breathing			
	*May keep in room *	0. (4.1. (.) 47.00			
	, -	Str (Mylanta) 15-30 cc			
	1 -	ded up to 6 times / 24 hours			
	Simple Indigestion				
		ng Capsules One capsule by			
	mouth three times da				
	•	5 mg / 30 ml 30 cc by			
		upset stomach ** Not to			
:		urs **. Please note, "ml" and	1		
	"cc" are equal units a	nd are used			
	interchangeably.				
		00 mg Peppermint 2 tabs			
		digestion * Maximum daily			
	dose: 10 tabs / 24 ho	urs *			

6899

#628 P.003/018

STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. Boiconto.				
		0374	B. WING		12/2	20/2023
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA			
HISTORIC	HOMES OF RUNNEMED	DE-EVARTS HOUSE	(WELL PERKINS OR, VT 05089	LANE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
R147	twice daily as needed g. Mucinex 600 mg tarmg) by mouth every 1 cough ** Not to excee h. Ketaconazole 2 % amount topically three for 5 - 10 minutes bef medication order is list medications, however not state the medicat and it is not being admedication. g. Dermagran Ointmeareas three times dails 3. For Resident #6 Diapplication four times One the afternoon of confirmed PRN medic #1, #3, and #6 did not and/or frequency of action for the risk of administrat a dose and/or frequences of the amount	les One capsule by mouth to soften stool abs 1-2 tablet(s) (600-1200 2 hours as needed for ad 4 tablets / 24 hours ** shampoo Apply small a times a week * Leave on fore rinsing off *. This ated with the PRN at the medication order does ation is to be used as needed anninistered as a scheduled ant Apply to red or open by as needed. clofenac Gel 1% One daily for pain. 12/20/23 the Manager cation orders for Residents at include the specific dose	R147			
R162 SS=E	V. RESIDENT CARE	AND HOME SERVICES	R162			
	5.10 Medication M	anagement				
	medication, prescription	ssist with or administer any on or over-the-counter there is not a physician's				

R162 Continued From page 3 written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure written, signed orders were on file and available for review for 3 out of 3 sampled residents (Residents #1, #3, and #6). Findings include. Page 9 of the facility's Policy and Procedure Manual states. "A copy of the Medication Administration Record (MAR) will go with the resident to be reviewed by the Primary Care Physician at the time of a routine visit. The MAR and physician's orders will be reconciled with the felectronic health record system for the organization that manages the facility) and signed by the physician "; however, policies and procedures ensuring physicians written, signed orders are on file and available for review for the following medications have not been developed by the facility. Per record review physician's written, signed medications orders were not on file and available for review for the following medications listed on the December 2023 Medication Administration Records (MARs) for Residents #1, #3, and #6: 1. For Resident #1: Nasal Spray 0.05 % One spray in each nostril three times daily as needed for nose bleeds ** Not to exceed 3 days in a row *** 2. For Resident #3: Acetaminophen 500 mg caplets One caplet by mouth every 6 hours as	Division of	of Licensing and Protect	tion			
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caplets One caplet by mouth every 6 hours as		for nose bleeds ** No				:
caplets One caplet by mouth every 6 hours as						
needed for pain.						

PRINTED: 01/09/2024 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		0374	B. WING		12	20/2023
NAME OF P	ROVIDER OR SUPPLIER		ET ADDRESS, CITY, STA			
HISTORIC	HOMES OF RUNNEMED	DE-EVARTS HOUSE	AXWELL PERKINS I DSOR, VT 05089	LANE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(XS) COMPLETE DATE
R162	Continued From page	÷ 4	R162			
	3. For Resident #6: Tone tablet by mouth	ramadol HCl 50 mg tablet 4 times daily				
	These findings were on the afternoon of 12	confirmed by the Manager 2/20/23.				
	for more than minima physician's written, significants	cient practice is a potential I harm to Residents as gned orders ensure nistered as the prescriber				
	intended.	motored do the property				
R164 SS=F	V. RESIDENT CARE	AND HOME SERVICES	R164			
	5.10 Medication Mar	nagement				
	5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:					
		e must delegate the administration of specific eated staff for designated				
	by: Based on staff interviewas a failure to ensur delegated the respons	is not met as evidenced ew and record review there e the Registered Nurse sibility for administration of o specific residents to 10 taff. Findings include:				
	and Procedure Manua Nurse (RN) employed Residential Care Horr	ge 15 of the facility's Policy al states, "A Registered I by [the home] the ne will have the authority mplementing and monitoring				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		0374	B. WNG		12/20/2023		
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA				
HISTORIC	HOMES OF RUNNEMED	DE-EVARTS HOUSE	WELL PERKINS L DR, VT 05089	ANE			
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R164	the delegation process medication administra staff." During an interview or the current RN employ 10 out of 14 staff resp administration at the hypevious Registered N redelegated to adminispecific residents by the Med delegated staff a medications only with determined the staff is required to administer accurately. Redelegate currently employed by who previously delegate administer medication the RN responsible for oversight at the home.	is to effect safe, accurate ation by properly trained in the afternoon of 12/20/23 byed by the home confirmed consible for medication home were delegated by the Nurse and had not been ister specific medications to the current RN. The permitted to administer a oversight by the RN who is competent in skills in medications safely and tion of staff by an RN by the home when the RN ated is no longer employed and staff continue to insunder the supervision of our medication administration	R164				
R167 SS=F	V. RESIDENT CARE	AND HOME SERVICES	R167				
	5.10 Medication Mana	agement					
	5.10.d If a resident re administration, unlicer medications under the	nsed staff may administer					
		nurse may administer PRN ions only when the home					

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Division of Licensing and Protection STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R WING 0374 12/20/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **40 MAXWELL PERKINS LANE** HISTORIC HOMES OF RUNNEMEDE-EVARTS HOUSE WINDSOR, VT 05089 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) R167 Continued From page 6 R167 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 of care for the use of PRN (as needed) psychoactive medications for all applicable facility residents (Residents # 3, #4, and #5). Findings include: Page 23 of the facility's Policy and Procedure Manual states, "Designated staff that administers medications may administer psychoactive medications only when approved by the RN and a written plan for the use of the medication has been developed... ". On the afternoon of 12/20/23 the Manager confirmed written plans for the administration of PRN psychoactive medications had not been developed for all residents of the home who are prescribed PRN psychoactive medications to include Residents #3, #4, and #5. In conclusion this deficient practice is a potential for more than minimal harm for all facility residents due to the increase risk of administration of PRN psychoactive medications without monitoring the medication's effect, and potential medication errors including misuse.

Division of Licensing and Protection STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 0374 12/20/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **40 MAXWELL PERKINS LANE** HISTORIC HOMES OF RUNNEMEDE-EVARTS HOUSE WINDSOR, VT 05089 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) R173 V. RESIDENT CARE AND HOME SERVICES R173 SS=F 5.10 Medication Management 5.10.h. (1) Resident medications that the home manages must be stored in locked compartments under proper temperature controls. Only authorized personnel shall have access to the keys This REQUIREMENT is not met as evidenced Based on observation and staff interview there was a failure to ensure all medications the home manages are stored in locked compartments and only authorized personnel have access to the medications. Findings include: Page 15 of the facility's Policy and Procedure Manual states, "All medications will be stored in a locked Med Room..." During the facility tour commencing at 11:10 AM on 12/20/23 medications were observed to be unsecured and accessible in resident's rooms and bathrooms as follows: 1. In Resident #1's room: Prescription sunscreen , Gold Bond Medicated Powder, Icv Hot Cream. Biotene Mouth Lubricant, TUMS, and Aspercreme. 2. In Resident #2's room: Scalpicin, TUMS, Neosporin, Extra Strength two bottles of acetaminophen, Gold Bond Eczema Relief

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R173	Continued From page	- 8 - 8	R173			
	Cream, Imodium, Moi					
	Melatonin, and Ketac	опагоје знагироо				
ı	3. In Resident #3's ro	oom: Gold Bond Medicated				
l l	Powder, Ketoconazol	le 2% Shampoo, Rexall				
		der. Additionally, several				
	1	y and several Albuterol				
		ed to be unsecured and nt #3's room. While Resident				
		ng self administration of				
		ne requirement to store				
	medications in a locke					
		sistered medications in order				
	to prevent unauthorize	red access and misuse.				
,	These findings were a					
	Manager during the fa	acility tour on 12/20/23.				
	In conclusion these de	eficient practices are a			İ	
	T = 1	than minimal harm for all				
	· · · · · · · · · · · · · · · · · · ·	to access to medications by				
	residents with varying self-administer medica					
	Sen-administer medica	adons.				
R179 SS=F	V. RESIDENT CARE	AND HOME SERVICES	R179			
	5.11 Staff Services					
	5.11.b The home mus					
	demonstrate compete	•				
		expected to perform before	,			
		are to residents. There re (12) hours of training each				
		rson providing direct care to		-		
	•	ng must include, but is not				
	limited to, the following					
	(1) Resident rights;					
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AND DI AN OF CODDECTION		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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R179	such as the Heimlich or ambulance contact (4) Policies and procreports of abuse, neg (5) Respectful and et residents; (6) Infection control relimited to, handwashin maintaining clean enviolement (7) General supervisional This REQUIREMENT by: Based on staff interviewas a failure to ensur completed all required include: Per review of the facil Manual, page 32 of the home] will provide at training/education in a thru December) to staresidents. This trainin with documentation keand must include, but following: 1. Resident Rights; 2. Resident emergence such as Heimlich man police or ambulance of	mergency evacuation; ncy response procedures, maneuver, accidents, police and first aid; edures regarding mandatory lect and exploitation; ffective interaction with measures, including but not ng, handling of linens, vironments, blood borne real precautions; and ion and care of residents. This is not met as evidenced ew and record review there the 5 out of 5 sampled staff the yearly trainings. Findings with a calendar year (January off providing direct care to g will be documented yearly, the providing direct care to g will be documented yearly.	R179	DEFICIENCY		
	The following training documented for all sta	is required and will be				

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Division of Licensing and Protection (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING 0374 12/20/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **40 MAXWELL PERKINS LANE** HISTORIC HOMES OF RUNNEMEDE-EVARTS HOUSE **WINDSOR, VT 05089** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) R179 R179 Continued From page 10 1. fire safety and emergency evacuation 2. policies and procedures regarding mandatory reports of abuse, neglect, and exploitation 3. confidentiality 4. HIPPA" (HIPAA) 1. The facility's policy and procedure related to staff trainings does not include all yearly trainings required by the licensing agency to include Respectful and Effective Interactions with Residents and Infection Control Measures. 2. Per review of yearly training records, 5 out of 5 sampled staff did not complete all required yearly trainings. At 4:19 PM on 12/20/23 the Manager confirmed documentation of the completion of all required yearly trainings was not on file and available for review for 5 out of 5 sampled staff. This deficient practice is a potential for more than minimal harm for all residents due to increased risk of inadequate staff education and training to provide resident care safely and effectively. R190 V. RESIDENT CARE AND HOME SERVICES R190 SS=F 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure criminal record and abuse registry checks were completed as required for 5

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Division of Licensing and Protection (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WNG 0374 12/20/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **40 MAXWELL PERKINS LANE** HISTORIC HOMES OF RUNNEMEDE-EVARTS HOUSE WINDSOR, VT 05089 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) R190 R190 Continued From page 11 out of 5 sampled staff. Findings include: Per review of the facility's Policy and Procedure Manual, policies and procedures have not been developed to ensure criminal record and abuse registry checks are completed as required. At 4:20 PM on 12/20/23 the Manager confirmed the required background checks were not on file and available for review for 5 out of 5 sampled staff. In conclusion this deficient practice is a potential for more than minimal harm for all residents, as the requirement for criminal background and abuse checks is intended to ensure all residents are care for safetly. R247 R247 VII. NUTRITION AND FOOD SERVICES SS=F 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 all perishable food items were labeled and dated. Findings include: Per review of the facility's Policy and Procedure Manual, specific policies and procedures related to storage and labeling of perishable food items have not been developed.

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R247	areas commencing at following perishable for be stored without the prepared. 1. In the refrigerator precondiments, a pitcher of chopped lettuce and single serving contains coleslaw were observed the items were opened. 2. In the freezer there leftovers without identified the items were prepared and without the date. On the morning of 12/20	facility kitchen and din 11:10 AM on 12/20/23 and items were observed dates they were opened erishable items including of orange juice, contained cucumbers, and staces of tartar sauce and ed to be without the dad or prepared. Were six containers of ifying labels and the dated, and 4 cartons of ices they were opened. 20/23 the Manager able food items were start freezer without identifying me were opened or icient practice is a potential of the potential or icient practice is a potential of the start of the	s the ed to ed or ng ners eks of lates e	R247			
R266 SS=F	residents due to food I IX. PHYSICAL PLANT			R266			
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his REQUIREMENT y: ased on observation ras a failure to ensure anitary, homelike env age 41 of the facility' lanual states the facility tour convironment. " and "v lant in good repair". uring the facility tour in 12/20/23 the follow ere observed: Resident bathrooms ithout non-skid rugs thout non-skid rugs alls and injuries. Resident #3's bedro eed of cleaning. Tiss ed, bedroom floor, b indowsill, in the bath athroom sink was in aseboard heater in the nd caps, and there w ping where the base as missing. A bottle	and staff interview there e care in a safe, functional, vironment. Findings include: Is Policy and Procedure sility "will provide a safe, omelike and comfortable will maintain the physical commencing at 11:10 AM ring environmental concerns Is were observed to be and shower mats to prevent com and bathroom were in use were observed on the athroom floor and the room. A leaking faucet in need of repair. The ne bathroom was missing were areas of exposed eboard radiator covering of Comet was observed to	R266			
abinet accessible to recluding disinfectant secondizing spray, and these findings were c	residents in the kitchen spray, Comet spray, d bleach spray. onfirmed by the Manager				
— V O — — IV Hyaraa alaminia un € iiii — eeinaanipae aloe hu	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L continued From page his REQUIREMENT reased on observation as a failure to ensure unitary, homelike envertients, homelike envertien	MES OF RUNNEMEDE-EVARTS HOUSE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Ontinued From page 13 his REQUIREMENT is not met as evidenced or as a failure to ensure care in a safe, functional, unitary, homelike environment. Findings include: age 41 of the facility's Policy and Procedure anual states the facility "will provide a safe, inctional, sanitary, homelike and comfortable invironment." and "will maintain the physical ant in good repair". Juring the facility tour commencing at 11:10 AM in 12/20/23 the following environmental concerns are observed: Resident bathrooms were observed to be thout non-skid rugs and shower mats to prevent list and injuries. Resident #3's bedroom and bathroom were in end of cleaning. Tissues were observed on the end, bedroom floor, bathroom floor and the indowsill, in the bathroom. A leaking faucet in inthroom sink was in need of repair. The inseboard heater in the bathroom was missing and caps, and there were areas of exposed be stored on the floor in the closet. Unsecured and cleaning chemicals in unlocked binet accessible to residents in the kitchen cluding disinfectant spray, Comet spray, and bleach spray. The see findings were confirmed by the Manager uring the facility tour commencing at 11:10 AM	DIDER OR SUPPLIER STREET ADDRESS, CITY, STAT 40 MAXWELL PERKINS L WINDSOR, VT 05089 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRICE Continued From page 13 As a failure to ensure care in a safe, functional, initary, homelike environment. 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Unsecured and cleaning chemicals in unlocked binet accessible to residents in the kitchen cluding disinfectant spray, Comet spray, and the facility tour commencing at 11:10 AM and the facility tour commencing at 11:10 AM The summary of the summary of the facility tour commencing at 11:10 AM The summary of the summary of the summary of the facility tour commencing at 11:10 AM	IDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 40 MAXWELL PERKINS LANE WINDSOR, VT 050899 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LS. (DENTIFFING INFORMATION)) IDERITARY REGULATORY OR LS. (DENTIFFING INFORMATION)) REQUIREMENT is not met as evidenced or as a failure to ensure care in a safe, functional, initiary, homelike environment. Findings include: age 41 of the facility's Policy and Procedure anual states the facility and provide a safe, notional, sanitary, homelike and comfortable environment. "and "will maintain the physical ant in good repair". Ling the facility tour commencing at 11:10 AM in 12/20/23 the following environmental concerns are observed: Resident bathrooms were observed to be thout non-skid rugs and shower mats to prevent its and injuries. Resident #3's bedroom and bathroom were in need of cleaning. Tissues were observed on the did, bedroom floor, bathroom floor and the ndowsili, in the bathroom A leaking faucet in throom sink was in need of repair. The seboard heater in the bathroom was missing did caps, and there were areas of exposed bring where the baseboard radiator covering as missing. A bottle of Comet was observed to stored on the floor in the closet. Unsecured and cleaning chemicals in unlocked binet accessible to residents in the kitchen cluding disinfectant spray, Comet spray, codorizing spray, and bleach spray, these findings were confirmed by the Manager ring the facility tour commencing at 11:10 AM	DIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, 2P CODE 40 MAXWELL PERKINS LANE WINDSOR, VT 60889 SUMMARY STATEMENT OF DEBICIENCIES GEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PREFIX TAG R266 R266 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PREFIX TAG PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PREFIX TAG PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDERS PLAN OF CORRECTION TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PROVIDERS TAG PROVIDERS TAG PROVIDERS TAG

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Division of Licensing and Protection (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 0374 12/20/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **40 MAXWELL PERKINS LANE** HISTORIC HOMES OF RUNNEMEDE-EVARTS HOUSE WINDSOR, VT 05089 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) m (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R302 R302 Continued From page 15 AM) to maintain staff competency in responding to possible fire emergency situations." Per review of documentation of fire drills conducted at the home on file and available for review for the previous year, fire drills were not conducted during the 1st, 3rd, and 4th quarters during the previous 12 months and drills were not conducted during the afternoon, evening, or night. At 1:15 PM on 12/12/23 the Manager confirmed the only documented fire drill on record for the previous 12 months was conducted on the morning of 4/14/23. 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.

12/20/23 HHR- Evarts House Survey POC

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

- MAR review conducted by RN Administrator and new orders provided by PCP's 1/3/24
- Monthly MAR review by RN to ensure that all medication orders contain the appropriate information is included. 1/31/24
 R147 Plan of Correction accepted by Jo A Evans RN on 1/18/24

R162-5.10c Staff will not assist with or administer any medication, prescription, or over the counter

medications for which there is not a physicians written signed order and supporting diagnosis or problem statement in the residents record.

- RN to review each residents record and contact PCP's for any medication that does not have an signed order- 2/28/24
- Monthly with each MAR review RN will ensure that all new medications on MAR have a written order in the medical record 2/28/24.

R162 Plan of Correction accepted by Jo A. Evans RN on 1/18/24

R164- 5.10 If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: A registered nurse must delegate the responsibility for the administration of specific medications to designated staff for designated residents

- RN Administrator will train and redelegate all appropriate staff by 1/31/24
- Administrative assistant will create an onboarding checklist for new staff to ensure that medication delegation is performed on all new staff. 2/29/24 R164 Plan of Correction accepted by Jo A Evans RN on 1/18/24

R167-5.10 If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the prn medication......

- RN Administrator will create plans of care for the use of and monitoring of psychoactive medications for each resident that requires them. 1/31/24
- Monthly the RN will review the MAR's and ensure that those receiving new psychoactive medications have the appropriate plans of care. 2/29/24

R167 Plan of Correction accepted by Jo A Evans RN on 1/18/24

R173- 5.10.h Resident medications that the home manages must be stored in locked compartments under proper temperature controls. Only authorized personal shall have access to the keys.

- RN Administrator will round on all resident rooms to ensure that there are no medications remaining in resident rooms. 1/31/24
- RN Administrator will assess each resident to determine their appropriateness to self-administer medications and contact the residents PCP for self-administration orders as appropriate. 2/29/24
- RN Administrator will provide education on medication safe practices to include medications in resident rooms and medication security 1/31/24

R179 5.11 The home must ensure that staff demonstrate competency in the skills and techniques that they are expected to preform before providing any direct care to residents. There shall be at least 12 hours of training each year for each staff person providing direct care to residents.

- Administrative assistant will update HHR's policy manual to include the two missing annual trainings. 2/28/24
- RN Administrator will review the assigned education modules annually to ensure they meet the requirements. 1/31/24
- RN administrator will monitor staff performance monthly and provide coaching to staff to complete the required trainings. 1/31/24
- RN administrator will require that all staff that have not meet the annual training requirements will be suspended until the modules are completed. 1/31/24

R179 Plan of Correction accepted by Jo A Evans RN 1/18/24

R190 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff

- HR will review all staff files to ensure that all staff have received the appropriate screenings.
 2/29/24
- For those that do not have the appropriate screenings HR will submit those screenings. 2/29/24
- Administrative assistant will add background screenings to new hire checklist. 2/29/24

R190 Plan of Correction accepted by Jo A Evans RN on 1/18/24

R247-7.2.b All perishable food and drink shall be labeled, dated, and held at proper temperatures.

- Dietary supervisor will develop policies and procedures related to food storage and labeling of perishable items. 1/31/24
- Dietary supervisor will a food labeling program to include a schedule of inspections for outdated and unlabeled items. 1/31/24
- Dietary supervisor will inspect each cooler and storage area weekly for outdates, food that is unsafe to eat and unlabeled items. 1/31/24
- Dietary supervisor will develop and implement a temperature monitoring program for all food containing refrigeration and freezer equipment. 1/31/24

R247 Plan of Correction accepted by Jo A Evans RN on 1/18/24

R266 9.1a The home must provide and maintain a safe, functional, sanitary, homelike, and comfortable environment.

- RN Administrator will purchase and install non-skid shower mats for all resident rooms. 2/29/24
- RN Administrator will implement a cleaning schedule for residents room and will monitor weekly for compliance. 1/3/24
- Facilities manager will install lock on cabinet in kitchen where chemicals are stored. 2/29/24
- Facilities manager will install a new faucet in residents room 2/29/24
- Facilities manager will fabricate and install protective covering for the missing heating covering for residents room 2/29/24
- RN Administrator will round in each residents room to ensure appropriate heating covering and non leaking faucets. If any additional identified facilities manager will be notified and appropriate repairs made. 2/29/24
- Facilities manager will round on all rooms monthly to ensure faucets are functioning appropriately. 2/29/24

• RN Administrator will round on all residents rooms to ensure no cleaning products remain in any of them. Education will be provided to staff regarding cleaning product safety. 1/31/24

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R302-9.11 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 or evacuation of the building when necessary. All staff shall be instructed periodically under the plan. Fire drills should be conducted quarterly and shall rotate times of day.....

- RN administrator will develop a schedule of fire drills to be performed by facilities staff 1/31/24
- RN will meet with facilities manager the week before the drill is scheduled to ensure that the drill is planned as scheduled. 1/31/24
- RN administrator will meet with facilities manager after each drill to ensure they were conducted and gather lessons learned to share with staff and update plan as needed. 1/31/24

R302 Plan of Correction accepted by Jo A Evans RN on 1/18/24