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

September 7, 2022

Ms. Lorraine Rodgers, Manager
Homestead Senior Living
64 Harborview Drive
St Albans, VT 05478-4477

Dear Ms. Rodgers:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 14, 2022.** Please post this document in a prominent place in your facility.

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

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

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
	0605	A. BUILDING: _____ B. WING _____	C 07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD SENIOR LIVING	64 HARBORVIEW DRIVE ST ALBANS, VT 05478

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R100	Initial Comments: An unannounced on site re-licensure survey and complaint investigation was conducted by the Division of Licensing and Protection on 7/12/22 with an additional day of on site investigation conducted on 7/14/22. The following regulatory deficiencies were identified: R128 V. RESIDENT CARE AND HOME SERVICES SS=E 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to administer medications consistent with physician's orders for 4 applicable residents due to medications not being ordered in a timely manner to maintain adequate stock. Per review of Medication Administration Records (MARs) the medications for 4 residents (Residents #1, #4, #5, and #8) were documented as medication unavailable and were not administered as ordered by the prescribing physician. 1. Resident #1 did not receive Vitamin B12 and Vitamin D3 as ordered for a period of 12 days; and Ferrous Gluconate (Iron supplement) and Lactoabacillus with Pectin (supplements for digestive health) for 6 days as of 7/12/22. 2. Resident #4 had not received Allopuninol	R100 R128	R 100 Homestead Senior Living is filing this Plan of Correction for the purpose of regulatory compliance. This Home is submitting this plan of correction to comply with applicable law and not as an admission or statement of agreement with respect to the alleged deficiencies herein. To remain in compliance with all state regulations, the Home has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the Home's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. R128 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. *Homestead has a written agreement with a Registered Nurse. All MTs and licensed professionals were in-serviced on 8/25-8/26/2022 to ensure a full understanding of the process for which all resident medications are ordered timely and available for administration IAW the practitioner's order. All resident medications are in stock and available for administration at this time.*	

R128 - R311 POC's accepted 9/6/22
J. Evans RN | PMC

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R128	Continued From page 1 (treatment for arthritis and gout, which can cause severe pain if left untreated) since 6/19/22. This medication issue was specifically addressed and cited during a complaint investigation in May of 2022. S/he also had not received a prescribed stool softener for 3 days as of 7/12/22; and had not received Irbesartan (for high blood pressure and neuropathy) and Venlafaxine (for depression) for 2 days as of 7/12/22. Withdrawal from Venlafaxine due to missed doses can cause flu like symptoms including fatigue, muscle pain, and nausea; issues with balance creating increased risk for falls, restlessness, nightmares, and difficulty concentrating. 3. Resident # 5 is an insulin dependant diabetic. S/he missed 2 doses of Humalog on 7/11/22 due to the medication being out of stock. Humalog is a fast acting insulin given before meals to regulate blood sugar levels. S/he also was not given a prescribed stool softener for two days as of 7/12/22. 4. Resident #8 had not received nutritional supplements including Vitamin D3 for a period of 7 days as of 7/12/22; and Calcium which was out of stock as of 7/11/22. The Lead Med Tech was unable to fax the information requested by the pharmacy to order these nutritional supplements because the facility fax machine was out of service as a result of the internet service fee not being paid. At 2:00 PM on 7/12/22 the Lead Med Tech confirmed the medications for Residents #1, #4, #5 and #8 were out of stock and not available to be administered as ordered.	R128		

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R140	Continued From page 2	R140	R 140	
R140 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.8 Physician Services 5.8.d All physicians' orders obtained via telephone shall be countersigned by the physician/licensed practitioner within 15 days of the date the order was given. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure signed physician's orders were obtained within 15 days of the date physician's orders were received, for 18 applicable residents. Findings include: 1. Based on review of Physician's Telephone Orders there were 44 telephone orders with receipt dates between 2/22/22 - 6/28/22 for 17 Residents (Residents #4, #6, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, and #23) identified as orders not signed by a physician within 15 days of receipt of the order. At 2:45 PM on 7/14/22 the Lead Med Tech confirmed the unsigned orders were faxed to physician's offices for signatures on 7/14/22. 2. On 5/26/22 Resident # 3 was admitted to Hospice. Medication orders dated 5/27/22 included: Haldol; Hyoscyamine; Acetaminophen; Bisacodyl; Lorazepam; Morphine Concentrate and Prochlorperazine. As of 7/12/22 signed telephone orders had not been received. This was confirmed by the LPN on the afternoon of 7/14/22.	R140	5.8.d All physicians' orders obtained via telephone shall be countersigned by the physician/licensed practitioner within 15 days of the date the order was given. *To allay future delays in countersignatures practitioners have been/will be advised to direct all physicians' orders to the resident's pharmacy of choice. In-service for all med techs and licensed nurses was conducted on 8/25-8/26/2022 (See attached) to reinforce this practice Physicians'orders are signed IAW Vermont state regulations or at minimum annually with resident's assessment. All orders will be signed within 15 days of receipt. Pharmacy of choice will provide a signed copy of the order with the delivery of the resident's drugs and/or the home will fax or hand deliver the current POS to the physician for signature within 15 days of receipt. Care that is coordinated with Hospice service providers will be reviewed to ensure all medication orders are updated, signed, and located in the resident's health record.*	

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R141	Continued From page 3	R141	R 141	
R141 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.9 Level of Care and Nursing Services 5.9.a Residents who require more than nursing overview or medication management shall not be retained in a residential care home unless the provisions of the following subsections (l)-(5) are all met: (1) The nursing services required are either: i. Provided fewer than three times per week; or ii. Provided for up to seven days a week for no more than 60 days and the resident's condition is improving during that time and the nursing service provided is limited in nature; or iii. Provided by a Medicare-certified Hospice program; and (2) The home has a registered nurse on staff, or a written agreement with a registered nurse or home health agency, to provide the necessary nursing services and to delegate related appropriate nursing care to qualified staff; and (3) The home is able to meet the resident's needs without detracting from services to other residents; and (4) The home has a written policy, explained to prospective residents before or at the time of admission, which explains what nursing care the home provides or arranges for, how it is paid for and under what circumstances the resident will be required to move to another level of care; and (5) Residents receiving such care are fully	R141	5.9.a Residents who require more than nursing overview or medication management shall not be retained in a residential care home unless the provisions of the following subsections (l)-(5) are all met: *The home has a written agreement with a Registered Nurse to provide necessary nursing services and delegate related appropriate nursing care to qualified staff. The Registered Nurse is in the process of conducting in-service training to include skills refresher, medication management and observation as well as delegation of tasks which will be completed by 9/2/2022. Staffing patterns are established to meet the care needs of residents to include licensed nurses, med techs, and caregivers. Staffing patterns will fluctuate in accordance with the needs of residents and the home's census. The home ensures the appropriate number of staff to meet each unique and individual need of every resident based on the resident's assessment. All service needs are outlined in the resident's care plan. All care staff have resident assignments by discipline and shift, which delineate which tasks are to be completed for each resident. All resident assessment will be reviewed and will be updated by 9/9/2022. To minimize the risk of this*	

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R141	Continued From page 4 informed of their options and agree to such care in the residential care home. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review there was a failure to maintain a registered nurse on staff to provide necessary nursing services and delegate appropriate nursing care to qualified staff; and a failure to ensure the needs of 3 applicable residents (Residents #3, #7, and #22) who require more than nursing overview and medication management do not detract from the needs of other residents. Findings include: 1. Nursing oversight including assessments, care planning, and delegation of care are the responsibility of the facility registered nurse. During the entrance interview on the morning of 7/12/22 the Executive Director confirmed the facility Registered Nurse is a "Compliance Nurse" scheduled to be on site 8 hours per week. On the afternoon of 7/12/22 a group of LNAs were observed discussing the needs of specific residents and determining a strategy for managing the work load to meet care needs. At 3:19 PM on 7/12/22 a LNA reported "there is no structure, no assignments", referred to facility care planning and scheduling as "chaotic", and stated lack of nursing supervision has resulted in care needs not being met. During an interview commencing at 11:45 AM on 7/14/22 the LPN confirmed the Lead Med Tech is responsible for "assignments for care". While the Lead Med Tech demonstrated proficiency in skills and knowledge during the course of the survey, assessment of patient care needs and delegation of patient care tasks is not within a Med Tech's scope of practice.	R141	*deficient practice reoccurring the home will conduct a monthly QA Audit and complete a review of a random sample of resident assignments and tasks.*	

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R141	Continued From page 5 2. During the Entrance Interview on the morning of 7/12/22 the Executive Director identified 3 residents on hospice (Residents #3, #7, and #22), which is end of life care focused on comfort and quality of life rather than curative care. Hospice Care requires ongoing nursing assessment to identify and delegate interventions to address the changing needs of residents during end of life care. Resident #3 was admitted to Hospice on 5/26/22. S/He had significant nursing care needs and was dependent on staff for positioning, management of a suprapubic catheter, pain and symptom management; and all Activities of Daily Living (ADLs) along with end of life emotional support. During the 2 PM med pass on 7/12/22 Resident #3 was observed calling out for help. Upon entering Resident #3's room the Med Tech was instructed by a Hospice Nurse from a Home Health Agency to administer Morphine Sulfate (medication for pain and anxiety) via oral syringe, continue to monitor Resident #3 and administer Lorazepam for anxiety as ordered, and asked the Med Tech to find staff to sit 1:1 with Resident #3 to provide end of life support until family members arrived. At 11:50 AM on 7/12/22 the Lead Med Tech confirmed the Registered Nurse had not completed med delegation activities including an observed med pass, medication administration skills assessment, or any other med delegation trainings with the two med delegated staff responsible for administering medications at the facility, and the agency employing the Hospice Nurse is not responsible for delegation to facility staff.	R141		

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R141	Continued From page 6 Direct care staff on duty for the 7:00 AM - 3:00 PM shift on 7/12/22 was limited to one Med Tech and two Caregivers who were responsible for providing all scheduled care and medication administration, as well as meeting ongoing care needs for residents requiring more than nursing oversight and medication administration. On 7/12/22 there was no Registered Nurse or Licensed Practical Nurse on duty. On 7/12/22 there were 54 residents residing at the facility, including 35 residents who required Scheduled Care. 3. Per review of records on 7/14/22 34 out of 54 applicable residents require Scheduled Care between the hours of 7:00 AM and 10:00 PM (Residents #1, #4 - #7, #9 - #20, and #22 - #38), and 26 out of 54 applicable residents require scheduled care between the hours of 1:00 AM and 6:00 AM (Residents #4 - #7, #10, #12 - #18, #22 - #27, #29, #31 - #38, and #38). The 34 residents requiring scheduled care include 2 Residents on Hospice (Residents # 7 and #22) who require more than nursing oversight and medication administration. Scheduled Care needs are unique to each individual resident and include assistance with Activities of Daily Living (ADLs) such as standing/transferring, bathing/showering, oral hygiene, grooming, toileting, prompts and assistance to the dining room for meals. Many residents require checks every two hours for incontinence and safety, and some require more complex care such as emptying catheter and colostomy bags, applying and removing compression stockings, skin assessments, and wound care. Scheduled Care is primarily provided by LNA's with the assistance of the Licensed Practical Nurses (LPNs) at the facility.	R141		

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R141	Continued From page 7 During an interview commencing at 11:45 AM on 7/14/22 the LPN stated the absence of a Director of Nursing and very limited access to a registered nurse for oversight has impacted completion of essential nursing tasks.	R141		
R144 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c.(1) Complete an assessment of the resident in accordance with section 5.7; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the registered nurse failed to complete an assessment of residents within 14 days of admission, annually, and when there is a change in physical and mental condition. Findings include: 1. Per record review Resident #1 was admitted to the facility on 4/30/21. There were no Resident Assessments on file in Resident #1's paper and electronic records. An initial assessment completed within 14 days of admission, yearly reassessment in April of 2022, and change of condition reassessment after a period of psychiatric decline resulted in hospitalization for approximately two months between April and June of 2022 were missing from Resident #1's records. This was confirmed by the Lead Med tech and LPN at 3:20 PM on 7/14/22. 2. Per record review Resident #2 was admitted to the facility on 10/26/2019. An annual	R144	R 144 5.9.c.(1) Complete an assessment of the resident in accordance with section 5.7. *Resident's assessments are completed pre-move in to establish appropriateness for residential care, within 14 days of admission, annually, and when there is a change in physical and mental condition. Reassessments of all residents are up to date as of 9/9/2022. Resident's requiring Hospice services are assessed, care is coordinated and provided by resident's Hospice provider of choice.* *Residents #1, #2, #6, and #7 that were noted to have missing assessments now have updated assessments.*	

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R144	Continued From page 8 reassessment for 2021 was missing from Resident #2's paper and electronic records, and the last Resident Assessment on file for Resident #2 was signed as completed on 12/8/2020. This was confirmed by the Lead Med tech and LPN at 3:20 PM on 7/14/22. 3. Resident #3 was admitted to the facility on 8/11/16. The last completed Resident Assessment was completed on 12/8/2020. Despite the fact the resident experienced significant health changes requiring hospitalization and eventually being admitted to Hospice, a reassessment was never completed. This was confirmed by the LPN on the morning of 7/14//22. 4. Resident #6 was admitted to the facility on 3/14/16. Review of Resident Assessment noted last assessment was completed on 2/23/22. There was a failure to conduct a yearly Resident Assessment. This was confirmed by the LPN on the morning of 7/14/22. 5. Resident # 7 was admitted to the facility on 4/6/22. An admission Resident Assessment was not completed as required. This was confirmed by the LPN on the morning of 7/14/22.	R144		
R145 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain	R145	R 145 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being.	

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R145	Continued From page 9 independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility registered nurse failed to develop written plans of care for three applicable residents (Resident #1, #2, and #3) based on abilities and needs identified in a resident assessment describing the care and services necessary to maintain independence and well being. Findings include: 1. Per review of records Resident #1 has a diagnoses of advanced Chronic Kidney Disease, Diabetes Insipidus (hormonal disease causing dehydration, thirst, frequent urination), Osteoarthritis, Osteoporosis, and Schizoaffective disorder. On 6/24/22 Resident #1's was found walking along a busy highway near the facility. Resident #1's Care Plan failed to address risk for elopement and wandering, and failed to address risk for dehydration and mineral imbalances associated with Diabetes Insipidus. 2. Per review of records Resident #2 has diagnoses of Atrial Fibrillation (abnormal heart rhythm), Hearing Loss, Depression and Anxiety, Alzheimer's Dementia, Cardiovascular Disease, and Arthritis. Resident #2's Care Plan failed to address his/her needs associated with loss of hearing. 3. Resident #3 was admitted to Hospice on 5/26/22. The resident had significant nursing care needs and was dependent on staff for positioning, management of a suprapubic catheter, pain and symptom management; and all Activities of Daily	R145	R 145 continued from previous page *The plan of care will identify the unique needs of the individual based on functional and physical capabilities. The registered nurse has completed 50% of the plans of care and will update the remaining 50% by 9/9/2022.*	

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R145	Continued From page 10 Living (ADLs) along with end of life emotional support. The Care Plan was last updated on 3/9/22 and no other plans to manage and support this resident was developed to assure the necessary care and services were directed and managed. During an interview commencing at 11:45 AM on 7/14/22 the LPN confirmed in the past a Director Of Nursing (DON) was responsible for creating and updating care plans. The LPN stated the absence of a DON, very limited access to a registered nurse for oversight, and a limited number of med delegated staff to administer medications has impacted completion of essential nursing tasks.	R145	R 146 5.9.c (3)	
R146 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.9.c (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to provide instruction and supervision to all direct personnel regarding each resident's health care needs and to delegate nursing tasks as appropriate. Findings include: On the afternoon of 7/12/22 a group of LNAs were observed discussing the needs of specific residents and determining a strategy for managing the work load to meet care needs.	R146	Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate. *The Registered Nurse will provide supervision for all direct care staff to be effective in managing workload to meet the care needs of residents. Each care giver is provided an assignment with specific instructions and tasks to be completed for each resident they are assigned to during their shift. The Registered Nurse is in the process of conducting competency skills check to ensure tasks can be delegated and will be completed by 9/2/2022. To minimize the risk of recurrence of this deficient practice all caregivers will receive a verbal review and introduction of resident care needs upon admission to the home and competency reviews with annual performance reviews or as needed.*	

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R146	Continued From page 11 At 3:19 PM a LNA reported "there is no structure, no assignments" and referred to facility care planning and scheduling as "chaotic". S/he stated lack of nursing supervision has resulted in evening care needs not being met. During an interview commencing at 11:45 AM on 7/14/22 the LPN confirmed the Lead Med Tech is responsible for Assignments for Care. While the Lead Med Tech demonstrated proficiency in skills and knowledge during the course of the survey, assessment of patient care needs and delegation of patient care tasks is not within a Med Tech's scope of practice.	R146	R 161 5.10.b The manager of the home is responsible for ensuring that all medications are handled according to the home's policies and that designated staff are fully trained in the policies and procedures.	
R161 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.b The manager of the home is responsible for ensuring that all medications are handled according to the home's policies and that designated staff are fully trained in the policies and procedures. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the Executive Director of the Residential Care Home (RCH) failed to ensure all medications are handled according to facility policies and ensure the designated staff are fully trained in policies and procedures. Findings include: Per record review the facility Medication Program Policy effective 2/15/2020 states the facility will	R161	*The Executive Director/Manager will ensure that all policies, and procedures related to medication management will be followed in accordance with MSL standards. The interim Executive Director has reviewed the medication management policies and procedures. The interim Executive Director was educated on Vermont's regulations to ensure residents receive medications and treatments in accordance with physician's orders. The Registered Nurse will complete refresher training, skill checks, observations, and delegation of duties to licensed nurses and certified med techs. Medication carts were consolidated to one, and expired and discontinued medications were discarded on 8/12/2022. All overflow medications were returned to pharmacy and/or responsible party. When neither option was available the*	

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R161	Continued From page 12 assure compliance with State Law and Regulations and the Executive Director will assure the Medication Program is in place. 1. The facility Medication Program Policy effective 2/15/2020 states all medications will be reordered when there is a 5 day supply left. Per review of Medication Administration Records (MARs) the medications for 4 residents (Residents #1, #4, #5, and #8) were documented as medication unavailable and were not administered as ordered by the prescribing physician. On 7/12/22 Resident #1's Vitamin B 12 and Vitamin D 3 had been out of stock for 12 days, Ferrous Gluconate (Iron supplement) and Lactobacillus with Pectin (supplements for digestive health) had been out of stock for 6 days . Resident #4 had not received Allopuninol (treatment for arthritis and gout, which causes severe pain if left untreated) since 6/19/22 because the medication was out of stock. This medication issue was specifically addressed and cited during a complaint investigation in May of 2022. On 7/12/22 Resident #4's stool softener had been out of stock for 3 days, and Irbesartan (for high blood pressure and neuropathy) and Venlafaxine (for depression) for 2 days. Resident # 5 is an insulin dependant diabetic. S/he missed 2 doses of Humalog on 7/11/22 due to the medication being out of stock. Humalog is a fast acting insulin given before meals to regulate blood sugar levels. His/her prescribed stool softener had been out of stock for two days as of 7/12/22. Resident #8's Vitamin D 3 had been out of stock for a period of 7 days as of 7/12/22; and Calcium was out of stock as of 7/11/22. At 2:00 PM on 7/12/22 the Lead Med Tech confirmed the medications for Residents #1, #4, #5 and #8 were out of stock and not available to be administered as ordered.	R161	*overflow remains locked in storage cabinet for future use. All IIDM residents have transitioned to insulin pens. Reordering of mail order medications has been streamlined for to minimize "not available" occurrences. All other residents are on cycle ordering (every 28 days). Medications will be destroyed upon residents' death, returned to pharmacy or to responsible party IAW residency agreement or applicable state law. Controlled substance count is completed shift to shift. Narcotic book is placed in locked medication cart. Licensed and unlicensed staff have been in-serviced on 8/25-8/26/2022 to include narc count, storage, destruction of meds, expired meds, returning meds, signed physician orders and medication transcription.*	

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R161	Continued From page 13 Please refer to tag 128. 2. The facility Medication Program Policy states any verbal or telephone order will be received and processed by staff according to State Law and Regulations, and a written order documenting the verbal or telephone order is signed and dated per regulatory guidelines. There was a failure to ensure medication orders were signed by a physician within 15 days of receipt of orders as outlined in the Vermont Residential Care Home Regulations. Based on review of Physician's Telephone Orders there were 44 telephone orders with receipt dates between 2/22/22 - 6/28/22 for 17 Residents (Residents #4, Resident #6, and Residents #9 ... Resident #23) identified as orders not signed by a physician within 14 days of receipt of the order. At 2:45 PM on 7/14/22 the Lead Med Tech confirmed the unsigned orders were faxed to physician's offices for signatures on 7/14/22. On 5/26/22 Resident # 3 was admitted to Hospice. Medication orders dated 5/27/22 included: Haldol; Hyoscyamine; Acetaminophen; Bisacodyl; Lorazepam; Morphine Concentrate and Prochlorperazine. As of 7/12/22 signed telephone orders had not been received. This was confirmed by the LPN on the afternoon of 7/14/22. Please refer to tag 140. 3. The facility Medication Program Policy states the facility will have a medical provider's order for all medications and treatments including over the counter medications and nutritional supplements. Per Medication Administration Record (MAR) review Resident #1 was administered Prednisone	R161		

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R161	Continued From page 14 (steroid medication for inflammation) 10 mg tablets during July of 2022. On record review there were no orders for Prednisone on file for Resident #1. At 3:03 PM on 7/14/22 the LPN confirmed Resident #1's order for Prednisone was transcribed from the medication bottle, and there was no verbal or written order on file for this medication. Please refer to tag 162. 4. The Medication Program Policy states The Executive Director will assure staff administering medications are trained per State requirements and have successfully passed all required training prior to administering medications. Per staff interview the Registered Nurse employed by the facility since the Director of Nursing Services resigned approximately three weeks prior to the on site investigation had not completed re-delegation of the two med techs employed at the facility under her nursing license. At 11:50 AM on 7/12/22 the Lead Med Tech confirmed the Registered Nurse had not completed med delegation activities including an observed med pass, medication administration skills assessment, or any other med delegation trainings with the two med delegated staff responsible for administering medications at the facility. Please refer to tag 164. 5. The Medication Program Policy states all medications must be properly labeled. Based on observation of the facility's storage of controlled substances, prefilled oral syringes containing morphine sulfate (narcotic pain medication) for Resident #7 were not labeled. This was confirmed with the contracted nurse on the	R161		

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R161	Continued From page 15 afternoon of 7/14/22 during an observation of narcotic storage. Please refer to tag 172. 6. The Medication Program Policy states expired and discontinued medications including medications in stock following a resident's death will be recorded on a Medications Returned for Destruction Form and returned to the pharmacy or disposed per the Community's disposal policy as soon as practical. Based on observation and staff interview there was a failure to dispose of medications left after the death of a resident, outdated medications, and discontinued medications for 6 applicable residents (Residents #14, #21, #22, #39, #40, and #41). Resident #14's Tramadol HCl 50 mg tablets expired on 5/26/22. Resident #21's Lamotrigine 100 mg tablets and Lamotrigine 150 mg tablets expired on 6/22/22. Resident #22's Lorazepam 0.5 mg tablets expired on 10/31/22. Discontinued medications belonging to 3 applicable residents (Resident #39, #40, and #41) were stored in the bottom drawer of the medication cart. Resident #39 passed away and was discharged on 6/17/22., Resident #40 passed away and was discharged on 7/2/22, and Resident #41 was discharged from the facility during the month of April 2022. At 3:15 PM on 7/14/22 the Lead Med Tech confirmed the outdated or discontinued medications were identified during the examination of the facility medication cart. Please refer to tag 176. 7. The Medication Program Policy states controlled substance count sheets are kept secure and controlled substance count sheets are maintained in a separate secure file. During	R161		

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R161	Continued From page 16 an interview commencing at 12:52 on 7/12/22 the Executive Director confirmed a book containing controlled substance administration records for all facility residents prescribed controlled substances was not available for review due to loss or theft. The storage of controlled substance administration records is required for a period of 7 years. The missing book contained resident controlled substance administration records up to and including medications administered in April of 2022. Please refer to tag 192.	R161		
R162 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview there was a failure to ensure all medication orders were signed by a physician. Findings include: 1. Based on review of Physician's Telephone Orders collected in a pile above the nursing office desk there were 42 telephone orders with receipt dates between 2/22/22 - 6/28/22 for 17 Residents (Residents #4, Resident #6, and Residents #9 ... Resident #23) identified as orders not signed by a physician within 14 days of receipt of the order. At	R162	R 162 5.10.c. Staff will not assist with or administer any medication, prescription, or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. *All licensed and unlicensed staff were in serviced to ensure only medications with a signed physician's order shall be administered. All resident Physician Order Sheets are in the process of being reviewed and will completed by 9/2/2022 for accuracy, signed and on file.*	

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R162	Continued From page 17 2:45 PM on 7/14/22 the Lead Med Tech confirmed the unsigned orders were faxed to physician's offices for signatures on 7/14/22. 2. Medication orders for Resident #3 dated 5/27/22 included: Haldol; Hyoscyamine; Acetaminophen; Bisacodyl; Lorazepam; Morphine Concentrate and Prochlorperazine. As of 7/12/22 signed telephone orders had not been received. This was confirmed by the LPN on the afternoon of 7/14/22. 3. Based on Medication Administration Record (MAR) review Resident #1 was administered Prednisone (steroid medication for inflammation) 10 mg tablets during July of 2022. On record review there were no orders for Prednisone on file for Resident #1. At 3:03 PM on 7/14/22 the facility nurse confirmed Resident #1's order for Prednisone was transcribed from the medication bottle, and there was no verbal or written order on file for this medication.	R162		
R164 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (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:	R164	R 164 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (2) A registered nurse must delegate the responsibility for the administration of specific medications to designated staff for designated residents *The Home has written agreement with a Registered Nurse. The Registered Nurse is in*	

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R164	Continued From page 18 Based on staff interview and record review the nurse failed to delegate responsibility for administration of specific medications to designated staff for designated residents for 2 of 2 applicable staff responsible for administering medications at the facility. Findings include: Per staff interview the Lead Med Tech stated the Registered Nurse employed by the facility since the Director of Nursing Services resigned approximately three weeks prior to the on site investigation had not completed re-delegation of the two med techs employed at the facility under her nursing license. At 11:50 AM on 7/12/22 the Lead Med Tech confirmed the Registered Nurse had not completed med delegation activities including an observed med pass, medication administration skills assessment, or any other med delegation trainings with the two med delegated staff responsible for administering medications at the facility.	R164	*the process of conducting skills assessment and competencies with licensed nurses, med techs, and unlicensed staff and will be completed on 9/2/2022.*	
R172 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h All medicines and chemicals used in the home must be labeled in accordance with currently accepted professional standards of practice. Medication shall be used only for the resident identified on the pharmacy label. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure all medications used in	R172	R 172 5.10.h All medicines and chemicals used in the home must be labeled in accordance with currently accepted professional standards of practice. Medication shall be used only for the resident identified on the pharmacy label. *To streamline the medication administration process, the Home consolidated medications into one (1) cart which included a full audit and disposal of all expired and discontinued medications. All labels were reviewed for accepted standards of practice. Overflow or expired medications were destroyed and returned to Health Direct Pharmacy 8/10/2022. To minimize the risk of recurrence of this deficient practice, the Home will audit med carts during cycle fill* every 28 *days and return and/or destroy overflow or expired medications to Health Direct Pharmacy or responsible party.*	

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R172	Continued From page 19 the Residential Care Home (RCH) are labeled in accordance with currently accepted professional standards of practice for 1 applicable resident (Resident #7). Findings include: Based on observation of the facility's storage of controlled substances, prefilled oral syringes containing morphine sulfate (narcotic pain medication) for Resident #7 were not labeled with the resident's name, medication name, medication strength and dose, and instructions for medication administration in accordance with the currently accepted professional standards for labeling medications. The use of properly labeled medications prevents medication errors by clearly identifying the resident the medication is prescribed for; the medication name, strength and dose; as well as how and when the medication is intended to be given. This was confirmed with the contracted nurse on the afternoon of 7/14/22 during an observation of narcotic storage.	R172		
R176 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (4) Medications left after the death or discharge of a resident, or outdated medications, shall be promptly disposed of in accordance with the home's policy and applicable standards of practice. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there	R176	R 176 5.10.h (4) Medications left after the death or discharge of a resident, or outdated medications, shall be promptly disposed of in accordance with the home's policy and applicable standards of practice. *All medications will be disposed of or returned to the pharmacy or responsible party after the death or discharge of a resident or with any outdated*	

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R176	Continued From page 20 was a failure to dispose of medications left after the death of a resident, outdated medications, and discontinued medications for 6 applicable residents (Residents #14, #21, #22, #39, #40, and #41). Findings include: At 3:15 PM on 7/14/22 the Lead Med Tech confirmed the following outdated or discontinued medications were identified during an examination of the facility medication cart: 1. Resident #14's Tramadol HCl 50 mg tablets expired on 5/26/22. 2. Resident #21's Lamotrigine 100 mg tablets and Lamotrigine 150 mg tablets expired on 6/22/22. 3. Resident #22's Lorazepam 0.5 mg tablets expired on 10/31/21. 4. Discontinued medications belonging to 3 applicable residents (Resident #39, #40, and #41) were stored in the bottom drawer of the medication cart. Resident #39 passed away and was discharged on 6/17/22., Resident #40 passed away and was discharged on 7/2/22, and Resident #41 discharged from the facility during the month of April 2022.	R176	*medication. Medications will be audited every 28 days with each cycle fill. Med Techs and nurses were in-serviced on 8/25-8/26/2022.*	
R178 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt,	R178	R 178 5.11.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies.	

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R178	Continued From page 21 appropriate action in cases of injury, illness, fire or other emergencies. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review there was a failure to provide sufficient staffing to ensure appropriate and prompt staff response for emergencies related to evacuation of residents unable to ambulate independently via stairways due to use of walkers and wheelchairs as well as bedridden residents. Findings include: 1. Resident #3 was admitted to Hospice on 5/26/22. The resident had significant nursing care needs and was dependent on staff for positioning, management of a suprapubic catheter, pain, and symptom management; and all Activities of Daily Living (ADLs) along with end of life emotional support. The resident was unable to ambulate and would have required the assistance of at least 2 staff members to transfer to a wheelchair and/or stretcher. 2. Resident #24 has a paralysis and is wheelchair bound with generalized weakness of his/her lower extremities. The resident is dependent on staff for assistance with ADLs and mobility is limited to the use of a wheelchair. S/he is unable to ambulate. 3. Per interview on the afternoon of 7/14/22 Resident #25 stated s/he had a recent fall on a Sunday night. Staff were unable to get the resident off the floor and EMS (Emergency Medical Services) were called for assistance. In an emergency evacuation Resident #25 would require assistance to safely ambulate down the stairs to exit the building. 4. Resident #7 presently on Hospice is experiencing activity intolerance due to dyspnea	R178	R 178 continued from previous page *The Home's staffing patterns fluctuate to meet the ever-changing care needs of residents. All residents will be reassessed for appropriateness to ensure safe egress from the home by 9/9/2022. The Home follows the Three Phase Evacuation process. (See attached) The Home met with Jeffery Bryant, State Fire Marshall on-site and spoke to Bob Cross, Fire Chief of Saint Albans Fire Department by phone, and reviewed the evacuation process with the Homes' Director of Maintenance and Regional Director of Operations. All staff were in-serviced on Fire Emergency Procedures. 8/24-8/26/2022 See attached.*	

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R178	Continued From page 22 and end stage cardiac disease. The resident is almost blind and is hard of hearing. The resident's ability to promptly vacate safely from the facility without assistance and direction is impracticable. 5. Per review of the Service Schedule for resident care there are 13 additional residents who would require assistance safely evacuating the building during an emergency. Residents #4 and #23 are wheelchair bound. Residents #19, #31, #32, and #34 ambulate with rolling walkers. Residents #12, #14, #26, #27, and #33 require daily scheduled assistance with safe ambulation to the bathroom and/or dining room. Resident's #16 and #17 would require assistance during an evacuation due to high risk for falls. Per review of the staff schedule for July of 2022 the typical overnight staffing pattern is limited to two staff, and day shift is often limited to 2-3 direct care staff. At 12:53 PM on 7/12/22 an LNA stated at times there are only 1-2 direct care staff on duty and appeals for more staff have been denied due to budgetary limitations. During an interview commencing at 4:22 PM on 7/12/22 the Executive Director acknowledged budgetary limitations have impacted ability to provide appropriate staffing. At 8:45 AM on 7/14/22 the Director of Maintenance acknowledged several residents would need to be physically carried down the stairs by two staff during an emergency evacuation. The number of residents unable to evacuate independently in combination with the current staffing ratios is a significant threat to staff's ability to evacuate the facility in a safe and timely manner during an emergency.	R178		

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R179	Continued From page 23	R179	R 179	
R179 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to complete required yearly trainings for staff providing direct care to residents. Findings include: Per review of in-service training records provided by the Executive Director on request during the	R179	5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. *Monthly meetings will be executed effective 9/2022 to facilitate staff training. In addition, all staff including caregivers, med techs, and licensed professionals have access to the Relias training portal. All employees must complete*	

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R179	Continued From page 24 course of the on site relicensure survey the required trainings to include Resident's Rights, Fire Safety and Emergency Evacuation, Emergency Response Procedures, Respectful and Effective Interactions with Residents, Infection Control Measures, and General Supervision and Care of Residents were not documented as completed for 5 out of 5 applicable staff. The Executive Director confirmed the required training's were not completed for all 5 staff sampled on the afternoon of 7/14/22.	R179	*required annual training requirements IAW MSL P&P and VT Division of Licensing and Protection NLT 12/31/22. (See attached Relias In-service) Ongoing in-service regarding the utilization of Relias training.*	
R191 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.12 Records/Reports 5.12.c A home must file the following reports with the licensing agency: 5.12.c.(1) When a fire occurs in the home, regardless of size or damage, the licensing agency and the Department of Labor and Industry must be notified within twenty-four (24) hours. A written report must be submitted to both departments within seventy-two (72) hours. A copy of the report shall be kept on file. 5.12.c.(2) A written report of any accident or illness shall be placed in the resident's record. Any untimely deaths shall be reported and a record kept on file. 5.12.c. (3) A report of any unexplained absence of a resident from a home for more than 12 hours shall be reported to the police, legal representative and family, if any. The incident	R191	R 191 5.12.c A home must file the following reports with the licensing agency: 5.12.c.(4) A written report of any breakdown or cessation to the home's physical plant's major services (plumbing, heat, water supply, etc.) or supplied service, which disrupts the normal course of operation. The licensee shall notify the licensing agency immediately whenever such an incident occurs. A copy of the report shall be sent to the licensing agency within seventy-two (72) hours. *Facsimile services were restored 7/13/22. No further disruptions noted. All staff were instructed to escalate any service failure issues to the executive leadership team in real time to ensure immediate response to disruptions in services. A written report will be submitted to the licensing department as required.*	

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R191	Continued From page 25 shall be reported to the licensing agency within twenty-four (24) hours of disappearance followed by a written report within seventy-two (72) hours, a copy of which shall be maintained. 5.12.c.(4) A written report of any breakdown or cessation to the home's physical plant's major services (plumbing, heat, water supply, etc.) or supplied service, which disrupts the normal course of operation. The licensee shall notify the licensing agency immediately whenever such an incident occurs. A copy of the report shall be sent to the licensing agency within seventy-two (72) hours. 5.12.c. (5) A written report of any reports or incidents of abuse, neglect or exploitation reported to the licensing agency. 5.12.c. (6) A written report of resident injury or death following the use of mechanical or chemical restraint. This REQUIREMENT is not met as evidenced by: Based on staff interview there was a failure to file a written report to the Division of Licensing and Protection regarding cessation of the home's inbound and outbound fax service due to non-payment of service fees, which disrupted the normal course of facility operations including essential nursing services. At 4:00 PM on 7/12/22 the Executive Director confirmed communications with providers regarding medication and treatment orders are primarily conducted via fax, and confirmed the facility inbound and outbound fax service was suspended due to non-payment. A review of an email communication from the service provider	R191		

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R191	Continued From page 26 addressed to the Executive Director and Business Manager dated 7/8/22 stated the account was suspended on 6/22/22 due to non-payment; and an email communication dated 7/1/22 stated the service had been suspended since at least 6/30/22 and the facility's corporate office was notified regarding the suspended service due to non-payment. The lapse in fax services presented a disruption of communications between resident providers and nursing services. On the afternoon of 7/12/22 the Lead Med Tech confirmed the lapse in services prevented staff from sending documents requested by the pharmacy that were required to dispense and deliver medications. The lapse in fax service resulted in medications not being administered as ordered; and prevented staff from sending requests for provider signatures and receiving signed orders.	R191		
R192 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.12 Records/Reports 5.12.d Reports and records shall be filed and stored in an orderly manner so that they are readily available for reference. Resident records shall be kept on file at least seven (7) years after the date of either the discharge or death of the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview there was a failure to store controlled substance medication records for all facility residents in a secure and orderly manner resulting in theft or loss of the records	R192	R 192 5.12.d Reports and records shall be filed and stored in an orderly manner so that they are readily available for reference. Resident records shall be kept on file at least seven (7) years after the date of either the discharge or death of the resident. *The Controlled Substance Book was located in the former Home's Executive Director's desk drawer on 8/24/22. It aligns with the missing information that was not able to be located during the visit. Staff were in-serviced on 8/26/2022 on proper storage of Controlled Substance book and all resident PHI.*	

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R192	Continued From page 27 that prohibits storage of these resident records for the required 7 year time period. Findings include: During an interview commencing at 12:52 on 7/12/22 the Executive Director confirmed a book containing controlled substance administration records for all facility residents prescribed controlled substances was not available for review due to loss or theft. The storage of controlled substance administration records is required for a period of 7 years. The missing book contained resident controlled substance administration records up to and including medications administered in April of 2022.	R192		
R222 SS=E	VI. RESIDENTS' RIGHTS 6.10 The resident's right to privacy extends to all records and personal information. Personal information about a resident shall not be discussed with anyone not directly involved in the resident's care. Release of any record, excerpts from or information contained in such records shall be subject to the resident's written approval, except as requested by representatives of the licensing agency to carry out its responsibilities or as otherwise provided by law. This REQUIREMENT is not met as evidenced by: Based on staff interview there was a failure to ensure protection of each resident's right to privacy related to the loss or theft of private health information for all facility residents prescribed controlled substances contained in a narcotics	R222	R 222 6.10 The resident's right to privacy extends to all records and personal information. Personal information about a resident shall not be discussed with anyone not directly involved in the resident's care. Release of any record, excerpts from or information contained in such records shall be subject to the resident's written approval, except as requested by representatives of the licensing agency to carry out its responsibilities or as otherwise provided by law. *The Controlled Substance Book was located in the former home's Executive Director's desk drawer on 8/24/2022. It aligns with the missing information that was not able to be located during the visit. Staff were in-serviced on 8/26/2022 on proper storage of the Controlled Substance Book and all resident PHI.*	

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R222	Continued From page 28 count book. Findings include: During an interview commencing at 12:52 on 7/12/22 the Executive Director confirmed a book containing controlled substance administration records for all facility residents prescribed controlled substances was missing due to loss or theft. The missing book contained resident's private health information including name, room number, physician, controlled substance medication orders, when the medication was given, and the amount of medication taken. The Executive Director was unable to identify the number of applicable resident's effected and the length of time the missing book documented.	R222		
R249 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.d The home shall assure that food handling and storage techniques are consistent with safe food handling practices. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure food handling and storage of dry goods was consistent with safe food handling practices. Findings include: During a tour of the facility food storage area conducted by the Director of Maintenance commencing at 9:22 AM on 7/14/22 bags of cake mix, boxes of hot chocolate and other items were observed placed on shelves beside containers of alcohol wipes, open boxes containing large binders of papers, paper products and other	R249	R 249 7.2.d The home shall assure that food handling and storage techniques are consistent with safe food handling practices. *Corrected in real time. Food was placed in proper containers and storage bags. Food was removed from floor and placed on shelves to prevent contamination. Dining Service staff were in-serviced on 8/25-8/26/2022 on food safety and sanitation. To prevent recurrence of deficient practice audits will be conducted monthly with use of the MSL Quality Assurance Tool.*	

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R249	Continued From page 29 non-food items. Open boxes containing bags of chips, boxes containing canned goods, and other food items were stored directly on the floor; and opened bags of pasta, flour, pudding, and other dried goods in paper and plastic packaging were not in sealed plastic containers with lids to prevent contamination. At 9:30 AM on 7/14/22 the Director of Maintenance confirmed the food storage practices in use are not consistent with safe food handling practices, and immediate corrective actions were taken to ensure dry goods food items are properly stored.	R249		
R258 SS=D	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.h All garbage shall be collected and stored to prevent the transmission of contagious diseases, creation of a nuisance, or the breeding of insects and rodents, and shall be disposed of at least weekly. Garbage or trash in the kitchen area must be placed in lined containers with covers. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, there was a failure to ensure a trash receptacles in the kitchen remained covered to prevent the transmission of contagious diseases, creation of a nuisance, or the breeding of insects and rodents. Findings include: Per observation on 7/14/22 at 3:30 PM an open trash can was observed beside the food prep area in the kitchen. The Food Services Manager	R258	R 258 7.3.h All garbage shall be collected and stored to prevent the transmission of contagious diseases, creation of a nuisance, or the breeding of insects and rodents, and shall be disposed of at least weekly. Garbage or trash in the kitchen area must be placed in lined containers with covers. *A trash can lid was purchased on 8/24/2022 and new receptacles have been ordered. ETA no later than 9/15/2022.*	

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R258	Continued From page 30 and Chef confirmed the presence of the uncovered kitchen trash can in the facility kitchen, noting a cover was needed.	R258		
R266 SS=F	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review there was a failure to provide care in a safe, functional, and homelike environment. Findings include: 1. During the course of a facility tour with the Executive Director commencing at 10:10 AM on 7/12/22 signs of excessive wear and rippling of the carpeting throughout the common areas of the facility was observed. The condition of the carpeting creates a risk for falls and injuries. The Executive Director confirmed the presence of rippling and excessive wear of the carpeting throughout the facility during the facility tour on 7/12/22. 2. During the course of a facility tour with the Executive Director commencing at 10:10 AM on 7/12/22 absence of telephones on each floor with emergency numbers posted beside them and absence of evacuation plans posted on the walls was observed on of each floor of the facility. The Executive Director confirmed the lack of phones	R266	R266 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike, and comfortable environment. *The Home has started the process of collecting quotes for new carpeting throughout the entire home (quote for first floor is attached). In addition a repair assessment has been scheduled for the entire home 9/6/2022.* *Telephones will be installed on each floor NLT 9/6/22.* *Emergency contact numbers have been posted by each elevator along with emergency evacuation plans.*	

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R266	Continued From page 31 with emergency numbers posted beside them and emergency evacuation plans posted on the walls of all floors during the facility tour on 7/12/22. 3. During the course of a tour conducted by the Director of Maintenance commencing at 9:22 on 7/14/22 cardboard boxes were observed stored within 6-8 inches of the ceiling and kitchen equipment was observed stored within 2-3 inches of the ceiling in the dry goods storage room located in the basement of the facility. The placement of large items on the top shelves in close proximity to the ceiling and sprinkler system poses a risk of obstruction of water flow from an activated sprinkler system. During the tour of the storage room the Director of Maintenance confirmed the storage of boxes and kitchen equipment in close proximity to the ceiling and sprinkler system, and acknowledged the risk for sprinkler water flow obstruction due to the placement of the stored items.	R266		
R302 SS=F	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed 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	R302	R 302 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented.	

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R302	Continued From page 32 documented. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure evacuation plans were posted and available to all residents, and a failure to conduct fire drills quarterly and rotate drill times. Findings include: 1. During the course of a facility tour with the Executive Director commencing at 10:10 AM on 7/12/22 absence of evacuation plans posted on the walls of each floor of the facility was observed. This was confirmed by the Executive Director during the facility tour on 7/12/22. 2. Per review of fire drill documentation all drills conducted during the overnight shift for the previous year were "silent" and "educational" drills conducted without sounding an alarm and evacuating residents. Additionally, all drills conducted during the first half of the previous year were also conducted as "silent" and "educational" drills without alarms and evacuation of residents. During an interview at 8:45 AM on 7/14/22 the Director of Maintenance confirmed fire drills conducted during the overnight shift over the previous year and all drills conducted from January 2022- June 2022 were considered educational trainings for facility staff and conducted without sounding alarms and evacuation of residents. The Director of Maintenance reported when drills are conducted with sounding of alarms and evacuation, the evacuation process is limited to moving the	R302	R 302 continued from the previous page *The Home shall have a posting of the evacuation plan on each floor for protection of all residents and staff in the building. Evacuation plans have been posted on each floor alongside the elevator. The Home follows the Three Phase Evacuation process. (See attached) The Home met with Jeffery Bryant, State Fire Marshall on-site and spoke to Bob Cross, Fire Chief of Saint Albans Fire Department by phone, and reviewed the evacuation process with the Homes' Director of Maintenance and Regional Director of Operations. All staff were in-serviced on Fire Safety and Emergency Procedures. 8/24-8/26/2022. Evacuation and sounded alarm fire drills will be conducted every shift on a quarterly basis. Documentation will remain on file in TELS for review.*	

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R302	Continued From page 33 residents and staff in the area surrounding the alarm to the other side of the nearest fire doors, and stated full evacuations of the facility are not conducted. The Director of Maintenance was not aware of any test drills completed with the Fire Marshall, or any documentation stating the facility is an approved Shelter in Place facility. Facilities approved as Shelter in Place buildings must meet specific safety requirements allowing inhabitants to remain in unaffected areas of a facility while awaiting emergency response by the fire department. The Executive Director was unable to provide documentation Shelter in Place approval per request on the afternoon of 7/14/22.	R302		
R303 SS=E	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.d There shall be an operable telephone on each floor of the home, at all times. A list of emergency telephone numbers shall be posted by each telephone. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure access to an operable telephone on each floor of the Residential Care Home (RCH) with a list of emergency numbers posted by each phone. Findings include: During the course of a facility tour with the Executive Director commencing at 10:10 AM on 7/12/22 absence of telephones on each floor with	R303	R 303 9.11.d There shall be an operable telephone on each floor of the home, at all times. A list of emergency telephone numbers shall be posted by each telephone. *Operable telephones will be installed on each floor on 9/6/22. Emergency contact telephone numbers have been posted in proximity of the elevator on each floor. (See attached) Residents and staff have been notified of install and postings. In the interim, all staff will carry a cell phone for use in the event of an emergency.*	

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R303	Continued From page 34 emergency numbers posted beside them was observed on each floor of the facility. The Executive Director confirmed the lack of phones with emergency numbers posted beside them during the course of the tour commencing at 10:10 on 7/12/22.	R303		
R311 SS=E	X. PETS 10.2.e Pet health records shall be maintained by the home and made available to the public. This REQUIREMENT is not met as evidenced by: Based on staff interview the Executive Director failed to maintain pet health records for the cats and dog owned by residents living in the home. During the facility tour commencing at 10:10 AM on 7/12/22 the Executive Director confirmed the presence of cats and a dog living in the facility. During the course of the survey the Executive Director was requested to provide pet health records for review. The Executive Director failed to provide the pet health records requested.	R311	R 311 10.2.e Pet health records shall be maintained by the home and made available to the public. *The Home has 5 pets. 3 are fully vaccinated and 2 have upcoming scheduled appointments on 8/29/2022 and 10/4/2022. (See attached) Residents will be required to submit health records from their veterinarian and required to maintain all immunizations IAW state regulations and guidelines. Pet health records will be reviewed annually.*	