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

April 18, 2024

Ms. Rae Bunce
Homestead Senior Living
64 Harborview Drive
St Albans, VT 05478-4477

Dear Ms. Bunce:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 12, 2024.** Please post this document in a prominent place in your facility.

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

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

Sincerely,

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

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0605	A. BUILDING: _____ B. WING _____	03/12/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site re-licensure survey was conducted by the Division of Licensing and Protection on 03/12/24. The following regulatory violations were identified:	R100	The filing of this plan of correction does not constitute an admission of the allegations set forth in this statement of deficiencies. This plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law.	
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to develop a written plan of care which includes all care and services required to maintain independence and well-being for one applicable resident (Resident #1). Findings include: The facility's Assessment and Service Plan policy and procedures effective 2/13/23 states, "The Wellness Director will assure all residents have a comprehensive assessment and Service Plan in place to assist staff in meeting their needs. " Per record review Resident #1 is diagnosed with cardiac conditions including Congestive Heart Failure, Hypertension, and Atrial Fibrillation; and is prescribed the anticoagulant medication Eliquis. Resident #1's Resident Assessment	R145	Resident #1 remains at the facility and the care plan has been updated to include the fall risk, risk of pain and interventions, and the cardiac risk, as well as the use of an anticoagulant. An in-service is to be provided to the nursing staff (LPNs and/or RNs) to review the assessment/service plan policy. A house wide audit is being performed to ensure all care plans are accurate to each individual Resident to maintain their independence and well-being. Random audits will then occur by the Wellness Director and/or designee weekly times 4 and monthly times 3 to ensure the care plans continue to ensure each Resident's plan describes how to assist the Resident to maintain their independence and well-being. Results of these audits will be brought to the monthly QA committee and reviewed. R 145 Accepted Jenielle Shea, 4/18/24	4/19/24

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 _____	03/12/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R145	Continued From page 1 completed on 1/8/24 indicates s/he has daily pain; and a Fall Risk Assessment completed on 12/27/23 indicates s/he is at risk for falls. Resident #1's plan of care provided for review on request on 3/12/24 does not address his/her risk for cardiac event, risk for bleeding associated with the use of anticoagulant medication, risk for falls, and interventions for pain management. This finding was confirmed by the Wellness Director at 3:02 PM on 3/12/24. In conclusion this deficient practice is a risk for more than minimal harm to this resident resulting from documenting an planning identified residents needs and interventions.	R145		
R167 SS=D	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: (5) 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 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.	R167	Resident #2 remains at the facility. This Resident's plan of care has been updated to include a written plan related to the use of PRN psychoactive medications to be administered by non-licensed staff. In-service has been provided to the facility's RN and med techs to review the PRN psychoactive medication administration policy. A house wide audit is being conducted to review all Residents that have PRN psychoactive medications ordered have a written plan for the administration of the PRN psychoactive medication by a non-licensed staff member. Continued on next page	4/19/24

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 _____	03/12/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R167	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the Registered Nurse (RN) failed to develop written care plans to demonstrate the use of as needed (PRN) psychoactive medications for 1 out 5 residents of the applicable sample. Findings include: Per record review Resident #2 has a physician's orders for Lorazepam 0.5 mg, take 1 tablet daily as needed for anxiety. A plan was not identified within the record to demonstrate appropriate indications of use for the medication, along with desired and undesired effects. Per the facility Policy and Procedures, a policy titled PRN Psychoactive Medication Administration, ". PRN psychoactive medications may be administered only when there is a written care plan for the use of the PRN medications." Per interview on 3/12/24 at 2:40 PM the Registered Nurse, confirmed a care plan has not been developed for unlicensed staff to reference prior to the administration of the PRN psychoactive medication for Resident #2. The deficient practice is a potential risk for more than minimal harm for all facility residents requiring PRN care plans due to administration of PRN psychoactive medications without monitoring the medication's effect, and potential medication errors including misuse.	R167	Random audits of these written plans and documentation will then occur by the Wellness Director and/or designee weekly times 4 and then monthly times 3 to ensure continued compliance of the written plans and documentation for the use of PRN psychoactive medications. Results of these audits will be brought to the monthly QA committee for review. R 167 Accepted Jenielle Shea, RN 4/18/24	
R173 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management	R173	See next page.	

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 _____	03/12/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R173	Continued From page 3 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 by: Based on observation, staff interview, and record review there was a failure to ensure medications are stored in locked compartments for one applicable resident (Resident #1). Findings include: The facility's Medication Program policy effective 2/13/23 includes procedures for medication storage which states, "The Medication cabinet, cart, refrigerators, and/or room will be locked at all times, unless directly monitored by the authorized medication staff. Only authorized personnel will be allowed in the medication area." The facility's Medication Program policy does not include procedures to ensure medications are not stored in the rooms of residents who require medication administration. During the facility tour commencing at 10:15 AM on 3/12/24 unsecured medications were observed in Resident #1's bathroom to include Aspercreme and Voltaren topical pain relievers, and TUMS antacid tablets. Physician's orders were not on file in Resident #1's record for Aspercreme and Voltaren. Resident #1's record contains a signed prescriber's order for TUMS.	R173	Resident #1 remains at the facility. This Resident is no longer storing medications or self-administering medications. In-servicing to occur with all nursing/clinical staff to review the medication policy and applicable procedure to identify if a Resident who is unable to self-administer medications is doing so and who to report this to at the community. A house wide educational memo has been sent to Residents/Families/POAs to explain this regulation. This will also be provided upon admission for any new Resident(s). A house wide audit will be performed on all Resident apartments to ensure they do not have medications in their apartments (if they are unable to self-administer) or, that their medications are locked in the apartment (if they are independent with medications). Random audits will be performed by the Wellness Director and/or designee weekly times 4 and then monthly times 3 on Residents who are not to be self-administering medications to ensure they do not have medications in their apartments. Results of these audits will be brought to the QA committee for review. R173 Accepted Jenielle Shea, RN 4/18/24	4/19/24

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 _____	03/12/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R173	Continued From page 4 The Resident Assessment on file indicates Resident #1 is not capable of self-administration and his/her medications are managed by the facility. On the afternoon of 3/12/24 the Wellness Director stated s/he was not aware Resident #1 was self-administering and storing medications in his/her room, and confirmed medications were unsecured and accessible in Resident #1's room. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents due to access to medications by residents incapable of safely self-administering medications; and for Resident #1 in particular due to potential contraindications associated with the use of Voltaren with his/her prescribed medications and medical conditions.	R173		
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;	R179	An all-staff in-service is being held on April 17, 2024, and the 7 trainings will be provided. 1:1 follow ups will be done with any staff unable to attend the scheduled all staff training. Once completed, a house wide audit will be performed to ensure all current/active staff have completed all 7 trainings for 2024. Trainings will continue throughout the year to meet the 12-hour regulation. An in-service is occurring with all managers of the facility to review the 7 mandated training courses all staff must complete prior to working with Residents and must be reviewed annually. A new orientation agenda has been developed that will ensure all new hires are educated on the 7 trainings prior to working directly with any Resident. Random audits of the new hires will occur by the executive director and/or designee weekly times 4 and then monthly times 3. Results of these audits will be brought to the monthly QA committee for review.	4/23/24

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 _____	03/12/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R179	Continued From page 5 (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 record review and staff interview the RCH failed to ensure that all staff providing direct care to residents had at least twelve (12) hours of required training each year. Findings include: During the course of a re-licensing survey on 3/12/24, the manager was requested to demonstrate via training records that staff employed at the RCH who provide direct care to residents had received the twelve (12) hours of required yearly training. Per record review, 3 out 5 staff completed the training for Resident Rights, 1 out 5 staff completed trainings for Fire safety and emergency evacuation, 1 out of 5 staff completed trainings for Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid, 4 out 5 staff completed trainings for Policies and procedures regarding mandatory reports of abuse, neglect and exploitation, 2 out 5 staff completed trainings for Respectful and effective interaction with residents, 3 out of 5 staff completed trainings for General supervision and care of residents.	R179	R179 Accepted Jenielle Shea, RN 4/18/24	

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 _____	03/12/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R179	Continued From page 6 Upon review of the provided electronic training module guide, the procedure indicates the required trainings to be assigned to staff upon hire and on an annual basis. Per interview on the afternoon of 1/30/24 the Manager confirmed the training records provided fore review. Additionally, the Area Executive Director confirmed the electronic training module guide titled "Relias: Vermont Assisted Living Facility" is the referenced document to account for the requirements set forth by the regulations, and the assignment of the required trainings upon hire and annually to all direct care staff. This deficient practice is a potential risk for more than minimal harm for all facility residents due to inadequate staff education and training to safely and effectively provide resident care.	R179		
R247 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure perishable food items were labeled and dated; and perishable beverages stored in the drink dispenser were held at or below 40 degrees Fahrenheit. Findings include:	R247	The juice machine has been removed from service. The items in the dry storage room have been labelled and dated or were disposed of as necessary. The policy for food temperatures has been updated to ensure that refrigerator temperatures do not go above 40 degrees. In-servicing to occur with all dietary staff on monitoring perishable food temps per policy, during meal service. Also to review the food non-food storage policy with a focus on Continued on the next page	4/19/24

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 _____	03/12/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R247	Continued From page 7 1. The facility policies and procedures titled Food-Non Food Storage provided for review on 3/12/24 states, all stock must be rotated with each new order received. Rotating stock is essential to ensuring the freshness and highest quality of food". During a tour of the dry storage room on the morning of 3/12/24 the following perishable food items were not labeled and dated as required: two 1 gallon containers of mayonnaise, two 1 gallon containers of Buttermilk Ranch dressing, 1 gallon container of Golden Italian dressing, 1 gallon container of Creamer Caesar dressing, two 1 gallon containers of Raspberry Vinaigrette dressing, nine 12 oz cans of Albacore Tuna, three 7 lb containers of Chocolate Pudding, four 7 lb containers of Vanilla Pudding, six 12 oz cans of evaporated milk, four 5 lb boxes of cornbread mix, three 3 lb bags of stuffing mix, and 3 large bags of croutons. These items were confirmed by the Dining Services Director at the time of finding. Per interview with the facility Executive Director s/he stated that it is the facilities policy and procedure to remove food from dry storage two months prior to the stated expiration date. 2. The facility's Food Temperature policy effective 2/26/21 states, " Foods will be maintained at proper temperature to ensure food safety"; and the Food Temperature procedures include: a. The temperature of potentially hazardous cold foods will be not greater than 40 degrees Fahrenheit served to residents." B. "Refrigerator temperatures should be	R247	Labelling and dating and rotating stock. Will also review the updated food temperature policy. An audit of the dry storage room will occur to ensure all items are labelled, dated and stock was rotated per policy. Random audits will then occur by the Executive Director and/or designee weekly times 4 and monthly times 3 of the dry storage room, of perishable food temps and of refrigerator temperatures. Results of these audits will be brought to the monthly QA committee for review. R 247 Accepted Jenielle Shea, RN 4/18/24	

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 _____	03/12/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R247	Continued From page 8 maintained at 33 degrees Fahrenheit to 42 degrees Fahrenheit."; which is not consistent with the maximum temperature for storage of refrigerated perishable foods and beverages identified in the Vermont Residential Care Home Licensing Regulations effective 10/3/2000. During observation of the lunch meal service on 3/12/24 perishable beverages stored in the refrigerated drink dispenser in the dining room were observed to be held at temperatures greater than 40 degrees Fahrenheit as follows: a. Strawberry Kiwi beverage 46.6 degrees Fahrenheit b. Citrus Peach juice beverage 45.3 degrees Fahrenheit c. Orange juice 43.9 degrees Fahrenheit At 11:50 AM on 3/12/24 the Kitchen and Dining Services Manager confirmed the beverages in the juice dispenser were held at temperatures above 40 degrees Fahrenheit; and on the afternoon of 3/12/24 the Kitchen and Dining Services Manager confirmed procedures were not in place for routine monitoring of the drink dispenser temperatures by staff. This deficient practice was previously cited on 10/11/23. In conclusion, these deficient practices are a potential risk for more than minimal harm due to food borne illness for all facility residents	R247		
R250 SS=F	VII. NUTRITION AND FOOD SERVICES	R250	See next page.	

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 _____	03/12/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R250	Continued From page 9 7.2 Food Safety and Sanitation 7.2.e The use of outdated, unlabeled or damaged canned goods is prohibited and such goods shall not be maintained on the premises. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure of the Residential Care Home (RCH) to ensure that outdated, unlabeled, or damaged canned goods were not maintained on the premises in accordance with Section 7.2e of the Vermont Residential Care Home Licensing Regulations effective 10/3/2000. Findings include: During a tour of the dry storage room on the morning of 3/12/24 the following perishable food items were noted to be expired: four 24 oz boxes Quick Grits expired on 1/04/23, two 24oz boxes of Quick Grits expired on 2/2/23, nine 28oz boxes of Creamy Rice Hot Cereal expired on 11/12/22, fifteen 13.5 oz cans of Coconut milk expired on 8/31/21, ten 16.7 oz containers of Caramel Sauce expired on 12/23, and one 16.7 oz container of Caramel Sauce expired on 01/24. This was confirmed by the facility Dining Services Director on 3/12/24 at 10:35 AM. Per facility policy and procedure titled food-Non-Food Storage states All stock must be rotated with each new order received. Rotating stock is essential to ensure the freshness and highest quality of all food. Per interview with the facility Executive Director s/he stated that it is the facilities policy and procedure to remove food from dry storage two months prior to the stated expiration date.	R250	All expired items have been removed from the community's dry storage room. In-servicing will be occurring with all dietary staff re: the food non-food storage policy, including when to use or remove items, as well as rotating items. A full audit will occur of the dry storage room to ensure all items are not nearly expired or expired. Random audits will then occur by the Executive Director and/or designee weekly times 4 and then monthly times 3 to monitor. Results of these audits will be brought to the monthly QA committee for review. R 250 Accepted Jenielle Shea, RN 4/18/24	4/19/24

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 _____	03/12/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R250	Continued From page 10 In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents related to risk of food contamination and food born illnesses.	R250		