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. Patricia Bauerle
Lakeview Community Care Home
322 St Paul Street
Burlington, VT 05401-4647

Dear Ms. Bauerle:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 18, 2023.** Please post this document in a prominent place in your facility.

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

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

Sincerely,

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

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
	0177	A. BUILDING: _____ B. WING _____	10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW COMMUNITY CARE HOME	322 ST PAUL STREET BURLINGTON, VT 05401

(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 10/18/23, with additional information provided by the facility Manager on 10/19/23. The following regulatory violations were identified:	R100		
R178 SS=I	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, 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 ensure that a sufficient number of qualified staff are available in the resident environment, outside of offices, at all times to ensure necessary person-centered care, provide a safe and supervised environment, or to assure prompt, appropriate action to address resident needs and other emergencies. Findings include: During the course of the relicensure survey on 10/18/23, a lack of supervisory oversite and staff monitoring of residents were observed by the survey team. On the morning of 10-18-23, staff were observed to remain in the nursing office behind a closed door without the ability to see or hear residents for extended periods of time. Upon entering the facility, Resident #1; who has	R178		

LICSW 1/5/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0177	A. BUILDING: _____ B. WING _____	10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW COMMUNITY CARE HOME	322 ST PAUL STREET BURLINGTON, VT 05401

(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
R178	Continued From page 1 diagnoses including schizoaffective disorder, nicotine dependence, type 2 diabetes, chronic obstructive pulmonary disease, and the presence of a cardiac pacemaker; was observed to be seated on the facility couch in a slumped position. Approximately thirty minutes later staff responded by approaching Resident #1 and stating, "Come on, let's get up and go have a cigarette" and placing a cigarette and lighter in Resident #1's hand. Resident #1 did not respond physically or verbally to staff's prompt to get up and have a cigarette. At the end of the facility tour the cigarette and lighter were observed to be on the floor in front of where Resident #1 had previously been seated. When questioned about the discarded cigarette and lighter staff reported Resident #1 was transferred to his/her room and was awaiting medical transport to the hospital via ambulance for lethargy. Additional concerns were identified during record review regarding the supervision and monitoring of Resident #2 who has a history of repeat falls. Per record review Resident #2's diagnoses include bipolar disorder, declining cognitive function, and a history of falls. Resident#2's current Resident Assessment form dated 9/8/23 indicates s/he has impaired long term and short-term memory, impaired decision making, an unsteady gait requiring use of a walker, and risk of wandering. A facility incident report dated 6/25/23 noted the Burlington Fire Department (FD) entered the facility and alerted staff that Resident #2 was found lying on the ground in front of the facility by someone in the community who called for medical assistance. Resident #2 required transport via ambulance to the hospital for evaluation of hip pain. On 7/1/23 Resident #2 again required emergency	R178	R178 Accepted. Carol Scott, LTCM	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0177	A. BUILDING: _____ B. WING _____	10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW COMMUNITY CARE HOME	322 ST PAUL STREET BURLINGTON, VT 05401

(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
R178	Continued From page 2 medical services when s/he was found lying prone on the ground outside another of the designated agency's facilities by a member of the community. Resident #2 was noted to have sustained a hit to his/her head and bruising to his/her knee. On 9/23/23 a facility resident and a community member went to the facility staff office to report Resident #2 was on the ground in front of the facility after falling down the stairs with his/her walker. Resident #2 was unable to get up and emergency medical services were required for a lift assist. While Resident #2's care plan indicates s/he requires a walker for ambulation, during the survey Resident#2's walker was observed to be left in the hallway in view of the office. Per record review Resident #3 has a diagnosis of schizophrenia with disturbed thought processes and is care planned to have staff check in frequently when s/he is seeking support. During the survey on 10/18/23 Resident #3 was observed multiple times to be wandering throughout the facility yelling for help and calling out staff members names without staff responding to his/her needs until prompted by surveyors. Additionally, Resident #3's care plan states s/he is triggered by the presence of Emergency Medical Service (EMS) responders, police or new people in the facility with care plan interventions to include frequent check-ins, and providing distractions via activities or engagement. While awaiting EMS response to Resident #1's needs, staff engagement with Resident #3 was not observed as outlined in his/her care plan. At approximately 11:20 AM on 10/18/23 a smoke detector was observed to be sounding. While enquiring about the sounding alarm kitchen staff	R178		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0177	A. BUILDING: _____ B. WING _____	10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW COMMUNITY CARE HOME	322 ST PAUL STREET BURLINGTON, VT 05401

(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
R178	Continued From page 3 was questioned and responded, "No, I am not sure where it is". On further investigation the smoke detector was observed by the survey team to be alarming on the second floor of the home. On entry to the second floor Resident #4, was observed leaving his/her room; and the survey team identified Resident #4's room as the source of the alarm. Resident #4's care plan indicates s/he is nicotine dependent. After observing approximately eight minutes of the alarm sounding without staff response the surveyor returned to the first floor of the facility to investigate the failure to respond. On returning to the first floor no staff were observed to be present in resident rooms or common areas, and efforts were not being made to address the sounding alarm of the smoke detector. Despite the sounding of a smoke alarm, staff were observed to be located in the nurse's office behind a closed door. When the Surveyor stepped into the staff office the sounding alarm was observed to be inaudible. Per record review of the facility's policy and procedure titled Health, Safety and Security (HSS) states, The HSS team is responsible for establishing and maintaining health, security, and safety related policies and programs and for oversight and support of Building. Per observation on 10/18/23 there was a lack of supervision and oversite utilized to prevent health, security, and safety related emergencies. During an interview on the afternoon of 10/19/23 the Manager of the facility was asked about the facility's policy and procedure for facility rounding and monitoring. The Manager replied "We have times for safety rounding, but no we do not have a policy that a staff member be present within resident areas at all times". The Manager	R178		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0177	A. BUILDING: _____ B. WING _____	10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW COMMUNITY CARE HOME	322 ST PAUL STREET BURLINGTON, VT 05401

(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
R178	Continued From page 4 confirmed that when the smoke detector was alarming during the survey the previous day staff on duty were all located in the nursing office behind a closed door.	R178		
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	R179	R179 Accepted. Sherry Ross, RN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0177	A. BUILDING: _____ B. WING _____	10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW COMMUNITY CARE HOME	322 ST PAUL STREET BURLINGTON, VT 05401

(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 was a failure to ensure 5 out of 5 sampled staff completed all required yearly trainings. Findings include: Per review staff training records it was noted that 5 out of 5 staff that provide direct patient care did not complete all the required yearly training to include: resident rights, fire safety and emergency evacuation, resident emergency response procedures, such as the Heimlich maneuver, accidents, police, or ambulance contact and first aid, policies, and procedures regarding mandatory reports of abuse, neglect and exploitation, respectful and effective interaction with residents, general supervision, and care of residents. This was confirmed by the Manager on 10/19/2023 during exit interview.	R179		
R228 SS=D	VI. RESIDENTS' RIGHTS 6.16 Residents have the right to formulate advance directives as provided by state law and to have the home follow the residents' wishes This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the Residential Care Home (RCH) failed to ensure the resident right to formulate advanced directives. Findings include: Based on record review and staff interview conducted on the afternoon of 10/18/23 it was noted that advanced directives could not be located within the resident's record and without	R228	R228 Accepted. Sherry Ross, RN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0177	A. BUILDING: _____ B. WING _____	10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW COMMUNITY CARE HOME	322 ST PAUL STREET BURLINGTON, VT 05401

(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
R228	Continued From page 6 notation that the resident declined to obtain advanced directives. This was confirmed by the facility Manager at the time of finding stating" To be honest some of our residents do not have advanced directives because the last manager did not obtain them. This has been on my list of things to work on".	R228		
R247 SS=D	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 staff interview and record review there was a failure to ensure all perishable food and drinks were labeled and dated. Findings include: During a tour of the facility kitchen and food service areas commencing at 9:45 AM on 10/18/23 the following perishable food items were observed to be improperly stored. In the refrigerator, multiple items were not labeled with the dates they were opened. These items include a gallon of milk, a premade pitcher of iced tea, a container of sour cream, a 3oz container of grape jelly, a 24oz container of grated parmesan cheese, a 28oz Italian dressing, 4 16oz containers of salad dressing, a 10oz container of relish, a 11.5oz container of mayonnaise, 3 12oz containers of mustard, a 1/2 gallon of half and half, a 24oz container of feta crumbles, a 1/2	R247	R247 Accepted. Sherry Ross, RN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0177	A. BUILDING: _____ B. WING _____	10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW COMMUNITY CARE HOME	322 ST PAUL STREET BURLINGTON, VT 05401

(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 gallon of orange juice, a 64oz container of apple juice, a 48oz container of salsa, and a 52oz container of olives. This was confirmed by the facility Team Lead at the time of finding.	R247		
R266 SS=D	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the RCH failed to provide care in a safe, functional, homelike environment. Findings include: During the facility tour commencing at 9:45 AM the baseboard heater located in the hallway outside the nursing station was noted to be in disrepair with exposed edges, additionally the baseboard heater located under the dining room table where a resident's feet would be while eating was noted to be in disrepair with exposed edges. This observation was confirmed by the facilities Team Lead at the time of finding.	R266	R226 Accepted. Sherry Ross, RN	
R270 SS=D	IX. PHYSICAL PLANT 9.2 Residents' Rooms 9.2.c Each bedroom shall have an outside	R270	R270 Accepted. Sherry Ross, RN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0177	A. BUILDING: _____ B. WING _____	10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW COMMUNITY CARE HOME	322 ST PAUL STREET BURLINGTON, VT 05401

(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
R270	Continued From page 8 window. (1) Windows shall be openable and screened except in construction containing approved mechanical air circulation and ventilation equipment. (2) Window shades, venetian blinds or curtains shall be provided to control natural light and offer privacy. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure window screens were in good repair in one resident room. Findings include: Per observation during the facility tour commencing at 9:45 AM the screen in resident room #6 was observed to be bent bowing outwards leaving the bottom of the window exposed. This was confirmed by the Manager during an interview with the Manager of the home on 10/19/23.	R270		
R284 SS=D	IX. PHYSICAL PLANT 9.4 Recreation and Dining Rooms 9.4.c Dining rooms shall be of sufficient size to seat and serve all residents of the home at the same time. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure the dining room was of sufficient size with seating to accommodate all	R284	R284 Accepted. Sherry Ross, RN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0177	A. BUILDING: _____ B. WING _____	10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW COMMUNITY CARE HOME	322 ST PAUL STREET BURLINGTON, VT 05401

(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
R284	Continued From page 9 residents of the home at the same time. Findings include: During the facility tour commencing on 10/18/23 at 9:45 AM, the facility dining room was observed to have three dining tables with seating for six residents in total. On 10/18/23 the facilities' current resident census was fourteen residents. Per interview with the facility Manager on the afternoon of 10/19/23, s/he confirmed this finding stating, "We moved out the other chairs during Covid and have never put them back in the dining room".	R284		
R303 SS=F	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 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 facility tour with the facilities Team lead commencing at 9:45 AM on 10/18/23 an absence of a telephone with emergency number posted was observed on the second floor of the facility. This observation was confirmed by the Manager	R303	R303 Accepted. Sherry Ross, RN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0177	A. BUILDING: _____ B. WING _____	10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW COMMUNITY CARE HOME	322 ST PAUL STREET BURLINGTON, VT 05401

(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
R303	Continued From page 10 during exit on 10/19/23.	R303		

HOWARD CENTER
Help is here.

Pamela M. Cota, RN
Licensing Chief
Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 054671-2306

January 5th, 2024

Dear Ms. Cota:

Below is the revised plan of correction for each deficiency cited during the re-licensing survey at the Lakeview Community Care Home of Howard Center that took place on October 18th, 2023.

R178 – 5.11.a

What action you will take to correct the deficiency: Manager and Program RN will review nursing care plans and resident plans of care for residents cited in tag with program staff during 11/22/23 staff meeting, allowing time for discussion, comprehension questions, and suggestions for improvement based on staff observation of resident behavior. Time will also be taken during this staff meeting to discuss situational awareness specifically at Lakeview as staff move about the facility performing their duties. Staff will be reminded to investigate any unusual sounds or noises, and if unable to do so (due to providing care for another resident, for instance) to notify another staff person or program leadership immediately. Howard Center is also currently developing a new Worker Safety Training for staff that among several topics will cover situational awareness and response in the workplace. Once this training is live, we will complete this as a team during team meeting. Program RN has also updated our Medication Administration Handbook and Procedure Guide, which includes information around emergency response (to medical events). All staff will be required to read this guide and updates to the guide will be highlighted during 11/22/23 staff meeting. Staff will continue to perform and document resident safety checks and hall checks at established times or at increased intervals PRN at direction of Program Manager and/or Program RN. Supervisor will monitor staff presence/engagement in the facility and provide in-the-moment guidance and schedule additional supervision as needed to support staff in performing their duties.

The noted issue with the smoke detector was resolved on the date of the survey pursuant to a required immediate plan of correction (posted on-site): Facilities had been contacted via several channels while surveyors were on site, with follow-up from Program Manager at approximately 4:30PM after they had not yet arrived on site to replace the smoke detector. Facilities staff were on site to replace the smoke detector at approximately 5:30PM (it had malfunctioned). At that time they identified another smoke detector in a resident room that was nearing its expiration date and they replaced it the following day. Facilities Staff and Fire Marshall provided Program Manager with more technical knowledge/understanding of how different parts of our fire suppression system work to improve communication with people not familiar with the system in our building. The Fire Marshall and their team were on site the following day to check our system and observe a practice fire drill; they reported that the building is up-to-code.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: Reviewing all resident nursing care plans and resident plans of care will be a part of on-boarding all new staff, as will reading the Medication Administration Handbook and Procedure Guide (both upon hire and when staff are preparing for medication delegation). Nursing care plans will be reviewed by RN at least annually and any time there is a change in client status to ensure they are up to date and include care and services necessary for each resident. Resident plans of care will be reviewed by Program Manager on the same annual schedule and with any changes in resident status. Updated plans will be reviewed during staff meetings so that staff are aware of changes. The Worker Safety Training will become a required training for all Howard Center staff.

How the corrective actions will be monitored so the deficient practice does not recur: RN will review nursing care plans at least annually and any time there is a change in client status. RN will maintain a record of dates nursing care plans were reviewed and the next time they need to be reviewed. Program Manager will review resident plans of care at least annually and any time there is a change in client status. RN and Program Manager will continue to collaborate to ensure that all information necessary for appropriate care and support is covered in these complimentary documents. Program Manager will provide supervision to staff in group and individual settings to ensure understanding of and compliance with plans so that residents are receiving appropriate care and monitoring without infringing on their rights. Staff will receive on-going guidance during individual supervision meetings, supervision in the course of work, and staff meetings around documentation of the

services and supports provided to residents, both related to normal patterns of behavior and emergency situations.

The dates corrective action will be completed: 11/27/2023, and within two weeks of availability of Worker Safety Training.

R179 – 5.11.b

What action you will take to correct the deficiency: All staff were notified of this deficiency and the need for action on all overdue Agency trainings during a staff meeting on 11/8/2023. Program Manager emailed all staff individually with a personalized list of trainings due with a required completion date of 11/27/2023. For any in-person Agency training not available during that timeframe, staff will be required to have signed up for the next available training. Program Manager will look at all staff training histories via our Mastery Institute system to monitor progress on 11/22/2023. This is a scheduled event in their calendar.

Additionally, it was observed that some trainings that are required to be completed through the Relias training website (such as our Medication Administration training module) were completed by staff but that was not accurately reflected in the Mastery Institute. Program Manager will assist staff where this situation applies so that their training status in our training system is correct.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: Agency policy requires compliance in regard to completing all required trainings. Supervisors and staff will both receive email notifications a month before trainings are due. Program Manager and Team Lead will provide new staff with a training schedule with required due dates for all trainings upon starting work as part of on-boarding. Program Manager and Team Lead will support all staff with accessing trainings (via assistance with technology, ensuring that they have interpretation services if needed, and changing work schedules to accommodate in-person training times). Program Manager will complete a quarterly review of Master Institute records for all staff and communicate with staff individually about trainings due in the upcoming quarter. This is a scheduled event in their calendar.

How the corrective actions will be monitored so the deficient practice does not recur: Program Manager will complete a quarterly review of Master Institute records for all staff, and

communicate with staff individually about trainings due in the upcoming quarter. This is a scheduled event in their calendar.

The dates corrective action will be completed: 11/27/2023

R228 – 6.16

What action you will take to correct the deficiency: Advance Directives, or signed forms indicating declination by the resident or guardian, will be kept on file in the staff office and in electronic format in our EHR (Credible). Residents received information about Advance Directives in their initial Resident Agreement; Program Manager will review the Advance Directive section of the agreement and update language as needed to reflect this requirement.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: New residents to the program will either need to have an Advance Directive in place or indicate via a signed form that they declined to have one prior to establishing residency. Howard Center Care Managers are required to gather information and offer assistance with Advance Directives on an annual basis, so Program Manager will collaborate with Care Manager to ensure that this process is in place for our residents and that Care Manager and Program Manager are effectively sharing information about resident Advance Directives as needed.

How the corrective actions will be monitored so the deficient practice does not recur: Annual review of forms/provision of information about Advance Directives to be completed by Care Manager. Program Manager or other leadership will audit EHR and on-site files to ensure compliance.

The dates corrective action will be completed: 11/27/2023

R247 – 7.2

What action you will take to correct the deficiency: All perishable items not labeled/dated were removed. Program Manager met with program cooks to discuss this deficiency. Program Manager will review all signage in kitchen related to labeling/food safety practices. This deficiency will be reviewed during a staff meeting so that all program staff understand the

need for labels. Program Manager will update daily kitchen chore list to include disposal of unlabeled/undated items.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: Assistant Director of Residential Programs for Howard Center is currently working on identifying a general food safety training module for residential staff. Cooks will report instances of disposing unlabeled perishable items to Program Manager so that additional supports and education can be provided to staff directly.

How the corrective actions will be monitored so the deficient practice does not recur: Program Manager will conduct monthly audit of labels/dates on items in the refrigerators and freezers. This is a scheduled event in their calendar.

The dates corrective action will be completed: 11/27/2023, and within two weeks of selection of appropriate food safety training

R266 – 9.1.a

What action you will take to correct the deficiency: Staff implemented a temporary solution – affixing the baseboard heater caps with electrical tape – until our Facilities team identified and implemented a longer-term solution (using screws to affix end caps).

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: A job order was placed on 11/9/23 requesting assistance our Facilities team. If we have further issues with end caps falling off and creating a hazard, we will submit additional job orders immediately upon discovery.

How the corrective actions will be monitored so the deficient practice does not recur: Program Manager and Team Lead will add baseboard heater checks to monthly safety checklist.

The dates corrective action will be completed: Completed.

R270 – 9.2c

What action you will take to correct the deficiency: Program Manager toured the facility on 11/13 and identified all rooms with window screens in need of repair. Job orders were submitted to our Facilities Team on 11/14/23.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: Resident rooms are accessed on a weekly basis (at minimum) for cleaning and gathering laundry. Staff will be directed to notify Program Manager immediately if they observe any issues with window screens. If issues are observed we will submit additional job orders immediately upon discovery.

How the corrective actions will be monitored so the deficient practice does not recur: Program Manager and other leadership will tour facility (via participating in daily activities/routines and/or inspections) on a regular basis.

The dates corrective action will be completed: 11/20/2023

R284 – 9.4

What action you will take to correct the deficiency: Chairs had been removed from the dining room as a result of DLP guidance during COVID (to shape the environment to promote social distancing where possible). Additional chairs were on site and have been relocated back to the dining room from storage.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: Chairs had been removed due to pandemic guidelines; they will not be removed again unless we receive guidance to do so in the future.

How the corrective actions will be monitored so the deficient practice does not recur: Program Manager and other leadership will tour facility (via participating in daily activities/routines and/or inspections) on a regular basis.

The dates corrective action will be completed: Completed.

R303 – 9.11

What action you will take to correct the deficiency: Emergency numbers will be posted in upstairs area. A job order will be placed with our Facilities team to install a small shelf for a portable phone unit connected to our resident phone line. Portable phone unit is already on-site. Program Manager will purchase a shelf and identify a safe location for shelf installation by 11/17/23.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: Once the shelf is installed and phone placed, signage will be posted directing residents to not remove phone from the upstairs area/return it to the docking station when not in use. Staff will be asked to return phone to upstairs docking station as they move around the house completing their duties.

How the corrective actions will be monitored so the deficient practice does not recur: Program staff and leadership will monitor location of phones when working in the facility.

The dates corrective action will be completed: 11/27/2023

Please reach out if you have any additional questions.

Sincerely,

LICSW

Patricia Bauerle, Senior Manager
Lakeview Community Care Home
322 Saint Paul Street

Howard Center
300 Flynn Ave
Burlington, VT 05401

pbauerle@howardcenter.org
802-343-2267