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 25, 2023

Ms. Meagan Buckley, Manager
Linden Residential Care
200 Wake Robin Drive
Shelburne, VT 05482

Dear Ms. Buckley:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 7, 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.

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
	0252	A. BUILDING: _____ B. WING _____	C 02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN RESIDENTIAL CARE	200 WAKE ROBIN DRIVE SHELBURNE, VT 05482

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R100	Initial Comments: The Division of Licensing and Protection conducted an unannounced on-site relicensure survey and investigation of 4 facility reported incidents on 2/6/23 and 2/7/23. The following regulatory deficiencies were identified related to the relicensure survey and investigation: V. RESIDENT CARE AND HOME SERVICES 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: Per observation, record review and staff interview there was a failure to ensure medication administration consistent with physician's orders. Findings include: Residents #4's physician ordered "Warfarin Sodium 3 mg tablet by mouth 2 x week. Monday Wednesday." His/her Medication Administration Record (MAR) on 2/6/23 states "Warfarin Sodium 3 mg tablet by mouth 2 x week. Monday Wednesday." To be administered in the morning (AM). A facility nurse was observed administering Resident #4's Warfarin at 2:21 PM on 2/6/23. On the afternoon of 2/6/23 and again on the morning of 2/7/23 it was observed Resident #4's health record did not include an order from his/her physician allowing the late administration of Warfarin on the afternoon of 2/6/23. On the morning of 2/7/23 the Director of Nursing	R100 R128	R128 Physician was notified of late medication administration for resident #4. Education will be provided to nurses of the requirement to obtain an order from a resident's physician to change the time of administration of medications. Random audits of resident medication administration records will be completed weekly x3 months by the DNS or designee to monitor effectiveness of this plan. After 3 months the DNS and Director of Health & Resident Services (DHRS) will determine the continued duration of the audits. Corrective action will be completed by 3/24/23.	

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R128	Continued From page 1 (DON) acknowledged Resident #4's Warfarin was given beyond the morning administration time, and without a physician's order for late administration.	R128	**Tag R128 POC accepted on 4/24/23 by J. Evans/P. Cota**	
R144 SS=D	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 record review and staff interview the Registered Nurse failed to complete Resident Assessments in accordance with Vermont State Residential Care Home Regulations section 5.7 effective October 3, 2000 to include admission assessments completed within 14 days of admissions, and reassessments annually and when there were significant changes in physical and mental condition for one applicable resident (Resident #3). Findings include: Per interview with the Director of Nursing (DON) commencing at 9:27 AM on 2/7/23 Resident #3 was admitted to the Residential Care Home (RCH) on 11/12/21 and 1/6/22 for brief stays, followed by an admission on 1/18/22 which the DON described as "permanent". Additionally Resident #3 was hospitalized 6/2/22 - 6/5/22; and again 11/28/22 - 12/7/22 due to significant changes in physical condition including decline in cardiac health and urosepsis requiring monitoring, medication changes, and treatment.	R144	R144 Resident #3 assessments are all up to date. Education to be provided to RNs regarding the completion of resident assessments. Random resident medical record audits will be conducted every two weeks x3 months by DNS or designee to monitor effectiveness of this plan. After 3 months, the DNS and DHRS will determine the continued duration of the audits. Corrective Action will be completed by 3/24/23. **Tag R144 POC accepted on 4/24/23 by J. Evans/P. Cota**	

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R144	Continued From page 2 Per record review Resident Assessments were signed as complete for Resident #3 on 12/12/22 and 7/18/22. During the interview commencing at 9:27 AM on 2/7/23 the DON; and the Nurse Manager who joined the interview briefly clarify the dates of Resident #3's admissions and hospitalizations; confirmed Resident Assessments were not completed for Resident #3 within 14 days after each admission to the facility, annually, and when there were significant changes in his/her physical condition.	R144		
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 record review and staff interview the Manager failed to ensure all medications are handled according to the home's polices and procedures. Findings include: The home's Medication Self - Administration policies and procedures effective September 2021 state .it is the responsibility of a Nurse to determine that the resident is capable to safely manage the medications; and to determine if a resident is capable of self-medication management and/ or participating in the self-medication administration process."	R161	R161 Nurses will be educated on the policy and procedure to determine if a resident meets the criteria to be approved to self-administer their medications. The resident self-medication assessments of all residents currently approved to be able to self-administer medications will be reviewed by the RN nurse supervisor and DNS to determine if the resident meets the criteria to self-administer medications. Resident self-medication assessments and care plans will be updated with any changes following this review.	

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R161	Continued From page 3 The Vermont State Resident Assessment form effective 4/1/09 states if a resident has problems taking medications as instructed/prescribed; does not know what his/her medication is for and how often to take medications; and/or is unable to communicate the desired effect of medication or unintended side effects of medications then the resident needs medication administration. 1. Per review of annual Comprehensive Self Med Assessments for January of 2023 completed by the Nurse Manager of the home, 6 applicable residents (Residents #2, #8, #9, #10, #11, and #12) did not meet the Vermont State Resident Assessment Form criteria for medication administration, however the were approved for medication self-administration at the home. *On 1/11/23 Resident #2 reported to staff unsecured medications in his/her apartment were missing and presumably stolen. On 1/17/23 Resident #2's Comprehensive Self Med Assessment noted Resident #2 to be "able to recognize hazards of letting meds unattended" and "is able to self-administer medications." On 2/7/23 Resident #2 and the Assistant Administrator confirmed Resident #2 continues to store self-administered medications in an unlocked kitchen cabinet and/or in his/her bathroom and does not lock his/her apartment door. *Resident #8 was noted to be unable to state the proper dosage and common side effects of his/her medication; s/he missed medication doses; and had "some confusion" related to the use of a PRN medication. His/her medications are prepared by a nurse and placed in a pill box once a week.	R161	DNS or designee will conduct a second review of resident self-medication assessments completed by nurses x3 months to monitor compliance with this plan. After 3 months, the DNS and DHRS will determine the continued duration of the audits. Staff will be educated regarding Linden Residential Care's policy regarding storage of medications. Residents approved to self-administer medications will be educated that medications need to be secured (locked) as part of the criteria to be approved to continue to self-administer medications. All other residents for whom staff are responsible to administer medications will also be educated that their medications need to be secured in their home.	

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R161	Continued From page 4 * Resident #9 was noted to have difficulty remembering the names and strength of his/her medications; and does not know what his/her medications are intended to treat and the potential side effects of the medications. His/her medications are prepared by a nurse and placed in a pill box once a week * On 1/17/23 Resident #10 stated "I messed up the pill box" filled by nursing once weekly for "self-administration". Sections of the pill box for four medication times were noted to require correction by staff. While it was determined Resident #10 was unable to self-administer medications prepared and placed in a pill box by nursing staff for morning and evening medications, nursing staff continued to approve of "self-administration" of a midday medication for Resident #10. * Resident #11 was noted to be unable to state the common side effects of his/her medications and to store his/her medications in a Ziplock bag on his/her desk. S/he was approved to self administer medications with documentation of no safety concerns by the Registered Nurse. * Resident #12 was noted to "save up meds to take as needs or take doses at unscheduled times" and to "take all [medications] in the AM so she does not forget". S/he was approved to "self-administer" medications "on his/her own every day". His/her medications are prepared by a nurse and placed in a pill box filled once a week On the afternoon of 2/6/23 the Nurse Manager confirmed Residents #2, #8, #9, #10, #11, and #12 were approved to self-administer medications. On the afternoon of 2/7/23 the Assistant Administrator and Administrator	R161	Nurse supervisor or designee will randomly audit the identified means by which residents approved to self-administer medications have chosen to secure their medications weekly x3 months to monitor the effectiveness of this plan. After 3 months, the DNS and DHRS will determine the continued duration of the audits. Corrective action will be completed by 3/24/23. **Tag R161 POC accepted on 4/24/23 by J. Evans/P. Cota**	

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R161	Continued From page 5 acknowledged the self-administration of medications when there is evidence the approved residents do not meet criteria for self-administration. 2. The home's Medication Self - Administration policies and procedures effective September 2021 state "Residents who self-administer medications are encouraged to use the medication cabinets in their home for storage of medications but may choose to store medications in other secure locations in their home". On the morning of 2/6/23 medications were observed to be unsecured in Resident's #5 and #7"s apartments; and on the morning of 2/7/23 medications were observed to be unsecured in Resident #2's apartment. On the afternoon of 2/7/23 the Assistant Administrator and Administrator acknowledged medications are unsecured in resident's apartments.	R161	R162 The Benadryl was removed from the home of Resident #2. Nurses and CRCAs will be educated that physician orders are required to assist with or administer any medication, to include over-the-counter medications. Nurse supervisor or designee will speak with each resident in an effort to identify over-the-counter medications in their home and educate residents that a physician's order is required for nursing to assist with or administer over-the-counter medications. A monthly memo will be provided to residents x3 months to remind them to let staff know if they purchased over-the-counter medications.	
R162 SS=D	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 signed medication orders for one medication for one applicable resident (Resident #2). Findings include;	R162		

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R162	Continued From page 6 At 9:30 AM on 2/7/23 a foil pack of Benadryl and sealed box of Benadryl were observed in the apartment of Resident #2 for which there were no orders listed in the resident's record. At 2:50 PM on 2/7/23 Registered Nurse confirmed there were no signed physician's order for Benadryl for Resident #2.	R162	Nurse supervisor or designee will conduct random audits with residents weekly x3 months to monitor the effectiveness of this plan. After 3 months, the DNS and DHRS will determine the continued duration of the audits. Corrective action will be completed by 3/24/23. **Tag R162 POC accepted on 4/24/23 by J. Evans/P. Cota**	
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: Based on staff interview and record review the Registered Nurse failed to delegate the responsibility for medication administration to 4 staff (Staff #3, #4, #5, and #6) responsible for medication administration to designated residents. Findings include: Per record review 4 out of 10 staff responsible for medication administration at the Residential Care Home had not been delegated by the Registered Nurse responsible for this task. On the afternoon of 2/6/23 the Assistant Administrator and Nurse Manager confirmed Staff #3, #4, #5, and #6 had not been delegated to administer medications by	R164	R164 The RN Supervisor responsible to delegate the responsibility for the administration of specific medications to designated staff for designated residents has been educated on the requirement specific to medication delegation. The RN supervisor responsible to delegate the responsibility for medication administration will do so for staff #3, #4, #5 and #6.	

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R164	Continued From page 7 the current Registered Nurse.	R164	The DNS or designee will audit the Nurse Supervisor's delegation of medication administration assessments x3 months to determine the effectiveness of this plan. . After 3 months, the DNS and DHRS will determine the continued duration of the audits. Corrective action will be completed by 3/24/23. **Tag R164 POC accepted on 4/24/23 by J. Evans/P. Cota**	
R173 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h. (1) Resident medications that the home manages must be stored in locked compartments under proper temperature controls. Only authorized personnel shall have access to the keys This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview there was a failure to ensure medication for 2 applicable residents (Resident #5, and Resident #7) were stored in a locked compartment accessible only to authorized staff. Findings include: During the tour of the facility commencing at 9:40 AM, on 2/6/23 Triamcinolone Cream was observed to be stored unsecured in Resident #5's bathroom; and a pill box containing Resident #7's self administered medications was observed to be stored unsecured on his/her kitchen countertop. During the facility tour on the morning of 2/6/23 the Assistant Administrator acknowledged the observation of unsecured medications stored in Resident #5 and #7's apartments.	R173	R173 Nurses and CRCAs will be educated on the requirement regarding medication management specific to storing medication in locked compartments. Resident #5 and resident #7 medications have been secured. The Nurse Supervisor or designee will ensure that medications that Linden Residential Care manages are stored in locked compartments.	

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R175	Continued From page 8	R175	The DHRS or designee will randomly audit resident homes x3 months to monitor the effectiveness of this plan. After three months, the DHRS and DNS will determine the continued duration of these audits. Correction action will be completed by 3/24/23. **Tag R173 POC accepted on 4/24/23 by J. Evans/P. Cota** R175 Linden Residential Care is able to provide residents capable of self-administration of their medications with a secure storage space to prevent unauthorized access to their medications. Resident #2's medications are located in a secure storage space in their home. Staff will be educated regarding Linden Residential Care's policy regarding storage of medications.	
R175 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (3) Residents who are capable of self-administration may choose to store their own medications provided that the home is able to provide the resident with a secure storage space to prevent unauthorized access to the resident's medications. Whether or not the home is able to provide such a secured space must be explained to the resident on or before admission. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and record review there was a failure to ensure medications belonging to one applicable resident (Resident #2) who self administers medications are stored in a secured storage space to prevent unauthorized access. Findings include: Per record review, on 1/11/23 Resident #2 reported a bottle of Sertraline 50 mg tablets was missing from his/her apartment and presumed to have been stolen. At 9:10 AM on 2/7/23 Resident #2 confirmed s/he stores self administered medications in an unlocked kitchen cabinet and/or in his/her bathroom. Resident #2 stated "I don't lock them up in that thing" while pointing to the facility provided locked medication cabinet. Resident #2 also confirmed s/he does not lock his/her door when leaving the apartment, and leaves the apartment door ajar when s/he is in the	R175		

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R175	Continued From page 9 apartment. At 3:02 PM on 2/7/22 the Assistant Administrator confirmed Resident #2 stores his/her medications in an unlocked cupboard, and often leaves his/her apartment door unlocked.	R175	Residents approved to self-administer medications will be educated that medications need to be secured (locked) as part of the criteria to be approved to continue to self-administer medications. Nurse supervisor or designee will randomly audit the identified means by which residents approved to self-administer medications have chosen to secure their medications weekly x3 months to monitor the effectiveness of this plan. After 3 months, the DNS and DHRS will determine the continued duration of the audits. Corrective action will be completed by 3/24/23. **Tag R175 POC accepted on 4/24/23 by J. Evans/P. Cota**	
R179 SS=D	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	R179	R179 Department Directors have been educated on annual education requirements. Staff #1 will complete annual training.	

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R179	Continued From page 10 by: Based on record review and staff interview there was a failure to ensure 1 out of 6 sampled staff completed all required yearly trainings. Findings include: Per record review one applicable staff (Staff #1) had not completed the required yearly including Resident Rights; Resident Emergency Response Procedure, Mandatory Reports of Abuse, Neglect and Exploitation; Respectful and Effective Interaction with Residents; Infection Control Measures, and General Supervision and Care of Residents. On the afternoon of 2/7/23 the Assistant Administrator confirmed Staff #1 had not completed all required yearly trainings since 2017.	R179	Nurse educator and department directors, managers, and supervisors will track and support education of staff to meet annual training requirements. Staff educational records will be audited, at minimum, at quarter 3 of the calendar year to monitor effectiveness of this plan. Corrective action will be completed by 3/24/23. **Tag R179 POC accepted on 4/24/23 by J. Evans/P. Cota**	
R190 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to complete criminal and abuse background checks for one applicable staff (Staff # 2). Findings include: At 3:15 PM on 2/7/23 the Director of Human Resources confirmed criminal record and adult abuse registry checks for Staff #1 were not completed for the employee's current contracted	R190	R190 The Human Resources Director has reviewed and understands the regulatory requirement regarding criminal record and abuse registry background checks for staff. Background checks for Staff #2 are up to date. All contracted nursing staff employee files will be audited to ensure compliance.	

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R190	Continued From page 11 employment period.	R190	Wake Robin will coordinate with contracted staffing agencies to secure updated criminal and abuse registry background checks prior to the commencement of each contracted employee's employment period or Wake Robin will secure the criminal record and abuse registry background checks on its own. HR Director or designee will audit contracted employee files x3 months to monitor effectiveness of this plan. After 3 months, HR Director and DHRS will determine the continued duration of the audits. Corrective action will be completed by 3/24/23. **Tag R190 POC accepted on 4/24/23 by J. Evans/P. Cota**	
R206 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.a The licensee and staff shall report any case of suspected abuse, neglect or exploitation to the Adult Protective Services (APS) as required by 33 V.S.A. §6903. APS may be contacted by calling toll-free 1-800-564-1612. Reports must be made to APS within 48 hours of learning of the suspected, reported or alleged incident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to report suspected cases of exploitation of one applicable resident(Residents # 2) within 48 hours of learning of the suspected incident. Findings include: Per record review Resident #2 reported a bottle of medication was missing from his/her room to staff on 1/11/23 and stated s/he thought someone had taken the medications. There was a failure to report the incident to the Adult Protective Services until 1/16/22, which was acknowledged by the Assistant Administrator and the Administrator on the afternoon of 2/7/23.	R206	R206 Staff will be educated about the Adult Protective Services (APS) reporting timeframe requirement.	
R207 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.b The licensee and staff are required to	R207		

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R207	Continued From page 12 report suspected or reported incidents of abuse, neglect or exploitation. It is not the licensee's or staff's responsibility to determine if the alleged incident did occur or not; that is the responsibility of the licensing agency. A home may, and should, conduct its own investigation. However, that must not delay reporting of the alleged or suspected incident to Adult Protective Services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to report suspected cases of exploitation of two applicable residents (Residents #1 and #2) to the Division of Licensing and Protection in a timely manner. Findings include: Resident #1 reported the theft of $80 from his/her apartment on 1/4/23. The incident was not reported to the Division of Licensing and Protection until 1/10/23. Resident #2 reported a bottle of medication was missing from his/her room to staff on 1/11/23 and stated she thought someone had taken the medications. There was a failure to report the incident to the Division of Licensing and Protection until 1/17/22. Delays in reporting of suspected exploitation of Resident's #1 and #2 to the Division of Licensing and Protection were acknowledged by the Assistant Administrator and the Administrator on the afternoon of 2/7/23.	R207	The DHRS or designee will audit reports made to APS x3 months to monitor effectiveness of this plan. After 3 months, The DHRS will determine the continued duration of audits. Correction action will be completed by 3/24/23. **Tag R206 POC accepted on 4/24/23 by J. Evans/P. Cota** R207 Staff will be educated on the requirements for reporting suspected or reported incidents of abuse, neglect or exploitation to the Division of Licensing & Protection (DLP). The DHRS or designee will audit reports made to DLP x3 months to monitor the effectiveness of this plan. After 3 months, the DHRS will determine the continued duration of audits. Corrective action will be completed by 3/24/23. **Tag R207 POC accepted on 4/24/23 by J. Evans/P. Cota**	
R230 SS=C	VI. RESIDENTS' RIGHTS	R230		

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R230	Continued From page 13 6.18 The enumeration of residents' rights shall not be construed to limit, modify, abridge or reduce in any way any rights that a resident otherwise enjoys as a human being or citizen. A summary of the obligations of the residential care home to its residents shall be written in clear language, large print, given to residents on admission, and posted conspicuously in a public place in the home. Such notice shall also summarize the home's grievance procedure and directions for contacting the Ombudsman Program and Vermont Protection and Advocacy, Inc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to post the home's grievance procedures in a pubic place in the home. Findings include: During the environmental tour commencing at 9:32 AM on 2/6/23 it was observed and confirmed by the Assistant Administrator the home's grievance policy was not posted in a public place in the home.	R230	R230 Linden Residential Care's grievance procedure will be posted in a public space. Corrective Action will be completed by 3/24/23. **Tag R230 POC accepted on 4/24/23 by J. Evans/P. Cota**	
R236 SS=F	VII. NUTRITION AND FOOD SERVICES 7.1.a. (5) The home shall keep menus, including any substitutions, for the previous month on file and available for examination by the licensing agency. This REQUIREMENT is not met as evidenced by: Based on staff interview there was a failure to maintain record of meal substitutions on file and	R236	R236 Dining staff will be educated on the requirement to keep menus, including substitutions, for the previous month on file and available for review. Dining services will put in place a system to maintain a record of menu substitutions that will be available for review as requested. The Dining Services General Manager or designee will conduct random weekly audits of records of menu substitutions x3 months to monitor the effectiveness of this plan. After 3 months, the Dining Services Director and DHRS will determine the continued duration of audits.	

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R236	Continued From page 14 available for examination by the licensing agency. Findings include: During the course of the facility tour commencing at approximately 9:40 AM on 2/6/23 the General Director of Dining Services confirmed a record of meal substitution is not maintained and available for review at the facility.	R236	Correction action will take place by 3/24/23. **Tag R236 POC accepted on 4/24/23 by J. Evans/P. Cota**	
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 label and date all perishable food items. Findings include: During a tour of the facility kitchen and food service areas commencing at 9:40 AM on 2/6/23 the following unlabeled and undated perishable food items were observed and confirmed by the General Director of Dining Services. * In the service area refrigerator: Six opened containers of ice cream, and an opened half gallon container of chocolate milk without dates indicating when they were opened. *In the kitchen reach in refrigerator # 2: Two half gallon containers of milk and a quart of heavy	R247	R247 Dining staff will be educated on the requirement for properly labeling, dating, and packaging/wrapping all perishable food and drink items. Examples cited under R247 have were corrected. The Dining Services General Manager or designee will conduct random audits the facility kitchen and food service areas weekly x3 months to monitor the effectiveness of this plan. After 3 months, the Director of Dining Services and the DHRS will determine the continued duration of audits. Corrective action will be completed by 3/24/23. **Tag R247 POC accepted on 4/24/23 by J. Evans/P. Cota**	

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R247	Continued From page 15 cream without dates indicating when they were opened. Several unwrapped baking trays of uncooked muffin batter and 6 stacked trays of raw bacon covered only with pieces of wax paper were without dates and labels indicating what was stored in the trays. *In the walk in refrigerator : undated opened containers of beef and chicken base, pureed ginger, prepared horseradish, and red curry paste. *In the kitchen freezer:: undated opened unsealed bags of mixed vegetables and hamburger patties, a container of pie crusts, and a bag of what appeared to be veggie burgers . * In the dry goods storage area: undated opened bags of brown rice, quinoa, and crispy fried onions.	R247	R266 Dining staff will be educated on the provision and maintenance of a safe, functional, and sanitary environment. The environmental concerns noted under number two (2.) in R266 have been corrected. The DNS or designee will conduct random interviews weekly with dining services staff x3 months regarding their role in response to resident emergencies to monitor effectiveness of this plan. The Dining Services General Manager or designee will conduct random weekly audits x3 months of the kitchen, food service areas, and dining room to monitor the effectiveness of this plan. After 3 months, the Dining Services Director and DHRS will	
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 and staff interview there was a failure to maintain a safe, functional, sanitary environment. Findings include: 1. During observation of lunch service in the dining room on 2/7/23 at approximately 11:50 AM	R266		

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R266	Continued From page 16 two Surveyors observed staff (Staff #1) approach Resident #7 who was seated at a table, then walk away from him/her. Another resident seated at the table then stood up, approached Resident #7, and began to pat him/her on the back. There were two additional staff in the dining room who continued serving other residents. At this point both Surveyors approached Resident #7 and observed him/her in a hunched over position and attempting to cough with a reddened face and audible abnormal breathing sounds indicative of choking. Staff #1 returned to the table, stated to Surveyors "I've already called for help over the radio", then walked into the Kitchen's service prep area. The Surveyors encouraged Resident #7 to cough until the Nurse Manager arrived. On the afternoon of 2/7/23 the Administrator acknowledged staff walked away from Resident #7 while s/he was choking during lunch service on 2/7/23. 2. During the tour of the kitchen and food service areas commencing at 9:40 AM on 2/6/23 the following environmental concerns observed in the dining room and confirmed by the General Director of Dining Services: *Clorox wipes stored on the service area cabinet accessible to residents *1 garbage can in the food service prep area and 2 garbage cans in the kitchen without lids which the Sous Chef confirmed customarily remain without lids *2 used cloth rags left directly on a kitchen countertop, and used rags left on the floor under the corner of the oven *an open half filled 5 gallon bucket of used cooking oil placed near the oven, which the Sous Chef confirmed customarily remains open for weeks at a time until the bucket is emptied when	R266	determine continued duration of audits. Corrective action will be completed by 3/24/23. **Tag R266 POC accepted on 4/24/23 by J. Evans/P. Cota**	

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R266	Continued From page 17 full. * a buildup of dust and oil on the kitchen exhaust hood above the oven. While a contracted company cleans the hood every 3 months, the Sous Chef confirmed there is no regularly scheduled cleaning of the hood by kitchen staff between the contracted quarterly service.	R266		
R270 SS=E	IX. PHYSICAL PLANT 9.2 Residents' Rooms 9.2.c Each bedroom shall have an outside 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 interview there was a failure to provide window screens for 2 applicable residents (Resident #2, Resident #6). Findings include: During tour of the facility commencing at approximately 9:40 AM on 2/6/23 windows in Resident #2's apartment were observed by two surveyors to be missing screens; and during a resident interview at approximately 9:15 AM on 2/7/23 windows in Resident #6's apartment were observed by two surveyors to be missing window screens.	R270	R270 The Director of Environmental Services has reviewed and is aware of the regulatory requirement that windows in resident rooms have screens. The missing window screens for resident #2 and #6 will be replaced. All resident homes will be checked to ensure window screens are in place. Environmental Services will develop and implement a process to ensure window screens are replaced when removed for repair or maintenance. Corrective action will be completed by 3/24/23.	

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R270	Continued From page 18 On the afternoon of 2/7/23 the Assistant Administrator acknowledged windows in Resident #2 and Resident #7's apartments were missing screens.	R270	Tag R270 POC accepted on 4/24/23 by J. Evans/P. Cota	
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 and staff interview there was a failure to provide an operable telephone with a list of emergency telephone numbers in an accessible area of the home. Findings include: During the course of the facility tour commencing at 9:40 AM on 2/6/23 the Assistant Administrator confirmed there is not an operable phone with emergency numbers posted provided for use at all times in the Residential Care Home.	R303	R303 A telephone was installed in an accessible area of the residential care neighborhood on 3/3/23. Emergency numbers will be posted by this telephone. Corrective action will be completed by 3/24/23. Tag R303 POC accepted on 4/24/23 by J. Evans/P. Cota	