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. Caitlin Bernardini, Manager
Maple Lane Retirement Home
33 Maple Lane
Barton, VT 05822-9494

Dear Ms. Bernardini:

Enclosed is a copy of your acceptable plans of correction for the re-licensure survey conducted on **January 10, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0140	A. BUILDING: _____ B. WING _____	01/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE LANE RETIREMENT HOME	33 MAPLE LANE BARTON, VT 05822

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R100	Initial Comments: The Division of Licensing and Protection conducted an unannounced on-site relicensure survey on 1/10/23. The following regulatory deficiencies were identified:	R100		
R126 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on observation the Registered Nurse failed to ensure the medical care needs of one applicable resident (Resident #2) were promptly met by seeking immediate medical attention after s/he choked at the dinner table, requiring staff to perform the Heimlich Maneuver. On the afternoon of 1/10/23 the Surveyor observed Registered Nurse return to the office and report to the Manager and Administrator that Resident #2 choked and staff performed the Heimlich maneuver during dinner service. After reporting this incident the nurse sat at the office desk without seeking medical attention for Resident #2, or calling the medical provider. After observing the Registered Nurse fail to take appropriate action, the Surveyor advised that medical attention was needed after a serious choking episode due to potential aspiration,	R126	R126 1. Residents residing in the facility that require immediate medical attention have the potential to be affected by the alleged deficient practice. 2. Resident was sent to the ER, via EMS, at the time of the event. Resident was evaluated at ER. There were no findings. Resident returned to the facility with no ill effects. 3. Local EMS has been contacted and a First Aid/CPR certification training will be conducted at the facility, for all staff at the facility, on 2/10/23. 4. A training was completed by all staff that work in the facility on the facility's choking policy and procedures on 2/10/23. 5. A yearly certification of CPR/First Aid will be conducted as part of the yearly mandatory in-services and to remain in regulatory compliance. 6. Audits will be completed as needed with acute medical events that occur in the facility to monitor effectiveness of the plan x3 months. 7. Facility will be in substantial compliance on 3/3/23. **Tag R126 POC accepted on 4/24/23 by J. Evans/P. Cota**	

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R126	Continued From page 1 injury, and swelling that could compromise the resident's airway. The Registered Nurse required further prompting from the Administrator, who directed the Registered Nurse to call 911 to seek medical attention for Resident #2. According to the National Library of Medicine website MedlinePlus.gov the appropriate actions to take during and after a choking event include telling someone to call 911 while first aid response is initiated, and ensure the person sees a doctor after the object is dislodged because complications could arise. (https://medlineplus.gov/ency/article/000049.htm#:~:text=After%20removing%20the%20object%20that,aid%20measures%20that%20were%20taken.)	R126		
R128 SS=G	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: Based on record review and staff interview there was a failure to administer medications consistent with physician's orders for 2 applicable residents (Residents # 3 and #4). Findings include: 1. Progress Notes for Resident #3 on 8/1/22 indicated a call was placed to his/her provider to clarify a discrepancy between a medication order for Gabapentin 300 mg capsules listed on the	R128	R 128 1. Resident #3 has had no lasting effect from the identified medication error. 2. Resident #4 had no identified negative effects related to the noted discrepancies. 3. Residents receiving medication have the potential to be affected by the alleged deficient practice. 4. Education will be provided to staff regarding the proper procedure to dispose of medication that is no longer ordered. 5. Education will be provided to staff regarding safe medication practices. 6. The RN for the facility has received education regarding the admission process to include the process for medication reconciliation on admission and throughout the residents stay.	

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R128	Continued From page 2 medication card and the Medication Administration Record (MAR). The note stated " on the card from Pharmacy it said take 2 capsules in the MAR it said take 1 capsule 4 x day... [staff at doctor's office] told me the 300 mg Gabapentin was [discontinued]... waiting for a fax from doctor's office". On 9/4/22 a Progress Note indicated Resident #3 was "given too much Gabapentin for 2 days" with further information noted stating 600 mg was ordered and 1200 mg was given. A Medication Error Report dated 9/4/22 documented a medication error on 9/1/22 and stated "gave medication that was [discontinued] Gabapentin cap 300 mg". The Medication Error Report indicated Resident #3 was "dizzy off balance almost fell a few times". On the afternoon of 1/10/23 the Manager confirmed Resident #3 sustained a fall on 9/1/22. On the afternoon of 1/10/23 the Registered Nurse and Manager confirmed medication errors occurred as a result of the failure to remove Resident #3's discontinued Gabapentin 300 mg capsules from the medication cart. 2. Per review of the Physician's Admission orders for Resident #4 provided on request by the Manager on the afternoon of 1/10/23 the signed admission orders were observed to be inconsistent with the medication orders entered on Resident #4's Medication Administration Record (MAR). Initially the Manager stated s/he had entered the medication orders on Resident #4's MAR according to the orders listed on the medication list signed by Resident #4's physician and faxed to the facility on 12/8/22, however as the surveyor noted multiple inconsistencies between the MAR and the orders signed by	R128	7. The Level 3 Manager, will monitor to ensure the reconciliation process is completed and documented for new admissions to the facility in collaboration with the Administrator at the Level 2 building as well as the Director of Clinical Services for the organization. 8. Facility will be in substantial compliance on 3/3/23. **Tag R128 POC accepted on 4/24/23 by J. Evans/P. Cota**	

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R128	Continued From page 3 Resident #4's physician on 12/8/22 the Manager confirmed the orders listed on the MAR were transcribed from the labels on the medications Resident #4 arrived with on admission, and a follow up with the physician had not occurred to request clarification regarding Resident #4's current medication orders. The Registered Nurse (RN) failed to maintain overview of Resident #4's medication reconciliation during the admission process to include ensuring an accurate current medication list was received on or before admission and contacting Resident #4's physician for clarifications when discrepancies were noted between the medication list received on 12/8/22 and the medications Resident #4 arrived with on 12/13/22. This lack of RN overview was confirmed by the Manager on the afternoon of 1/10/23. The following inconsistencies were noted in Resident #4's medication orders and administration due to the absence of RN overview: * Per signed medication orders received on 1/11/23 Lamotrigine 200 mg by mouth at bedtime was ordered. Lamotrigine 100 mg daily at 8 am was administered as listed in Resident #4's MAR. * Per signed medication orders received on 12/13/22 Oxycodone/Acetaminophen 5 mg/325 mg was ordered every 4 hours as needed for lower left quadrant abdominal pain on 12/9/22. Resident #4's MAR listed Oxycodone/Acetaminophen 5 mg/325 mg every 4-6 hours as needed for pain and failed to identify the specific time between doses as ordered and the specific type of pain the medication was	R128		

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R128	Continued From page 4 prescribed to treat. An additional order was listed in Resident #4's MAR for Oxycodone 5 mg every 6 hours as needed for pain for which there was no signed physician's order on record. This medication was documented as administered on 1/10/23. * Victoza 0.6 mg subcutaneous injection was ordered once daily for 4 weeks to begin on 1/3/23, followed by increase to 1.2 mg for 4 weeks, then increased to 1.8 mg. Administration of Victoza began on 1/5/23. Resident #4's MAR incorrectly identified the dose as .6 mg and failed to include a leading zero before the decimal point. According to fda.gov "Existing healthcare standards suggest dose designations for decimal amounts should always use leading zeros" (https://www.fda.gov/media/88498/download). This standard practice is in place to prevent a 0.6 mg dose from being mistaken as a 6 mg dose. * Quetiapine scheduled and PRN (as needed) orders were incorrectly entered into the MAR as Quetrapine. * All orders entered into the MAR were incomplete and did not include the medication route (the way a medication is taken into the body, such as by mouth), the date the medication was ordered, and potential side effects of each medication.	R128		
R144 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.9.c.(1) Complete an assessment of the resident in accordance with section 5.7;	R144		

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R144	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the Registered Nurse failed to conduct Resident Assessments in accordance with Vermont Residential Care Home Regulation section 5.7 for 6 out of 6 facility residents (Residents #1, #2, #3, #4, #5, and #6). Findings include: On the afternoon of 1/10/23 the Registered Nurse stated s/he was unaware of the regulatory requirement to complete Resident Assessments within 14 days after admission, annually, and whenever there is a change in a resident's mental or physical condition. On the afternoon of 1/10/23 the Manager stated she had asked the Administrator if Resident Assessments were required at the facility, however the Administrator was also unaware of this regulatory requirement. At 2:25 PM on 1/10/23 the Registered Nurse confirmed Resident Assessments had not been completed for any residents of the facility for at least three years.	R144	R 144 1. There were no identified negative effects related to the deficient practice. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. Facility Management, as well as RN, are aware of the requirement for resident assessments. The regulatory requirements were reviewed. 4. Resident assessments have been completed for all residing residents. 5. The Administrator of the Level II facility, in collaboration with the Director of Clinical Services for the organization will support the facility manager to ensure compliance with the regulation in the future and conduct audits as needed with new admissions, changes in condition, and annually. 6. The facility will be in substantial compliance on 3/3/23. **Tag R144 POC accepted on 4/24/23 by J. Evans/P. Cota**	
R147 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (4) Maintain a current list for review by staff and physician of all residents' medications. The list shall include: resident's name; medications; date medication ordered; dosage and frequency of administration; and likely side effects to monitor;	R147		

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R147	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the Registered Nurse failed to maintain a current medication list for one applicable resident (Resident #4). Findings include: Resident #4 was admitted to the facility on 12/13/22. Per review of the physician's admission orders for Resident #4 provided on request by the Manager on the afternoon of 1/10/23 the signed admission orders were observed to be inconsistent with the medication orders entered on Resident #4's Medication Administration Record (MAR). In addition to the inconsistencies noted between the MAR and the admission orders provided by the Manager, the medication list and MAR did not contain the dates the medications were ordered, and the likely side effect to monitor. Initially the Manager stated s/he had entered the medication orders on Resident #4's MAR according to the orders listed on the medication list signed by Resident #4's physician and faxed to the facility on 12/8/22, however during the record review on the afternoon of 1/10/23 as the surveyor noted multiple inconsistencies between the orders in the MAR and the orders signed by Resident #4's physician on 12/8/22 the Manager confirmed the orders listed on the MAR were taken directly from the labels on the medications Resident #4 arrived with on admission. As of 1/10/23 the Registered Nurse had not followed up with the physician for clarification regarding the inconsistencies between the signed physician's orders received on 12/8/22 and the medications Resident #4 arrived with on admission on 12/13/22. Accurate current medication orders	R147	R147 1. Resident #4 has no identified negative effects related to the deficient practice. 2. Residents receiving medication have the potential to be affected by the deficient practice. 3. Education has been provided regarding the requirement to include the date of the order on physician orders. 4. Education has been provided to staff regarding the process for identifying likely side effects of medications administered. 5. The RN for the facility has received education regarding the admission process to include the process for medication reconciliation on admission and throughout the residents stay. 6. The Level 3 Manager as well as the Administrator of the Level II facility will monitor to ensure the reconciliation process is completed and documented for new admissions to the facility, and that a current list of medications for residents are maintained in collaboration with the Director of Clinical Services for the organization. 7. The facility will be in substantial compliance on 3/3/23 **Tag R147 POC accepted on 4/24/23 by J. Evans/P. Cota**	

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R147	Continued From page 7 were not requested and received until 29 days after admission on 1/11/23. Please refer to tags 128 and 189.	R147		
R164 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: (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: The Registered Nurse failed to delegate the responsibility for the administration of medications to facility residents to one designated staff who administers medications as part of his/her assigned job duties. At 2:45 PM on 1/10/23 the Manager and Registered Nurse confirmed one applicable staff (Staff # 1) had not been delegated by the Registered Nurse to administer medications to facility residents, which is an assigned job duty for Staff #1	R164	R164 1. No residents were identified to have been negatively affected by the alleged deficient practice. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. RN was trained on the regulation of appropriate delegation training and oversite to applicable staff within the facility. 4. Staff # 1 was trained and medication delegated on 1/11/23 by the RN. 5. All other staff was re-trained and medication delegated on the week of 1/11/23 to 1/17/23 by the RN. 6. The facility will be in substantial compliance on 3/3/23. **Tag R164 POC accepted on 4/24/23 by J. Evans/P. Cota**	
R168 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication	R168		

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R168	Continued From page 8 administration, unlicensed staff may administer medications under the following conditions: (6) Insulin. Staff other than a nurse may administer insulin injections only when: i. The diabetic resident's condition and medication regimen is considered stable by the registered nurse who is responsible for delegating the administration; and ii. The designated staff to administer insulin to the resident have received additional training in the administration of insulin, including return demonstration, and the registered nurse has deemed them competent and documented that assessment; and iii. The registered nurse monitors the resident's condition regularly and is available when changes in condition or medication might occur. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the Registered Nurse failed to ensure the competency of staff administering insulin to one applicable resident (Resident # 3). Findings include: During observation of the administration of Novolog fast acting insulin to Resident #3 before the evening meal on 1/10/23, the unlicensed staff administering the insulin was observed attempting to attach the needle before sanitizing the rubber seal and needle attachment point on the insulin pen. The unlicensed staff stated s/he was unaware of the need to sanitize the seal and attachment point before attaching the needle when the surveyor halted the administration	R168	R168 1. Resident #3 had no negative effects as a result of the alleged deficient practice. 2. Residents requiring insulin and other medication administration have the potential to be affected by the alleged deficient practice. 3. RN was trained on the regulation of appropriate delegation training and oversite to applicable staff within the facility. 4. Staff # 1 was trained and medication delegated on 1/11/23 by the RN, which included the proper administration of insulin. 5. All other staff was re-trained and medication delegated on the week of 1/11/23 to 1/17/23 by the RN, which included the proper administration of insulin. 6. Education will be provided to staff responsible for medication administration regarding appropriate infection control techniques. 7. Competency assessments have been completed for staff responsible for the administration of insulin and other medications. 8. Facility will be in substantial compliance on 3/3/23. **Tag R168 POC accepted on 4/24/23 by J. Evans/P. Cota**	

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R168	Continued From page 9 process to prevent risk of infection for the resident receiving the insulin. Once the areas were sanitized and the needle was applied, the staff attempted to administer the insulin in an area different from the area that was sanitized with an alcohol wipe, and the staff was redirected to the previously sanitized area to prevent risk of infection for the resident. On return to the med cart following the administration, the staff was observed placing the the resident's glucometer on top of the med cart and taking off his/her gloves. As the staff moved towards the glucometer to put it away s/he was asked to don gloves to prevent risk of infection to the staff as the glucometer had not been sanitized. After the staff donned gloves s/he required prompting to sanitize the glucometer and top of the med cart where the glucometer was placed, and stated s/he was unaware of the need to sanitize the device after use as an infection control measure. Following the observed administration of insulin on the afternoon of 1/10/23 the Registered Nurse confirmed the potential risk of infection for the resident receiving insulin and staff administering insulin due to the unlicensed staff's lack of knowledge and competency related to the insulin administration process.	R168		
R172 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h All medicines and chemicals used in the home must be labeled in accordance with currently accepted professional standards of practice. Medication shall be used only for the resident identified on the pharmacy label.	R172		

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R172	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to store and label medications belonging to two applicable residents (Residents #3 and #4) according to currently accepted professional standards. Findings include: At 6:30 PM on 1/10/23 the Registered Nurse confirmed the following medications were not labeled and/or stored according to currently accepted professional standards: * Opened Novolog and Lantus Insulin Pens belonging to Resident #3 were observed without the date they are due to expire 28 days after the pens were opened written on the label. * An uncovered open plastic medication administration cup was observed with a Metformen 1,000 mg tablet belonging to Resident #4 was observed in the top drawer of the medication cart with the word "HOLD" written on the side of the cup.	R172	R172 1. No residents were identified to have been negatively impacted by the alleged deficient practice. 2. Residents requiring medication have the potential to be affected by the alleged deficient practice. 3. Education has been provided to staff responsible for medication administration regarding the requirements for labeling and storage of medications. 4. The Manager of the facility will conduct audits on a weekly basis to monitor effectiveness of the plan. 5. The facility will be in substantial compliance on 3/3/23. **Tag R172 POC accepted on 4/24/23 by J. Evans/P. Cota**	
R176 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (4) Medications left after the death or discharge of a resident, or outdated medications, shall be promptly disposed of in accordance with the home's policy and applicable standards of practice.	R176		

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R176	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview there was a failure to ensure the prompt disposal of outdated and discontinued medications. Findings include: At 6:30 PM on 1/10/23 the Registered Nurse confirmed the following expired and discontinued medications were stored in the medication cart and medication refrigerator: *A medication card containing Donepezil 5 mg tablets discontinued on 9/26/22 belonging to Resident #6. * House stock multivitamins that expired 3/2022 *Stool softener that expired 4/2022 * 2 opened vials of Aplisol (for Tuberculosis testing) that expired on 2/21/22 and 9/19/22	R176	R 176 1. No residents were negatively affected by the alleged deficient practice. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. Education will be provided to staff regarding the requirement to dispose of discontinued and expired medication. 4. All expired medications were discarded and disposed of per policy and procedure by the RN and Manager on 1/11/23. 5. A weekly audit will be conducted by the Manager or RN to ensure compliance in the future. 6. The facility will be in substantial compliance on 3/3/23. **Tag R176 POC accepted on 4/24/23 by J. Evans/P. Cota**	
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;	R179		

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R179	Continued From page 12 (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 record review and staff interview there was a failure to ensure 5 out of 5 sampled staff completed the required yearly trainings. Findings include: Per record review 5 out of 5 sampled staff did not complete the required yearly trainings in Resident Emergency Response and First Aid, and Respectful and Effective Interaction with Residents. Per interview with the Manager on the afternoon of 1/10/23 it was confirmed the facility does not provide these required trainings, therefore they were not completed by all staff. On the afternoon of 1/10/23 the Manager confirmed Staff #1 , #2, and #5 also did not complete required trainings in Resident Rights; Fire Safety and Emergency Response; and Mandatory Reporting of Abuse, Neglect, and Exploitation.	R179	R179 1. No residents were identified to have been negatively impacted by the alleged deficient practice. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. The manager of the facility is aware of the requirement for required trainings. 4. Local EMS has been contacted and a First Aid/CPR certification training will be conducted at the facility, for all staff, on 2/10/23. 5. A fire safety, emergency response in-service was conducted on 1/13/23 at the facility, for all staff, by the Maintenance Director. 6. Respectful and Effective Interaction in-service was conducted on 2/10/23. 7. All staff at the facility attended orientation at the Level 2 building either on the dates of 1/19/23 and 1/20/23 or on the dates of 1/23/23 and 1/24/23. All additional mandatory in-services were obtained during this time. 8. The manager of the facility will maintain and monitor records to ensure required trainings are conducted at least yearly. 9. The facility will be in substantial compliance on 3/3/23 **Tag R179 POC accepted on 4/24/23 by J. Evans/P. Cota**	

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R189	Continued From page 13	R189		
R189 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.12.b. (3) For residents requiring nursing care, including nursing overview or medication management, the record shall also contain: initial assessment; annual reassessment; significant change assessment; physician's admission statement and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of physician visits, signed telephone orders and treatment documentation; and resident plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure the resident records of 6 applicable residents (Resident #1, #2, #3, #4, #5, and #6) who require nursing overview and medication management included initial assessments, annual reassessments, and significant change assessments; and the resident record of 1 applicable resident (Resident #4) included a physician's admission statement to include current medication orders. Findings include: 1. On the afternoon of 1/10/23 the Registered Nurse stated s/he was unaware of the regulatory requirement to complete Resident Assessments within 14 days after admission, annually, and whenever there is a change in a resident's mental or physical condition. On the afternoon of 1/10/23 the Manager stated she had asked the Administrator if Resident Assessments were required at the facility, however the Administrator was also unaware of this regulatory requirement.	R189	R189 1. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 2. Facility Management, as well as RN, are aware of the requirements for Resident Assessments. 3. The RN has been provided education regarding the medication reconciliation process for residents newly admitted and with new physician orders. 4. Resident assessments have been completed for all current residents residing in the facility. 5. Manager of facility, the Administrator of the level II facility, and the Director of Clinical Services for the organization will ensure ongoing compliance with the regulation. 6. The facility will be in substantial compliance on 3/3/23. **Tag R189 POC accepted on 4/24/23 by J. Evans/P. Cota**	

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R189	Continued From page 14 At 2:25 PM on 1/10/23 the Registered Nurse confirmed Resident Assessments had not been completed for any residents of the facility for at least three years. Please refer to tag 144. 2. Per review of the physician's admission orders for Resident #4 provided on request by the Manager on the afternoon of 1/10/23 the signed admission orders were observed to be inconsistent with the medication orders entered on Resident #4's Medication Administration Record (MAR). Initially the Manager stated s/he had entered the medication orders on Resident #4's MAR according to the orders listed on the medication list signed by Resident #4's physician and faxed to the facility on 12/8/22, however during the record review on the afternoon of 1/10/23 as the surveyor noted multiple inconsistencies between the orders in the MAR and the orders signed by Resident #4's physician on 12/8/22 the Manager confirmed the orders listed on the MAR were taken directly from the labels on the medications Resident #4 arrived with on admission, and a follow up with the physician had not occurred for clarification regarding Resident #4's current medication orders as of 1/10/23. Please refer to tags 128 and 147.	R189		
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.	R190		

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R190	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to conduct criminal background checks and abuse registry checks for one applicable staff (Staff #1). Findings include: Per record review Staff #1 was hired to work at the residence on 9/20/04. Vermont Criminal Background Checks and Abuse Registry Checks were conducted during previous employment in October of 1995. Additional checks to include Vermont Criminal Background Checks on 11/23/07 and Abuse Registry Check on 12/4/07 were conducted, however there was a failure to conduct the required background checks in September of 2004 when Staff #1's most recent employment began at the residence. At 2:20 PM on 1/10/22 the Human Resources representative and Administrator from the organization that manages the residence confirmed the required criminal background checks and abuse registry checks were not conducted when Staff #1 was hired in 2004.	R190	R190 1. No residents were negatively affected by the alleged deficient practice. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. All background checks for staff #1 were completed on 1/12/23 4. All background checks, on all staff at the facility were re- conducted on 1/12/23. 5. All background checks, for all active employees, will be conducted yearly. 6. The manager of the facility will maintain a tracking record of all active employees to monitor continued compliance. 7. The facility will be in substantial compliance on 3/3/23. **Tag R190 POC accepted on 4/24/23 by J. Evans/P. Cota**	
R221 SS=D	VI. RESIDENTS' RIGHTS 6.9 Residents may manage their own personal finances. The home or licensee shall not manage a resident's finances unless requested in writing by the resident and then in accordance with the resident's wishes. The home or licensee shall keep a record of all transactions and make the record available, upon request, to the resident or legal representative, and shall provide the resident with an accounting of all transactions at least quarterly. Resident funds must be kept	R221		

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R221	Continued From page 16 separate from other accounts or funds of the home. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure a written request for management of personal finances by the facility Administration for one applicable resident (Resident # 1). Findings include: Per record review and interview with the Manager and the Administrator of the organization that manages the residence on the afternoon of 1/10/23, Resident #1's personal finances are managed by the facility. While Resident #1's physician signed a statement indicating s/he is unable to manage his/her own finances, there is no written request from Resident #1 for the management of his/her personal funds by the facility. The Administrator stated Resident #1 is unable to sign a written request, however the Administrator also confirmed Resident #1 had signed the facility Admission Agreement demonstrating ability to sign documents. The management of Resident #1's funds without a written request for this service was confirmed by the Administrator at 1:50 PM on 1/10/23.	R221	R221 1. Resident #1 had no negative impact related to the alleged deficient practice. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. An agreement for the facility to manage resident's funds has been drafted and added to the admission agreement. The Manager, or designee, will be responsible upon admission to assist the resident to sign the agreement if so desired. 4. Resident # 1 has signed the agreement on 2/8/23. 5. The manager of the facility will conduct audits with new admissions and as needed to monitor for continued compliance. 6. The facility will be in substantial compliance on 3/3/23. **Tag R221 POC accepted on 4/24/23 by J. Evans/P. Cota**	
R234 SS=C	VII. NUTRITION AND FOOD SERVICES 7.1.a.(3) The current week's regular and therapeutic menu shall be posted in a public place for residents and other interested parties.	R234		

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R234	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to post a weekly menu in a public place for review by residents and other interested parties. Findings include: During the course of the survey including observation of the lunch meal service it was noted a weekly menu was not posted for review. Per staff interview only the daily menu is posted for review on a board in the dining area. Additionally the posting of the daily menu does not include a list of alternative foods available in the event a resident chooses not to eat the planned meals. Additionally the daily menu posted in the dining area does not include a list of alternative food options available if the resident chooses not to eat the planned prepared meal. At 12:07 PM on 1/10/23 staff serving lunch confirmed a weekly menu is not posted for review by residents and other interested parties including a list of alternative food items available should the resident choose not to eat the planed meal.	R234	R234 1. No residents were negatively affected by the alleged practice. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. Staff have been trained on the regulation and weekly menus are now being posted every Sunday for that week, as well as a list of available alternatives. 4. The manager of the facility will monitor weekly to ensure continued compliance with the requirements. 5. The facility will be in substantial compliance on 3/3/23. **Tag R234 POC accepted on 4/24/23 by J. Evans/P. Cota**	
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	R266		

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R266	Continued From page 18 by: Based on observation and staff interview there was a failure to provide and maintain care in a safe, functional, sanitary, homelike, and comfortable environment. Findings include: 1. On arrival at the facility a very strong malodorous environment was noted in the staff office. The staff present on arrival stated the odor was presumed to be a dead mouse or another dead animal. Throughout the course of the survey the odor was also noted in the kitchen and storage room adjacent to the kitchen, and in the area above the office and kitchen on the second floor of the residence currently used for trainings. When the Manager was questioned regarding the plan to address the issue s/he stated there was a plan for maintenance set a trap under the area where the odor was noted. When the surveyor noted a deceased animal can not crawl into a trap the manager stated maintenance was attending to the issue, however the odor remained and was observed to worsen throughout the duration of the survey without discovery of the source or evidence of a plan for resolution. 2. Per observation, the laundry room door was wide open. The Manager conducting the tour confirmed the door to this area of the residence customarily remains open. The facility is single staffed with the exception of when the Manager and/ or the Registered Nurse are on site. The single staff is responsible for all tasks including medication administration, resident care, cleaning, and serving meals prepared and delivered by the nursing home located next to the residence, which leaves the area unmonitored when staff does not have the entrance to the laundry room in their line of sight. The unlocked laundry room was observed to contain bleach;	R266	R266 1. No residents were negatively affected by the alleged deficient practice. 2. Residents residing in the facility had the potential to be affected by the alleged deficient practice. 3. On 1/11/23 the Maintenance Department located a deceased rodent, under the building, in a crawl space. The rodent was disposed of and the malodorous environment dissipated. 4. On 1/15/23, a pest control service did an examination on the property and premises. At the time it was determined that there was no issue with rodents and that it was an isolated incident. Recommendations were to continue with current pest control practices. 5. On 1/17/23 a locked door, that unlocks upon activation of a fire alarm, was placed between the kitchen and the identified areas of concern. The door is locked and is opened by a keypad with a code, that only staff have access to. 6. The manager of the facility is aware of the requirement to ensure potentially hazardous equipment or supplies is not accessible to residents. 7. On 1/13/23 the kitchen was thoroughly cleaned including all appliances and surfaces. 8. A part time housekeeping staff was hired for the facility. 9. Staff were educated on the process of the labeling and dating of food items located in the refrigerator and the requirements for maintaining a clean environment.	

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R266	Continued From page 19 paint cans; detergents; as well as 13 large sharps containers and 2 small sharps containers filled with hazardous medical waste. 3. The unlocked garage and storage area accessible via the unlocked laundry room was noted to contain hazardous materials including power tools, brake cleaner, siding stain, paint, motor oil, gasoline, asphalt sealant, antifreeze, and propane tanks. This area was confirmed accessible via the laundry room and unlocked on days maintenance personnel are working. 4. During the kitchen tour the inside of the oven was observed to have an accumulation of oily residue and crumbs, and all kitchen surfaces were observed to be in need of cleaning. The kitchen refrigerator contained a can of bean dip and 2 containers of parmesan cheese without dates indicating when these items were opened; and the resident refrigerator in the dining room was observed to contain a gallon of milk, 2 pitchers of juice, seltzer, whipped butter, cranberry juice and a container of cranberry juice without labels indicating when they were opened. 5. In a shared bathroom a resident's disposable razor was observed to be stored in a dirty tray on a shelf that was accessible to all residents, and an electric razor was observed to be stored on a sink located between the two living areas in a double occupancy room and accessible to both residents. Dried fecal matter on toilet seats, and toilet scrubbers stored in unclean buckets, were observed in the double occupancy room and in a single occupancy resident room located across the hall from the double room. There were capped wires protruding from a hole in the wall near the ceiling in the hallway between the two rooms. One single occupancy resident room	R266	10. All resident rooms/bathrooms have been cleaned and a cleaning schedule for resident rooms/bathrooms has been created. 11. The salon was thoroughly cleaned on 1/12/23 and the mattress discarded. 12. The capped wires have been safely removed and the small whole in the wall has been fixed, sanded, and painted. 13. The screen that was not in the window, was located in the resident's room, and has been re-installed in the appropriate window. 14. The Manager, or a designee, will conduct weekly audits to ensure continued compliance. 15. The facility will be in substantial compliance on 3/3/23 **Tag R266 POC accepted on 4/24/23 by J. Evans/P. Cota**	

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R266	Continued From page 20 adjacent to the living room was missing a window screen 6. In a small room used as a salon for residents all surfaces including the counter, sink, floor, salon chair, and walls were in need of cleaning and sanitizing; and there was dried shaving cream in the sink which the Manager reported had been there for approximately one week. There was a single mattress stored on its side with half of it inside the shower stall and the other half jutting into the small room. The findings listed above were confirmed by the Manager during the course of the facility tour on 1/10/23.	R266	R302 1. No residents were negatively affected by the alleged deficient practice. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. The Maintenance Director, as well as the facility Administration, are aware of the requirement to conduct a quarterly fire drill, on alternating times/shifts. 4. A documented fire drill was conducted on 1/18/23 both residents and staff were involved in the drill. 5. Fire drills will be conducted on a quarterly basis, on rotating times/shifts, and the Maintenance Director or designee will ensure compliance with the plan. 6. An Emergency Preparedness Plan was drafted on 1/25/23, staff were educated on the plan and a copy placed in the office for reference. 7. The manager of the facility will monitor for continued compliance. 8. Facility will be in substantial compliance on 3/3/23.	
R302 SS=F	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced by:	R302		

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R302	Continued From page 21 Based on record review and staff interview there was a failure to conduct fire drills during the previous year. Findings include: On the afternoon of 1/10/23 the Director of Maintenance confirmed fire drills had not been conducted during the previous year at the facility.	R302	**Tag R302 POC accepted on 4/24/23 by J. Evans/P. Cota**	