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

November 12, 2024

Michael Flournoy, Manager
Margaret Pratt Community
210 Plateau Acres
Bradford, VT 05033

Dear Mr. Flournoy:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 3, 2024.** Please post this document in a prominent place in your facility.

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

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

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0659	A. BUILDING: _____ B. WING _____	C 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGARET PRATT COMMUNITY	210 PLATEAU ACRES BRADFORD, VT 05033

(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: The Divsion of Licensing and Protection completed an unannounced on-site annual relicensure survey, investigation of three complaints, and investigaton of one facility reported incident on 10/1/24-10/3/24. The following regulatory deficiencies were identified:	R100	R128 1) **Action to correct the deficiency**: Resident #1 – the medication was administered, however due to an issue with the way the order was entered into our electronic medical record, PointClickCare (PCC), it does show that 3 doses (not 5) were missed. The RN was aware of the technical issue and instructed the medication to be given at the time. Resident #2 - The nurse was counseled for the medication error on 10/7/24. Initial audit of controlled medication completed 10/7/24. Incident Report for Medication Error completed on 10/29/2 with family and PCP notifications. 2) **Measures to ensure that deficient practice does not re-occur.** All staff administering medications will document each medication they give in the residents eMAR. If eMAR is not available documentation will be completed in progress note until eMAR is available. When prefilled syringes are used, each prefilled syringe will be identified with different brightly colored sticker by dose documented on the sticker. 3) **Method of monitoring.** HSD/AHSD will review PCC missed medication administrations report daily. Controlled medications will be audited: weekly x 4 weeks, monthly x 3 months, then quarterly. 4) **Date of completion.** Completion date: 11/30/24 R128 Plan of Correction accepted by Jo A Evans RN on 11/10/24	
R128 SS=F	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 staff interview and record review there was a failure to ensure medications were administered as ordered for 2 applicable residents (Residents #1 and #2). Findings include: The facility's Medication Administration Study Guide includes procedures to ensure administration of medications as ordered. The facility's Medication Policies Overview states the facility will handle reordering of any medications from the pharmacy, and all staff who are administering medications will document each medication they give in the Resident's medication administration record. 1. Resident #1 is prescribed Keppra (anti-seizure medication) 1,000 mg twice daily. Resident #1's September 2024 Medication Administration Record (MAR) indicates 5 consecutive doses of	R128		

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Michael Flournoy TITLE Executive Director (X6) DATE 11/5/24

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R128	Continued From page 1 Keppra were not administered on 9/18/24-9/20/24. Documentation of the reason for the 5 missed doses of Keppra was not on file in Resident #1's MAR and Progress Notes. Resident #1's diagnoses include intractable Epilepsy (seizures not easily or completely controlled with medications) with a history of Status Epilepticus, which is a life-threatening medical emergency resulting from a sustained single seizure or rapidly occurring cluster of seizures without adequate recovery time. A letter written by Resident #1's Neurologist on 3/11/24 states s/he should take care to avoid triggers for seizures, and includes missed medications on a list of triggers for seizures. Per interview at 5:09 PM on 10/3/24 the Director of Health Services (DHS) confirmed Resident #1's September 2024 MAR indicates 5 doses of Keppra were not administered on 9/18/24 - 9/20/24 and was unable to identify why the doses of Keppra were not administered. Additionally, Resident #1's record contains Nurse Practitioner's orders signed on 9/26/24 which state "Bring meds to [him/her], especially evening medications to [decrease] risk of falls in this age group". His/her record also contains a second signed order from a Nurse Practitioner dated 9/30/24 which states, " All medication to be administered in [his/her] room with supervision". Per interview on the afternoon of 10/2/24 the Director of Health Services (DHS) confirmed both signed orders were received by the facility and were on file and available for review in his/her resident record. The DHS confirmed this order was not being followed by the home due to Resident #1's behaviors during medication administration and ability to ambulate. Resident #1's record does not include documentation of communication with the prescribing Nurse	R128		

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R128	Continued From page 2 Practitioners regarding the facility's concerns related to administration of medications in Resident #1's room. 2. Resident #2 was prescribed Morphine Solution 20 mg/ml for hospice comfort measures during end-of-life care. Per review of signed medication orders provided by the nursing staff and Resident #2's September 2024 Medication Administration Record, Resident #2 was prescribed Morphine Solution 20 mg/ml 0.5 ml (10 mg) by mouth every 4 hours as a scheduled medication, with an additional order for 0.5 ml (10 mg) to be given by mouth every 2 hours as needed for pain and shortness of breath. Per review of controlled substance count sheets, Resident #2 was given twice the amount of Morphine Solution prescribed for three consecutive doses administered as follows on 9/1/24: a. 20 mg given at 12:00 AM administered as the dose scheduled for 1:00 AM b. 20 mg given at 2:05 AM administered as a PRN (as needed) dose c. 20 mg given at 5:15 AM administered as the dose scheduled for 5:00 AM This finding was confirmed by the Director of Health Services at 5:17 PM on 10/3/24.	R128		
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	R144		

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R144	Continued From page 3 by: Based on staff interview and record review there was a failure to ensure completion of Resident Assessments in accordance with Section 5.7 of the Vermont Residential Care Home Licensing Regulations effective 10/3/2000 for 1 applicable resident (Residents #3). Findings include: Policies and procedures related to resident assessments were not provided for review on request on the afternoon of 10/3/24. Per record review, Resident #3 was admitted to the home on 5/22/23. His/her admission assessment was signed as completed by an RN on 7/1/23, 40 days after admission. On 8/4/24 Resident #3 was hospitalized due to shortness of breath and low oxygen saturation rates. On discharge back to the facility on 8/7/24, Resident #3 required continuous oxygen supplementation via nasal cannula and had a new diagnosis of Chronic Obstructive Pulmonary Disease (COPD). At 3:36 PM on 10/3/24 the Executive Director confirmed Resident #3's admission assessment was not completed within 14 days of admission, and a significant change assessment was not completed in response to changes in Resident #4's physical condition including a new diagnosis of COPD and use of continuous oxygen supplementation via nasal cannula.	R144	R144 1)**Action to correct the deficiency.** An initial admission assessment was started by a nurse on 5/11/23, however it was never signed to show as complete in PCC. Due to nursing staff turnover, it was not completed and signed by a nurse until July 2023. When resident #3 returned from the hospital on 8/12/24, the orders were updated and progress notes were written regarding the change in condition. The resident was transferred back out to the hospital on 8/24/24, before the 14 days re-admission period was complete. An audit will be conducted by the HSD of all current residents to ensure timely completion of Required Assessments has been met. 2) **Measures to ensure that deficient practice does not re-occur.** The Assistant HSD will conduct an audit on all new admissions for completeness on day 14. 3)**Method of monitoring.** The Assistant HSD will complete a "New Resident Checklist" when each resident is admitted, which will be reviewed at the quarterly Quality Assurance and Performance Improvement (QAPI) meeting. 4)**Date of completion**: Audit of current residents required assessments: 11/30/24 R144 Plan of Correction accepted by Jo A Evans RN on 11/10/24	
R169 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management	R169		

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R169	Continued From page 4 5.10.e Staff responsible for assisting residents with medications must receive training in the following areas before assisting with any medications from the licensed nurse: (1) The basis for determining "assistance" versus "administration". (2) The resident's right to direct the resident's own care, including the right to refuse medications. (3) Proper techniques for assisting with medications, including hand washing and checking the medication for the right resident, medication, dose, time, route. (4) Signs, symptoms and likely side effects to be aware of for any medication a resident receives. (5) The home's policies and procedures for assistance with medications. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure one applicable resident's right to refuse medications and direct their own care (Resident #1). Findings include: The facility's Assistance with Medications policy identifies the resident right to direct their own care, including the right to refuse medications. During an interview commencing at 11:29 AM on 10/2/24, Resident #1 stated on the morning of 9/30/24 s/he wanted to take his/her blood pressure medications first, eat breakfast, then return to take the rest of his/her medications. Resident #1 stated the Med Tech said this was a refusal, and when s/he came back after breakfast the Med Tech had wasted the medications s/he had requested to take on return. Per Resident #1,	R169	R169 1) **Measures to correct the deficiency:** We have updated the Medication Management Overview that outlines the policies and procedures that MPC staff will follow regarding medication administration. This will be shared with residents and/or responsible parties and ask that everyone sign the updated overview, indicating their understanding of our policies, and their willingness to adhere to them. Additionally, we have updated our policy on Medication Refusal, to include more detailed language about how long unit-dose medications that are opened will be held if a resident refuses to accept them. Specific to resident #1, MPC will draft and present a Negotiated Risk Agreement for Medication Administration, documenting the need to take medication as prescribed during medication administation times and the risks associated with, but not limited to, failure to do so. The negotiated risk will also detail the risks possible when the resident exhibits unsafe behaviors associated with the medication, such as diversion of medications (cheeking or hiding medication and leaving the medication unattended in apartment or common areas). Med Administration staff will receive training on Resident's Right of Refusal in support of prescribed physicians order. 2 **Measures to ensure deficient practice does not re-occur:** (a)The facility will update the Policies with specifics for Medication Administration times and procedures for "refused" Medications. (b)The facility will include an Acknowledgement and Acceptance of the updated Medication Management Policies and Procedures for all new residents upon admission, and will require all existing residents to also accept the updates and sign the Acknowledgement form. This will provide indication that residents are fully aware of their rights and the facility's responsibilities related to medication administration.	

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R169	Continued From page 5 the night before the incident s/he only had one more dose of the anti-seizure medication Keppra, which meant now s/he didn't have any. Resident #1 stated s/he "got very upset, and panicked". Following this incident, a family member took Resident #1 to the prescribing neurologist's office to get an order for Keppra, and purchased the medication at a local pharmacy to ensure Resident #1 had access to the medication. A Progress Note dated 9/30/24 states Resident #1 refused medication when offered, and was "deciding when [s/he] would or would not take them". Resident #1 is noted to have say that s/he was going to have a seizure after his/her morning dose of the anti-seizure medication Keppra was refused and "wasted according to procedures for medication administration". Per interview on the afternoon of 10/2/24, the Director of Health Services confirmed the Keppra wasted was the last dose in stock, with a delivery expected in the afternoon. Resident #1's diagnoses include intractable Epilepsy (seizures not easily or completely controlled with medications) and a history of Status Epilepticus, which is a life-threatening medical emergency resulting from a sustained single seizure or rapidly occurring cluster of seizures without adequate recovery time. Per record review, a letter written by Resident #1's Neurologist on 3/11/24 states s/he should take care to avoid triggers for seizures, and includes missed medications on a list of triggers for seizures. Per interview commencing at 1:20 PM on 10/2/24, the Med Tech on duty during this incident stated on the morning of 9/30/24 Resident #1 wanted to only take blood pressure meds and wanted to take the other pills after s/he came back up from breakfast, at lunch or sometime later. When told this was a refusal, Resident #1	R169	3) **Method of Monitoring**: The QAPI committee will review medication administration policies and practices, as well as any Negotiated Risk Agreements in place. 4) **Date to be Completed**: Negotiated Risk Agreement 11/13/24 Updated Policies 11/8/24 Signed updated Resident/Responsible Party Acknowledgements 11/18/24 R169 Plan of Correction accepted by Jo A Evans RN on 11/10/24	

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R169	Continued From page 6 responded s/he was not refusing. S/he left the cart cursing and name calling, went to breakfast, and the meds were documented as refused and wasted. The Med Tech stated this occurred around 8:00 am, and identified the morning med pass time frame as 7:00 AM - 10:00 AM. Resident #1 returned after breakfast, waited for other residents to finish taking meds, and sat watching the Med Tech. The Med Tech stated s/he asked if the resident wanted help with anything. Resident #1 responded that s/he wanted his/her medication, cursed and called the Med Tech names, and banged his/her walker when told s/he had refused the medications. Per the Med Tech, Resident #1 escalated to the point s/he thought the resident was going to hit him/her. Resident #1 was told this behavior was not acceptable in the common areas, and to go back to his/her apartment to calm down. A Nursing Progress Notes dated 9/30/24 indicates other residents present were moved to a different area and noted to be upset by the incident. Per this Progress Note, Resident #1 was informed his/her abusive behavior would not be accepted or tolerated, and s/he was told "to cease such behavior and that [s/he] would be evicted according to facility policy". The Progress Note dated 9/30/24 also states Resident #1's family was notified regarding the incident, and informed of a plan for Resident #1 to administer his/her own medications. Per Staff interviews on 10/2/24 and documentation review, Resident #1 has demonstrated inability to safely self administer medications. On the afternoon of 10/2/24 the DHS confirmed Resident Assessments on file in Resident #1's record indicate s/he is incapable of self administration and medication administration is required. Per review of the Resident Assessment signed as	R169		

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R169	Continued From page 7	R169		

completed by the DHS on 8/19/24, Section L. Medications documents Resident #1 has problems taking medications as prescribed and does not know how often to take medications, which are indications Resident #1 requires medication administration. Per record review, the facility receives Enhanced Residential Care funds for care and services provided to Resident #1 including medication administration under the supervision and delegation by a Registered Nurse.

During an interview commencing at 3:48 PM on 10/2/24 the Director of Health Services (DHS) stated on 10/1/24 an agreement had been reached with Resident #1 and his/her family members, and described the terms of the agreement as, "if [Resident #1] refuses one med, then the med pass is over. [S/he] is not going to refuse medications, if [s/he] is going to refuse something then we are going to get an order to [discontinue]. [S/he] is to take all of [his/her] medications as prescribed."; and stated, "Once the meds are popped they are wasted."

Per record review, the agreement Resident #1 was asked to sign states, "If refuses medications for any med pass that will end that med pass. Will wait until next medication pass. If there is a medication [s/he] wants to refuse, will follow proper channels in call MD and obtain a [discontinue] of that medication.[sic]". This agreement was signed by Resident #1, and entered into his/her Plan of Care. During the interview commencing at 11:29 AM on 10/2/24, Resident #1 stated, "I was told I had to sign the paper about taking pills yesterday, I did not understand it. I don't understand what I signed ..." .
This agreement denies Resident #1 the right to

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R169	Continued From page 8 direct his/her own care and the right to refuse medications. On the afternoon of 10/2/24, the Director of Health Services confirmed Resident #1's medications were documented as refused and wasted during the morning med pass on 9/30/25, and confirmed Resident signed an agreement developed by the facility which denies the right to refuse medications.	R169		
R172 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h All medicines and chemicals used in the home must be labeled in accordance with currently accepted professional standards of practice. Medication shall be used only for the resident identified on the pharmacy label. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure insulin pens for one applicable resident (Resident #4) are labeled in accordance with currently accepted professional standards of practice. Findings include: The facility's Labeling and Storage of Medications policy is consistent with this regulatory requirement. When an insulin pen is opened, the current professional standard is to label the pen with the date it was opened to prevent use of this medication beyond the expiration date. According to the American Diabetes Association website,	R172	R172 1)**Action to correct the deficiency.** Med Techs will be educated on the procedures for dating insulin when opened to ensure insulin is discarded in accordance with "The American Diabetes Association" guidelines. The medication carts were audited by the nursing staff on 10/4/2024. 2)**Measures to ensure that deficient practice does not re-occur.** The medication carts will be monitored for proper labeling at each monthly cycle fill change. 3)**Method of monitoring:** Nurses will conduct documented random spot checks of the medication carts. Documentation to be reviewed by the QAPI Committee. 4)**Date of completion.** Med Techs to Complete Insulin Training Program by 11/30/2024. Audits to be started by 11/1/24 and then on-going. R172 Plan of Correction accepted by Jo A Evans RN on 11/10/24	

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R172	Continued From page 9 disposable insulin pens are discarded after the pen has been in use for 28-32 days depending on the type of insulin. Individual insulin pens are labeled with the date they are first "opened" to ensure they are discarded within a set period of time are they are removed from the refrigerator for use. During a review of the medication cart in the home's memory care center commencing at 11:00 AM on 10/3/24 1 Insulin Lispro Kwik Pen and 1 Lantus Solostar Insulin Pen belonging to Resident #4 were observed to be stored in the top drawer of the medication cart without a label indicating the date the pens were opened. This finding was confirmed by the Med Tech on duty at 11:02 AM on 10/3/24, and acknowledged by the Director of Health Services on the morning of 10/3/24.	R172		
R176 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (4) Medications left after the death or discharge of a resident, or outdated medications, shall be promptly disposed of in accordance with the home's policy and applicable standards of practice. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure prompt disposal of	R176	R176 1)**Action to correct the deficiency.** The medication carts were audited by the nursing staff on 10/4/2024. 2) **Measures to ensure that deficient practice does not re-occur.** Med Techs will be educated on the procedures for expiration dates for all medications . 3)**Method of monitoring.** Nurses will conduct documented random spot checks of the medication carts. Documentation to be reviewed by the QAPI Committee. 4)**Date of completion.** Audits to be started by 11/1/24 and then on-going. Med Tech education for expired medication 11/30/24	

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R176	Continued From page 10 outdated medications for 3 applicable residents (Residents #5, #6, and #7). Findings include: The facility's Labeling and Storage of Medications policy is consistent with this regulatory requirement; and the facility's Destruction of Medications policy states "any medications that are expired will be disposed of immediately". During a review of the medication cart commencing at 11:00 AM on 10/3/24 the following outdated medications were observed to be stored in the medication cart: a. For Resident #5: Loperamide 2 mg tablets expired on 9/2/24 b. For Resident #6: Loperamide 2 mg capsules expired on 9/18/24, and Furosemide 20 mg tablets expired on 5/16/24 c. For Resident #7: Melatonin 3 mg tablets expired on 8/3/24, and Acetaminophen 325 mg tablets expired on 9/10/24. These findings were confirmed by the Med Tech at 11:27 AM on 10/3/24 and acknowledged by the Licensed Practical Nurse Shift Supervisor on the morning of 10/3/24.	R176	R176 Plan of Correction accepted by Jo A Evans RN on 11/10/24	
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	R179		

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	0659	A. BUILDING: _____ B. WING _____	C 10/03/2024

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MARGARET PRATT COMMUNITY	210 PLATEAU ACRES BRADFORD, VT 05033

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R179	Continued From page 11 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 documented completion of all required trainings was not on file and available for review for 4 out of 5 sampled staff. Findings include: On the afternoon of 10/1/24 the Executive Director was requested to provide training records for a sample of 5 staff. Per review of staff training records provided for review, documented completion of all required yearly trainings for 4 out of 5 sampled was not on file and available for review. At 5:03 PM on 10/1/24 the Executive Director confirmed training records indicated 4 out of 5 staff did not complete all required yearly trainings.	R179	R179 1. **Action to correct deficiency**: MPC uses both in-person and Relias training for staff. The 4 staff identified as having some trainings missing are completing the trainings. 2. **Measures to ensure deficient practice does not re-occur**: Standardization of the community's orientation and onboarding procedures will be implemented to ensure all new hires complete their core curriculum that includes at a minimum the training as outlined in RCH 5.11.b. All staff members are scheduled for the annual trainings monthly required through Relias. 3. **Method of Monitoring** The Business Office Director will provide monthly Relias completion reports to all managers. Managers, during monthly QA committee reviews will follow up on completion reports and ensure their staff members are actively participating and are current in their required training. 4. **Date to be completed.** 11/30/24 R179 Plan of Correction accepted by Jo A Evans RN 11/10/24	

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R190 R190 SS=F	Continued From page 12 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 staff interview and record review there was a failure to ensure completion of all required criminal record and abuse registry checks for 5 out of 5 sampled staff. Findings include: On the afternoon of 10/1/24 the Executive Director was requested to provide criminal record and abuse registry checks on file for a sample of 5 staff. Per review of the records provided for review, all required background checks were not completed for 5 out of 5 staff. This finding was confirmed by the Executive Director at 4:55 PM on 10/1/24.	R190 R190	R190 1. **Action to correct deficiency**: MPC is registering with the VCIC to become a qualified entity so that the missing national checks can be completed through them. 2. **Measures to ensure deficient practice does not re-occur**: The MPC policy on criminal background checks will be updated to include national checks. 3. **Monitoring Method**: The quarterly QAPI committee meeting will include a review of a report from the Business Office Director on required background checks. 4. **Date to be completed**. 11/30/2024 R190 Plan of Correction accepted by Jo A Evans on 11/10/24	
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 ensure care in a safe environment related to secure storage of	R266	R266 1. **Action to correct deficiency**: All cleaning supplies have been checked for proper labels. Staff will receive updated training about the importance of proper labeling and storage of cleaning supplies and chemicals. All staff in Memory Care have received additional training on the requirement for the supply closet to be locked at all times, and additional keys have been assigned. 2. **Measure to ensure deficient practice does not re-occur**: Staff will be re-trained on proper labeling and storage of chemicals. Signs will be posted to remind staff not to store cleaning supplies in food storage areas. 3. **Monitoring Method**: All Department Managers will monitor for unsecured cleaning supplies daily as they round the building. 4. **Date to be completed**. 10/13/2024.	

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R266	Continued From page 13 hazardous chemicals, cleaning products, and health and beauty products. Findings include: The facility's Food Storage and Equipment policy states, "Poisonous compounds (such as cleaning products and insecticides) shall be labeled for easy identification and shall not be stored in the food storage area unless they are stored in a separate. Locked compartment within the food storage area." Policies and procedures to ensure secure storage of hazardous chemicals and cleaning supplies in locked compartments in resident accessible areas were not on file and available for review on request. During a tour of the home on the morning of 10/1/24 unsecured hazardous chemicals, cleaning products, and health and beauty aids were observed the be accessible to residents in the following areas of the home: 2. In the open kitchenette between the kitchen and dining room an unlocked cabinet was observed to contain an unlabeled spray bottle of what appeared to be disinfectant, and a spray bottle of stainless steel cleaner and polish was observed. This finding was confirmed by the Executive Director at 10:18 AM on 10/1/24. On return to this kitchenette following the kitchen tour, a 75 oz. bottle of dishwasher detergent was observed on the kitchenette floor under the sink facing the dining room. This finding was confirmed by the Kitchen Manager and the Director of Maintenance at 11:02 AM on 10/1/24. 2. During a tour of the home's Memory Care Center on the morning of 10/1/24 a large double door closet was observed to be unlocked, leaving	R266	R266 Plan of Correction accepted by Jo A Evans RN on 11/10/24	

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R266	Continued From page 14 bins filled with health and beauty products, sunscreen, and fingernail polish remover accessible to the residents. This residents living in this area of the home are diagnosed with cognitive impairment which hinders their ability to safely manage access to these items. This finding was confirmed by the Director of Maintenance at 10:34 AM on 10/1/24.	R266		
R291 SS=F	IX. PHYSICAL PLANT 9.6 Plumbing 9.6.d Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure water temperatures in resident accessible areas are maintained at or below 120 degrees Fahrenheit. Findings include: The facility's Plumbing policy states, "Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas." During a tour of the home on 10/1/24 water temperatures were observed to be maintained above 120 degrees Fahrenheit in the following areas accessible to residents: a. First floor kitchenette sinks 122.0 degrees b. Memory Care Center Resident Room #110 125.1 degrees c. Assisted Living Room #205 125.8 degrees d. 2nd floor community kitchen sink 122.0 degrees	R291	1. **Action to correct deficiency**: On 10/1/2024, during the survey proceedings, the Facilities Director adjusted the hot water settings and restored temps to within the temperature standard of 120 degrees or below. Subsequent readings over the next two days demonstrated further compliance. 2. **Measures to ensure deficient practice does not re-occur**: The Facilities Director is conducting daily water temperature checks. The community has contacted ARC Mechanical and scheduled a visit to inspect our existing system. 3. **Monitoring Method** The Executive Director and the QAPI Committee will review the water temperature logs. 4. **Date to be completed.** Logged daily checks completed beginning 10/13/2024. R291 Plan of Correction accepted by Jo A Evans RN on 11/10/24	

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R291	Continued From page 15 The facility took the immediate action of adjusting the boiler. Following this corrective action, water temperatures in resident accessible areas were observed to be maintained at or below 120 degrees Fahrenheit. These findings were confirmed by the Director of Maintenance and the Executive Director on the morning of 10/1/24.	R291	R302 1. **Action to correct deficiency**: The MPC Emergency and Disaster Plan, November 2023, will be revised. The current text in the plan states "Drills will be conducted on a random, unannounced basis for each shift at least once per quarter. The drills required for each shift in a quarter shall not be conducted in the same month. Drills may include resident participation, or their involvement may be simulated at the discretion of the Executive Director".	
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: Based on staff interview and record review there was a failure to complete fire drills at least once quarterly and to rotate the timing of drills as required. Findings include: The facility's Emergency and Disaster Plan	R302	A revision of the current plan will state "fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night". The Fire and Emergency Training Plan will be reviewed and revised to include steps to ensure residents who are not safely behind their apartment fire doors, but are found to be positioned in a common area at the time of an alarm activation will be instructed or, if necessary, be assisted to move behind fire doors until an "all clear" has been sounded or evacuation measures must be employed. 2. **Measures to ensure deficient practice does not re-occur:** Fire and Emergency training is to be scheduled for all staff members that will include all revised changes to the Fire and Emergency Plan. Residents will receive a printed copy of Resident Actions During a Fire Emergency. Residents and staff will participate in a scheduled Fire and Emergency Plan meeting and subsequent drill to receive step-by-step instructions and practical experience relating to the newly revised plan. 3. **Monitoring Method**: Will be implemented as MPC conducts its next fire drill through managerial observation and documentation of actions noted during the drills. An after-action assessment for each drill will be written by the Executive Director and the results of which will be reviewed by the QAPI Committee. 4. **Date to be completed**. 11/30/2024.	

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R302	Continued From page 16 effective November 2023 includes Section C Fire Drills, which is not consistent with regulatory requirements. On the morning of 10/1/24 the Executive Director was requested to provide the home's fire drill record for review. Per review of the records provided for review: a. During the first quarter a drill was documented as occurring on 1/31/24 at 4:45 AM, however the home's alarms were not activated and the staff did not complete an evacuation of the home or document a process of ensuring residents were located in or moved to areas behind fire doors. A second Fire Drill Report for this quarter listed an event on 3/5/24 at 2:10 PM which as an actual activation of the facility's alarm system due to smoke in the kitchen. b. During the second quarter a drill was documented as occurring on 5/30/24 at 1:30 PM. The Fire Drill Report indicates the home was not evacuated and states staff radioed that residents were safe, however the there is no documentation of a process occurring to ensure residents were located in or moved to areas behind fire doors. c. During the third quarter an actual incident was documented as a fire drill on 7/27/23 at 2:25 PM. This event occurred when smoke from a microwave in a resident's room entered the first floor hallway and triggered the alarm system. The facility was not evacuated and there is no documentation of staff ensuring residents were located in or moved to areas behind fire doors. d. During the fourth quarter of the previous year a "Silent Drill - walk thru for new staff members"	R302	R302 Plan of Correction accepted by Jo A Evans RN 11/10/24	

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R302	Continued From page 17 was conducted on 11/28/23 at 1:30 PM with a "verbal" signal rather than activation of alarms. This drill occurred without evacuation of the residents or documentation of a process occurring to ensure residents were located in or moved to areas behind fire doors. At approximately 3:00 PM on 10/1/24 the Executive Director confirmed actual events were documented as fire drills during the first and third quarters of the year. On the afternoon of 10/1/24 the Executive Director acknowledged timing of drills was not rotated to include all required time frames; and the Fire Drill Reports for drills conducted during the first, second, and fourth quarters did not document completion of all required tasks to include sounding of alarms and evacuation of the home or ensuring residents were behind fire doors.	R302		
R313 SS=F	XI. RESIDENT FUNDS AND PROPERTY 11.1 A resident's money and other valuables shall be in the control of the resident, except where there is a guardian, attorney in fact (power of attorney), or representative payee who requests otherwise. The home may manage the resident's finances only upon the written request of the resident. There shall be a written agreement stating the assistance requested, the terms of same, the funds or property and persons involved. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure written signed requests were obtained from all facility residents for whom	R313	R313 1. **Action to correct deficiency:** The Business Director will contact each resident and/or legal representative for whom the community provides management of personal funds and obtain a signed written request and/or form authorizing the community to manage respective funds. 2. **Measures to ensure deficient practice does not re-occur:** The Business Director will include a copy of the resident and/or their legal representative's written request and/or form with each resident's funds envelope, and record receipt of each letter on the Personal Funds Log. 3. **Monitoring Method**: The Executive Director will inspect all personal funds management records on a quarterly basis to verify compliance of regulations regarding written requests, accountability, safeguarding, and reporting of respective funds. 4. **Date to be implemented**: 10/13/2024	

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R313	Continued From page 18 the facility manages funds (Residents #8, #9, #10). . Findings include: Per record review, the facility's Management of Resident's Funds policy states the facility may manage the resident's finances only upon the written request of the resident. During an interview commencing at 1:35 PM on 10/1/24 the Executive Director confirmed the facility had not obtained written signed request to manage resident funds for all applicable facility residents to include Residents #8, #9, #10. This was reconfirmed by the Executive Director during a review of findings on 10/3/24.	R313	R313 Plan of Correction accepted by Jo A Evans RN on 11/10/24	
R314 SS=F	XI. RESIDENT FUNDS AND PROPERTY 11.2 If the home manages the resident's finances, the home must keep a record of all transactions, provide the resident with a quarterly statement, and keep all resident funds separate from the home or licensee's funds This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to provide quarterly statements to all applicable residents for whom the facility provides management of personal funds (Residents #8, #9, #10). Findings include: Per record review, the facility's Management of Resident's Funds policy states if the facility manages the resident's funds, the facility must provide the resident with a quarterly statement. During an interview commencing at 1:35 PM on	R314	R314 1.**Action to correct deficiency.** The Business Office Director will provide a quarterly statement to all residents and/or legal representative for whom the community provides management of personal funds. In addition, the community will keep a record of all transactions, and keep all resident funds separate from the community's funds. 2. **Measures to ensure deficient practice does not re-occur**: Business Director will maintain a Personal Funds Log for all personal funds managed by the community and include a record of quarterly statement due date completion. 3. **Monitoring Method**: The proper management and reporting of resident personal funds will be verified by a quarterly Executive Director review of records. 4. **Date to be Implemented** 10/13/2024.	

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R314	Continued From page 19 10/1/24 the Executive Director confirmed the facility does not provide quarterly statements to facility Residents #8, #9, and #10 for whom the facility manages personal funds. This was reconfirmed by the Executive Director during a review of findings on 10/3/24.	R314	R314 Plan of Correction accepted by Jo A Evans RN on 11/10/24	