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 14, 2023

Ms. Colleen Lee, Manager
Memory Care At Allen Brook
99 Allen Brook Lane
Williston, VT 05495

Dear Ms. Lee:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 24, 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
	0656	A. BUILDING: _____ B. WING _____	01/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORY CARE AT ALLEN BROOK	99 ALLEN BROOK LANE WILLISTON, VT 05495

(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: On 1/17/23 the Division of Licensing and Protection conducted an unannounced on-site relicensure survey, with additional information received on 1/24/23. The following regulatory deficiencies were identified:	R100	***For education purposes, the entirety of these results will be reviewed with all care staff at our next staff meeting on 2/28/23.***	
R128 SS=D	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 ensure medications are administered as ordered for 2 applicable residents (Resident #1 and Resident #8). Findings include: 1. Resident #1's physician ordered Acetaminophen 650 mg by mouth every 4 hours as needed for Pain and Fever. Resident #1's Medication Administration Record (MAR) lists APAP (Acetaminophen) 1,000 mg by mouth three times daily as needed for Pain. 2. Resident #8 is prescribed Lactase (Lactaid) 3,000 units twice daily with lunch and dinner. On 1/2/23 - 1/4/23, 1/7/23, 1/8/23, 1/10/23 - 1/12/23, 1/15/23, and 1/16/23 doses of Lactaid were not given as indicated by staff circling their initials on the MAR, and on 1/5/23 a dose was not signed as given. Documentation on the back of Resident #8's MAR indicated Lactose was "held- not	R128	**Plan of Correction 5.5c** 1. The nurse will update the MAR in order to reflect and be consistent with physician orders for all errors found. The Nurse will review all documentation received from provider's offices and ensure there is a signature with all new orders. In the event there is not, RN will obtain a signed telephone order or signed order from provider that has been sent to Health Direct Pharmacy. 2. The nurse will conduct a monthly audit of the MAR. The Nurse will review physician orders in comparison to the MAR to ensure accurate and consistent information for all resident medications, treatments, and dietary services. Nursing will make any changes that are not consistent with physician orders. 3. The nurse corrected the inconsistent MARS on 2/15/2023. **Tag R128 POC accepted on 4/14/23 by J. Evans/P. Cota**	

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R128	Continued From page 1 needed" on 1/4/23, 1/7/23, 1/11/23, 1/12/23, 1/15/23, and 1/16/23; however there was no documentation of signed orders to hold Lactase or follow up with Resident #8's provider to clarify when this medication should be held. On the afternoon of 1/17/23 the Manager acknowledged mediations for Resident #1 and Residents #8 were not administered as ordered. and a follow up with Resident #8's physician regarding administration of Lactase had not occurred.	R128		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the Registered Nurse failed to ensure a plan of care describing the care and services necessary for the wellbeing of one applicable resident. Findings include: Resident #3 was admitted to hospice on 10/5/22. Per record review Resident #3's plan of care was not updated to include instructions for contacting hospice providers and administration of comfort	R145 SS=D	**Plan of Correction 5.9c (2)** 1. Resident #3 passed away on 1/30/2023; therefore, we are unable to update this individual's care plan. 2. However, the nurse will institute the following in order to ensure care plans are accurate and updated appropriately: All care plans will be updated annually and upon significant change in a residents care status and admission to hospice. The care plans will provide vital care information to all care staff, regarding resident care and hospice instructions. 3. Nursing will review and update care plans upon significant change for accuracy, based on resident's current needs. 4. All care plans will be reviewed and updated by 2/28/2023. **Tag R145 POC accepted on 4/14/23 by J. Evans/P. Cota**	

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R145	Continued From page 2 medications. On the afternoon of 1/17/23 the Manager acknowledged Resident #3's plan of care was not updated to include care and services related to hospice care.	R145		
R163 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (1) A registered nurse must conduct an assessment consistent with the physician's diagnosis and orders of the resident's care needs as required in section 5.7.c This REQUIREMENT is not met as evidenced by: Per record review and staff interview there was a failure to complete resident assessments according to section 5.7c of the Vermont State Residential Care Home Regulations for one applicable resident (Resident #3). Findings include: Resident #3 was admitted to the facility on 2/15/18 and admitted to hospice on 10/5/22. Per review of Resident Assessments completed for Resident #3, a significant change of condition assessment was not completed following his/her admission to hospice. On the afternoon of 1/17/22 the Manager confirmed a Resident Assessment was not completed by the Registered Nurse when Resident #3 was admitted to hospice.	R163	**Plan of Correction 5.10.d** 1. Resident #3 passed away on 1/30/2023; therefore, we are unable to update this individual's resident assessment. 2. However, Nursing will institute the following in order to ensure resident assessments are accurate and updated appropriately: All resident assessments will be updated annually and upon significant change in a residents care status and admission to hospice by the nurse. 3. The nurse will review and update resident assessments upon significant change for accuracy, based on resident's current needs. 4. All resident assessments will be reviewed and updated by 2/28/2023. **Tag R163 POC accepted on 4/14/23 by J. Evans/P. Cota**	

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R171	Continued From page 3	R171		
R171 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include: (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, including the reason why and the actions taken by the home; (3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect; (4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and (5) For residents receiving psychoactive medications, a record of monitoring for side effects. (6) All incidents of medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to document the effect of the administration of PRN (as needed) medications for 3 applicable residents (Residents #1, #3, and #8) Findings include: Resident #1 is prescribed Ibuprofen 400 mg by mouth twice daily as needed for pain. This PRN medication was administered on 1/14/23 without	R171	**Plan of correction 5.10.g** 1. Effective 2/15/23 and going forward Med Passers will be educated to follow up on any PRN given. A nurse will complete daily to weekly audits of the MAR until staff have shown improvement. After improvement is identified, the nurse will complete a monthly MAR audit. Nurse will create a PRN checklist to include during change of shift medication count. **Tag R171 POC accepted on 4/14/23 by J. Evans/P. Cota**	

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R171	Continued From page 4 documentation of the effects of administration . Resident #1's MAR lists APAP (acetaminophen) 1,000 mg by mouth three times daily as needed for pain. This PRN medication was administered on 1/13/23 and 1/14/23 without documentation of the effects of administration. Resident #3 is prescribed 2 mg of liquid Morphine solution every 1 hour as needed for pain and shortness of breath. This PRN medication was administered on 12/7/22, 12/20/22, 12/21/22,12/23/22, 1/4/23, 1/10/23, 1/13/23, 1/16/23, and 1/17/23 without documentation of the effects of administration. Resident #3 is prescribed Lorazepam 0.5 mg by mouth every 2 hours as needed for nausea, vomiting, anxiety, insomnia, and myoclonus (muscle spasms). This medication was administered on 12/5/22 without documentation of the effects of administration . Resident #8 is prescribed Trazodone 25 mgby mouth at bedtime as needed for insomnia. This PRN medication was administered on 12/2/22, 12/5/22, 12/7/22, 12/13/22, 12/22/22, 12/25/22, and 1/5/23 without documentation of the effects of administration. On the afternoon of 1/17/23 the Manager acknowledged the effects of PRN medication administration for Residents #1, #3, and #8 were not documented in the Medication Administration Record.	R171		
R172 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management	R172		

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R172	Continued From page 5 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 Morphine sulfate oral syringes for 3 applicable residents (Residents #2, #3, and #4) were labeled in accordance with currently accepted professional standards. Findings include: During a review of the medication administration system and medication cart on the evening of 1/17/23 oral syringes of morphine sulfate for Residents #2, #3, and #4 were observed without labels on each syringe indicating the resident's name, medication name, medication strength and dose, and instructions for medication administration in accordance with the currently accepted professional standards for labeling medications. The use of properly labeled medications prevents medication errors by clearly identifying the resident the medication is prescribed for; the medication name; strength and dose; as well as how and when the medication is intended to be given. The unlabeled individual oral syringes of Morphine sulfate were placed in Ziploc bags stored in the medication cart. Each bag had the resident's name written on it, however the ink on the bags containing the syringes for Resident #3 and Resident #4 had worn off and were no longer legible. On the afternoon of 1/17/23 the Manager	R172	**Plan of Correction 5.10.h** 1. Resident #3 passed away on 1/30/2023. The nurse will create labels for resident #2 and #4 morphine syringes. These labels will include resident's name, medication name, medication strength and dose, and instructions for medication administration. These labeled syringes will be stored in a plastic bag in the med cart. This plastic bag will also have a label including resident's name, medication name, medication strength and dose, and instructions for medication administration. 2. Upon receiving new orders for syringe medications, a label will be generated and applied. 3. Medication passers will be educated on the following: They will be instructed to notify the nurse on duty and not to administer any syringe medication without the appropriate label. 4. On 2/15/23, resident #2 and resident #4 morphine syringes were labeled. The labels include resident's name, medication name, medication strength and dose, and instructions for medication administration. **Tag R172 POC accepted on 4/14/23 by J. Evans/P. Cota**	

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R172	Continued From page 6 confirmed oral syringes containing Morphine Sulphate for Residents #2, #3, and #4 were not labeled according to currently accepted professional standards.	R172		
R179 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there	R179	**Plan of Correction 5.11.b** 1. All training records have been reviewed and staff #1 and staff #2 have been instructed to complete required courses by 2/28/2023. 2. For all new hires going forward, all 7 mandatory trainings will be completed during HR orientation, prior to staff training onsite and providing direct resident care. Staff will also be required to complete 8 hours of Best Friends Approach to Alzheimer's care training within 30 days of hire. 3. Monthly reminders will be communicated to all staff. We will complete quarterly review of staff trainings and provide updated tracking sheets of course completion to ensure continued compliance. **Tag R179 POC accepted on 4/14/23 by J. Evans/P. Cota**	

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R179	Continued From page 7 was a failure to ensure 2 out of 5 sampled staff completed required yearly trainings. Findings include: Per review of training records for a period of 12 months prior to the survey, Staff #1 failed to complete yearly training in Resident's Rights; and Staff #2 failed to complete all required yearly trainings including Resident Rights; Fire Safety and Emergency Evacuation; Resident Emergency Response Procedures and First Aid; Policies and Procedures Regarding 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 1/17/23 the Manager confirmed 2 out of 5 sampled staff did not complete the required yearly trainings.	R179		
R234 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure the weekly menu was posted in a public place. Findings include: During observation of lunch meal service on 1/17/23 it was noted a weekly menu was not posted in a public area.. At approximately 12:15 PM on 1/17/23 the Kitchen Manager acknowledged the weekly menu was not posted.	R234	**Plan of Correction 7.1.a (3)** 1. The weekly menu has been posted on the resident bulletin board effective 1/18/2023. 2. In order to ensure that the menu is posted weekly, the food services manager will set a weekly reminder in their outlook calendar. Staff will also be educated to inquire about the menu, if they do not see it posted on the bulletin board. 3. The food service manager has posted the menu, created an outlook reminder and educated staff on 2/15/2023. **Tag R234 POC accepted on 4/14/23 by J. Evans/P. Cota**	

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R247 SS=E	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure all perishable food items are labeled and dated. Findings include: During the facility tour commencing at 10:00 AM on 1/17/23 the following perishable food items were observed and confirmed by the Manager to be stored in the kitchen without required labels including: * In the refrigerators: A tray of uncooked hamburger patties covered with a piece of wax paper; containers of chopped fruits and vegetables; cheese wrapped in plastic wrap, opened cream cheese; an opened box of eclairs; opened gallons of mayonnaise and salad dressings; opened containers of ketchup, mustard, strawberry sauce, chocolate sauce, and spaghetti sauce; and an opened container of garlic in water were observed without dates indicating when they were prepared or opened. Additionally a plastic tub containing unprepared vegetables placed on visibly soiled paper towels was observed in the refrigerator. * In the freezer: A uncovered tray of fish sticks; and opened bags and containers of fries, sausage, and bacon were observed without	R247	**Plan of correction 7.2.b** 1. On 1/19/2023, the food service manager did a complete review of the refrigerator, freezer and pantry. Refrigerator – the food service manager has ensured that all open unlabeled foods have been properly labeled including the food item and date opened. He also ensured that opened refrigerated foods are now packaged and covered safely in containers or bags. Freezer – on 1/20/23 the manager and food service manager gutted the freezer, reorganized, and eliminated stacking of products. On 2/15/2023, the food service manager labeled freezer items and purchased containers for safe frozen food packaging. Pantry – The food service manager has ensured that all open unlabeled foods have been properly labeled including the food item and date opened. He also ensured that open foods are now packaged and covered safely. 2. The Food Service Manager will provide food storage, labeling and sanitation education to all cooks. We will also add a refrigerator, freezer and pantry review to the daily checklist for the closing cook to complete. This will include ensuring all open products are labeled and covered properly in both the refrigerator, freezer and pantry. 3. The checklist and staff education will be instituted by 2/28/2023. **Tag R247 POC accepted on 4/14/23 by J. Evans/P. Cota**	

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R247	Continued From page 9 labels indicating when they were opened or prepared. * The kitchen cabinets and pantry contained: an opened gallon of Worcestershire sauce, opened bags of sugar and cake mix, and several containers of herbs and spices with the lids left open were observed without dates.	R247	**Plan of Correction 9.1.a** 1. On 2/15/23 a work order was generated for Cathedral Square maintenance to install new hooks for mops, brooms and dustpans to be hung on the wall to ensure unfettered access. Effective 2/15/23 the cart will be positioned to not block the exit. On 1/17/23, the garbage lid was located and placed on garbage bin. On 2/15/23 the food service Manager purchased a new compost bucket lid, allowing compost to covered. On 1/17/23 the mop bucket was properly emptied in the janitorial closet. On 1/17/23, the items were removed from the top of refrigerator and freezer. A monthly cleaning schedule is being developed and will be posted for hood cleanings. We will also add a stovetop, grill, oven and microwave cleaning to the daily checklist for the closing cook to complete. On 1/17/23 the food service manager reviewed the pantry and disposed of all dented cans. Egg noodles and disposable cups were moved from the pantry floor and placed on a shelf. On 1/24/23 the manager educated the intern on proper donning and doffing of gloves during meal service. All cleaning products and chemicals will be removed from resident rooms. On 1/17/23 all cleaning products and chemicals were removed from common areas. Medications found during survey will be removed from #2's room. Resident #1 passed away 2/1/23. 2. With new hooks installed, all cleaning devices will be hung on the wall allowing for a clear pathway to the exit. On 2/17/23 the food service manager purchased a smaller cart to ensure it would not block the exit going forward. With purchase of new compost bucket and reacquired garbage lid, covers will be in place at all times. The food service manager will confirm weekly lids are being used.	
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 a safe, functional, sanitary environment. Findings include: During the environmental tour of the facility commencing at 10:00 AM on 1/17/23 the following observations were confirmed by the facility Manager. 1. Safety and sanitation issues observed in the facility kitchen included: * Access to the kitchen exterior exit partially blocked by a stainless steel cart, brooms, and dust pans; missing lids on the compost bucket and kitchen garbage which the Chef and Kitchen Manager confirmed is the customary practice and not limited to periods of time when food is being	R266		

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R266	Continued From page 10 prepared; a mop bucket which was not in use containing dirty water and confirmed by the Kitchen Manager to be routinely dumped in the kitchen sink instead of the utility sink located an area adjacent to the kitchen; items stored on top of the refrigeration unit within 2-6 inches of the ceiling and potentially obstructing the spray of water from the sprinkler heads should a fire occur; build-up of dust and grime on the exhaust hood above the cooking area; and the buildup of oil and grease on the stovetop and grill surfaces posing a risk for fire. The microwave, oven and all kitchen surfaces were in need of cleaning. The Chef and Kitchen Manager confirmed there was no set schedule for kitchen cleaning and maintenance. * Dented cans of pinto beans and cranberry sauce were observed in the kitchen pantry; and a large dented can of pineapple was observed in an additional pantry closet in the hallway outside the kitchen. * A large bag of egg noodles was observed stored directly on the floor in the kitchen pantry; and sleeves of disposable plastic cups were observed stored directly on the floor in the hallway pantry closet. * During observation of lunch service an intern was observed wearing the same pair of gloves as s/he served food, assisted residents, and returned used dishes to the kitchen area, which is a risk for infection transmission. 2. Hazardous Chemicals accessible to the facility residents, all of whom are diagnosed with dementia, were observed in residents rooms and in an unlocked cabinet in the dining room. The unlocked cabinet in the dining room contained	R266	**Plan of Correction 9.1.a (continued)** Food Service Manager will educate staff regarding proper mop bucket use and confirm with cooks that it is being filled and emptied using the utility sink in the janitorial closet. Food service manager will educate staff on importance of not storing items on top of refrigerator and freezer due to risk of sprinkler heads not working properly. Food service manager will educate and instruct on how to properly clean stove, grill, exhaust hood, microwave, and oven. By 2/28/23 a monthly hood cleaning schedule will be posted and we will also add a stovetop, grill, oven and microwave cleaning to the daily checklist for the closing cook to complete. By 2/28/23 staff receiving and putting away food orders will be instructed to carefully inspect all canned goods for dents. Any dented or damaged cans will be returned immediately. In order to ensure items are not stored on floor, signage will be put in place in the pantry by 2/28/23. By, 2/28/23 all staff will be educated on proper donning and doffing of gloves and food service safety during meals. Effective 1/17/23, staff have been instructed to store all cleaning supplies, wipes and chemicals in the locked janitorial closet. By 2/28/23 the manager and director of nursing will inspect all resident rooms and remove any cleaning supplies and chemicals identified. Resident #1 passed away on 2/1/23. All medications will be stored based on the physician's order. All medications and creams will be removed from resident apartments by 2/28/23. Director of nursing will educate all staff that medications and creams cannot be stored in residents' apartments without an order directing so. 3. All above plans of action will be completed by 2/28/23. **Tag R266 POC accepted on 4/14/23 by J. Evans/P. Cota**	

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	0656	A. BUILDING: _____ B. WING _____	01/24/2023

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R266	Continued From page 11 Renegade Daily Disinfectant Cleaner, X-treme Hand Sanitizer, Wax Polish, and Expo Whiteboard Cleaner. Personal cleaning supplies and chemicals observed in resident rooms included OxiClean spray, Windex spray, detergents and sanitizers, nail polish remover and rubbing alcohol. 3. Medications observed stored and accessible in resident rooms included Vicks VapoRub, Cortisone gel, Ben Gay muscle rub, and Miralax in Resident #1's room; and Erythromycin ointment in Resident #2's room. Resident #1 and Resident #2 did not have signed orders on file to store and self-administer these medications, as confirmed by the Manager and Director of Operations for the company that manages the facility on the afternoon of 1/17/23.	R266		
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.	R302	**Plan of Correct 9.11.c** 1. At the beginning of each year, the manager will schedule in advance a minimum of one fire drill for staff quarterly. The manager will add a reminder to their outlook calendar to ensure completion. Throughout the year, these fire drills will rotate times of the day to include morning, afternoon, evening and night. 2. Manager met with Deputy Chief Timothy Gerry from the Williston Fire Department on 2/16/23. She reviewed our Fire Emergency Plan with him. He approved our plan and stated we do not need to include audible alarms or involve the fire department in our drills. **Tag R302 POC accepted on 4/14/23 by J. Evans/P. Cota**	

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R302	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to conduct quarterly fire drills including sounding of alarms; and to rotate drill times to include at least one drill during the morning, afternoon, evening, and night yearly. Findings include: Per review of fire drill records for a 12 month period prior to the survey there were no fire drills conducted to include sounding of alarms. The facility conducted a Silent Drill in September of 2022; and fire drill scenario staff trainings in May, June. August, September, November, and December of 2022; however documentation of these events indicated alarms were not sounded and only the Silent Drill conducted in September included facility residents. On the afternoon of 1/17/23 the Manager confirmed fire drills were not completed as required during the 12 months prior to the survey.	R302	**Plan of Correction 11.2** 1. On 1/18/23 manager reviewed and updated ledgers with all transactions in order to get correct balance for residents #1,5, 6 & 7. For all residents, manager compared ledgers to resident petty cash on hand and corrected any incorrect ending balance with Cathedral Square funds. This allowed the ledger and petty cash on hand to balance. 2. On 1/18/23 manager printed ledgers for petty cash binder allowing manager and director of nursing to input transactions at that time. This will reduce errors with transactions not being recorded. 3. Manager will compare ledger to petty cash on hand quarterly. 4. Completed on 1/18/23.	
R314 SS=E	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 observation, record review, and staff interview there was a failure to maintain accurate records of all transactions and to provide accurate quarterly reports for 4 out of 7 applicable	R314		

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R314	Continued From page 13 residents (Residents #1,#5, #6, and #7) receiving assistance with management of finances from the home. Findings include: Per record review the reported amount of available funds was not consistent with the amount of money on hand for 4 applicable residents, as observed during a count of all resident funds with the Manager on the afternoon of 1/17/23. * Resident #1 reportedly had $64.94 on hand, however during count only $28.32 was on hand. The Manager had failed to account for $3.33 spent while shopping on 10/10/22, $20 charged for foot care on 11/1/22, and $13.31 spent while shopping on 11/3/22. This left 2 cents which could not be accounted for. * Resident #5 reportedly had $507. 31 on hand, however during count only $487.56 was on hand. The Manager had failed to account for $20 charged for footcare on 11/1/22, leaving 25 cents which could not be accounted for. * Resident #6 reportedly had $90.50 on hand, however during count only $54.71 was on hand. The Manager had failed to account for $17.10 spent while shopping on 10/7/22 and $20 charged for footcare on 11/1/22, leaving $1.31 that could not be accounted for. * Resident #7 reportedly had $50.25 on hand, however during count $30.25 was on hand. The Manager had failed to account for $20 charged for foot care on 11/1/22. On the afternoon of 1/17/23 the Manager confirmed the amount of funds on hand was not consistent with the amount counted, and accurate	R314	**Tag R314 POC accepted on 4/14/23 by J. Evans/P. Cota**	

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R314	Continued From page 14 records of all transactions were not maintained for 4 residents.	R314		