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

June 23, 2023

Anne Steinberg, Manager
Michaud Memorial Manor
47 Herrick Road
Derby Line, VT 05830-8759

Dear Ms. Steinberg:

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

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

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0143	A. BUILDING: ______ B. WING ______	04/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAUD MEMORIAL MANOR	47 HERRICK ROAD DERBY LINE, VT 05830

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R100	Initial Comments: On 4/18/23 the Division of Licensing and Protection conducted an unannounced on-site relicensure survey. The following regulatory deficiencies were identified:	R100		
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 observation, record review, and staff interview there was a failure to administer medication as ordered for 1 applicable resident (Resident #1). Findings include: At 4:17 PM the Charge Nurse confirmed the Patient Care Attendant (PCA) failed to administer an Advair 231-21 mcg Inhaler to Resident #1 as ordered. The PCA failed to ensure the Resident rinsed his/her mouth following administration of this steroid inhaler as instructed in the Medication Administration Record (MAR). The practice of rinsing the mouth following use of a steroid inhaler is ordered to prevent fungal infection of the mouth, which is a side effect of this medication.	R128	R128 1. There was no apparent harm to resident #1 as a result of the medication error. 2. Education was provided immediately on 4/18/23 to the PCA making the error. 3. The instructions were highlighted on the MAR to call attention to the need to have the resident rinse their mouth after administering an inhaler. 4. All Nurses/PCA's were educated at the Nurse meeting on 5/9/23. 5. Date of Completion: 5/9/23 R128-Accepted by Carolyn Scott 6-23-23	
R134 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7 Assessment	R134		

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R134	Continued From page 1 5.7.a An assessment shall be completed for each resident within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The resident's abilities regarding medication management shall be assessed within 24 hours and nursing delegation implemented, if necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to complete a Resident Assessment within 14 days of admission for 2 applicable residents (Residents #2 and #7). Findings include: 1. Resident # 2 was admitted to the home on 5/22/18. At 6:20 PM on 4/18/23 the Manager confirmed the admission assessment for Resident #2 was signed by the Registered Nurse as completed on 6/14/18. 2. Resident #7 was admitted to the home on 1/6/22. At 7:47 PM on 4/18/23 the Manager confirmed the admission assessment for Resident #7 was signed by the Registered Nurse as completed on 1/22/22.	R134	R134 1. The two assessments cited were from 2018 and 2022 and were completed by a former RN. The current RN is aware of the regulation regarding timing of assessment completion and is committed to meeting the requirement. 2. Once the RN completes an assessment, the administrator will review it for accuracy and timeliness in order to monitor for compliance. 3. Date of Completion: 5/9/23 R134-Accepted by Carolyn Scott 6-23-23	
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:	R234		

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R234	Continued From page 2 Based on observation and staff interview there was a failure to ensure the weekly menu is posted in a public place. Findings include: During the facility tour commencing at 9:22 AM on 4/18/23 the Administrator confirmed a weekly menu was not posted in a public place for residents and other interested parties to view.	R234	R234 1. The weekly menu was posted on the bulletin board outside of the dining room on 4/18/23 and the Dietary Manager was educated to update it weekly. 2. Staff members were educated at an All-Team Meeting on 5/9/23. 3. Kitchen audits were completed weekly from 4/24/23 - 5/26/23 to ensure that the correction was effective. 4. Audits will be completed monthly for at least six months to monitor for continued compliance. 5. Date of Completion: 5/9/23 R234-Accepted by Carolyn Scott 6-23-23	
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 were labeled and dated. Findings include: During at tour of the facility commencing at 9:22 AM on 4/18/23 the Activity Director confirmed the following opened perishable food items were observed without labels and dates: 1. In the beverage fridge: a) freezer- "sugar on snow" in uncovered containers, and open half gallon ice cream b) fridge- ginger ale, chocolate syrup, gallons of lowfat milk and orange juice 2. In the prepared foods fridge: a) freezer- unsealed bags of mixed vegetables,	R247		

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R247	Continued From page 3 pie crusts; bags of green beans, peas, breaded chicken, cheese balls, tater tots, hash browns, and box of mozzarella sticks b) fridge- two containers non-dairy creamer, Italian dressing, and almond milk 3. Walk-in fridge: b) containers of chopped vegetables including onions and tomatoes, half onion, and radishes 4. Walk-in freezer: b) unsealed boxes of turnovers, mini pretzels, garlic knots, dough for pie crusts, and two large containers of ice cream	R247	R247 1. The unlabeled items were labeled on 4/18/23. 2. A sign was placed on the refrigerator reminding staff to label and date everything on 4/19/23. 3. Staff education was completed at All Team Meeting on 5/9/23. 4. Kitchen audits were completed weekly from 4/24/23 - 5/26/23 to ensure that the correction was effective. 5. Audits will be completed monthly for at least six months to monitor for continued compliance. 6. Date of Completion: 5/9/23 R247-Accepted by Carolyn Scott 6-23-23	
R266 SS=D	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure care in a safe, functional, sanitary, homelike and comfortable environment. Findings include: During the facility tour commencing at 9:22 AM on 4/18/23 the Manager confirmed the following environmental observations: 1. In the facility kitchen the walk in freezer contained 5 open boxes coffee placed directly under the under compressor	R266	R266 1. The boxes of coffee were moved on 4/18/23. Staff education was provided at an All-Team Meeting on 5/9/23. 2. Kitchen audits were completed weekly from 4/24/23 - 5/26/23 to ensure that the correction was effective. 3. Audits will be completed monthly for at least six months to monitor for continued compliance. 4. Date of Completion: 5/9/23	

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R266	Continued From page 4 with ice forming on top of the boxes from water leaking from the compressor. 2. The facility Salon was missing a window screen, and there was a strong smell of chemicals coming from the salon throughout the back hallway of first floor. The Salon is located directly beside Resident #2's room. 3. Resident #2's bathroom was observed to have mildew stained shower grout, a Foley catheter urine bag on shower hand rail, and open Ziploc bag containing items used to provide Foley catheter care was taped to bathroom wall. There was duct tape on the floor around the base of the sink, and covering an electrical outlet beside sink which did not have a Ground Fault Circuit Interrupter (GFCI). According to the U.S. Consumer Product Safety Commission GFCI devices provide protection from severe electrical shocks, especially in vulnerable areas where electrical equipment is near water (https://www.cpsc.gov/s3fs-public/099_0.pdf). 4. Cleaning products were observed to be unsecured and accessible to residents including Lysol spray and nail polish remover in the room of Resident #4's who has Dementia.	R266	R266 1. An air conditioning unit was installed in the window in the beauty shop on 4/18/23. 2. A window fan with reversible air-flow and temperature control has been ordered and will be installed upon arrival to increase ventilation 3. The building will be monitored for strong odors when the hairdresser is giving perms to ensure that the fan is effective. 4. Date of Completion: no later than July 1, 2023. 1. The foley catheter and supplies were removed from Resident #2 bathroom on 4/18/23. 2. The base of the shower was re-grouted on 4/19/23. 3. The outlet was replaced with a GFCI outlet on 6/19/23. 4. The flooring around the base of the sink was repaired on 6/19/23. 5. The chemicals were removed from Resident #4 room on 4/18/23. 6. The administrator spoke to the family to provide education regarding not leaving chemicals in the room on 4/20/23. 7. Education was provided to staff at an All-Team Meeting on 5/9/23. 8. All resident rooms were audited between 4/24/23 and 5/9/23 to ensure that there is no mildew in any showers and no chemicals are accessible to residents. 9. Audits to be conducted monthly for at least six months to monitor for continued compliance 10. Date of Completion: 6/19/23 R266-Accepted by Carolyn Scott 6-23-23	
R270 SS=E	IX. PHYSICAL PLANT 9.2 Residents' Rooms 9.2.c Each bedroom shall have an outside window. (1) Windows shall be openable and screened	R270		

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R270	Continued From page 5 except in construction containing approved mechanical air circulation and ventilation equipment. (2) Window shades, venetian blinds or curtains shall be provided to control natural light and offer privacy. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure all bedroom windows are openable and screened for 2 applicable residents (Residents # 5 and #6). Findings include: During the facility tour commencing at 9:22 AM on 4/18/23 the Manager confirmed Resident #5's room was missing the crank handle to open one window; and Resident #6's room was missing one window screen.	R270	R270 1. The screen in Resident #6 room was replaced on 4/18/23. 2. The missing crank in Resident #5 room was replaced on 4/20/23. 3. All resident rooms were audited between 4/24/23 and 5/9/23 to ensure that all windows are functioning properly and screens are present. 4. Audits to be conducted monthly for at least six months to monitor for continued compliance. 5. Date of Completion: 5/9/23 R270-Accepted by Carolyn Scott 6-23-23	
R313 SS=D	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 record review and staff interview there was a failure to ensure a written request for management of personal funds for 1 applicable	R313		

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R313	Continued From page 6 resident (Resident #8). Findings include: On the afternoon of 4/18/23 the Manager confirmed a written request for facility management of personal funds for Resident #8 was not available for review on request.	R313	R313 1. Resident Funds Agreement was signed by the POA of resident #8 on 4/19/23. 2. The administrative assistant or designee will audit resident financial files upon admission and every quarter to ensure all new residents have a Resident Funds Agreement form. 3. Date of Completion: 4/19/23 R313-Accepted by Carolyn Scott 6-23-23	