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

May 9, 2024

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

Dear . Steinberg:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 1, 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
	0143	A. BUILDING: ______ B. WING ______	C 04/01/2024

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

(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 4/1/24 the Division of Licensing and Protection conducted an unannounced on-site relicensure survey and investigation of 2 facility reported incidents. The following regulatory deficiencies were identified:	R100		
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 staff interview and record review there was a failure to ensure development of a plan of care to address needs related to food allergies/sensitivities, pain management, and use of the medication Nitroglycerin for one applicable resident (Resident #1). Findings include: Per record review, the home's Nursing Overview policy provided by the Administrator for review on request on the afternoon of 4/1/24 includes a procedure which states, "The nursing staff shall be responsible to ... Develop and maintain a care plan for each resident", however the Nursing Overview policy does not indicate the plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being.	R145	R145 Resident #1's care plan was reviewed and revised to include needs related to food allergies/sensitivities, pain management and use of the medication Nitroglycerin. A review of all active resident care plans will be conducted and any findings will be corrected upon discovery. All nursing staff will be educated on the Care Planning policy. All care plans will be reviewed periodically and with any significant change to ensure timely revisions and updated person-centered interventions. The corrective action will be monitored by monthly care plan audits for a minimum of three months to ensure that substantial compliance is maintained. The audits will be reported to the quality assurance committee at the scheduled meeting. Completion Date: No later than June 1, 2024	

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R145	Continued From page 1 Per record review Resident #1 has food allergies including chocolate and tomatoes. During an interview on the afternoon of 4/1/24, the Director of Nursing (DON) stated Resident #1 has food sensitivities to chocolate and and tomatoes, not food allergies, and eating these foods causes reflux. The DON stated the facility tries to help limit the amount of these items Resident #1 consumes. Resident #1 is diagnosed with osteoarthritis; and a recent history of a gout flare up, arm pain, and left side pain resulting from a rib fracture in January of 2024; and is prescribed the medications including Celecoxib, Gabapentin, and Acetaminophen for pain management. Resident #1 is prescribed the medication Nitroglycerin as needed for chest pain. Per record review Resident #1's Plan of Care does not describe care and services to address food allergies/sensitivities, pain management, and use of the PRN (as needed) medication Nitroglycerin. This finding was confirmed by the DON at 1:55 PM on 4/1/25. In conclusion this deficient practice is a risk for more than minimal harm to all residents resulting from unidentified residents needs and interventions.	R145	R145 Plan of Correction accepted by Jo A Evans Rn on 5/8/24 This page intentionally left blank	
R162 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or	R162		

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R162	Continued From page 2 problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure physician's written signed orders were on file and available for review for medications prescribed for one applicable resident (Resident #1). Findings include: The facility's Medication Management policy effective 5/14/19 states, "There must be a physician's written, signed order and supporting diagnosis or problem statement in the resident's record for all medication (prescription or over-the-counter) administered by staff, or for which staff give administration assistance." Per review of the April 2024 Medication Administration Record, Resident #1 is prescribed the PRN (as needed) medication Ventolin HFA 90 mcg inhaler; and a titration of the medication Seroquel with weekly dose increases scheduled during the first two weeks of April 2024. Per record review physician's written, signed orders for administration of the Ventolin inhaler as needed for shortness of breath, and increasing doses of the medication Seroquel prescribed for Schizophrenia were not on file and available for review on 4/1/24. These findings were confirmed by the Director of Nursing at approximately 2:00 PM on 4/1/24. In conclusion this deficient practice is a potential risk for more than minimal harm to Residents as physician's written, signed orders ensure the medication, dose, route, and frequency of administration are communicated as the prescriber intended.	R162	R162 Resident #1's missing signed Physician's orders for the two medications were printed from the pharmacy's website and placed in the residents file on 4/1/24. All Med Techs and Nurses have access to the pharmacy's website and can retrieve all active orders. DON will re-educate nursing staff, ensuring that each Med Tech and Nurse can log on to the pharmacy website to find electronically signed orders. A Review of all active resident MAR's will be conducted no later than June 1, 2024, ensuring that we have a signed order for each medication. Any findings will be corrected upon discovery. To monitor for effectiveness, the DON will review every resident file, ensuring each file contains physicians' written signed orders that coincide with the MAR at time of annual assessment. Completion date: No later than June 1, 2024 R162 Plan of Correction accepted by Jo A Evans RN on 5/8/24	

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R190	Continued From page 3	R190		
R190 SS=F	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 complete all required criminal background and abuse registry checks for 3 out of 5 sampled staff. Findings include: Per record review the facility's policies and procedures for employee criminal background and abuse registry checks state the checks conducted by the facility "completely fulfills the requirements set by the State of Vermont"; however the policy states the required Vermont Criminal Information Center (VCIC) criminal background and Vermont Agency of Human Services (AHS) adult and child abuse registry checks are conducted through a national organization, and do not include documentation directly from the VCIC and AHS offices as required. On the morning of 4/1/24 the Administrator was requested to provide documentation of criminal background and abuse registry checks for a sample of 5 staff. Per review of the documentation provided for review, all required checks were not completed for 3 out of 5 sampled staff. This finding was confirmed by the Administrator at 1:41 PM on 4/1/24. In conclusion this deficient practice is a potential	R190	R190 Vermont Catholic Charities contracts with [redacted] and they run complete background checks including VTAHS Adult/Child Registry checks and VCIC. Further, Vermont Catholic Charities runs the VTAHS Adult/Child Registry check and VCIC. Beginning January 1, 2024, Vermont Catholic Charities has continued to run the VTAHS and VCIC internally, but now also prints and scans the VTAHS Adult/Child Registry and VCIC checks to supplement the [redacted] report. New hires; run immediately. Existing staff annually. As of January 1, 2024 new and current employees (annuals) have state checks printed and included in the background check package, then uploaded to the individual SharePoint sites. Responsible party: [redacted] Manager- Office of Safe Environments One employee was missing the printed copy of the VCIC form from the 2024 annual background checks. A copy of that check is now available as of end of day April 1, 2024. continued on next page...	Name of contracted company removed by DLP 5/9/24 Name removed by DLP 5/9/24

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R190	Continued From page 4 risk for more than minimal harm for all residents, as the requirement for criminal background and abuse checks is intended to ensure all residents are free from the risk of harm.	R190	R190 continued... Going forward, the administrator will conduct quarterly audits of all new employees and an annual audit for all current employees to verify that all employees have background checks available for review, including the VCIC. Date Completed: April 26, 2024 R190 Plan of Correction accepted by Jo A Evans RN on 5/8/24	
R200 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure development of and access to policies and procedures that govern all services provided by the home. Findings include: On 4/1/24 the Administrator was requested to provide policies and procedures related to maintenance of the residential environment, and disposal of outdated food items. The Administrator confirmed policies and procedures related to these services were not on file and available for review on 4/1/24. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents due to failure to provide accessible information and clear instructions related to tasks staff are required to perform.	R200	R200 A policy related to maintenance of the residential environment has been developed and added to the Policy and Procedures Manual. The existing Food Service policy has been updated to include language related to prevention of spoilage of food items. Staff were educated on the new policy and changes to existing policies at the All Team Meeting on 4/26/24. Date of Completion: 4/26/24 R200 Plan of Correction accepted by Jo A Evans RN on 5/8/24	
R203 SS=D	V. RESIDENT CARE AND HOME SERVICES	R203		

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R203	Continued From page 5 5.17 Death of a Resident 5.17.a In those deaths in which the law applies (such as an unexpected, untimely death), pursuant to 18 V.S.A. §5205 (a), the manager shall be responsible for immediately notifying the regional medical examiner This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure the Residential Care Home (RCH) notified the Regional Medical Examiner in the event of an unexpected or untimely death in accordance with Section 5.17a of the Vermont Residential Care Home Licensing Regulations effective 10/3/2000. Findings include: Per review, the facility's policy entitled Death of a Resident states, "At the time of the death of a resident the Home shall ...notify the appropriate governing body." The Death of a Resident policy includes procedures which state, "In those deaths in which the law applies (such as an unexpected or untimely death) ... the administrator or designee shall ... Immediately notify the Regional Medical Examiner"; and indicates in the event of an death within forty-eight (48) hours of a fall or injury the medical examiner is to be notified. Per record review conducted on 4/1/24, Resident #2 was admitted on 2/2/21 with diagnosis of mucular degeneration, mild memory impairment, atrial fibrillation, congestive heart failure, renal disease, carcinoma in colon, hypertension, and depression. On 10/27/22 Resident #2 was admitted to Hospice following a new diagnosis of an aortic aneurysm. On 12/29/23 the facility nurse was requested in Resident #2's room following a fall. On arrival the nurse observed Resident #2	R203	R203 This was an expected death. The on-call nurse notified the hospice agency and next of kin. The policy for reporting the death of a resident has been updated to read more clearly: "In those deaths in which the law applies (such as unexpected or untimely deaths) and for all deaths within 48 hours of a fall, the administrator or designee shall call 911; immediately notify the Regional Medical Examiner; Notify the responsible person (if any), next of kin or relative." Facility staff were educated on notification requirements on 2/29/24. Upon the death of a resident, both the administrator and the DON will be notified immediately and will verify if notification of the medical examiner is required. Date Competed:4/26/24 R203 Plan of Correction accepted by Jo A Evans RN on 5/8/24	

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R203	Continued From page 6 lying supine with staff supporting his/her head. Resident #2 was able to verbalize that s/he slid out of his/her chair, and hit his/her head on the floor. A 3 cm by 3 cm hematoma was noted on the back right side of Resident #2's head. On 12/30/23 the facility Registered Nurse (RN) was notified at approximately 3:58 AM that Resident #2 was found on the floor next to his/her bed and was unresponsive. Upon entering the facility at approximately 4:30 AM the RN assessed Resident #2 and found s/he was not breathing and did not have cardiac function. Although the RN notified VNA hospice and Resident #2's responsible party, the Regional Medical Examiner was not notified of Resident #2's death within 48 hours of a fall. During an interview conducted during the investigation on 4/1/24, the Administrator confirmed the Regional Medical Examiner was not notified of Resident #2's death. In conclusion this deficient practice is a potential risk of harm related to not ensuring proper medical, and legal oversite of potential causes of death.	R203	R224 The Home had safeguards in place to protect the Resident Funds from unauthorized access (in a lockbox, in a locked file cabinet, in a locked office); however the Home was a victim of a theft which is still under criminal investigation by the Vermont State Police. Upon discovery of this theft, the Home immediately notified affected residents and their POA's that their accounts had been made whole by Vermont Catholic Charities, resulting in no loss of funds to any residents; thus no residents were exploited. continued on next page...	
R224 SS=F	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by:	R224		

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R224	Continued From page 7 Based on record review and staff interview there was a failure to ensure and protect the right to be free from exploitation for 10 applicable residents (Residents #4, #5, #6, #7, #8, #9, #10, #11, #12, and #13). Findings include: The facility has written policies and procedures entitled Resident Funds Procedures which describe the process for receiving, accounting for, and distributing resident's personal funds managed by the home; however the facility has not developed written policies and procedures for safeguarding and preventing unauthorized access to resident's personal funds managed by the home. Per record review conducted on 4/1/24, on Tuesday 1/30/2024 personal funds belonging to 10 residents managed by the facility were missing and could not be accounted for by the administrative assistant entrusted with management and safeguarding of the residents' funds. The combined total amount stolen from the applicable residents in January of 2024 was $1,166.39. At 3:05 PM on 4/1/24 the Administrator confirmed the exploitation of 10 residents whose personal funds were unaccounted for by the administrative staff. In conclusion this deficient practice resulted in actual harm to 10 facility residents due to exploitation as evidenced by the confirmed theft of the resident's personal belongings.	R224	R224 continued... The Home has since implemented additional security measures (changed location of storage, additional safe and keys hidden and locked separately) and the policy has been updated to include "All resident funds cash must be stored in a lock box, which is stored in a secure area of the home. Access should be limited to the Administrator, the Administrative Assistant or other authorized personnel." The Home will continue to follow its policy regarding management and safeguarding of resident funds, including monthly audits of all funds, completed by the Administrator, the Administrative Assistant and an accountant at Vermont Catholic Charities. Date Completed: 4/26/24 R224 Plan of Correction accepted by Jo A Evans RN on 5/8/24.	
R246 SS=F	VII. NUTRITION AND FOOD SERVICES	R246		

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R246	Continued From page 8 7.2 Food Safety and Sanitation 7.2.a Each home must procure food from sources that comply with all laws relating to food and food labeling. Food must be safe for human consumption, free of spoilage, filth or other contamination. All milk products served and used in food preparation must be pasteurized. Cans with dents, swelling or leaks shall be rejected and kept separate until returned to the supplier. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure disposal of expired perishable food items to ensure all food items are free of spoilage and safe for human consumption. Findings include: On 4/1/24 policies and procedures for disposal of expired food items were not on file and available for review on request. During the tour of the facility kitchen commencing at 9:10 AM on 4/1/24 the following perishable food items in the food storage area were observed to be expired : a. a large container of oats expired on 11/6/2022 b. a 56 fluid ounce container of Sesame oil expired on 8/9/2022 c. a 5 gallon container of vegetable oil expired on 2/2023 Additionally one large dented can of pasta sauce, and one small can without a label were observed in the food storage area. These findings were confirmed by the Administrator on the morning of 4/1/24.	R246	R246 The dented can, the can with the missing label and the outdated items in the dry storage area have been discarded. Although the items were outdated, the 2022 dates were the dates they were received in facility, not their expiration dates. These items were infrequently used bulk items, and it is believed that none of them had been used since prior to their expiration date. The facility has changed the procedure for labeling and storage of infrequently used and bulk items. In addition to labeling infrequently used or bulk items with the date they were received, they will be labeled with a use-by date; items will be discarded after the use-by date. Cooks were educated on proper handling of dented canned goods and missing labels, and the use-by dates at the cook's meeting on 4/25/24. Facility QA audits have been updated to include checking for use-by dates on infrequently used/bulk items. Audits will be conducted at least monthly for 6 months and then as determined necessary by the Administrator, Dietary Manager or designee. Date Completed: 4/26/24	

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R246	Continued From page 9 In conclusion, this deficient practice is a potential risk for more than minimal harm due to food borne illness for all facility residents.	R246	R246 Plan of Correction accepted by Jo A Evans RN on 5/8/24	
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 a safe, functional, comfortable, and homelike living environment in one applicable resident's room (Resident #3). Findings include: At 1:46 PM on 4/1/24 the Administrator confirmed policies and procedures related to maintenance of the residential living environment had not been developed. During the tour of the second floor of the home commencing at 9:35 AM on 4/1/24 the flooring in Resident #3's room was observed to be unsafe and in poor condition. Sections of the flooring along the bedside and pathway used to access areas of the Resident #3's room, bathroom, and entryway were swollen and eroded with what appeared to be moisture damage. Damaged areas of the flooring were cracked, peeling, and discolored with what appeared to be mold or mildew. Resident #3 uses a walker to ambulate, and the condition of the flooring is a risk for falls	R266	R266 We disagree with the assessment of the condition of the floor. There was no mold or mildew present. The top layer of the laminate flooring had peeled away in some areas causing the discoloration. New flooring has been ordered for the affected area and will be replaced no later than May 15, 2024. All staff were educated at the All Team Meeting on 4/26/24 regarding how to place a work order. Monthly QA audits will be completed by the administrator or designee for 6 months and then as determined necessary to identify any additional areas of the building in need of repair. Completion Date: No later than May 15, 2024 R266 Plan of Correction accepted by Jo A Evans RN on 5/8/24	

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R266	Continued From page 10 and injury. The Administrator stated the damage was caused by the resident's frequent episodes of urinary incontinence. The Administrator stated the flooring would be replaced when Resident #3 was no longer residing in the room, and indicated there was no plan to transfer or discharge the resident. This finding was confirmed by the Administrator during the tour of the second floor of the home commencing at 9:35 AM on 4/1/24. In closing this deficient practice is a risk for more than minimal harm for all facility residents due to failure to ensure a safe, functional, sanitary, homelike, and comfortable environment. This deficient practice is a risk for more than minimal harm for Resident #3 due to the the unsafe and unsanitary nature of flooring damaged by exposure to urine, the potential psychological impact and discomfort of living in a room in poor repair, and the risk for falls and injury.	R266	This page intentionally left blank	