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 4, 2022

Ms. Jamie Goodwin, Manager
North End Ranch
2 Westview Court
Rutland, VT 05701

Dear Ms. Goodwin:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 13, 2022.** 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
	0667	A. BUILDING: _____ B. WING _____	C 09/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH END RANCH	2 WESTVIEW COURT RUTLAND, VT 05701

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R100	Initial Comments: On 9/13/22 the Division of Licensing and Protection conducted an unannounced on-site re-licensure survey and investigation of one complaint. The following regulatory deficiencies were identified:	R100	Please see attached Plan of Correction	
R128 SS=E	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 the medications for 2 applicable residents (Residents #2 and #3) were administered according to doctor's orders. Findings include: 1. Resident #2's physician ordered Psyllium Fiber (for constipation) 2 capsules once daily and as needed (PRN). His/her Medication Administration Record (MAR) indicates Psyllium Fiber is ordered as 2 capsules once daily, and the PRN (as needed) order for Psyllium Fiber was not included on the MAR. Resident #2's physician ordered Acetaminophen 500 mg every 4 hours as needed for pain. His/her MAR indicates Acetaminophen is ordered as 1000 mg twice daily as needed for pain. Resident #2 's physician ordered Pepto Bismol (for stomach upset) 15 mL four times daily as needed. His/her MAR indicates Pepto Bismol is ordered as 30 mL for every ½- 1 hour as needed. Resident #2's	R128		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Jami Goodwin — Supervisor, LNA — 10/19/2022

R128 – R999 POC's accepted 10/28/22 JEvans RN/PMC

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R128	Continued From page 1 physician ordered Chlorhexidine Gluconate mouthwash 15 mL to be swished in mouth for 30 seconds daily then spit out. His/her MAR indicates Resident #2's toothbrush to be dipped into Chlorhexidine Gluconate mouthwash and applied to gumline once daily. Resident #2's physician ordered Bacitracin Ointment (antibiotic) twice daily as needed. His/her MAR indicates Bacitracin Ointment is to be applied topically to cuts and abrasions as needed. Resident #2's physician ordered Barrier Cream (to prevent skin breakdown) applied twice daily. His/her MAR indicated Barrier Cream is to be applied every day as needed. At 5:31 PM on 9/13/22 the Registered Nurse confirmed the orders in the MAR for Resident #2's Psyllium Fiber, Acetaminophen, Pepto Bismol, Chlorhexadine Gluconate, Bacitracin, and Barrier Cream were not consistent with the prescribing physician's orders. 2. Resident #3's September 2022 MAR lists Ondansetron 4mg every 6 hours as needed for nausea/vomiting. A line was drawn through the order for Ondansetron on Resident #3's signed admission orders form. At 4:55 on 9/13/22 the Registered Nurse confirmed the crossed out order for Ondansetron was overlooked during Resident #3's admission process, and Ondansetron was entered into Resident #3's MAR as if it was ordered.	R128		
R135 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 Assessment 5.7.b If a resident requires nursing overview or	R135		

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R135	Continued From page 2 nursing care, the resident shall be assessed by a licensed nurse within fourteen days of admission to the home or the commencement of nursing services, using an assessment instrument provided by the licensing agency. This REQUIREMENT is not met as evidenced by: Based on record reveiw and staff interview there was a failure to complete an intial assessment within 14 days of admission for one applicable resident (Resident #3). Findings include: Per record review on the morning of 9/13/22 a Resident Assessment had not been completed for Resident #3 since s/he was admitted to the Residential Care Home (RCH) on 7/25/22. On the afternoon of 9/13/22 the Registered Nurse confirmed an initial assessment was not completed within 14 days of Resident #3's admission. The Registered Nurse signed a Resident Assessment as complete for Resident #3 on the afternoon of 9/13/22.	R135		
R136 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced	R136		

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R136	Continued From page 3 by: Based on staff interview and record review, the Residential Care Home (RCH) nurse failed to annually reassess 2 applicable residents using the assessment instrument provided by the licensing agency. (Resident #1 and Resident #2.) Findings include: 1. Resident #1 who requires nursing overview and special care treatment via Hospice was last assessed by a RCH nurse on 4/16/21. Despite the physical changes and deterioration of Resident #1's health, it was confirmed on 9/13/22 at 1:30 PM by the RCH nurse the required resident assessment had not been completed and was over due by 5 months. 2. Resident #2 requires care and assistance with Activities of Daily living (ADLs) due to Moderate Intellectual Disabilities, Generalized Anxiety Disorder, Cardiovascular conditions, Syncope and collapse (dizziness with fainting), and Insomnia. It is unclear when Resident #2 was admitted to the RCH as facility staff and agency administrators were unable to provide his/her admission date. Based on review of Resident #2's records Resident Assessments were completed in 2020 and 2022, and an annual assessment was not completed in 2021. On the afternoon of 9/13/22 the Registered Nurse confirmed only Resident Assessments for 2020 and 2022 were maintained in Resident #2's record and an annual re-assessment was not completed in 2021.	R136		
R145 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2)	R145		

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R145	Continued From page 4 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, the RCH nurse failed to develop a written plan of care for 3 of 3 applicable residents. (Residents #1, #2, and #3) Findings include: 1. Resident # 1 has a diagnosis of developmental disability and is dependent on staff for all his/her care needs. Presently Resident #1 has demonstrated a decline in health and recently diagnosed with Failure to Thrive and has been admitted to Hospice for end-of-life care. As a result, Resident #1's care needs have increased and closer monitoring of oral intake, pain management, deterioration of skin integrity and decline in ambulation. Per record review a written plan of care was not developed by the RCH nurse based on Resident #1's abilities and needs. 2. Resident #2's diagnoses include Moderate Intellectual Disabilities, Generalized Anxiety Disorder, Cardiovascular conditions, Syncope and collapse (episodes of dizziness with fainting), and Insomnia. His/her care needs include assistance with Activities of Daily Living including bathing and personal hygiene, incontinence care, assistance with mobility including use of a walker and staff use of a gait belt, and monitoring for choking during meals. S/He is at risk for falls due	R145		

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R145	Continued From page 5 to mobility issues and a risk for elopement due to insomnia and a history of going outside when he wakes during the night despite difficulties with mobility. Per record review a written plan of care was not developed by the RCH nurse based on Resident #2's abilities and needs. 3. Resident #3's diagnoses include Mild Intellectual Disabilities, Anxiety and Major Depressive Disorders, an unspecified Non-Psychotic Mental Disorder, hearing loss, difficulty swallowing; and cardiovascular, respiratory, digestive, and neurological conditions. Resident #3 was admitted to the RCH in the end of July 2022. A care plan to address Resident #3's physical and psychological needs was not developed by the Registered Nurse. Per record review a written plan of care was not developed by the RCH nurse based on Resident #3's abilities and needs. Per interview on 9/13/22 at 12:55 PM, the RCH nurse stated s/he was informed by administrative staff care plans were not necessary because an individual treatment plan (ISA) for each resident was completed by the Mental Health Agency who oversee the management of the RCH.	R145		
R173 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h. (1) Resident medications that the home manages must be stored in locked compartments under proper temperature controls. Only authorized personnel shall have access to the	R173		

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R173	Continued From page 6 keys This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure medications for 1 applicable resident (Resident #1) were stored in a locked compartment accessible only to authorized staff. Findings include: On the afternoon of 9/13/22 a bottle of anti-fungal powder and two tubes of Calmoseptine (topical medication for skin irritation) belonging to Resident #1 were stored in an unlocked drawer in the resident bathroom. At 2:24 PM on 9/13/22 Med Delegated staff confirmed medications were stored in unlocked compartments in the resident's bathroom. On the afternoon of 9/13/22 the Registered Nurse acknowledged medications were stored in the resident bathroom in an unlocked compartment.	R173		
R176 SS=D	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:	R176		

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R176	Continued From page 7 Based on observation and staff interview there was a failure to ensure the disposal of outdated medications for 2 applicable residents (Residents #2 and #4). Findings include: During a tour of the medication room on the morning of 9/13/22 two expired vials of Shingrix (Shingles vaccination) belonging to Resident #4 were observed stored in the medication refrigerator. One vial expired on 2/18/22 and the other on 4/9/22. At 9:50 AM on 9/13/22 the Director of Adult and Residential Services confirmed two expired vials of Shingrix belonging to Resident #4 were stored in the medication refrigerator. During an inspection of the medication cart commencing at 2:16 PM on 9/13/22 the storage of Bacitracin Ointment (topical antibiotic) that expired in July of 2022 belonging to Resident #2 was observed. At 2:24 PM on 9/13/22 med delegated staff confirmed expired Bacitracin Ointment belonging to Resident #2 was stored in the medication cart.	R176		
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:	R179		

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R179	Continued From page 8 (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, the Residential Care Home (RCH) owner failed to ensure 2 out of 5 applicable staff received the required 12 hours of training each year. Findings include: During the course of the survey on 9/13/22 the Risk and Compliance Manager was requested to provide documentation of in-service trainings including Resident Rights; Fire Safety and Emergency Evacuation; Resident Emergency Response Procedures and First Aid; Mandatory Reporting of abuse, neglect and exploitation; Respectful and Effective Interaction with residents; Infection Control measures; and General Supervision and Care of Residents. for a sample of 5 applicable staff. On review of the documentation provided 2 out of 5 applicable staff (Staff #4 and #6) failed to complete all required yearly trainings. Staff #4 failed to complete trainings in Fire Safety and Emergency Evacuation. Staff #6 failed to complete trainings	R179		

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R179	Continued From page 9 in Fire Safety and Emergency Evacuation, as well as Emergency Response Procedures and First Aid. At 1:54 PM on 9/13/22 the Risk and Compliance Manager confirmed confirmed the trainings were not completed by Staff #4 and #6.	R179		
R207 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.b The licensee and staff are required to report suspected or reported incidents of abuse, neglect or exploitation. It is not the licensee's or staff's responsibility to determine if the alleged incident did occur or not; that is the responsibility of the licensing agency. A home may, and should, conduct its own investigation. However, that must not delay reporting of the alleged or suspected incident to Adult Protective Services. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RCH failed to file a report with Adult Protective Services (APS) and the Licensing Agency (Division of Licensing and Protection) after learning of an injury a resident had sustained. (Resident #1). Findings include: Per record review, Resident #1 was sent to the Emergency Department (ED) on 8/17/22 after demonstrating a failure to drink and eat and was complaining of possible abdominal pain. Medical assessment while in the ED identified minimally displaced fractures of Resident #1's right 8th, 9th & 10th ribs along with a small pleural effusion	R207		

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R207	Continued From page 10 (fluid buildup between the lungs and chest). The resident was admitted to the hospital x 2 days and discharged back to the RCH. Although the RCH staff were unaware of Resident #1 fractured ribs until informed by hospital staff, an internal investigation was not conducted. In addition there was a failure to report the injuries of unknown origin to both APS and the Licensing Agency. This was confirmed at approximately 6:10 PM on 9/13/22 when the Risk and Compliance Manager stated staff were unaware of the requirement to report the injury of unknown origin to APS and the Licensing Agency.	R207		
R221 SS=E	VI. RESIDENTS' RIGHTS 6.9 Residents may manage their own personal finances. The home or licensee shall not manage a resident's finances unless requested in writing by the resident and then in accordance with the resident's wishes. The home or licensee shall keep a record of all transactions and make the record available, upon request, to the resident or legal representative, and shall provide the resident with an accounting of all transactions at least quarterly. Resident funds must be kept separate from other accounts or funds of the home. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review there was a failure to ensure accuracy in accounting of funds, a written request for management of funds, and to provide a quarterly accounting of all transactions for 3 out of 3	R221		

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R221	Continued From page 11 applicable residents (Residents #1, #2, and #3). Findings include: During a count of resident funds managed by the facility conducted with the Risk and Compliance Manager it was observed the accounting of funds stored for Residents #1, #2, and #3 were inaccurate and the total amount written on the accounting sheets were greater than the amount of funds stored in the locked boxes for all three applicable residents. The locked boxes for all three resident each contained a ziploc bag with coins not accounted for on the home's accounting forms. Additionally the of the records for Residents #1, #2, and #3 did not include a signed written requests for management of funds and documentation of quarterly accounting of all transactions provided to the resident or their guardians. At 12:10 on 9/13/22 the Risk and Compliance Manager confirmed inaccuracy in the accounting of residents funds, and the failure to complete written requests for management of funds and provide quarterly accounting of all transactions for all three applicable residents (Residents #1, #2, and #3).	R221		
R230 SS=C	VI. RESIDENTS' RIGHTS 6.18 The enumeration of residents' rights shall not be construed to limit, modify, abridge or reduce in any way any rights that a resident otherwise enjoys as a human being or citizen. A summary of the obligations of the residential care home to its residents shall be written in clear language, large print, given to residents on admission, and posted conspicuously in a public place in the home. Such notice shall also summarize the home's grievance procedure and	R230		

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R230	Continued From page 12 directions for contacting the Ombudsman Program and Vermont Protection and Advocacy, Inc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to post a copy of the Resident's Rights and the facility Grievance Procedures in a public place in the home. Findings include: On the afternoon or 9/13/22 it was observed copies of Resident's Rights and the facility Grievance Procedures were not posted in a public place in the home. At approximately 6:20 PM on 9/13/22 the Risk and Compliance Manager confirmed the failure to ensure copies of the Resident's Rights and facility Grievance Policies were posted in the home.	R230		
R266 SS=E	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, sanitary, homelike environment. Findings include: During the course of the facility tour commencing at 9:20 AM on 9/13/22 missing and/or damaged screens were observed in 3 out of 4 resident	R266		

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R266	Continued From page 13 rooms. Resident #1's room had a ripped screen in one window, and another window's screen had a bent frame that did not fit in the window frame properly. In Resident #2's room one window screen was torn, another screen frame had tape around the parameter holding it in the window frame; and another window was blocked by a dresser, did not have screens or handles to open the window. Resident #4's room did not have screens in any of the windows. Please see tag 270 In Resident # 1 and Resident #4's rooms wall mounted hand sanitizers were observed on walls along the side of the resident's beds. Placement of the sanitizers created risk for injury and unintentional dispensing of the sanitizer on to the resident's beds. In the common areas of the home a bent window screen frame was observed in a living room window, and the vinyl base molding along a wall in the dining room was detached from the wall. A wooden folding TV tray and a chair were placed directly in front of the medication room doorway. The TV tray was unstable and tipped easily, and both items were partially blocking access to the medication room. During the tour of the facility commencing at 9:20 AM on 9/13/22 the Director of Adult and Residential Services confirmed the missing and damaged screens in the living room and rooms of Residents #1, #2, and #4; the detached base molding in the dining room; the placement of the TV tray and chair in front of the medication room doorway; and the placement of wall mounted hand sanitizer dispensers on walls along the length of the beds in Resident #1 and #4's rooms during the course of the facility tour commencing	R266		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0667	A. BUILDING: _____ B. WING _____	C 09/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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R266	Continued From page 14 at 9:20 AM on 9/13/22.	R266		
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 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 the windows in the bedrooms of 3 applicable residents (Resident #1, #2, and #4) had window screens in good repair. Findings include: During the course of the facility tour commencing at 9:20 AM on 9/13/22 missing and/or damaged screens were observed in 3 out of 4 resident rooms. Resident #1's room had a ripped screen in one window, and another window's screen had a bent frame that did not fit in the window frame properly. In Resident #2's room one window screen was torn, another screen frame had tape around the parameter holding it in the window frame; and another window was blocked by a dresser, did not have screens or handles to open the window. Resident #4's room did not have screens in any of the windows. The Director of	R270		

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R270	Continued From page 15 Adult and Residential Services confirmed the missing and damaged screens in the rooms of Residents #1, #2, and #4 during the course of the facility tour commencing at 9:20 AM on 9/13/22.	R270		
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 record review and staff interview there was a failure to conduct fire drills at least quarterly and to rotate times of day to include drills conducted during the morning, afternoon, evening, and night shifts. Findings include: Per record review one fire drill was conducted during the previous year on 8/24/22 at 5 PM. Documentation of the fire drill performed did not include the names of the staff who participated in the drill. On the afternoon of 9/13/22 the Risk and Compliance Manager confirmed the fire drill on	R302		

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R302	Continued From page 16 8/24/22 at 5 PM was the only fire drill conducted during the previous year.	R302		
R310 SS=E	X. PETS 10.2.d Pets must be free from disease including leukemia, heartworm, hepititis, leptos psorisos, parvo, worms, fleas, ticks, ear mites, and skin disorders, and must be current at all times with rabies and distemper vaccinations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure the 2 cats living in the home were current with all required vaccinations and scheduled veterinary care. Findings include: Per observation and staff interview the facility is home to two cats. Per review of veterinary records vaccines for both cats including the FeLV Annual vaccine (Feline Leukemia Virus Vaccination) and the FVRCP (a core vaccine for three common feline diseases) annual vaccine were not completed as scheduled on 10/19/21, and rabies vaccinations were not completed as scheduled on 2/26/21. One cat had not had an annual fecal examination since 12/14/2015 and the other since 10/19/20. Feline fecal examinations are scheduled annually to identify and treat parasitic and bacterial infections which could compromise the health of the pet and residents of the home. On the afternoon of 9/13/22 the Risk and Compliance Manager confirmed both cats living in the home were not current with scheduled vaccinations and veterinary care.	R310		

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R999 SS=D	MISCELLANEOUS 4.12 License Certificate The home's current license certificate shall be protected and appropriately displayed in such a place and manner as to be readily viewable by persons entering the home. Any conditions which affect the license in any way shall be posted adjacent to the license certificate. Based on observation and staff interview there was a failure to display a copy of the license certificate in a place and manner as to be readily viewable by persons entering the home. Findings include: On the afternoon or 9/13/22 it was observed the facility license certificate was not displayed in a place within the facility where it could be viewed by persons entering the home. At approximately 6:20 PM on 9/13/22 the Risk and Compliance Manager confirmed the home's license certificate was not displayed in the home.	R999		

Plan of Correction Response for Site Visit of 9/13/2022

North End Ranch
2 Westview Court
Rutland, VT 05701

R128 – Resident Care
Action: Residential nurse called all residents' Primary Care Physicians and requested and received updated medication, treatment and dietary services orders. Then resident nurse updated each resident's Medication Administration Record. In addition, the Residential Nurse relayed this information to all Direct Support Staff.
Systemic Change & Monitoring: To ensure each resident's medication, treatment, and dietary services are consistent with the physician's orders, the Residential Nurse will ensure that the MARS and the Residents Care Plans are kept up to date. In addition, the Residential Nurse will have ongoing communication and training with the Direct Support staff.
Corrective Action completion:
This process will be ongoing and corrective action was immediately acted upon.

R135 – Assessment
Action –On the day of the review, there was a pending Nursing Assessment which brought this facility out of compliance with this regulation. The Residential Nurse had begun the nursing assessment for resident #3, however this service had not been locked and signed. On 9/13/2022 the Residential Nurse locked and signed this document.
Systemic Change – North End Ranch's Management along with the Agency's Quality Manager will review North End Ranch's Intake workflow. The Intake process will be revised to include a checklist and will include notifications in the Electronic Medical Record to prompt the Residential Nurse of the need to complete an assessment for all new residents within 14 days of admission to North End Ranch. The Intake process will also outline the next steps in the process which is for the Residential Nurse to develop resident care plans and for the Residential Nurse to communicate the contents of these care plans to the Direct Service Staff.
Monitoring – The checklist and notifications about required intake assessment will be added in the Electronic Medical Record. This notification will go to North End Ranch's Management Team, and the RMHS Medical Director to ensure all nursing assessments are completed within the required timeframe.
Corrective Action completion:
Intake workflow review will be completed by 11/1/2022.
Revised intake workflow will be in place by 11/30/2022.

Janie Goodwin Supervisor / LNA 10/25/2022

R136 – Annual Assessments
Action – Residential nurse completed annual nursing assessment for all residents by 9/15/22.
Systemic Change – North End Ranch management will ensure that there is a structure created to ensure the Direct Service Staff are scheduled to meet with the Residential Nurse to review the resident's care plan annually or when there is a revised care plan due to a change in a resident's physical or mental condition.
Monitoring – The checklist and notifications about required intake assessment will be added in the Electronic Medical Record. This notification will go to North End Ranch's Management Team, and the RMHS Medical Director to ensure all annual nursing assessments are completed within the required timeframe.
Corrective Action Completion:
Review of care plan and assessment timelines will be complete by 11/30/2022.
New plan will be implemented in the Electric Medical Record and in staff training by 11/30/2022.

R145 - Written Plan of Care
Action: North End Ranch management reviewed resident Care Plans with Residential Nurse, and requested changes to the CCN Electronic Medical Record to accommodate North End Ranch care plans in the Electric Medical Record (previously these had been hand-written). This was completed by 10/11/22. New care plans for each resident as required are in progress.
Systemic Change: Addition of North End Ranch Care Plan into Electronic Medical Record allows management and Service Coordinator to easily track these plans. This care plan requirement will be added into the Intake process review, and the requirement for necessary updates with change in resident conditions will be prompted in the QDDP summary. This prompt will include notifications to resident nurse, NER management and CCN Medical Director.
Monitoring: Addition of Care Plan to EHR and prompts to QDDP Summary form will allow management to track plans, and will prompt a check on the care plan each month.
Corrective Action Completed:
Care Plan form is added to EHR as of 10/11/22.
Revised Care Plans for each resident completed by 10/31/22.
Care Plan requirement reviewed as part of the Intake Review, by 11/30/2022.
Additional necessary changes to QDDP Summary and other services in EHR completed by 11/30/022.

R173 – Medication Management / Storage
Action: All resident bedrooms & bathrooms to be searched for any medications stored outside of locked compartments. Medication storage requirements to be reviewed with staff.
Systemic Changes: Management to retrained staff on medication storage requirements to emphasized that these requirements apply to any medication ordered by a doctor. This training will require a sign off to ensure that this information is reviewed with all staff who work at North End Staff (including subs).

Monitoring: The night staff will be given the tasks of checking the facility nightly to ensure all mediations have been stored properly. In addition, Risk and Compliance will perform unannounced spot checks of medication storage on a regular basis.
Corrective Action: The night staff will begin evening medication storage checks as of 11/1/2022.

R176 – Medication disposal
Action: A process will be created to ensure that any medication that is no longer prescribed to a resident and any medications for a resent who was discharged from North End Ranch will be removed from the home and disposed of properly.
Systemic Change: North End Ranch's Management Team and the Agency's Quality Manager will create a Discharge Checklist to be completed when a resident is discharged from North End Ranch. This Discharge Checklist will include the step of disposing of all medications for any resident who has left the facility. To further ensure that medications that should no longer be on site are disposed of in a timely manner, all medication delegated staff, will be trained to check the medication cart/closet as a routine task. A form will be created so that medication delegated staff can note when a particulate medication's expiration date is coming due.
Monitoring: In addition, Residential Nurse will be prompted in her monthly Nursing Contact note to review medications and identify any unnecessary or expired medications for disposal. Discharge checklist will be part of discharge workflow, and included in the Electronic Medical Record so it can be monitored by Risk & Compliance. Nursing contact notes will record any medications identified for disposal.
Plan of Correction Completed:
Discharge process review completed by 11/15/2022. Necessary changes in Electronic Medical Record to discharge process and nursing notes complete by 11/30/2022.

R179 – Staff Services / Training
Action: Staff who were out of compliance are being scheduled to complete the required training.
Systemic Changes: Any new hires or existing employees will not be scheduled until all required trainings are complete. Training systems will be reviewed to identify prompts to managers to alert them to employees who are out of compliance.
Monitoring: CCN uses Relias Training as a training platform. The program administrative team will use this platform to pull regular reports for the North End Ranch Management to notify them of staff training requirements.
Completion Dates:
As 11/30/2022, supervisors will no longer schedule staff who have not completed the required trainings.
As of 11/1/22, Adult Services Administrative Coordinator will pull monthly reports on training status.

R207 — APS Reporting

Action: Review Mandatory Reporting Requirements with all North End Ranch Staff. This review will include not only when to make a report to Adult Protective Services but will also review which other individuals/Agency's need to be made aware that a report has been made. (Resident's Guardian, DAIL – Critical Incident, & Division of Licensing)

Systemic Change: The shift notes were changed in the Electronic Medical Record so that any time a staff member recorded an incident – such as a fall – the system will send a notification to the Program Manager and Manager of Risk and Compliance, to better ensure awareness of potentially reportable incidents. Staff training will be updated to emphasize the rules governing reportable incidents and this training with review

Monitoring: Managers will review reporting in case of unknown origin injuries with staff in supervisions and meetings, and review incidents as they occur.

Completion Dates:

Electronic Medical Record changed as of 10/3/22. All North End Ranch will be retrained on Mandatory Reporting as of 11/30/2022. This training will require a sign off to ensure that all staff have received this training.

R221 – Personal Finances

Action: Money for each resident was accounted for on 9/14/22, including coins, and the accounting sheet stored in the lock box with the money was updated.

Systemic change: 1) Quarterly accounting of transactions will be updated and signed by North End Ranch Management and entered into the Electronic Medical Record. 2) Money management agreements will be also be added to the Intake process. 3) In addition, Quarterly reports will be sent out to all of the resident guardians.

Monitoring: The quarterly accounting will be reviewed as part of the resident's regular monthly QDDP summary / review, by the Service Coordinator, to make sure it is kept up to date. Going forward, when the residents' money is being counted, there will be 2 staff involved.

Completion Dates:

Training for service coordinator will be completed by 11/30/2022.
Updated QDDP Summary checklist will be completed by 11/30/2022.

R230 – Rights posted

Action: Risk & Compliance Manager ordered a cork board, which will be installed in the home, where the enumeration of rights will be posted.

Systemic Change: The corkboard is placed on the wall in a common area of the home, required notices are posted, and updating of the notices will be part of North End Ranch Management duties.

Monitoring: Program Manager will review; Risk team will perform regular, unannounced spot checks.

Schedule:
This notice area will be installed by 10/15/22.
Spot checks will be performed beginning in November 2022.

R266 – Safe & Sanitary Environment
Action: Maintenance work orders were submitted for 1) window repair or replacement. 2) window screen repair or replacement 3) removal of hand sanitizer dispensers in the bedrooms immediately 4) molding repair in the dining room. The folding table was immediately removed from the hallway.
Systemic Change: The site safety officer will conduct biannual inspections of the home in fall and spring with a specific eye for group home regulations. A coy of this completed inspection form will be sent to the Risk & Compliance Manager.
Monitoring: Site safety officer will present report on inspections to the Agency's Safety Committee.
Completion Dates: Site safety officer will perform the first inspection by 11/30/2022.

R270 - Residents Rooms
Action: A Maintenance work order was submitted to ensure that windows in the resident bedrooms are openable and screened. The Maintenance Department Coordinator has reached out to a local window & glass company to do needed repair or replacement.
Systemic Change: The twice a year building inspection will include the check of windows and window screens.
Monitoring: A copy of the completed building inspection form will be sent to the Risk & Compliance Manger. Results of the inspections will be presented to the Agency's Safety Committee as well.
Completion Dates: The first inspection will take place by 11/30/2022.

R302 – Disaster & Emergency Preparedness
Action: NER team immediately created and posted emergency protocols in the home. An emergency fire drill was held within two weeks.
Systemic change: Protocols will be monitored and updated as part of the biannual site safety inspection. The NER manager will schedule the fire drills.
Monitoring: Fire drill records will be monitored by the Risk Manager and reported to the Safety Committee.
Completion Dates:
Fire drills to meet the annual requirement by January 2023 have been scheduled as of 10/13/22.
Fire drill records will be reported to the Safety Committee starting in November 2022

R310 – Pets
Action: Cats were scheduled for updated exam and vaccinations on Thursday 9/15/22.
Systemic change: Pet health will be assigned to a member of staff who will ensure that they are scheduled for annual exams and vaccination updates.
Monitoring: Annual update will be reported to the Safety Committee.
Completion Dates:
Vaccinations were updated 9/15/22.
Staff member assigned to job by 10/31/22.

R999 – License Certificate
Action: License was ordered for update, and was posted in a framed glass display in the home's office.
Systemic change: License posting site has been updated. Upon approval, this corrective action plan will be posted next to the license for public inspection.
Monitoring: Annually, or if there are any updates to the license, updates will be presented to the Compliance Committee.
Completion Dates:
License posted by 10/10/22.
First agenda presentation to Compliance Committee will be in November 2022.