

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

October 30, 2024

Stephanie Sweet, Manager Residential Care At The Manor 577 Washington Highway Morrisville, VT 05661-8972

Dear Ms. Sweet:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 23, 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

FORM APPROVED Division of Licensing and Protection (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 0378 09/23/2024 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **577 WASHINGTON HIGHWAY** RESIDENTIAL CARE AT THE MANOR MORRISVILLE, VT 05661 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) R100 R100 Initial Comments: On 9/23/24 the Division of Licensing and Protection conducted an unannounced on-site R 134 All new residents have the potential annual relicensure survey. The following to be affected by this practice regulatory deficiencies were identified: To correct the deficiency, the RN R134 V. RESIDENT CARE AND HOME SERVICES R134 has been educated to the SS=D requirement. To ensure that the deficient practice 5.7 Assessment does not recur, the residential care Manager will audit the admission 5.7.a An assessment shall be completed for each resident within 14 days of admission, assessments within 24 hours of the consistent with the physician's diagnosis and admission to ensure the med orders, using an assessment instrument provided Management portion of the by the licensing agency. The resident's abilities assessment has been completed. regarding medication management shall be Another audit will be completed 10 assessed within 24 hours and nursing delegation days post admission to ensure that implemented, if necessary. the assessment is completed. This REQUIREMENT is not met as evidenced To monitor so the deficient practice does not recur, a final check by the Based on record review and staff interview there residential care manager will be was a failure to ensure completion of Resident completed 14 days after admission Assessments within 14 days of admission for 2 to confirm that the assessment applicable residents (Residents #1 and #2). been completed and signed by the Findings include: The home's policies and procedures related to To be completed by 10/23/24. completion of resident assessments on admission are consistent with regulatory requirements. R134 Plan of Correction accepted by Jo A Evans RN on 10/25/24 Per record review, Resident #1 was admitted to

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

the home on 8/14/24, and his/her admission assessment was signed as completed by the Registered Nurse on 9/2/24. Per record review, Resident #2 was admitted to the home on 7/12/24, and his/her admission assessment was signed as complete on 9/15/24. At 4:50 PM on

Q4H211

TITLE Resident Care (X6) DATE
E Services 10/25/24

Derector If continuation sheet 1 of 4

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		0378	B. WING		09/23/2024				
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, ST						
RESIDENTIAL CARE AT THE MANOR MORRISVILLE, VT 05661									
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE				
R134	Continued From page	1	R134						
	confirmed the admiss	Care and Services Director ion assessments on file for were not completed within							
R179 V. RESIDENT CARE AND H		AND HOME SERVICES	R179	R179 all residents have the pote to be impacted by this practice	ntial				
	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:			To correct the deficiency, the mistraining was identified, It was identified that the employees had complete of the required training except fo topic, #3 Resident emergency response procedures and first aitraining in this topic was provided current employees.	ntified ed all r 1 d. A				
	such as the Heimlich or ambulance contact (4) Policies and proce reports of abuse, negl (5) Respectful and effresidents; (6) Infection control numited to, handwashir maintaining clean envipathogens and universidents.	ncy response procedures, maneuver, accidents, police and first aid; edures regarding mandatory ect and exploitation; fective interaction with measures, including but not ng, handling of linens, ironments, blood borne		To ensure that this deficient practions not recure this education we provided as part of Mandatory education for all new employees well as part of their Mandatory at training. To monitor that the deficient practices not occur again the staff are evaluation will include verification all the annual mandatory educative requirements have been completed by 10/23/24	as nnual ctice nnual n that ion ted.				
	by:	is not met as evidenced ew and record review 5 our		R179 Plan of Correction accept Jo A Evans RN 10/25/24	ed by				

Q4H211

PRINTED: 10/10/2024 FORM APPROVED

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE S COMPLI		
		0378	B. WING		09/2	3/2024	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 577 WASHINGTON HIGHWAY MORRISVILLE, VT 05661							
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	D BE COMPLETE		
R179 R190 SS=F	of 5 sampled staff did yearly trainings. Finding The home's policies a staff trainings includes trainings to be comple not include all yearly to licensing agency. During the survey on and Services Director documentation of comyearly trainings for a sof the documentation 5 sampled staff did not yearly trainings. This is Resident Care and Secon 9/23/24. V. RESIDENT CARE. 5.12.b.(4) The results of the crim registry checks for all This REQUIREMENT by: Based on staff interviews a failure to complete record and abuse regisampled staff. Finding The home's policies a	not complete all required ngs include: Ind procedures related to a list of mandatory sted by staff. This list does rainings required by the 19/23/24 the Resident Care was requested to provide appletion of the required sample of 5 staff. Per review provided for review, 5 out of at complete all required finding was confirmed by the ervices Director at 3:54 PM AND HOME SERVICES In not met as evidenced ever and record review there ete all required criminal stry checks for 5 out of 5 is include: Ind procedures related to ckground checks have not de the requirement	R179	R190 All residents have the pot to be impacted by this process. To correct the deficient practic home's policies and procedure related to completion of backgronecks been updated to includ requirement implemented on 5/1/2023. National background checks will be completed for existing employees. To ensure this deficient practic doesn't recur, a verified creder system will be used to complete comprehensive healthcare background checks and verific services to ensure that staff and volunteers meet both state and national standards and expects.	e, the s round e the e the ation ad		

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Division of Licensing and Protection (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ____ B. WING ____ 09/23/2024 0378

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

577 WASHINGTON HIGHWAY

(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
R190	Continued From page 3 During the survey on 9/23/24 the Resident Care and Services Director was requested to provide documentation of criminal record and abuse registry checks completed for a sample of 5 staff. Per review of the documentation provided for review, 5 out of 5 staff did not complete all required criminal record and abuse registry checks. This finding was confirmed by the Resident Care and Services Director at 3:51 PM on 9/23/24.	R190		
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