

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

July 11, 2023

Mr. Carl Erickson, Manager Riverview Life Skills Center 197 Highlander Drive Jeffersonville, VT 05464-9591

Dear Mr. Erickson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 5**, **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

Pamila MCotaRN

Licensing Chief

SATUREMENT OF DEPICIONAL DISTRICTION AND PROVIDER OR AUPPLIER AND PLAN OF CORRECTION 10214 **ETHECT ADDRESS, CITY, STATE, LIP CODE 197 HIGHLANDER DRIVE RIVERVIEW LIPE SKILLS CENTER **THIGHLANDER DRIVE RIVERVIEW LIPE SKILLS CENTER **THE SKILLS CENTER **	Division o	Division of Licensing and Protection							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 197 HIGHLANDER DRIVE JEFFERSONVILLE, VT 08649 RIVERWEW LIFE SKILLS CENTER SUMMAY STATEMENT OF DEPOSEMENTS SUMMAY STATEMENT OF DEPOSEMENTS SUMMAY STATEMENT OF DEPOSEMENTS (RICH OBSTOCKES SAVET STATEMENT OF DEPOSEMENTS (RICH OBSTOCKES SAVET SAVET STATEMENT OF DEPOSEMENTS (RICH OBSTOCKES SAVET SAVET STATEMENT OF DEPOSEMENTS (RICH OBSTOCKES SAVET SAV	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(AZ) MOLTH EE OPTION		(X3) DATE SURVEY COMPLETED				
NAME OF PROVIDER OR SUPPLIER RIVERVIEW LIFE SKILLS CENTER 197 HIGHLANDER DRIVE JEFFERSONVILLE, VT 05664 PROVIDES RIVER SUMMARY STATEMENT OF DEPICIENCIES (PACH DEPICE/SUM MAY 12 PRECEDED BY TULL PRETER RIVER (PACH DEPICE/SUM MAY 12 PRECEDED BY TULL PRETER RIVER (PACH DEPICE/SUM MAY 12 PRECEDED BY TULL PRETER RIVER (PACH DEPICE/SUM MAY 12 PRECEDED BY TULL PRETER RIVER (PACH DEPICE/SUM MAY 12 PRECEDED BY TULL PRETER RIVER	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A, BUILDING:]				
NAME OF PROVIDER OR SUPPLIER RIVERVIEW LIFE SKILLS CENTER 197 HIGHLANDER DRIVE JEFFERSONVILLE, VT 05664 PROVIDES RIVER SUMMARY STATEMENT OF DEPICIENCIES (PACH DEPICE/SUM MAY 12 PRECEDED BY TULL PRETER RIVER (PACH DEPICE/SUM MAY 12 PRECEDED BY TULL PRETER RIVER (PACH DEPICE/SUM MAY 12 PRECEDED BY TULL PRETER RIVER (PACH DEPICE/SUM MAY 12 PRECEDED BY TULL PRETER RIVER (PACH DEPICE/SUM MAY 12 PRECEDED BY TULL PRETER RIVER							ľ		
NAME OF PROVIDER OR SUPPLIER RIVERVIEW LIFE SKILLS CENTER 197 HIGHLANDER DRIVE SEPREDONULLE, VT 06644 PREPARA SECOND COMPRISON WHICH OF EMPICIONES DEVIALS PREPARA REGILATORY OR LISC IDENTIFYING INFORMATION) REGILATORY OR LISC IDENTIFYING INFORMATION PREPARA RIOD Initial Comments: On 4/5/22 the Division of Licensing and Prolection or underlined an unennounced un site religionaure oursey. The following registering the menture of the flag and procedure, Stiff SSS-E C.9 (a) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the Registered nurse failed to provide instruction and supervision to direct care staff regarding procedures for managing a feeding tube for 1 applicable resident (Resident #1). Findings include: Resident #1 has a feeding tube to sustain nutritional needs and takes no food or medications by mouth. During the administration without checking for correct placement of the feeding tube in the stomach. When the Medical contents to flow into the tube via gravity, then the responded by moving the syrings lower than Resident #1 stomach. When the Medical contents to flow into the tube via gravity, then the liting the syrings before as the field flowed back through the tube, which is not a standard practice for rebacking tube placement of the fleeting the syrings before some field flowed back through the tube, which is not a standard practice for rebacking tube placement.			0214	B. WING		04/0	5/2023		
RIVERVIEW LIFE SKILLS CENTER 197 HIGHLANDER DRIVE JEFFERSONVILLE, VT D864 RUNDERS PLAN OF CORRECTION READ DEPOCHATY OR LIGHTERING PROPERTY. RECOLLATORY OR LIGHTERING NORMATION) RIVE RIVE RIVE Initial Comments: On 4/5/23 the Division of Licensing and Protection conducted an unannounced on site reliannours oursey. The following regulatory deficiencies were identified: RIVE RIVE									
RIVERVIEW LIFE SKILLS CENTER SUMMARY STATEMENT OF SEPCEMORES TAG REGULATORY OF U.S. CENTERVIEW OF SEPCEMORES TAG RIDD Initial Comments: On 4/5/23 the Division of Licensing and Protection or nutre relicence were identified: RIDD Initial Comments: On 4/5/23 the Division of Licensing and Protection conducted an unannounced on site relicence were identified: RIDD Initial Comments: RIDD Initial Comments: On 4/5/23 the Division of Licensing and Protection conducted an unannounced on site relicence were identified: RIDD Initial Comments: RIDD Initial Comments: On 4/5/23 the Division of Licensing and Protection conducted an unannounced on site relicence were identified: RIDD Initial Comments: RIDD Initial Comme	NAME OF PR	ROVIDER OR SUPPLIER							
PROJECT SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST SE PRECIDED BY THE RECOUNTY OR LIST DEPICIENCY MUST SE PRECIDED BY THE RECOUNTY OR LIST DEPICIENCY MUST SE PRECIDED BY THE RECOUNTY OR LIST DEPICIENCY MUST SE PRECIDED BY THE RECOUNTY OR LIST DEPICIENCY MUST SE PRECIDED BY THE RECOUNTY OR LIST DEPICIENCY MUST SET DEPICIENCY MUST SET DEPICIENCY MUST SET DEPICIENCY MUST SET DEPICE AND MUST SET DEPOCRATION OF MUST SET DEPOCR		Wilher Burn LO GENTER							
PREFIX TAG R100 Initial Comments: On 4/5/23 the Division of Licensing and Protection conducted an unannounced on site relicence some site of the state of the s	RIVERVIE	M FILE SKIFFS CENTER	JEFFER	SONVILLE, VT	****		,		
R100 Initial Comments: On A/6/23 the Division of Licensing and Protection conducted an unannounced on site relicences were identified: R146 V. RESIDENT CARE AND HOME SERVICES SS=E 6.9. (a) Provide instruction and supervision to all direct care personnel regarding such resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; Based on observation and staff interview, the Registered nursi falled to provide instruction and supervision to direct care staff regarding procedures for managing a feeding tube for 1 applicable resident (Resident #1). Findings include: Resident #1 has a feeding tube to sustain nutritional needs and defectations at 3:20 PM on 4/6/23 the Med Tech was observed initiating formula feeding and medication administration of multitional formula and medications administration without checking for correct placement of the feeding tube in the stomach. When the Med Tech was requested to pause to check for placement she responded by moving the synthy leno without the checking tipe or the stomach. When the Med Tech was requested to pause to check for placement she responded by moving the synthy leno without placement is the responded by moving the synthy leno without the object on the feeding the interview of the responded by moving the synthy leno without the object on the feeding the placement the placement the placement the placement the placemen	(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	N RE			
R100 R100 Initial Comments: On 4/5/23 the Division of Licensing and Protection conducted an unannounced on site reliaencure outney. The following regulatory deficiencies were identified: R146 R146 R146 R146 V. RESIDENT CARE AND HOME SERVICES SS-E G. B. L. (0) Provide instruction and supervision to all direct care personnel regarding each resident's heatth care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the Registered nurse failed to provide instruction and supervision to direct care staff regarding procedures for managing a feeding tube for 1 applicable resident (Resident #1). Findings include: Resident #1 has a feeding tube to sustain nutritional needs and takes no food or medications by mouth. During the administration of nutritional formula and medications at 3:20 PM on 4/5/23 the Med Text was observed initiating formula feeding tube in the stomach. When the Med Text was requested to pause to check for placement s/he responded by moving the synthysic leaves than Resident #1's torso allowing the stomach when the Med Text was requested to pause to check for placement s/he responded by moving the synthysic leaves than Resident #1's torso allowing the stomach when the Med Text was requested to pause to check for placement s/he responded by moving the synthysic loves than Resident #1's torso allowing the stomach when the Med Text was requested to pause to check for placement s/he responded by moving the synthysic leaves than Resident #1's torso allowing the stomach was requested to pause to check for placement s/he responded by moving the synthysic loves than Resident #1's torso allowing the stomach was requested to pause to check for placement s/he responded by moving the synthysic loves than Resident #1's torso allowing the stomach was requested to pause to check for placement s/he responded by moving the synthysic loves than Resident #1's torso allowing the stomach was requested to p		(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	, - ,	CROSS-REFERENCED TO THE APPROPR	RIATE			
relianneurs ourvey. The following regulatory deficiencies were identified: R146 V. RESIDENT CARE AND HOME SERVICES SS=E 6.9 (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and runtifional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the Registered nurse failed to provide instruction and supervision to direct care staff regarding procedures for managing a feeding tube for 1 applicable resident (Resident #1). Findings include: Resident #1 has a feeding tube to sustain nutritional needs and takes no food or medications by mouth. During the administration of nutritional frending and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula and medications at 3:20 PM on 4/5/23 the Med Tech was observe	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	IAG					
relianneurs ourvey. The following regulatory deficiencies were identified: R146 V. RESIDENT CARE AND HOME SERVICES SS=E 6.9 (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and runtifional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the Registered nurse failed to provide instruction and supervision to direct care staff regarding procedures for managing a feeding tube for 1 applicable resident (Resident #1). Findings include: Resident #1 has a feeding tube to sustain nutritional needs and takes no food or medications by mouth. During the administration of nutritional frending and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula and medications at 3:20 PM on 4/5/23 the Med Tech was observe			4-41		All Barrersma Nesell	9110	11.1771		
relianneurs ourvey. The following regulatory deficiencies were identified: R146 V. RESIDENT CARE AND HOME SERVICES SS=E 6.9 (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and runtifional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the Registered nurse failed to provide instruction and supervision to direct care staff regarding procedures for managing a feeding tube for 1 applicable resident (Resident #1). Findings include: Resident #1 has a feeding tube to sustain nutritional needs and takes no food or medications by mouth. During the administration of nutritional frending and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula and medications at 3:20 PM on 4/5/23 the Med Tech was observe	R100	Initial Comments:		R100	Note: All collection higher	II ap			
relianneurs ourvey. The following regulatory deficiencies were identified: R146 V. RESIDENT CARE AND HOME SERVICES SS=E 6.9 (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and runtifional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the Registered nurse failed to provide instruction and supervision to direct care staff regarding procedures for managing a feeding tube for 1 applicable resident (Resident #1). Findings include: Resident #1 has a feeding tube to sustain nutritional needs and takes no food or medications by mouth. During the administration of nutritional frending and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula and medications at 3:20 PM on 4/5/23 the Med Tech was observe					Started during the mon	JK W			
relianneurs ourvey. The following regulatory deficiencies were identified: R146 V. RESIDENT CARE AND HOME SERVICES SS=E 6.9 (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and runtifional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the Registered nurse failed to provide instruction and supervision to direct care staff regarding procedures for managing a feeding tube for 1 applicable resident (Resident #1). Findings include: Resident #1 has a feeding tube to sustain nutritional needs and takes no food or medications by mouth. During the administration of nutritional frending and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula and medications at 3:20 PM on 4/5/23 the Med Tech was observe		On 4/5/23 the Divisio	n of Licensing and	1	May 2023	,			
relianneurs ourvey. The following regulatory deficiencies were identified: R146 V. RESIDENT CARE AND HOME SERVICES SS=E 6.9 (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and runtifional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the Registered nurse failed to provide instruction and supervision to direct care staff regarding procedures for managing a feeding tube for 1 applicable resident (Resident #1). Findings include: Resident #1 has a feeding tube to sustain nutritional needs and takes no food or medications by mouth. During the administration of nutritional frending and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula refeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula and medications at 3:20 PM on 4/5/23 the Med Tech was observe		Protection conducted	an unannounced on site		halak cher.				
deficiencies were identified: V. RESIDENT CARE AND HOME SERVICES SS=E V. RESIDENT CARE AND HOME SERVICES S.9(0) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and rutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the Registered nurse failed to provide instruction and supervision to direct care staff regarding procedures for managing a feeding tube for 1 applicable resident (Resident #1). Findings include: Resident #1 has a feeding tube to sustain nutritional needs and takes no food or medications by mouth. During the administration of nutritional formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding of correct placement of the feeding tube in the stomach. When the Med Tech was requested to pause to check for placement she responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then litting the eyringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding		relingagura ourvay. T	he following regulatory	- 1			1		
R146 SS=E V. RESIDENT CARE AND HOME SERVICES G.9(0) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the Registered nurse falled to provide instruction and supervision to direct care staff regarding procedures for managing a feeding tube for 1 applicable resident (Resident #1). Findings include: Resident #1 has a feeding tube to sustain nutritional needs and takes no food or medications by mouth. During the administration of nutritional formula and medications at 3:20 PM on 4/8/23 the Med Tech was observed initiating formula feeding and medications at 3:20 PM on 4/8/23 the Med Tech was observed initiating formula feeding and medication administration without checking for correct placement of the feeding tube in the stomach. When the Med Tech was requested to pause to check for placement of the feeding tube in the stomach contents to flow into the tube via gravity, then litting the eyringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding									
Registered nurse failed to provide Instruction and supervision to direct care staff regarding procedures for managing a feeding tube for 1 applicable resident (Resident #1). Findings include: Resident #1 has a feeding tube to sustain nutritional needs and takes no food or medications by mouth. During the administration of nutritional formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medication administration without checking for correct placement of the feeding tube in the stomach. When the Med Tech was requested to pause to check for placement she responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then lifting the eyringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding		College, Supplied to 14 and 14			10146				
Registered nurse failed to provide Instruction and supervision to direct care staff regarding procedures for managing a feeding tube for 1 applicable resident (Resident #1). Findings include: Resident #1 has a feeding tube to sustain nutritional needs and takes no food or medications by mouth. During the administration of nutritional formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medication administration without checking for correct placement of the feeding tube in the stomach. When the Med Tech was requested to pause to check for placement she responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then lifting the eyringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding	5446	V OCCUPENT OARE	AND HOME SERVICES	R146	River a Acido	a fric	<u> </u>		
Registered nurse failed to provide Instruction and supervision to direct care staff regarding procedures for managing a feeding tube for 1 applicable resident (Resident #1). Findings include: Resident #1 has a feeding tube to sustain nutritional needs and takes no food or medications by mouth. During the administration of nutritional formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medication administration without checking for correct placement of the feeding tube in the stomach. When the Med Tech was requested to pause to check for placement she responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then lifting the eyringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding		V. KESIDENT CARE	AND HOME SERVICES	1	Going forward with go	יין נקיה בין אמ			
Registered nurse failed to provide Instruction and supervision to direct care staff regarding procedures for managing a feeding tube for 1 applicable resident (Resident #1). Findings include: Resident #1 has a feeding tube to sustain nutritional needs and takes no food or medications by mouth. During the administration of nutritional formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medication administration without checking for correct placement of the feeding tube in the stomach. When the Med Tech was requested to pause to check for placement she responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then lifting the eyringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding	33-E			1	1 1 molinian Done polar	e; Staff			
Registered nurse failed to provide Instruction and supervision to direct care staff regarding procedures for managing a feeding tube for 1 applicable resident (Resident #1). Findings include: Resident #1 has a feeding tube to sustain nutritional needs and takes no food or medications by mouth. During the administration of nutritional formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medication administration without checking for correct placement of the feeding tube in the stomach. When the Med Tech was requested to pause to check for placement she responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then lifting the eyringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding		5.9 /0\			Tixbe porcy and for	1. M. L.			
Registered nurse failed to provide instruction and supervision to direct care staff regarding procedures for managing a feeding tube for 1 applicable resident (Resident #1). Findings include: Resident #1 has a feeding tube to sustain nutritional needs and takes no food or medications by mouth. During the administration of nutritional formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medication administration without checking for correct placement of the feeding tube in the stomach. When the Med Tech was requested to pause to check for placement she responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then lifting the eyringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding		φ,φ.υ (σ)			Will be trained and it	VIIIDE	7/5		
Registered nurse failed to provide instruction and supervision to direct care staff regarding procedures for managing a feeding tube for 1 applicable resident (Resident #1). Findings include: Resident #1 has a feeding tube to sustain nutritional needs and takes no food or medications by mouth. During the administration of nutritional formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medication administration without checking for correct placement of the feeding tube in the stomach. When the Med Tech was requested to pause to check for placement she responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then lifting the eyringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding		Provide instruction a	nd supervision to all direct		10 Hackensch	ale do	1		
Registered nurse failed to provide instruction and supervision to direct care staff regarding procedures for managing a feeding tube for 1 applicable resident (Resident #1). Findings include: Resident #1 has a feeding tube to sustain nutritional needs and takes no food or medications by mouth. During the administration of nutritional formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medication administration without checking for correct placement of the feeding tube in the stomach. When the Med Tech was requested to pause to check for placement she responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then lifting the eyringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding					Mocamented They mount	الما الماسيدية	1		
Registered nurse failed to provide instruction and supervision to direct care staff regarding procedures for managing a feeding tube for 1 applicable resident (Resident #1). Findings include: Resident #1 has a feeding tube to sustain nutritional needs and takes no food or medications by mouth. During the administration of nutritional formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medication administration without checking for correct placement of the feeding tube in the stomach. When the Med Tech was requested to pause to check for placement she responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then lifting the eyringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding					Tal I she sheement At	- Mix			
Registered nurse failed to provide instruction and supervision to direct care staff regarding procedures for managing a feeding tube for 1 applicable resident (Resident #1). Findings include: Resident #1 has a feeding tube to sustain nutritional needs and takes no food or medications by mouth. During the administration of nutritional formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medication administration without checking for correct placement of the feeding tube in the stomach. When the Med Tech was requested to pause to check for placement she responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then lifting the eyringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding					Check The Fretelling Ph	Den-	}		
Registered nurse failed to provide instruction and supervision to direct care staff regarding procedures for managing a feeding tube for 1 applicable resident (Resident #1). Findings include: Resident #1 has a feeding tube to sustain nutritional needs and takes no food or medications by mouth. During the administration of nutritional formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medication administration without checking for correct placement of the feeding tube in the stomach. When the Med Tech was requested to pause to check for placement she responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then lifting the eyringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding			-		Drive to misting That	V-5 -			
Registered nurse failed to provide instruction and supervision to direct care staff regarding procedures for managing a feeding tube for 1 applicable resident (Resident #1). Findings include: Resident #1 has a feeding tube to sustain nutritional needs and takes no food or medications by mouth. During the administration of nutritional formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medication administration without checking for correct placement of the feeding tube in the stomach. When the Med Tech was requested to pause to check for placement she responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then lifting the eyringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding		This REQUIREMENT is not met as evidenced			You from We Will Check	,			
Registered nurse failed to provide instruction and supervision to direct care staff regarding procedures for managing a feeding tube for 1 applicable resident (Resident #1). Findings include: Resident #1 has a feeding tube to sustain nutritional needs and takes no food or medications by mouth. During the administration of nutritional formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medication administration without checking for correct placement of the feeding tube in the stomach. When the Med Tech was requested to pause to check for placement she responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then lifting the eyringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding		•		j	VILLIER LA GENERATING	a gastra	-[
applicable resident (Resident #1). Findings include: Resident #1 has a feeding tube to sustain nutritional needs and takes no food or medications by mouth. During the administration of nutritional formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medication administration without checking for correct placement of the feeding tube in the stomach. When the Med Tech was requested to pause to check for placement s/he responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then litting the eyringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding				1	White Comen De 100 to	C/	1		
applicable resident (Resident #1). Findings include: Resident #1 has a feeding tube to sustain nutritional needs and takes no food or medications by mouth. During the administration of nutritional formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medication administration without checking for correct placement of the feeding tube in the stomach. When the Med Tech was requested to pause to check for placement s/he responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then litting the eyringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding					Antend sprior to wing				
applicable resident (Resident #1). Findings include: Resident #1 has a feeding tube to sustain nutritional needs and takes no food or medications by mouth. During the administration of nutritional formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medication administration without checking for correct placement of the feeding tube in the stomach. When the Med Tech was requested to pause to check for placement s/he responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then litting the eyringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding					The state of the s	ullha			
medications by mouth. During the administration of nutritional formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medication administration without checking for correct placement of the feeding tube in the stomach. When the Med Tech was requested to pause to check for placement s/he responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then lifting the eyringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding				1	De low and procedure &	11/12/2	}		
medications by mouth. During the administration of nutritional formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medication administration without checking for correct placement of the feeding tube in the stomach. When the Med Tech was requested to pause to check for placement s/he responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then lifting the eyringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding			Resident #1). Findings	Ì	Voltan & provide	-ence			
medications by mouth. During the administration of nutritional formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medication administration without checking for correct placement of the feeding tube in the stomach. When the Med Tech was requested to pause to check for placement s/he responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then lifting the eyringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding	ł	include:			in MAIN to Cont				
medications by mouth. During the administration of nutritional formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medication administration without checking for correct placement of the feeding tube in the stomach. When the Med Tech was requested to pause to check for placement s/he responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then lifting the eyringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding	}				10 1. A				
medications by mouth. During the administration of nutritional formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medication administration without checking for correct placement of the feeding tube in the stomach. When the Med Tech was requested to pause to check for placement s/he responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then lifting the eyringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding					to-Start				
of nutritional formula and medications at 3:20 PM on 4/5/23 the Med Tech was observed initiating formula feeding and medication administration without checking for correct placement of the feeding tube in the stomach. When the Med Tech was requested to pause to check for placement s/he responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then lifting the syringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding					h				
on 4/5/23 the Med Tech was observed Initiating formula feeding and medication administration without checking for correct placement of the feeding tube in the stomach. When the Med Tech was requested to pause to check for placement s/he responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then lifting the eyringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding		medications by mout	in. During the administration	1			1		
formula feeding and medication administration without checking for correct placement of the feeding tube in the stomach. When the Med Tech was requested to pause to check for placement s/he responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then lifting the eyringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding		1 "		1	m P146				
without checking for correct placement of the feeding tube in the stomach. When the Med Tech was requested to pause to check for placement s/he responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then lifting the eyringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding	1				1 2	-	1		
feeding tube in the stomach. When the Med Tech was requested to pause to check for placement s/he responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then Iffing the syringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding	<u> </u>			1	C. Scott/J. Evans				
was requested to pause to check for placement s/he responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then Iffing the syringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding	İ			l			ł		
s/he responded by moving the syringe lower than Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then Iffing the syringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding	1								
Resident #1's torso allowing the stomach contents to flow into the tube via gravity, then Iffling the syringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding									
contents to flow into the tube via gravity, then Ifting the syringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding	1			1	1		1		
Iffting the eyringe higher so the fluid flowed back through the tube, which is not a standard practice for checking tube placement. The feeding									
through the tube, which is not a standard practice for checking tube placement. The feeding		contents to flow into the tube via gravity, then			· ·				
for checking tube placement. The feeding		I through the tube with	iner so the fiuld flowed back lightie not a standard practice	1	1		1		
	Elededore of L.P.	1	MORROW. THE ICCUMS				<u>'</u>		

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

TITLE

(X6) DATE

Division of Licensing and Protection							
STATEMENT OF DEFICIENCIES (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
0214		8. WING	8, WING		5/2023		
			DDRESS, CITY, STAT	CC ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER		ILANDER DRIVE				
RIVERVIE	W LIFE SKILLS CENTER		SONVILLE, VT 0	5464			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	B€	(X5) COMPLETE DATE	
R146	Continued From page 1 process was observed and noted to proceed without issues or concerns. The Med Tech stated s/he had not received specific training regarding the tube feeding process to include instructions for checking tube placement. On the afternoon of 4/5/23 the Registered Nurse indicated s/he was unaware of a facility policy for tube feeding, however a copy of the facility's Protocol and Procedure for Bolus Feedings effective December 19, 2018 was provided for review by a staff member. This document states "Placement of [the Resident's] feeding tube has to be confirmed prior to all fluids given through his/her tube", and Indicates the procedure for checking placement is to attach the appropriate size syringe to the feeding tube, ensure the plunger is in the syringe, gently pull back on the plunger to withdraw stomach contents without pulling on the feeding tube, then put the fluids		R146				
R174 SS≓E	the Med Tech had no the facility Protocol a Feedings and did not feeding tube during to medication administra- citation. V. RESIDENT CARE 5.10 Medication Man 5.10.h. (2)	4/5/23 the RN acknowledged to been educated regarding and Procedure for Bolus to check the placement of the second feeding and ation. This is a repeat AND HOME SERVICES	R174				
	Medications requiring refrigeration shall be stored in a separate, locked container impervious to						

Division of Licensing and Protection

PRINTED: 06/26/2023 FORM APPROVED

Division of Licensing and Protection							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
AND PLAN C	F GORRECTION	. IDEISTIFICATION PONDER.	A. BUILDING: _				
	*	0214	B. WING		04/0	5/2023	
	<u> </u>		DRESS, CITY, STA	TE ZIP CODE			
NAME OF PE	ROVIDER OR SUPPLIER	The state of the s	LANDER DRIVE				
RIVERVIE	W LIFE SKILLS CENTER	,	ONVILLE, VT 0	5464			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAĞ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
R174	Continued From page	2	R174	*****			
	water and air if kept in for storage of food. This REQUIREMENT by: Based on observation	n the same refrigerator used is not met as evidenced and staff interview there		A medication lock-box purchased for the pur	cas pose	delan	
	same refrigerator use separate, locked confidence of the facility tou on 4/5/23 a kitchen recontain medications were shelves as food locked boxes impervimedications stored in open unsealed box of these subcutaneous Osteoporosis), and 2 insulin pen injectors (which were stored un	the refrigerator Included an ontaining a Forteo 20 meg pen injector (for Lantus Solar 100 units/ml for Diabetes) in Ziploc bags		A medication lock-box purchased for the pur of securely and safely Storing any medical needs to be refridge Tag R174 accepted on 7/10/23. C. Scott/J. Evans		7/5/23	
	medications stored in food were not contain	a kitchen refrigerator with ned in separate locked re impervious to water and					
R179 S\$=F	V. RESIDENT CARE	AND HOME SERVICES	R179				
	5.11 Staff Services						
	providing any direct of shall be at least twelv						

X0M611

Division s	f Licensing and Profes	tion			
STATEMENT	f Licensing and Protect of DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		0214	B. WING		04/05/2023
	ROVIDER OR SUPPLIER	197 HIGH	DDRESS, CITY, 87/ ILANDER DRIVI SUNVILLE, VT	=	
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	8E COMPLETE
R179	Continued From page residents. The trainle limited to, the following (1) Resident rights: (2) Fire safety and etc. (3) Resident emerges such as the Heimilch or ambulance contact. (4) Policies and progreports of abuse, new (5) Respectful and experiments. (6) Infection control limited to, handwash maintaining clean empathogens and universidents. (7) General supervisors a failure to ensure residents completed Findings include: Per review of staff to previous year:	ing must include, but is not ong: Imagency evacuation; Imagency evacuation; Imagency response procedures, Imagency exact and first oid; Including mandatory glect and exploitation; Infective interaction with Imagency regarding mandatory Infective interaction with Imagency inter		R179 Staff Training Trecord staff will be given as and training or press by the stafe of VT. he provide it hour after annually. We will include that not limited to the required inservices elucation on our po- and procedures spe to our resident pop this elucation and the will be locumented staff Los Binder an updated monthly Tag R179 accepted on 7/10/23	Ircy chic outon raining In our
	administration training requirement for the Care of Residents to			C. Scott/J. Evans	
	*2 out of 5 staff did during the previous	not complete any trainings year.			
	On the afternoon of confirmed 5 out of 5	4/5/23 the Manager sampled staff did not			

Division o	f Licensing and Protec	ction		W-1		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	A. BUILDING:		COMP ET. MP	
			B, WING		04/0	5/2023
		0214	. 1		1 0470	J/2023
NAME OF PE	ROVIDER OR SUPPLIER		DRESS, CITY, STA			;
RIVERVIE	W LIFE SKILLS CENTER)	LANDER DRIVI ONVILLE, VT (
040.15	SI INMARY ST	ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
(X4) iD PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	COMPLETE DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		
R179	Continued From page	e 4	R179			
	complete all required					
	Outplotes an insquire	,,				
R190 SS≐F	V. RESIDENT CARE	AND HOME SERVICES	R190			
	5.12.b.(4)					
	The results of the crir registry checks for all	minal record and adult abuse I staff.		Going forward with background checks: he resubmitting background checks to rewrent en when we will keep or sinal conferment of background checks of Discarding them	her	
ı	This REQUIREMENT	☐ is not met as evidenced		Dades sure to backgood	0	1/
	by:			resubmitting aucigran	diam'r.	7/5/23
		ew and staff interview there de documentation of criminal		Checks for Current CA	Midlecs"	7 /
		se registry checks for 5 out		en cult keep original Co	pres	
	of 5 sampled staff. Fi	indings include:	- [al lesson O oher to	instact	
	At 2:50 PM on 4/5/23	the Manager confirmed		of packet ourse		
	documentation of cris	minal record and abuse		of Siscarding Them		
		pleted upon hire for 5 out of 5 as not on file and available				
		d, "I do them every once in a		Tag R190 accepted on 7/10/23	-	
	while I throw out th			C. Scott/J. Evans		
R221 \$S≕F	VI. RESIDENTS' RIG	ентs	R221			
	6.9 Residents may n	nanage their own personal				
	finances. The home	or licensee shall not manage				
		unless requested in writing				
		hen in accordance with the le home or licensee shall				,
		ransactions and make the				
	record available, upo	n request, to the resident or				
		and shall provide the				
		ounting of all transactions at lent funds must be kept				
		accounts or funds of the				}

home.

PRINTED: 06/26/2023 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			X3) DATE SURVEY COMPLETED	
0214		B. WING	B. WING		04/05/2023	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 197 HIGHLANDER DRIVE RIVERVIEW LIFE SKILLS CENTER JEFFERSONVILLE, VT 05464						
(X4) ID PREHX TAG	ID SUMMARY STATEMENT OF DEFICIENCIES HIX (EACH DEFICIENCY MUCT BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD DEFICION SHOULD DEFICIENCY)		(X6) COMPLETE DATE
R221	Continued From page	3 5	R221			
	by: Based on record reviewas a fallure to keep transactions, provide transactions, and to e request to manage furesidents (Residents Findings include: On the afternoon of 4 records and count of residents for whom the was conducted with the At 5:32 PM on 4/5/23 written requests to maccounting of all transof quarterly reports presidents for the second counting of all transof quarterly reports presidents for whom the second counting of all transof quarterly reports presidents.	the Manager confirmed anage funds, accurate sactions, and documentation rovided to the residents tatives were not on file and		Financial record registra been Developed docum Client personal spending These registries will a workered regularly an reviewed with the rest on a quaterly basis Continued Signed by rest and filed. Tag R221 accepted on 7/10/23 C. Scott/J. Evans		7/5/23

Division of Licensing and Protection