AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

June 25, 2024

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 **May 6, 2024.** Please post this document in a prominent place in your facility.

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

If you have any questions, please feel free to contact me at (802) 585-0995.

Sincerely,

Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0214	A. BUILDING: ___ B. WING ___	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW LIFE SKILLS CENTER	197 HIGHLANDER DRIVE JEFFERSONVILLE, VT 05464

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R100	Initial Comments: On 5/6/24 the Division of Licensing and Protection conducted an unannounced on-site annual re-licensure survey. The following regulatory deficiencies were identified:	R100		
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 by: Based on staff interview and record review there was a failure to ensure completion of Resident Assessments annually for 2 out of 3 sampled residents (Residents #1 and #2). Findings include: On the afternoon of 5/6/24 the Licensee confirmed policies and procedures that govern Resident Assessments had not been developed by the home. 1. Per record review, Resident #1 was admitted to the home on 2/16/06 . His/her last annual resident assessment on file was completed on 4/12/23. Resident #1's annual assessment for 2024 was due 24 days prior to the survey on 5/6/24. 2. Per record review, Resident #2 was admitted	R136	All residential assessments have been completed, signed by RN, sent to LCCFC Coordinator accepted and returned to Riverview and have been filed. Riverview has contacted LCCFC requesting dates of when current residential Assessments are due. Having this list will eliminate future RA's from being past due. R.A. Policy & Procedure has been developed and filed in our Policy & Procedure manual. R136 Plan of Correction accepted by Jo A Evans RN on 6/24/24	5/29/24

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R136	Continued From page 1 to the home on 3/29/20. The most recent annual assessment on file for Resident #2 was dated 6/7/23; however this assessment is incomplete as was not signed by a Registered Nurse, which is required for completion of the Resident Assessment form. Per review of Resident #2's assessment dated 6/7/23: a. Section A.0. Individual Identification Question 4 inaccurately indicates this was an admission assessment. b. Section N.1. Signatures Question 1a. states the Administrative Manager completed the assessment. c. Question 4, which is where the Registered Nurse signs, the form to certify the accompanying information accurately reflects resident assessment information that was collected/coordinated by the RN on the dates specified, is without a signature. d. Section N.1. Signatures Question 5. is filled in to indicate the assessment was signed as complete on 6/7/23 These findings were confirmed by the Licensee on the afternoon of 5/6/24. In conclusion this deficient practice is a risk for more than minimal harm due to the failure to identify resident strengths, weaknesses, preferences, and needs during the assessment process, which is the basis of resident care planning.	R136		
R147 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (4)	R147		

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R147	Continued From page 2 Maintain a current list for review by staff and physician of all residents' medications. The list shall include: resident's name; medications; date medication ordered; dosage and frequency of administration; and likely side effects to monitor; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure all medication orders for 3 out of 3 sampled residents (Residents #1, #2, and #3) included a specific dose and frequency of administration. Findings include: On the afternoon of 5/6/24 the Licensee was requested to provide a copy of the facility's policies and procedures to ensure medication orders include all required information . In response the Licensee provided the facility's Medication Management policies and procedures, and Medication Administration Policies and Procedures. The documents provided for review do not include policies and procedures to ensure all medication orders are complete and include the specific dose and frequency of administration. Per review of the May 2024 Medication Administration Records (MARs) for a sample of 3 residents, the MARs for 3 out of 3 residents listed medication orders which did not include a specific dose and frequency of administration including the amount of time between doses of PRN (as needed) medications. 1. Resident #1's MAR listed: a. "Metronidazol CRE 0.75% Apply to affected area topically daily"	R147	Corrective action: Orders edited and returned to pharmacy. Updated orders signed by providers Systemic changes Provider orders will be monitored and updated as needed. New meds/med changes will be accompanied by signed order. RN will ensure orders are complete Monitoring Nursing will review POs monthly with delivery of meds, and update as needed R 147 Plan of Correction accepted by Jo A Evans RN on 6/24/24.	5/26/24

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R147	Continued From page 3 b. "Sm Fiber Pow Use as directed every morning as needed for bowel regularity/constipation" 2. Resident #2's MAR listed: a. "APAP [acetaminophen] 500 mg tabs 1-2 tablets by mouth every 8 hours as needed" 3. Resident #3's MAR listed: a. "Baclofen tab 20 mg 1 tablet by mouth twice daily as needed for back pain" b. "Calcium Antacid 500 mg tabs 1-2 tablets three times daily as needed for stomach ache or acid reflux" c. "Fiber Smooth Powder S/F 1 tablespoonful by mouth as needed" d. "Prep H CRE 1% Apply 1 application externally as needed" e. "Pro Air HFA 2 puffs by mouth every 4-6 hours as needed for wheezing/dyspnea" f. "Refresh Tears 0.5 % Bottle Drop Instill 2 drops in each eye as needed" g. " Triple Antibiotic Ointment Use as Directed as needed" At 3:35 PM on 5/6/24 the Registered Nurse confirmed medications listed in the sampled resident's May 2024 Medication Administration Records were incomplete and did not include the specific dose and frequency of administration including the amount of time required between doses for PRN (as needed) medications. In conclusion this deficient practice is a risk for more than minimal harm for all residents due to administration of medications at an incorrect dose and/or frequency to address the symptoms or conditions the medication is intended to treat, and the failure to ensure the information listed on the MAR conveys instructions for administration as the prescriber intended.	R147		

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R147	Continued From page 4 This is a repeat citation.	R147	Corrective Action for R164 on page 8	
R162 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to obtain physician's written, signed orders for medications administered to 2 out of 3 sampled residents (Residents #1 and #3). Findings include: The facility's Medication Management policies and procedures state, "There must be a physician's orders for all prescriptions and PRN medications"; however this policy does not state physician's written, signed orders are required for all medications administered to facility residents. Per record review, Physician's written signed orders were not on file and available for review for the following medications listed in the May 2024 Medication Administration Record: 1. For Resident #1: a. "Sertraline tab 25 mg Take one tablet by mouth daily" b. "Melatonin cap 10 mg 1 capsule by mouth at bedtime"	R162	Corrective action: Delegation of all staff transferred to current nurse. Staff who do not give meds are not delegated. Systemic changes Tracking of delegated staff, prompt re-delegation of staff when there is a nursing change Monitoring Tracking of staff delegation updates on Excel spreadsheet R164 Plan of Correction accepted by Jo A Evans RN on 6/24/24.	5-10-24

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R162	Continued From page 5 2. For Resident #3: a. "Refresh Plus DRO 0.5 % OP 1 drop in each eye twice daily" b. "Omeprazole Cap 20 mg 1 capsule by mouth 30 minutes before morning meal as needed for reflux" c. " Prep H CRE 1% Apply 1 application externally as needed" d. "Aspercreme w/Lidocaine Patch Apply 1 patch topically daily as needed - on 12 hours/off 12 hours" e. "Baclofen tab 20 mg 1 tablet by mouth twice daily as needed for back pain" f. "calcium Antacid 500 mg 1-2 tablet(s) by mouth three times daily as needed for stomach ache or acid reflux" Orders provided to the Surveyor for the following medications listed on Resident #3's MAR were printed from the pharmacy's website after the Surveyor's request for physician's written signed orders was made, and were not on file and available for review prior to the Surveyor's request: g. "Jardiance tab 10 mg 1 tablet by mouth daily " printed at 3:53 PM on 5/6/24 h. : Mag Oxide tab 400 mg 1 tablet by mouth daily" printed at 3:54 PM on 5/6/24 On the afternoon on 5/6/24 the Registered Nurse confirmed medication orders listed on the May 2024 Medication Administration Record for the sampled residents were not on file and available for review on request. In conclusion, this deficient practice is a risk for more than minimal harm to residents because physician's written, signed orders ensure the medication, dose, route, and frequency of	R162	Corrective action: Signed Physician orders obtained from pharmacy Systemic changes POs will be monitored and updated as needed. Signed PO will be printed out for all new meds & med changes Monitoring Nurse will review POs monthly to ensure orders are signed. R162 Plan of Correction accepted by Jo A Evans RN on 6/24/24.	5-26-24

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R162	Continued From page 6 administration are communicated as the prescriber intended. This is a repeat citation.	R162		
R164 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (2) A registered nurse must delegate the responsibility for the administration of specific medications to designated staff for designated residents This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the Registered Nurse failed to delegate the responsibility for the administration of specific medications to designated staff for specific residents. Findings include: The facility's Medication Management policy states, " Only employee delegated by a Registered Nurse are to pass out medications and only after instructed on how to administer the medication..". The facility's Medication Administration Policy and Procedure effective 9/19/2014 includes a Policy Statement which states, " The Registered Nurse is responsible for the delegation and proper administration of medications of all unlicensed assisting staff." and "Unlicensed staff may only perform medication administration when delegated by the RN."	R164	See page (5) Staff delegation	5-10-24

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R164	Continued From page 7 Per record review the facility's current Registered Nurse's employment at the facility began on 2/26/24. This finding was confirmed by the Administrative Manager at 3:36 PM on 5/6/24. The current Registered Nurse confirmed at 3:33 PM on 5/6/24 that s/he had not re-delegated three of the staff who administer medications to the residents of the home under his/her nursing supervision and licensure. In closing this deficient practice is a potential risk for more than minimal harm for all facility residents resulting from the failure to ensure staff who administer medications have been properly trained to safely and accurately administer medications.	R164	See p(5) re: staff delegation	
R180 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.c All training to meet the requirements of 5.11.b shall be documented. Training in direct care skills by a home's nurse may meet this requirement, provided the nurse documents the content and amount of training This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to provide documentation of the required yearly trainings completed completed by all staff. Findings include: On the afternoon of 5/6/24 the Licensee was requested to provide copies of the home's	R180	Corrective action Training log was found. Continuing to provide training through monthly meetings and weekly topics/in-person sessions Systemic changes Documentation process updated: training to be tracked on Excel spreadsheet (over...)	5-12-24

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R180	Continued From page 8 policies and procedures related to staff trainings. The Licensee provided a document entitled Core Training Module which states the facility will train and supervise the home's Case Managers, Life Skills Aides, Community Support/Transitional Living Personnel (overnight aides/care giver). The Licensee also provided a document entitled Outline of the Core Training Module which lists 9 areas of training; however the trainings listed do not include the trainings required by the licensing agency. Policies and procedures related to the trainings required by the licensing agency were not on file and available for review on 5/6/24. On the morning of 5/6/24 the Registered Nurse and a Manager of the home were requested to provide documentation of completion of the required staff trainings for a sample of 5 staff. At 1:53 PM on 5/6/24 the Registered Nurse confirmed documentation of staff trainings was not on file and available for review for all facility staff. This deficient practice is a potential risk for more than minimal harm for all facility residents due to the failure to ensure adequate staff education and training to safely and effectively provide resident care, and to maintain documentation of staff trainings on file and available for review.	R180	Records reorganized Monitoring Mandatory monthly meetings documented Weekly topics given one-on-one checkins with staff to cover questions / concerns Records tracked on Excel spreadsheet R180 Plan of Correction accepted by Jo A Evans RN on 6/24/24.	5-12-24
R190 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced	R190		

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R190	Continued From page 9 by: Based on staff interview and record review there was a failure to complete all required criminal record and abuse registry checks for 5 out of 5 sampled staff. Findings include: The Licensee was requested to provide copies of the home's policies and procedures that govern employee criminal record and abuse registry background checks. In response to this request the Licensee provided a copy of the Vermont Agency Of Human Services Department of Disabilities and, Aging and Independent Living Background Check Policy Effective April 1, 2006 and Corrected on May 1, 2006 to the Surveyor for review. The policy provided for review is an outdated public document which is not consistent with the licensing agency's current Residential Care Home regulatory requirements for criminal record and abuse registry checks. On the morning of 5/6/24 an Administrative Manager of the home was requested to provide documentation of the required criminal record and abuse registry checks checks for a sample of 5 staff. At 1:21 PM on 5/6/24 the Administrative Manager confirmed the required background checks were not completed as required for 5 out 5 sampled staff. In conclusion this deficient practice is a potential risk for more than minimal harm for all residents, as the requirement for criminal background and abuse checks is intended to ensure all residents are free from the risk of harm. This is a repeat citation.	R190	Corrective action All background checks complete, National check discussed at time of the review will be handled by the payroll company Systemic changes Background checks will be completed by payroll company in the future. P&P updated Monitoring Payroll company will monitor compliance R190 Plan of Correction acepted by Jo A Evans RN on 6/24/24.	5-30-24

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R200	Continued From page 10	R200		
R200 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to develop policies and procedures that govern all services provided by the home. Findings include: On 5/6.23 the facility's Administrators were requested to provide copies of policies and procedures developed by the home related to deficient practices identified during the survey process for review. Policies and procedures governing the following areas of service were not on file and available for review on request: 1. Resident Assessments 2. Obtaining complete mediation orders which include the specific dose and frequency of administration 3. Maintaining the residential environment 4. Fire Drills 5. Employee background checks 6. Management of Resident Funds On the afternoon of 5/6/24 the Licensee confirmed policies and procedures governing all areas of service had not been developed by the home. In conclusion this deficient practice is a potential	R200	Corrective action P&Ps updated/written on all subjects Systemic changes Discussion ongoing regarding items to be added/included in Policies & Procedures Monitoring P&P to be reviewed quarterly and updated as needed R200 Plan of Correction accepted by Jo A Evans RN on 6/24/24.	5/26/24

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R200	Continued From page 11 risk for more than minimal harm for all facility residents due to failure to provide accessible information and clear instructions related to tasks staff are required to perform.	R200	R221 Corrective action Resident funds re-conciled	
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 provide all applicable residents or their representatives with quarterly statements regarding the status of resident's personal funds managed by the home (Residents #1, #4, #5 and #6); and a failure to ensure accurate accounting of all transactions for one applicable resident (Resident #5). Findings include: On 5/6/24 the Managers of the home were requested to provide copies of policies and procedures which govern management of personal funds for residents. On the afternoon of	R221	Systemic changes Resident funds will be reconciled quarterly and statement sent to the resident or guardian as app-ropriate Monitoring Resident funds will be reconciled on a quarterly basis R221 Plan of Correction accepted by Jo A Evans RN on 6/24/24.	5-12-24

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R221	Continued From page 12 5/16/24 the Licensee confirmed policies and procedures governing management of resident's personal funds had not been developed. 1. On the afternoon of 5/6/24, the Administrative Manager was requested to provide documentation of quarterly statements provided to residents or their representatives regarding the status of resident's personal funds managed by the home. At 1:21 PM on 5/6/24 the Administrative Manager confirmed the home does not provide the required quarterly statements of the status of personal funds managed by the home to residents or their representatives. 2. Per review of the accounting of resident funds with the Administrative Manager on the afternoon of 5/6/24 the record of transactions for Resident #5 was found to be inconsistent with the amount of money held by the home belonging to the resident, indicating a failure to accurately record all of the resident's financial transactions. Resident #5's record of transactions stated s/he had $9.14 more than the amount observed on hand in the resident's envelope. This finding was confirmed by the Administrative Manager at 1:21 PM on 5/6/24. In closing this deficient practice is a potential risk for more than minimal harm for all facility residents due to the failure to accurately manage resident funds; and the failure to ensure residents and/or their representatives are provided the opportunity to review and confirm the accuracy of all transactions. This is a repeat citation.	R221		

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R246	Continued From page 13	R246	Corrective Action	
R246 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.a Each home must procure food from sources that comply with all laws relating to food and food labeling. Food must be safe for human consumption, free of spoilage, filth or other contamination. All milk products served and used in food preparation must be pasteurized. Cans with dents, swelling or leaks shall be rejected and kept separate until returned to the supplier. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure all foods stored and served at the home are procured from food sources that comply with all food and food labeling laws; and a failure to ensure foods stored and served at the home are free of spoilage. Findings include: The Food Storage policy provided by the Licensee provided for review on 5/6/24 states, "No food items shall be kept that are not from regulated sources, i.e., grocery store. No homemade syrups, jams, or garden items shall be allowed to be kept in facility." 1. During a facility tour commencing at 10:40 AM on 5/6/24 perishable food items procured from sources other than those which comply with laws relating to food and food labeling laws were observed in the refrigerators of both the upper and lower level kitchens of the home to include 4 opened mason jars containing a brown liquid reported by Staff to be maple syrup. Opened mason jars of what appeared to be jam and an	R246	All refrigerators and freezers inspected: expired and unlabeled items discarded; all items remaining are dated including pantry perishables Systemic changes *Refrigerators, freezers and pantries will be inspected weekly when groceries are delivered. Expired/unlabeled items will be discarded. *Signage and perishable food info posted on refrigerators *Food items not from a regulated source may not be served to residents	5-27-24

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R246	Continued From page 14 unknown red sauce were also observed. All of the jars were without required food labels. Only one of the opened jars was labeled with a date, which was 5/11/22. On the morning of 5/6/24 Staff confirmed the contents of the jars were not prepared at the home, and stated items in the unlabeled mason jars were likely brought to the home by a resident's family member. 2. During the tour of the kitchen on the lower level of the home on the morning of 5/6/24 expired and moldy foods were observed in a refrigerator including a bottle of Lea and Perrins Worcestershire Sauce dated as opened on 11/30/2021. The expiration date was worn off the bottle; however per telephone call to the Lea and Perrins Consumer Center on the afternoon of 5/15/24, Worcestershire Sauce expires two years from the date the product is manufactured. A package of sliced turkey dated as opened on 4/6/24 was also observed in this fridge. The manufacturer's label on the turkey package stated, "Use within 7 days of opening". The Registered Nurse confirmed these findings during the tour of the kitchen on the lower level of the home on 5/6/24. In a refrigerator in the kitchen on the upper level of the home an unlabeled and undated mason jar containing an unidentified brown liquid was observed with mold growing inside the jar. This finding was confirmed by the Licensee on the afternoon of 5/6/24. In conclusion, these deficient practices are potential risks for more than minimal harm due to food borne illness for all facility residents.	R246	Monitoring Refrigerators, Freezers and pantries will be inspected weekly R246 Plan of Correction accepted by Jo A Evans RN on 6/24/24.	

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R247	Continued From page 15	R247		
R247 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure all perishable foods and beverages are labeled and dated as required. Findings include: The home's Food Storage policy states, "All leftover and perishable items must be labeled and dated". During a tour commencing at 10:40 AM on 5/6/24 perishable foods and beverages were observed in both kitchens of the home without identifying labels and the dates the items were opened or prepared as follows: 1. In the upstairs kitchen: a. Dry goods stored in the cabinets including bread crumbs, flours, sugars, and shortening were observed without the dates the items were opened. A container of butter or margarine on the counter was without a date. b. In the first refrigerator 6 containers of leftovers and several jars containing unknown items were observed without identifying labels and the dates the items were prepared. Perishable items	R247	See R246 p(14) Corrective action Perishable food and drink labeled and dated, stored at proper temperatures Systemic changes Staff education, signage posted, Monitoring Refrigerators, freezers and pantries will be inspected weekly R247 Plan of Correction accepted by Jo A Evans RN on 6/24/24.	6-27-24

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R247	Continued From page 16 without the dates they were opened or prepared included cheeses, half and half, margarine, several condiments and dressings, and a plastic bag filled with potato peels. c. A second refrigerator was observed with undated opened items including sour cream; numerous salad dressings, sauces, and condiments; an unidentified brown liquid in a pint jar with mold growing inside the jar and 3 additional jars without identifying labels or dates; 2 jars of apple sauce; 2 containers of liquid Coffee Mate non-dairy creamer; 1 gallon of milk, 1 prepared juice in a pitcher; 1 personal drink bottle without an identifying label and date; whipped toping; cheesecake; 2 bags and 1 container of cheese; a jar of olives; and a jar of chopped garlic. d. In the freezer of one of the refrigerators there were 3 open undated bags of berries and an undated box of Bubba Burgers left open. 2. In the lower level kitchen: a. All opened perishable items stored in the cabinets were observed to be without labels indicating the dates the items were opened. A container of butter or margarine on the counter was without a date. b. In one refrigerator, opened perishable items were observed without labels indicating the dates the items were open included butter, yogurts, cream cheese and sour cream; almond milk; whipped topping; bottles of liquid Coffee Mate; numerous dressings, condiments, and sauces; jam; maple syrup; 3 jars of brown liquid without an identifying label or date; an undated and unlabeled plate of what appeared to be cooked	R247		

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R247	Continued From page 17 chicken; 2 tubs of sliced deli meat and 2 packages of sliced pepperoni; multiple packages of sliced and shredded cheese with an opened undated a package of bacon placed on top of them; 3 containers of leftovers without dates, 2 of which were without identifying labels; and a jar of applesauce with sauce left on the outside of the lid. c. A second fridge was observed with a large crock pot with what appeared to be cooked chicken without an identifying label or date the food inside was prepared; and a partially covered pie which was without an identifying label. Two 4 packs of an unlabeled and undated perishable item that appeared to be a baked good were observed in the door of this fridge. There were opened undated containers of BBQ sauce, prepared horseradish, 2 bottles of pancake syrup, mayonnaise, tartar sauce, half and half, and Mountain Dew soda. These findings were confirmed by the Registered Nurse during the tour of the home on the morning of 5/6/24, and acknowledged by the Licensee on the afternoon of 5/6/24. In conclusion, this deficient practice is a potential risk for more than minimal harm due to food borne illness for all facility residents. This is a repeat citation.	R247		
R266 SS=F	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a	R266		

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R266	Continued From page 18 safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure care in a safe, functional, sanitary, homelike and comfortable environment related to poor repair and unsanitary practices in 3 out of 4 bathrooms of the home. Findings include: On the afternoon of 5/6/24 the Licensee was requested to provide copies of the facility's policies and procedures governing maintenance of the Residential Care Home's (RCH's) environment including the bathrooms of the home. In response the Licensee provided pages 70-73 of a public document developed by the Vermont Department of Health Division of Environmental Health Food and Lodging Programs entitled Health Regulations for Food Service Establishments effective December 1, 2003 for review. The Residential Care Home is not licensed and operating as a food service establishment; however, on the afternoon of 5/6/24 the Licensee stated the pages of this document provided for review are the facility's policies and procedures governing the home's living environment including maintenance of the walls, floors, and ceilings in the bathrooms of the home. Policies and procedures governing the maintenance of the residential environment developed by and applicable to the RCH were not on file and provided for review on request by the Licensee. Per review of pages 70 - 73 from the Health Regulations for Food Service Establishments	R266	corrective action P&P adjusted to reflect current policies & procedures systemic changes P&Ps will be updated as needed Monitoring P&P to be reviewed quarterly & updated as needed	5-26-24

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R266	Continued From page 19 provided for review by the Licensee the following statements were included in this document: a. Page 70 Section A. General contains a reference to "toilet rooms" which states "Floor surfaces shall be of smooth, non-absorbent, and so constructed as to be easily cleanable" b. Page 1 Section D. Floors, Good Repair states, "The physical facilities shall be maintained in good repair" c. Page 72 Section C. Walls and Ceiling, Good Repair states, "All walls and ceilings ...shall be kept clean and in good repair. " During a tour of the home commencing at 10:40 AM on 5/6/24 the following environmental concerns were observed: 1. On the lower level of the home the flooring in both bathrooms was observed with water damage extending from the base of the shower or tub. a. In one of the bathrooms the vinyl flooring extending approximately 2-3 feet outwards from the bathtub was observed to be discolored and had darkened areas that appeared to be mildew. Along the exterior base of the tub pieces of flexible trim were observed to be poorly attached. There was a build-up of what appeared to be grime and/or mildew along the edges of the trim, wall, flooring and in a 2-3 inch gap between two pieces of trim near the middle of the tub's base. The damage in two areas of flooring in this bathroom was so severe the vinyl was peeling away, leaving holes. b. In the second lower level bathroom the water damage extended approximately 6-8 feet outwards from the shower, with the edges of the laminate flooring planks observed to be warped, buckling, and peeling, leaving an uneven and	R266 1.	Corrective action The flooring was replaced with new flooring in one of the two lower bathroom. In the second lower bathroom, new flooring is scheduled for replacement. Contractor visited facility 5/30 and will provide an estimate	5-30-24

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R266	Continued From page 20 unsafe surface which is a risk for injury. 2. The bathrooms on the lower level of the home were in poorly maintained and in need of repair.	R266		
	a. The Closet Bolts used to secure the base of the toilets to the floor were without the protective caps used to prevent injury due to contact with the bolt ends protruding from the base of the toilet. In one bathroom long bolt ends were protruding approximately 2 inches up from the toilet base.	2 a.	[illegible] County plumbing is scheduled to replace existing toilets with new industrial strength toilets.	5-30-24
	b. The bathtub in one of the lower level bathrooms had two damaged areas where the interior surface of the tub was no longer intact. The damaged area on the side wall of the tub was discolored with appeared to be mildew, and the damaged area on the floor of the tub was pushed inward creating a risk for injury due to the rough and uneven surface. Cracks and holes in a tub allow water to seep through, which commonly leads to mold, mildew, and damage to the surrounding surfaces and underlying structures.	2 b	In the lower bathroom with the tub, bath tub and flooring is scheduled to be replaced.	
	c. The radiators in both lower level bathrooms were observed to be covered with rust.	2 c.	lower level bathroom radiators covers will be painted.	
	d. The fiberboard ceiling in one of the lower level bathrooms was observed with staining from water damage; cracks and a hole in the fiberboard tiles, and areas of rust forming on the metal framework that supports the tiles.	2 d.	Fiberboard ceilings in lower bathroom will be replaced.	
	3. Unsanitary practices were observed in one bathroom creating a risk for infection due to exposure to pathogens including: a. A toilet plunger was stored directly on floor without a container to prevent toilet water from	3. a.	Toilet plunger will be stored in separate container.	

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R266	Continued From page 21 leaking on to the floor after use and contact with the plunger. b. Three resident toothbrushes were stored with the bristle ends down in the same cup on the bathroom counter, which is a risk for infection due to cross contamination. These findings were confirmed by the Registered Nurse during the environmental tour commencing at 10:40 AM on 5/6/24, and acknowledged by the Administrative Manager following the tour. 4. At approximately 2:00 PM on 5/6/24 one of two bathrooms on the upper level of the home was observed with a rusted radiator; and with cracks and staining that appeared to be mildew on the ceiling above the shower. In the same bathroom the exterior base of the shower had multiple brown stains. A stained long white strip of what appeared to be tape or trim was placed along the edge of the flooring close to the exterior base of the tub. A blackened area was visible between the strip and the shower. The caulking at the base of the tub along this area was peeling up and missing in some areas. The Licensee and Administrative Manager acknowledged these findings on the afternoon of 5/6/24. In conclusion these deficient practices are a potential risk for more than minimal harm to all facility residents due to exposure to unsafe and unsanitary conditions; and due to the physical and psychological impact of living in a poorly maintained environment that is not comfortable and homelike. This is a repeat citation.	R266 3. b. 4.	Resident toothbrushes will be Stored in residents' bedrooms. Three toothbrushes in question were not in use by residents and have been discarded ceiling and flooring will be repaired and radiators will be painted. The caulking around the tub will be replace when flooring and tub is replaced. R266 Plan of Correction accepted by Jo A Evans RN on 6/24/24.	5-30-24

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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 staff interview and record review there was a failure to complete fire drills on a quarterly basis and to rotate drill times to include morning, evening, and night drills. Findings include: On 5/6/24 the Licensee was requested to provide a copy of the facility's policies and procedures that govern fire drills at the home for review. In response, the Licensee provided a copy of the home's emergency procedures for an actual fire in the home which did not include policies and procedures for conducting fire drills. On the afternoon of 5/6/24 the Licensee confirmed policies and procedures governing fire drills at the home had not been developed. On the morning of 5/6/24 the Administrative Manager was requested to provide	R302	Corrective action: Fire drills scheduled for rotating times Systemic changes Fire drills will be conducted quarterly with a different time of day each quarter Monitoring Fire drills will be documented as to date, time, and duration R302 Plan of Correction accepted by Jo A Evans RN on 6/24/24.	5-22-24

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R302	Continued From page 23 documentation of fire drills conducted at the home during the previous year. Per review of the documentation provided, fire drills had not been conducted during the first and third quarters; and drills times were not rotated to include morning, evening, and night drills as all fire drills were routinely completed at 1:30 PM. These findings were confirmed by the Administrative Manager of the home at 12:57 PM on 5/6/24. This deficient practice is a potential risk for more than minimal harm for all facility residents due to missed opportunities for staff and residents to practice the evacuation process, and identify effective procedures for safe and timely evacuation.	R302		