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

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

November 18, 2024

Darshane Campbell, Manager
Single Steps
62 Barre Street
Montpelier, VT 05602-3508

Dear Ms. Campbell:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 14, 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,

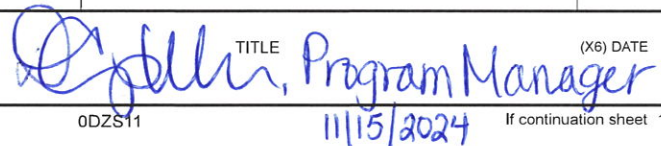
Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0153	A. BUILDING: ______ B. WING ______	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINGLE STEPS	**62 BARRE STREET MONTPELIER, VT 05602**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite relicensure survey, along with a complaint investigation and facility reported incident was conducted by the Division of Licensing and Protection on 10/14/24 and completed on 10/22/24. Regulatory deficiencies were identified as a result of the onsite relicensure survey. Findings include:	R100	Please find Single Steps' plan of correction attached.	
R128 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure medications are administered according to physician's orders for three applicable residents (Resident #1 Resident # 2 and Resident #3). Findings include: Per resident record review three residents of the applicable sample physician's orders did not include specific directions of use for Resident #1, # 2 and #3. The as needed medication order(s) did not include directions in the hours of frequency to administered the medications. Resident #1 has an order for Methocarbonol. The order states Methocarbonol 500 mg by mouth three times a day as needed. Resident #2 has an order Propanolol. The order states Propanolol 10 mg by mouth four times a day as needed for anxiety. Resident #2 has an	R128		

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



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0153	A. BUILDING: ___ B. WING ___	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINGLE STEPS	62 BARRE STREET MONTPELIER, VT 05602

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R128	Continued From page 1 order for Clonazepam that state to take 0.5 mg, 1 tablet by mouth twice daily as needed for anxiety. Resident #3 has an order for Clonazepam 0.5 mg take 1 tablet by mouth twice daily as needed for anxiety and an order for Clonidine 0.2 mg take 1 tablet by mouth twice daily as needed for agitation. Additionally, Resident #1 has an order for Ibuprofen 200 mg take 2 tablets by mouth every 6 hours as needed for pain. Per the Medication Administration record on 7/24/24 Resident #1 was administered Ibuprofen at 12:00 PM and 4:15 PM. Per interview in the afternoon on 10/14/24, the Director of Nursing confirmed the as needed (PRN) medications orders did not include complete directions in the frequency the medications are to be administered, additionally the DON confirmed the administration of Ibuprofen to be less than the 6 hours apart.	R128		
R145 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by:	R145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0153	A. BUILDING: ____ B. WING ____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINGLE STEPS	62 BARRE STREET MONTPELIER, VT 05602

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R145	Continued From page 2 Based on record review and staff interview there was a failure to ensure the development of a plan of care that addresses the medical needs of the facility residents. Findings include: A record review of an applicable sample of 3 residents was performed. Upon review of the resident records, a care plan was not identified for review. Per review of Resident #1 electronic medication administration record, the resident is administered Ibuprofen and Tylenol (as needed) for pain. Resident #1 treatment plan does not indicate a problem area of pain or interventions to aide in pain management. Per review Resident #2 had a diagnosis of Diabetes, through record review a plan of care was not identified to aide in the care and services necessary to monitor Diabetic care needs such as signs and symptoms of hypoglycemia (low blood sugar.) Per interview in the afternoon of 10/14/24, the Director of Nursing (DON) confirmed plans of care is not developed by a Registered Nurse. The RN explained on admission, a treatment plan is developed and updated by the client and staff (non-clinical) to develop goal oriented plans, that aide in life skills. Through the interview the DON explained the treatment plans do not include a nurse component to identify necessary care and services required to promote well being directed by the nurse, the DON confirmed a plan of care is not developed for Resident #1, #2, and #3.	R145		
R160 SS=F	V. RESIDENT CARE AND HOME SERVICES	R160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0153	A. BUILDING: ______ B. WING ______	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINGLE STEPS	62 BARRE STREET MONTPELIER, VT 05602

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R160	Continued From page 3 5.10 Medication Management 5.10.a Each residential care home must have written policies and procedures describing the home's medication management practices. The policies must cover at least the following: (1) Level III homes must provide medication management under the supervision of a licensed nurse. Level IV homes must determine whether the home is capable of and willing to provide assistance with medications and/or administration of medications as provided under these regulations. Residents must be fully informed of the home's policy prior to admission. (2) Who provides the professional nursing delegation if the home administers medications to residents unable to self-administer and how the process of delegation is to be carried out in the home. (3) Qualifications of the staff who will be managing medications or administering medications and the home's process for nursing supervision of the staff. (4) How medications shall be obtained for residents including choices of pharmacies. (5) Procedures for documentation of medication administration. (6) Procedures for disposing of outdated or unused medication, including designation of a person or persons with responsibility for disposal. (7) Procedures for monitoring side effects of psychoactive medications. This REQUIREMENT is not met as evidenced by: Based on staff interview, RCH failed to ensure policies and procedures are developed in accordance with home's practices of medication	R160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0153	A. BUILDING: ______ B. WING ______	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINGLE STEPS	62 BARRE STREET MONTPELIER, VT 05602

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R160	Continued From page 4 management. Per interview via telephone on 10/18/24 at 9:15 AM with the Manager and additional follow-up correspondence via electronic mail on 10/22/24, the Manager was unable to provide formal policies and procedures developed for medication administration processes, to include Disposal of outdated or unused medications, including designation of a person or persons with responsibility for disposal.	R160		
R176 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (4) Medications left after the death or discharge of a resident, or outdated medications, shall be promptly disposed of in accordance with the home's policy and applicable standards of practice. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview RCH failed to ensure expired medications were disposed of in accordance to facility policy and applicable standards of practice. Per observation of the Medication cabinet, medications were identified as expired. The medications identified were Calamine Lotion expired 7/2022, Anti-Diarrhea, Loperamide 2 mg tablets, expired 8/2024, Lexapro 20 mg expired on 8/31/24, Clonidine 0.2 mg tablet expired on	R176		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0153	A. BUILDING: ______ B. WING ______	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINGLE STEPS	62 BARRE STREET MONTPELIER, VT 05602

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R176	Continued From page 5 9/1/24, Intestinal Formula- Herbal Supplement expired on 4/2024, Saline Nasal Spray expired on 5/2024, Docusate Sodium 100 mg capsule expired on 5/5/2024, Bisacodyl Suppository 10 mg expired on 3/2024. Per interview in the afternoon of 10/14/24, the Director of Nursing, confirmed the identified expired medication and explained all expired medications are to be removed and wasted promptly. Refer to Tag R160.	R176		
R190 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the RCH failed to ensure criminal background checks were available for review. Per record review 3 out of 5 staff records did not include a National Criminal background checks and 2 out of 5 staff of the applicable sample records did not include completed annual background to include Vermont Criminal Information Center (VCIC) and Abuse registry checks. Per interview on 10/14/24 at 3:10 PM the Director of Resident Programs confirmed National Background checks were not completed for 3 out	R190		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0153	A. BUILDING: ______ B. WING ______	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINGLE STEPS	**62 BARRE STREET** **MONTPELIER, VT 05602**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R190	Continued From page 6 of 5 staff and annual checks were not completed for VCIC and abuse registry of the applicable staff. Through the interview, the RCH acknowledged to be unaware of the updated guidance regarding background check requirements per the memorandums provided by licensing agency, on 10/22/22 and 5/1/23 and confirmed the policy is not updated to reflect the requirements established in the guidance provided by the licensing agency.	R190		
R238 SS=F	VII. NUTRITION AND FOOD SERVICES 7.1.a. (7) The home shall maintain sufficient food supplies at hand on the premises to meet the requirements of the planned weekly menus. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the RCH failed to ensure the food supply was sufficient to the planned menu for the week. Per interview on 10/14/24 at 12:00 PM, staff confirmed the planned menu for the week, for dinner on 10/14/24 the RCH would be serving chicken alfredo. Per observation of the kitchen areas, the required food items to prepare chicken alfredo (chicken and alfredo sauce) were not observed as available to prepare for the dinner meal. Per interview on 10/14/24 at 12:05 PM, the Director of Resident programs confirmed the food items to prepare chicken alfredo were not available within the home to prepare for the meal.	R238		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0153	A. BUILDING: ____ B. WING ____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINGLE STEPS	62 BARRE STREET MONTPELIER, VT 05602

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R238	Continued From page 7 S/he directed the staff to plan an alternate meal and update the menu accordingly.	R238		
R242 SS=F	VII. NUTRITION AND FOOD SERVICES 7.1.c. (1) Each home shall provide residents with three nutritionally balanced, attractive and satisfying meals in accordance with these regulations. Meals shall be served at appropriate temperature and at normal meal hours. Texture modifications will be accommodated as needed. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to provide three meals per day in accordance with regulations for all residents. Findings include: During the facility tour commencing at 10:00 AM and through continuous observations revealed staff were not present to assisting residents in meal preparations for lunch service and at approximately 3:50 PM, staff were provided verbal prompt and que from the Director of Resident Porgams to prepare dinner for the residents. The administion agreement states "...Breakfast and lunch are buffet style and you will be expected to serve yourself during these hours.Residents take turns preparing dinner .. If you are unable to participate in meal prep or chose not to, staff will prepare the meal." The posted menu indicated for the dinner meal	R242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0153	A. BUILDING: ______ B. WING ______	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINGLE STEPS	62 BARRE STREET MONTPELIER, VT 05602

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R242	Continued From page 8 on 10/14/24, staff to prepare the meal. Per interview at 12:05 PM Staff confirmed residents of the home are responsible for making their own breakfast and lunch daily, residents aide in developing the dinner menu and each resident is assigned an evening to prepare a meal. Staff confirmed to provide supervision and assistance with meals, and the menu will indicate who is to prepare dinner, if unassigned staff are to prepare the dinner meal. A telephone interview on 10/18/24 at 9:15 AM with the Manager confirmed the meal practices of residents preparing meals for breakfast, lunch and dinner. The Manager confirmed the expectation of staff during meals is to aide in meal planning and one staff is responsible for filling out the weekly menu with residents and the assigned staff as "menu planner" makes sure that residents' meals are balanced and nutritious.	R242		
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, record review and staff interview, the RCH failed to ensure food that was out of date was removed and not stored within the food storage areas.	R247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0153	A. BUILDING: ____ B. WING ____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINGLE STEPS	62 BARRE STREET MONTPELIER, VT 05602

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R247	Continued From page 9 Per observation of the food storage areas perishable items were observed to be stored and available for consumption. Within the refrigerator, several deli meats and cheeses were observed to be stored beyond the use by date indicated on the packaging and an 18 count carton of eggs with an expiration date of 9/29/24. Also, the dry storage pantry contained several items expired as printed by the manufacturer (alfredo sauce, pancakes mix, tomato sauce, packages of instant mashed potatoes.) Per interview on 10/14/24 at 12:15 PM, staff confirmed the expired items identified through the observation of the refrigerator(s) and dry storage pantry.	R247		
R251 SS=F	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.a All food and drink shall be stored so as to protect from dust, insects, rodents, overhead leakage, unnecessary handling and all other sources of contamination. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the RCH failed to ensure storage of food was protected from sources of contamination. Per observation of the Kitchen, on the counter a basket storing multiple varying types of bread were open to air also, on the counter a tiered shelving rack was storing onions, tomatoes and clementines, these items presented to be wilted,	R251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0153	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED 10/14/2024

NAME OF PROVIDER OR SUPPLIER: **SINGLE STEPS**

STREET ADDRESS, CITY, STATE, ZIP CODE: **62 BARRE STREET MONTPELIER, VT 05602**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R251	Continued From page 10 soft skins and presenting in the early stages of rotting. Within this area, fruit flies were observed to be flying in the presence of the bread, and produce on the shelving rack. Per interview on 10/14/24 at 11:40 AM , staff confirmed the produce items to present with signs of spoilage, the bread to be open to air and the presence of fruit flies amongst the food.	R251		
R266 SS=F	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the RCH failed to maintain a safe and homelike environment. During the facility tour commencing at 10:15 AM on 10/14/24 the following environmental concerns were observed: 1. The main refrigerator, oven, microwave and countertops had food and beverage spills on surfaces and were in need of cleaning. There was a presence of fruit flies observed in the kitchen, near fruit and vegetables stores on a tiered rack and near bread stored in basket. 2. Within the kitchen three fly traps were observed hanging from the fire system sprinkler	R266		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0153	A. BUILDING: ____ B. WING ____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINGLE STEPS	**62 BARRE STREET MONTPELIER, VT 05602**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R266	Continued From page 11 system, near a counter area of the kitchen. The traps were observed to have several flies attached to the trap. 3. Containers of cleaning products were stored on a shelf, per a facility posting all chemicals are to be stored in basement with the door secured via lock. At 12:05 PM on 10/14/24 the Staff confirmed the environmental concerns observed during the facility tour.	R266		

Single Steps' Plan of Correction for Survey conducted on 10/14/2024

Deficiency Regulation Code	Plan for Correction	Date Implemented
R128 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders.	Each Residents' ordering physicians have been contacted to obtain updated orders including hours of frequency parameters. Retraining of staff in regard to administration practices of PRN medications and hours of frequency parameters to be completed by program RN.	11/26/2024, Implemented by RN r 128 Accepted Jenielle Shea, RN 11/18/24
R145 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being;	Creation of a Residential Plan of Care as part of the admission process, in addition to the separate Treatment Plan within 30 days of each admission date and to be updated on an on-going basis. These plans will cover the current care needed for each individual resident including but not limited to physical needs, assistance with their medical and or assistive devices, and assistance with their activities of daily living.	12/2/2024, Implemented by Program Manager and Program RN, monitored by Program RN R 145 Accepted Jenielle M. Shea, RN 11/18/2024
R160 5.10.a Each residential care home must have written policies and procedures describing the home's medication management practices.	A physical copy of all policies will be printed and placed in the staff office of the home. Policies and location will be reviewed with staff to ensure easy access. These policies were created prior to this survey. Location was not easily available to staff.	11/26/2024, Implemented by Program Manager and Program RN R 160 Accepted Jenielle M. Shea, RN 11/18/2024
R176 5.10 h (4) Medications left after the death or discharge of a resident, or outdated medications, shall be promptly disposed of in accordance with the home's policy and applicable standards of practice.	All medications left after death or discharge of a resident as well as outdated medications will be disposed of in a med buster disposal system within 24 hours of aforementioned event.	11/26/2024, Implemented by Program RN R 176 Accepted Jenielle M. Shea, RN 11/18/2024
R190 5.12.b (4) The results of the criminal record and adult abuse registry checks for all staff.	**Please see Plan attached**	**Please see Plan attached** R 190 Accepted Jenielle M. Shea, RN 11/18/2024
R238 7.1.a. (7) The home shall maintain sufficient food supplies at hand on the premises to meet	The mealtime policy requires Staff to review what the menu for the day and to survey the kitchen to ensure the food needed for the day is available and accessible.	11/26/2024, Implemented by Program Manager, monitored by Program Staff R 238 Accepted Jenielle Shea, RN 11/18/24

the requirements of the planned weekly menus.		
R242 7.1.c. (1) Each home shall provide residents with three nutritionally balanced, attractive, and satisfying meals in accordance with these regulations. Meals shall be served at appropriate temperature and at normal meal hours. Texture modifications will be accommodated as needed.	Staff's expectations have been posted clearly on Staff's daily checklist. Staff will utilize this checklist to ensure residents are getting their proper assistance around mealtime. The checklist is located in the Staff office next to the medication cabinet.	11/26/2024, Implemented by Program Manager R 242 Accepted Jenielle Shea, RN 11/18/2024
R247 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.	Overnight's Staff expectations are to check the temperatures on the fridges and freezers. The Manager has moved the overnight staff's expectation notice from behind the Staff door to a more visible area in the office. Manager will check every morning to ensure this was completed. Labels will reflect the expiration dates already printed on the containers rather the date purchased. This is to minimize confusion and aide the residents with knowing what food is expired.	11/26/2024, Implemented and monitored by Program Manager R247 Accepted Jenielle Shea, RN 11/18/24
R251 7.3.a All food and drink shall be stored so as to protect from dust, insects, rodents, overhead leakage, unnecessary handling and all other sources of contamination.	Staff will follow their newly implemented daily checklist which requires a check of open or rotting food. If Staff discover something open or rotting, policy states they are to dispose of the food appropriately.	11/26/2024, Implemented and monitored by Program Manager R251 Accepted Jenielle Shea, RN 11/18/2024
R266 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment.	Single Steps Staff will take walk throughs of the home daily to specifically check for spillage and unclean kitchen handles, and counters. Staff will not utilize hanging fly traps. Staff will instead use countertop plugs to zap any flies. As per the cleaning products policy, chemicals will be placed on the shelves behind the locked basement door. Staff will check for unlocked chemicals daily on their walkthroughs.	11/26/2024, Implemented by Program Manager, monitored by Program Staff R266 Accepted Jenielle Shea, RN 11/18/2024

Names redacted by DLP 11/15/24

Deficiency Regulation Code: R190

To: [redacted], CSP Residential Programs Director
From: [redacted] Director of Human Resources
CC: [redacted] CSP Division Director

Subject: POC for background checks deficiencies found re: RCH Licensing Regulations in re-licensing survey for Single Steps

WCMHS Human Resources has been advised that the October 14, 2024 Division of Licensing and Protection's re-licensing survey of Single Steps found deficiencies in the employee files of criminal record and adult abuse registry checks. The purpose of this memo is to describe the plan of correction (POC) to address the deficiencies.

In accordance with section 5.12.b.(4) of the Residential Care Home Licensing Regulations, "(t)he results of the criminal record and adult abuse registry checks for all staff" must be maintained and on kept on file. Additionally, the agency must conduct background checks, including national criminal background checks, in accordance with updated guidance published by VT AHS/DAIL on October 24, 2022 and with which compliance was mandated by May 1, 2023.

WCMHS Human Resources management was provided the updated DAIL guidance by CSP management on October 24, 2022, the purpose of which was to clarify "*what kinds of background checks Facilities are required to undertake* to determine whether a prospective or current employee" is eligible for employment. The guidance included the mandate to conduct national criminal background checks, in addition to VCIC checks, Vermont Child Protection and Adult Abuse Registry searches, and OIG exclusion searches; however, it has come to light as a result of the re-licensing survey that the required inclusion of national criminal background checks in the comprehensive background checks process was not implemented at the time that guidance was initially received.

To the extent WCMHS current background checks processes continue to accord with the requirements that existed prior to the updated guidance issued by DAIL in October 2022 and do not include national criminal background checks, the WCMHS Human Resources department is actively working to bring employee background checks systems and processes into compliance with the updated requirements for such, as outlined below:

1. **Action to be taken to correct the deficiencies:**

    a. Implementation of administrative systems and utilization of third-party service provider to conduct all required background checks and registry searches: The current process and systems utilized do not allow for national criminal background checks to be conducted; as such, the agency will contract with a third-party service provider to conduct national criminal and Vermont Criminal Information Center background checks and searches of the U.S. DHHS OIG List of Excluded Individuals/Entities (LEIE List) and sex offender registries. Vermont Child Protection Registry and Vermont Adult Abuse Registry checks will continue to be requested of those entities by WCMHS HR staff.

b. Conduct background checks and complete files, as needed, for current employees: National criminal background checks will be conducted for all current employees to fulfill the requirement. Employee files will be audited, and any additional checks needed will be conducted to ensure that all checks are conducted and on file for current staff.

2. **Measures/systemic changes to ensure continued compliance:** Upon implementation of the background checks system as described in 1.a., all required background checks will be conducted for new employees at the time of initial hire and periodically thereafter. Files with results of completed background checks will be maintained by Human Resources.

3. **Ongoing monitoring to maintain compliance:** Administrative systems will be implemented to comply with requirements for collection and maintenance of background check information. Periodic, internal file audits will be performed to ensure compliance.

   Additionally, program management will continue to provide notice to Human Resources of changes to background checks and related requirements, and the Human Resources Director will ensure that appropriate and timely action is taken in response to all such changes.

4. **Dates by which corrective action will be completed:**

   a. System implementation and checks for new employees: The expected date by which implementation of systems to conduct all required checks and searches, including national criminal background checks, is December 15, 2024. All required background checks will be performed upon hire for employees hired on or after implementation of those systems.

   b. Background checks and files for current employees: The date by which background checks will be conducted and files will be completed for staff hired prior to implementation is anticipated to be January 30, 2025.