VERMONT

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

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

April 4, 2023

Mr. Aaron Aldridge, Manager
Spruce Mountain Inn, Inc
Po Box 153, 155 Towne Avenue
Plainfield, VT 05667-0153

Dear Mr. Aldridge:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 20, 2022.** Please post this document in a prominent place in your facility.

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

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

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
	0527	A. BUILDING: _____ B. WING _____	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRUCE MOUNTAIN INN, INC	PO BOX 153, 155 TOWNE AVENUE PLAINFIELD, VT 05667

(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
T 001	Initial Comments On 12/20/22 the Division of Licensing and Protection conducted an unannounced on-site relicensure survey. The following regulatory deficiencies were identified:	T 001		
T 037 SS=E	V.5.8.c Resident Care and Services 5.8 Medication Management 5.8.c Staff shall not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's or other licensed health care provider'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 the Registered Nurse failed to ensure signed physician's orders for medications for 3 out of 3 residents sampled residents. (Residents #1, #2, and #3). Findings include: 1. Resident #1 was admitted to the facility on 12/12/22. His/her Medication Administration Record (MAR) lists orders for scheduled medications including Abilify (antipsychotic), Auvelity (antidepressant), and Lorazepam (for anxiety). Resident #1's MAR lists medications for use as needed (PRN) including Ibuprofen, Tussin cough syrup, Acetaminophen, Diphenhydramine (Benadryl), Calcium Carbonate (Tums), Pepto Bismol, and Guaifenesin (Mucinex). On the evening of 12/20/22 the Director confirmed there were no signed medication orders for all medications on Resident #1's MAR.	T 037	Please see P.O.C. attached. thank you!	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Edward A. Foden II, Assistant Director 01-27-2023

Edward G. Foden IV, LCMHC Director 02/01/2023

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T 037	Continued From page 1 2. Resident #2 was admitted to the facility on 10/27/22. His/her MAR lists orders for scheduled Vitamin D; and for PRN medications including Ibuprofen, Tussin cough syrup, Acetaminophen, Diphenhydramine (Benadryl), Calcium Carbonate (Tums), Pepto Bismol, and Gauifenesin (Mucinex). At 8:30 PM on 12/20/22 the Director confirmed there were no signed orders for Vitamin D, Ibuprofen, Tussin, Acetaminophen, Diphenhydarmine, Calcium Carbonate, Pepto Bismol, and Guaifenesin for Resident #2. Additionally, every page of Resident #2's MAR includes an entry typed in bold and capitalized print at the bottom that states "SEVERE ALLERGY TO LAMICTAL, ALSO ALLERGIC TO PENICILLIN AND SEASON, HAS EPIPEN", however there are no signed orders on record for the administration of an Epipen for Resident #2. An unlabeled EpiPen observed in the medication cart was confirmed by the Assistant Director on the afternoon of 12/20/22 as belonging to Resident #2. Please refer to tag 0045. 3. Resident #3 was admitted to the facility on 10/20/22 and his/her MAR lists orders for PRN medications including Ibuprofen, Tussin, Acetaminophen, Diphenhydarmine, Calcium Carbonate, Pepto Bismol, and Guaifenesin. On the evening of 12/20/22 the Director confirmed there were no signed orders for the PRN medications listed in Resident #3's MAR.	T 037		
T 045 SS=D	V.5.8.h Resident Care and Services 5.8 Medication Mangement 5.8.h All medicines and chemicals used in the	T 045		

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T 045	Continued From page 2 residence must be labeled in accordance with currently accepted professional standards of practice. Medication shall be used only for the resident identified on the pharmacy label. This REQUIREMENT is not met as evidenced by: Per observation and staff interview there was a failure to ensure a medication stored in the medication cabinet for one applicable resident (Resident #2) was labeled with the resident's name and instructions for use. Findings include: At 12:35 PM on 12/20/22 the Assistant Director confirmed an EpiPen belonging to Resident #2 was stored in the medication storage cabinet without a label identifying the name of the person for whom the medication was prescribed and instructions for use. Please refer to tag 0037.	T 045		
T 052 SS=E	V.5.9.b.1.2.3.4.5.6.7 Resident Care and Services 5.9 Staff Services 5.9.b. The residence must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures,	T 052		

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T 052	Continued From page 3 such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure 1 out of 5 staff sampled completed all required yearly trainings. Findings include: Per record review 1 out of 5 staff sampled did not complete the required yearly training in respectful and effective interactions with residents. On the afternoon of 12/20/22 the Director and Assistant Director acknowledged training records did not include the completion of the required yearly training in respectful and effective interactions with residents for 1 out of 5 sampled staff.	T 052		
T 054 SS=F	V.5.9.d Resident Care and Services 5.9 Staff Services 5.9.d The licensee shall not have on staff a	T 054		

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T 054	Continued From page 4 person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the residence as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection and the Department for Children and Families in accordance with 33 V.S.A. §6911 and 33 V.S.A. §4919 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of personnel background checks for 5 of 5 employees on 12/20/22, the TCR conducted national background checks on the employees, however the background checks did not include criminal background checks beyond single counties in Vermont. Findings include: Per review of the background checks on 12/20/22, the TCR utilizes a national background screening organization as part of their hiring process; however the national screening conducted is limited to criminal background checks for single counties based on the employee's "address history, potential criminal or arrest records, and other potential information	T 054		

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T 054	Continued From page 5 provided during search submission", and does not include the use of the VCIC (Vermont Crime Information Center) which includes all counties within Vermont.	T 054		
T 127 SS=F	VII.7.2.b 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 temperature. Hot foods shall be kept hot at 135 degrees F and cold foods shall be kept at 41 degrees F or cooler. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure all perishable foods are labeled, dated, and held at proper temperatures. Findings include: During a tour of the kitchen and food storage areas commencing at 9:47 AM on 12/20/22 the following deficiencies related to the storage of perishable food items were observed and confirmed: In the reach in kitchen refrigeration unit food items without dates indicating when they were opened or prepared included a plastic box containing packages of sliced meat; tubs of chopped vegetables; a container of hamburger without the date it was removed from the freezer to thaw; a bag of peeled garlic cloves; a gallon of almond milk; two jars of bouillon; a bowl of chopped lettuce covered with plastic wrap; and condiments and sauces including BBQ sauce, sour cream, and bottles of hot sauce. Additionally	T 127		

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T 127	Continued From page 6 there were jars of hot sauce prepared by the chef dated 10/12. In the kitchen refrigerator food items without dates indicating when they were prepared or opened included 3 pitchers of various drinks; 2 containers of jam; gallons of orange juice, almond milk, and cow's milk; parmesan cheese; and condiments including 7 various hot sauces, relish, mayonnaise, soy sauce, ginger, garlic, hoisin sauce, tartar sauce, and 10 containers of various salad dressings. The Chef confirmed the unlabeled and undated perishable food items listed above at 10:19 AM on 12/20/22. In the refrigerator near the back entryway of the home where items belonging to residents are stored, the freezer was observed to contain partially thawed items including pints of ice cream, popsicles, ice cream sandwiches, a box of single serving pizzas, and a box of sausage links in an unclosed box. There was no thermometer in the refrigerator or freezer, and no documentation indicating the temperatures within the unit are monitored to ensure safe food storage temps. This observation was confirmed by the Chef at 10:32 AM on 12/20/22. A thermometer placed in the freezer after the partially thawed foods were observed indicated the temperature inside the freezer was 5 degrees Fahrenheit when rechecked twice during the course of the survey. According to the United Stated Food and Drug Administration web site (www.fda.gov) freezer temperatures should be at or below zero degrees Fahrenheit and checked periodically. This observation was acknowledged by the Director on the afternoon of 12/20/22.	T 127		

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T 146 SS=F	IX.9.1.a Physical Plant 9.1 Environment 9.1.a The residence must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure a safe, functional, sanitary, homelike environment. Findings include: 1. Based on observation and staff interview there was a failure to ensure all perishable foods are labeled, dated, and held at proper temperatures. Findings include: During a tour of the kitchen and food storage areas commencing at 9:47 AM on 12/20/22 the following deficiencies related to the storage of perishable food items were observed and confirmed: In the reach in kitchen refrigeration unit food items without dates indicating when they were opened or prepared included a plastic box containing packages of sliced meat; tubs of chopped vegetables; a container of hamburger without the date it was removed from the freezer to thaw; a bag of peeled garlic cloves; a gallon of almond milk; two jars of bouillon; a bowl of chopped lettuce covered with plastic wrap; and	T 146		

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T 146	Continued From page 8 condiments and sauces including BBQ sauce, sour cream, and bottles of hot sauce. Additionally there were jars of hot sauce prepared by the chef dated 10/12. In the kitchen refrigerator food items without dates indicating when they were prepared or opened included 3 pitchers of various drinks; 2 containers of jam; gallons of orange juice, almond milk, and cow's milk; parmesan cheese; and condiments including 7 various hot sauces, relish, mayonnaise, soy sauce, ginger, garlic, hoisln sauce, tartar sauce, and 10 containers of various salad dressings. The Chef confirmed the unlabeled and undated perishable food items listed above at 10:19 AM on 12/20/22. In the refrigerator near the back entryway of the home where items belonging to residents are stored, the freezer was observed to contain partially thawed items including pints of ice cream, popsicles, ice cream sandwiches, a box of single serving pizzas, and a box of sausage links in an unclosed box. There was no thermometer in the refrigerator or freezer, and no documentation indicating the temperatures within the unit are monitored to ensure safe food storage temps. This observation was confirmed by the Chef at 10:32 AM on 12/20/22. A thermometer placed in the freezer after the partially thawed foods were observed indicated the temperature inside the freezer was 5 degrees Fahrenheit when rechecked twice during the course of the survey. According to the United Stated Food and Drug Administration web site (www.fda.gov) freezer temperatures should be at or below zero degrees Fahrenheit and checked	T 146		

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T 146	Continued From page 9 periodically. This observation was acknowledged by the Director on the afternoon of 12/20/22. Additional environmental concerns observed in the kitchen and food storage areas included: * The walls and turntable inside the microwave for resident use near the back entryway were splattered and stained with dried food, and a strong unpleasant odor noted when the microwave was opened. * The kitchen trash can and compost bucket were observed to be uncovered and without a lids, which the Chef confirmed is the customary practice throughout the duration of his/her shift and not limited to periods of time when food is being prepared. * Uncovered bins of salt and pepper without lids were observed on the countertop, which the Chef confirmed customarily remain open until they are wrapped when the kitchen is closed at night. Please refer to tag 0127. 2. During an environmental tour of the common areas, work spaces, and resident rooms conducted by the Operation Manager and commencing at 10:35 AM on 12/20/22 the following environmental deficiencies were observed and confirmed: * A bin containing cleaning chemicals including all purpose cleaner, air freshener, and Windex window cleaner; and a mop bucket containing water and cleaning solution were observed beside the bottom of the stairs between the rear entryway and living room. The bin and mop bucket were observed unattended by the bottom	T 146		

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T 146	Continued From page 10 of the stairs on arrival at the facility at 9:00 AM; and remained accessible to residents during the tour and after the Housekeeper reportedly left the facility to travel to Costco, which is an hour away from facility. * The basement door was unlocked, leaving various cleaning chemicals and disinfectants stored on a shelf at the top of the basement stairs accessible to residents. A trash can placed at the top of the basement stairs containing laundry was observed to be partially blocking access the landing at the top of the stairway. The Operations manager confirmed the trash can is customarily at the top of the stairs. * A bottle of Spray and Wash stain remover was observed beside boxes of cereal in an unlocked cabinet used for storage of food items belonging to residents in the living room. * The Housekeeper's supply closet adjacent to the living room does not have a lock, leaving chemicals and hazardous materials accessible to residents including cleaning chemicals, Lysol disinfectant, and wood preservative accessible to residents. A box of tea bags was observed on the shelf beside the disinfectant spray and other chemicals. * A small unsecured sharps container was observed on a table beside the medication cabinet in the common area between the dining room and main stairway to the resident rooms. Additionally staff administers and assists in administration of medications in this open and highly trafficked common area of the facility, which does not allow for privacy when residents are taking medications.	T 146		

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T 146	Continued From page 11 These observations were confirmed by the Operation Manager during the facility environmental tour commencing at 10:35 AM on 12/20/22.	T 146		
T 187 SS=E	IX.9.11.c Physical Plant 9.11 Disaster and Emergency Preparedness 9.11.c Each residence shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure fire drills are conducted on at least a quarterly basis; at least one drill is completed during the morning, afternoon, evening, and night yearly; and the names of staff participating in drills is documented. Findings include: On the afternoon of 12/20/22 the Director and Assistant Director acknowledged fire drills completed during the previous year did not include at least one drill conducted in the second quarter and at least one drill conducted during the	T 187		

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T 187	Continued From page 12 evening. Additionally, documentation of the drill conducted in July of 2022 did not include the names of staff who participated in the drill.	T 187		

Plan of Correction

Deficiency:

T037- V.5.8.c Resident Care and Services

5.8 Medication Management

5.8.c Staff shall not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's or other licensed health care provider's written, signed order and supporting diagnosis or problem statement in the resident's record.

Plan of Correction:

1. Standing orders will be provided by a licensed health care provider for all prescription medication. Residents of Spruce Mountain Inn (the Program) will only be allowed to take over the counter (OTC). medication that has been approved by the psychiatrist consulting with the Program.
2. Standing orders for medication will be emailed from prescribing doctor to the Program prior to a resident enrolling in the program. The consulting psychiatrist for the Program will sign a standing order upon meeting with the resident. This standing order will be kept in the front section of the MAR for each resident, as well as the medication folder located in the resident's Bestnotes (EMR) file.
3. The RN for the Program will review the MAR and medication folder in Bestnotes weekly to ensure standing orders are present for any medications prescribed and made available to residents for supervised self-administration.
4. This corrective action will be completed by February 8, 2023.

Tag T 037 POC accepted on 4/3/23 by J. Evans/P. Cota

Deficiency:

T045 – V.5.8.h Resident Care and Services

5.8 Medication Management

5.8.h All medicines and chemicals used in the residence shall be labeled in accordance with currently accepted professional standards of practice. Medication shall be used only for the resident identified on the pharmacy label.

Plan of Correction:

1. Epi Pens (the medication in question) will be kept in original packaging to include prescription information and directions.
2. The RN for the program will ensure all medications will be labeled with prescription information.
3. The RN will review the medication supply cabinet each week to ensure this regulation is met.
4. This corrective action will be completed by January 30, 2023.

Tag T 045 POC accepted on 4/3/23 by J. Evans/P. Cota

Deficiency:

T052 – V.5.9.b.1.2.3.4.5.6.7 Resident Care and Services

5.9 Staff Services

5.9.b. The residence must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following:

1) Resident rights

2) Fire Safety and emergency evacuation

3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid

4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation

5) Respectful and effective interaction with residents

6) Infection control measures, including but not limited to, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions

7) General supervision and care of residents

Plan of Correction:

1. Staff training will be tailored to meet the categories listed in regulation 5.9.b.1-7.
2. Staff training will be scheduled in a manner that ensures annual renewal of training in the areas specified in regulation 5.9.b.1-7. For example, if "resident rights" are trained in January of 2023, resident rights will be trained again by or before January, 2024.
3. The Assistant Director of the Program will schedule and oversee the provision of training and the annual schedule of trainings to meet this requirement.
4. The corrective action will be complete by February 24, 2023.

Tag T 052 POC accepted on 4/3/23 by J. Evans/P. Cota

Deficiency:

T054 – V.5.9.d Resident Care and Services

5.9 Staff Services

5.9.d The licensee shall not have on staff a person who has had a charge of abuse, neglect...The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and contacting the Division of Licensing and Protection and the Department for Children and Families in accordance with 33 V.S.A. §6911 and 33 V.S.A. §4919 to see if prospective employees are on the abuse registry or have a record of convictions.

Plan of Correction:

1. The Program will ensure that an all-county background check is completed before an employee is cleared to work unsupervised by other staff.
2. The background check provider will be chosen in compliance with state criteria.

3. The HR director for the Program will ensure the background check provider remains in compliance annually.
4. The corrective action will be completed by March 1, 2023.

Tag T 054 POC accepted on 4/3/23 by J. Evans/P. Cota

Deficiency:

T127 – VII.7.2.b Nutrition and Food Services

7.2 Food Safety and Sanitation

7.2.b All perishable food and drink shall be labeled, dated and held a proper temperature. Hot foods shall be kept hot at 135 degrees F and cold foods shall be kept at 41 degrees F or cooler.

Plan of Correction:

1. All food will be labeled and dated. New thermometers will be placed in all refrigerators.
2. All food has been labeled and dated. New thermometers have been placed in all refrigerators. Signs will be posted to ensure labeling and dating. Temperatures will be checked and logged daily.
3. Kitchen policies and procedures will be updated.
4. The corrective action will be completed immediately, effective January 25, 2023.

Tag T 127 POC accepted on 4/3/23 by J. Evans/P. Cota

Deficiency:

T146 – IX.9.1.a Physical Plant

9.1 Environment

9.1.a The residence must provide and maintain a safe, functional, sanitary, homelike and comfortable environment.

Plan of Correction:

-Food must be labeled, dated, and stored at the proper temperature

1. All food will be labeled and dated. New thermometers will be placed in all refrigerators.
2. All food has been labeled and dated. New thermometers have been placed in all refrigerators. Signs will be posted to ensure labeling and dating. Temperatures will be checked and logged daily.
3. Kitchen policies and procedures will be updated
4. The corrective action will be completed immediately, effective January 25, 2023.

-Resident microwave:

1. Housekeeping staff will clean the microwave daily Monday-Wednesday, residents will clean the microwave daily Thursday-Sunday.
2. Cleaning the microwave will be added to the kitchen clean-up checklist.
3. Staff will check that the microwave is clean, daily.
4. The corrective action will be completed immediately, effective January 25, 2023.

-Uncovered bins and salt and pepper containers

1. Garbage, compost, salt and pepper will be covered when not in use
2. Kitchen policies and procedures will be updated
3. The corrective action will be completed immediately, effective January 25, 2023.

-Cleaning caddy (bin) with cleaning chemicals and mop bucket left unattended at the base of the stairs.

1. Housekeeping staff will keep cleaning caddy with them throughout the day and lock it up in the staff bathroom when not in use. Housekeeping staff will put the mop bucket in the supply closet when not in use.
2. These policies will be added to the duties listed in the housekeeper job description.
3. Housekeeping staff will keep cleaning caddy with them throughout the day and lock it up in the staff bathroom when not in use. Housekeeping staff will put the mop bucket in the supply closet when not in use.
4. The corrective action will be completed immediately, effective January 25, 2023.

-Chemicals kept at the top of the basement stairwell, accessible to residents. Dirty laundry hamper kept at top of the stairs, blocking access to the landing.

1. Housekeeping staff has moved the mop bucket to the housekeeping closet, where it will be stored from now on. The laundry bin will be moved tight to the corner at the top of the stairs, removing any blockage on the landing to the stairs. Staff has moved all chemicals to a cupboard where they will be securely locked.
2. Staff of the Program will maintain these new storage locations and policies.
3. Housekeeping staff has moved the mop bucket to be stored in the housekeeping closet. The laundry bin will be moved tight to the corner at the top of the stairs, removing any blockage on the landing to the stairs. Staff has moved all chemicals to a cupboard where they will be securely locked.
4. The corrective action will be completed immediately, effective January 25, 2023.

-Bottle of spray and wash stain remover stored next to cereal boxes in residents' personal food storage area.

1. The bottle of spray and wash was removed from the food storage cabinet. Housekeeping staff will remind the staff and residents of the Program that these items cannot be stored with their food at the next community meeting. Housekeeping staff will ensure that all chemicals remain locked up in the appropriate locations.
2. Staff will ensure that chemicals remain locked up in the appropriate locations by checking common areas and food areas weekly.
3. The bottle of spray and wash was removed from the food storage cabinet. Housekeeping staff will remind the staff and residents of the Program that these items cannot be stored with their food at the next community meeting. Housekeeping staff will ensure that all chemicals remain locked up in the appropriate locations.
4. The corrective action will be completed immediately, effective January 25, 2023.

-Housekeeping supply closet was not locked and chemicals and cleaning agents were kept in the closet. Staff's personal box of tea was kept in the closet.

1. Chemicals and cleaning agents were removed and securely locked in the appropriate places. Housekeeping staff removed personal tea box. Locks have been ordered and will be installed on the closet to create a secured space to keep housekeeping chemicals and cleaning agents.
2. The housekeeping closet will become a locked and secure location for storage of cleaning agents and the mop bucket when it's not in use during the day.
3. The bottle of spray and wash was removed from the food storage cabinet. Housekeeping staff will remind SMI staff and residents that these items cannot be stored with their food at the next community meeting. Housekeeping staff will ensure that all chemicals remain locked up in the appropriate locations.
4. The corrective action will be completed immediately, effective January 25, 2023.

-Unsecured "sharps" container

1. The "sharps" container will remain locked in the medication cabinet, and only made available for the disposal of sharps. After use, the container will be returned to the locked medication cabinet for safe keeping.
2. Staff assisting resident's with supervised self-administration of medication will double-check that the sharps container has been returned to the cabinet before locking the cabinet door.
3. There will be a permanent note located in the MAR to prompt staff to return the sharps container to the cabinet.
4. The corrective action will be completed immediately, effective January 27, 2023.

Tag T 146 POC accepted on 4/3/23 by J. Evans/P. Cota

Deficiency:

-T187- IX.9.11.c Physical Plant

9.11 Disaster and Emergency Preparedness

9.11.c Each residence shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons 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 fire drill and the names of participating staff members shall be documented.

Plan of Correction:

1. Fire drills will be scheduled in accordance with the requirement. Time of day will be indicated to ensure compliance with the four different times of day noted in the requirement.
2. The Fire Marshall shall review this policy and require confirmation of the plan (prior), and compliance with the policy following a fire drill. In the event that the standard has not been met, another drill will be scheduled to ensure compliance.
3. The Fire Marshall shall oversee these proceedings and report to the director and assistant director before and after planned fire drills.

4. The corrective action will be completed by February 1, 2023.

Tag T 187 POC accepted on 4/3/23 by J. Evans/P. Cota