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

January 5, 2024

Ms. Mary Belanger, Manager
St Joseph's Residential Care Home
243 North Prospect Street
Burlington, VT 05401-1609

Dear Ms. Belanger:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 6, 2023.** Please post this document in a prominent place in your facility.

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

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
	0155	A. BUILDING: ______ B. WING ______	C **12/06/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S RESIDENTIAL CARE HOME	**243 NORTH PROSPECT STREET** **BURLINGTON, VT 05401**

(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 on-site re-licensure survey in conjunction with a complaint investigation was conducted by the Division of Licensing and Protection on 12/06/23. The following regulatory violations were identified:	R100		
R136 SS=D	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 the Registered Nurse (RN) failed to complete a Resident Assessment following a significant change in one applicable resident's physical condition (Resident #2). Findings include: Resident #2's admission Resident Assessment Form signed by the RN on 8/8/23 indicated s/he did not have an unsteady gait, and was not participating in physical therapy or receiving home health services. Additional assessments completed by the RN on 8/3/23 indicated Resident #2 had a low falls risk with no ambulatory issues, did not require the use of any assistive devices including a walker, and did not have an abnormal gait or balance issues. A Home Health assessment completed on	R136		

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R136	Continued From page 1 10/9/23 indicated Resident #2 had diminished sensory perception in both legs, weakness, limited range of motion in his/her hands and feet, foot pain due to rheumatoid arthritis, and gait issues. Physical Therapy was initiated to address deficits including pain; poor strength, balance, mobility, and endurance; and risk for falls. Per record review, a significant change in status Resident Assessment was not completed in response to the changes in Resident #2's physical condition indicated in the home health assessment completed on 10/9/23. This finding was confirmed by the Licensed Practical Nurse on the afternoon of 12/6/23.	R136	R136-5.7 When any resident has a change that impacts the resident's functioning, an assessment will be updated. If any therapy is initiated we will reassess and care plan. We have rehab. rounds with physical therapy twice a month DON or designee will have the charts, care plans at meeting to check on the documentation. Therapy notes will be printed out with goals, approaches and progress notes. DON will make them part of the care plan. Resident #2 has always used a walker which is and always was on the assessment and care plan. ■ has not had any falls since admission. PT attempted on 11/10/2023 refused to participate and D/C'd on 11/14/2023. If change in resident condition assessment will be done at that time. DON responsible. Completed on 12/14/2023 Pronoun removed by DLP 1/5/24 Tag R136-Accepted by Carol Scott-LTCM 1-5-24	
R145 SS=D	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: Based on staff interview and record review there was a failure to develop a written Plan of Care describing the care and services required to maintain well-being for one applicable resident (Resident #2). Findings include: Per review of the facility's Plans of Care, each	R145		

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R145	Continued From page 2 plan begins with a section that states, "Standards of Care: These are the expectations that all residents who require assistance with ADLs (activities of daily living) will receive:". The list that follows includes, "Care Plans will be updated with any additional changes in resident's status or when interventions need to be added or discontinued." and "Most Importantly, the Care Plan is about the resident and what they need from staff to meet their individual needs. ". Per record review Resident #2 was transported to the emergency department on 12/1/23 due to shortness of breath, hypoxia (poor oxygenation) and complaints of chest and back pain. On 12/1/23 Resident #2 was diagnosed with a myocardial infarction (heart attack), and admitted to the hospital where s/he received inpatient care until discharged back to the home on 12/5/23. Resident #2 returned with several new medications including the anticoagulant medication Clopidogrel. On 12/6/23 staff on site were not aware Resident #2 had been hospitalized for a heart attack. Per record review, Resident #2's Plan of Care was not updated to include the hospital discharge instructions including daily weight monitoring; the prescribed cardiac diet including no added salt and low saturated fat; signs and symptoms indicating need to seek medical help; and precautions related to use of anticoagulant medications including injury prevention, risk for bleeding, and signs/symptoms of internal bleeding. Additionally Resident #2's Plan of Care does not address risk for falls associated with his/her history of poor sensory function and weakness of lower limbs; gait abnormalities; pain and deformities of feet and hands caused by rheumatoid arthritis.	R145	R145-5.9 Regarding resident #2, When a resident is readmitted, the charge nurse/med tech will look at Transition of Care from the hospital. Charge nurse/med tech will add a note to resident charge noting any changes. Caregiver's assignment sheet updated due to anticoagulant. The resident has not fallen, resident's fall risk assessment completed on 8/3/2023 resident was at a low risk. Always has used ▇ walker when out of room. Care plan has been updated regarding mobility and failed Physical Therapy. DON is responsible for compliance Completed by 12/30/2023 Pronoun removed by DLP 1/5/24 Tag 145- Accepted by Carol Scott, LTCM 1-5-24	

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R145	Continued From page 3 On the afternoon of 12/6/23 the Licensed Practical Nurse confirmed Resident #2's Plan of Care did not address care services required to maintain his/her well-being.	R145		
R171 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include: (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, including the reason why and the actions taken by the home; (3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect; (4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and (5) For residents receiving psychoactive medications, a record of monitoring for side effects. (6) All incidents of medication errors. This REQUIREMENT is not met as evidenced by: Based on Staff interview and record review there was a failure to ensure medications administered	R171		

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R171	Continued From page 4 as ordered for one applicable resident (Resident #2). Findings include: The facility's policies and procedures for Medication Documentation states, "Any and all discrepancies found in orders, MARs, treatment sheets, or medication labels will be reported to the RN or LPN on-call." Medication orders listed on Resident #2's December Medication Administration Record (MAR) were not consistent with the signed prescriber's medication orders on file as follows: 1. The MAR listed Diphenhydramine 25 mg tablet One tablet by mouth every 4 hours as needed for mild allergic reaction, however on 9/25/23 Resident #2's provider wrote an order to stop Diphenhydramine as this medication is not safe in elderly population, and to start Loratadine 10 mg PRN (as needed) daily for allergy symptoms. An order for Diphenhydramine remained on Resident #2's December 2023 MAR and the order for Loratadine was not entered on his/her MAR. 2. Resident #2's provider ordered Insta-Glucose for use as needed for hypoglycemia (low blood sugar), however his/her MAR indicated this medication was ordered for Hypoglycemia or Hyperglycemia (high blood sugar). A signed provider's order for Glucose tablets for low blood glucose level below 60 was also on file in Resident #2 record, however the order for Glucose tablets listed on the MAR also incorrectly indicated this medication was intended to treat both low and high blood sugar levels. 3. Resident #2's provider ordered 180 mg Gas Relief capsules, however an order for 125 mg	R171	R171 SS=D #1 This is now corrected and medication available for resident. The process of switching the MAR month to month will be done by two people, checking against the new MAR and the prior month MAR. Two people will do the check on the first of the month when the previous MAR is replaced with new MAR. This procedure will be in place, and staff will be educated. 1/19/2024. DON Responsible #2 Resident #2, Memo will be sent out to all nurses and med techs to remember the orders in the MAR must match the order and label exactly. Will be complete by 1/19/2024 Responsible: DON #3 The order for the Gas Relief 125mg has been discontinued for lack of use and resident using TUMS routinely. This is the same as #2 about orders been exact as the order from provider writes it. Memo and in person meetings will be completed by 1/19/2024. Responsible: DON	

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R171	Continued From page 5 Gas Relief capsules was listed on the MAR. 4. Hydrocortisone cream is a topical medication used to treat inflammation and itching caused by skin conditions. Resident #2's provider ordered Hydrocortisone 1% topical cream. While Resident #2's signed order on file for Hydrocortisone cream did not include the condition the medication was intended to treat, and unsigned telephone order on file indicated this medication was prescribed for Psoriasis (skin rash). The order for Hydrocortisone 1% cream listed on Resident #2's MAR indicated this medication was intended to treat insomnia. 5. Resident #2's record included orders for Acetaminophen 325 mg tablets 2 tabs (650 mg) by mouth every 4 hours for pain or temperature above 99.4 degrees Fahrenheit not to exceed 4 doses in 24 hours; however the medication order listed in the MAR for Acetaminophen 325 mg tablets included a pain scale that was not included in the signed provider's orders. Resident #2 also had prescriber's orders for Acetaminophen 500 mg tablets 1 tab by mouth every 4 hours for pain; however on 12/5/23 the medication order in the MAR for acetaminophen 500 mg tablets was written over to indicate administration of 1-2 tablets by mouth every 8 hours as needed for pain or fever, not to exceed 6 tabs = 3,000 mg in 24 hours. *It is important to note the potential maximum daily dose of acetaminophen if utilizing the acetaminophen orders for 325 mg tabs and the orders for 500 mg tabs as listed in the MAR and in the prescriber's orders exceeds the standard maximum daily dose recommendation not to exceed 3,,000 mg per day. The combination of	R171	#4 The order for hydrocortisone on resident#2 sent for clarification on 8/8/2023 on telephone order was addressed by provider in an electronically signed script with attached diagnoses of psoriasis on 8/10/23. The DX. Insomnia has been changed to psoriasis. The hydrocortisone is now kept in medication cart applied by staff. Staff educated about unsigned telephone orders. This responsibility has been assigned to LPN checking weekly for returned signed orders, then report to RN. Responsible DON #5 Resident's (#2) Acetaminophen orders have been reconciled. The resident's Acetaminophen 325mg has been discontinued. This will be covered as written in #2 and #3 that orders must match exactly how provider has written to be done by 1/19/2024. Responsible DON	

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R171	Continued From page 6 325 mg orders and 500 mg orders of Acetaminophen is a potential risk for overdose. 6. Resident #2's provider ordered Vitamin D 3 125 mcg (5,000 IU), however the MAR listed an order for Vitamin D 3 1,000 IU to be administered as a 1/2 tablet identified as a 500 mg daily dose. Resident #2's record did not include documentation of requests to clarify prescriber's orders listed above which were incomplete, unclear, or inconsistent with the medication orders as they appeared on Resident #2's December 2023 MAR. On the afternoon of 12/6/23 the Licensed Practical Nurse confirmed orders listed in Resident #2's December 2023 MAR were not consistent with the prescriber's signed medication orders. 7. Per record review, on 11/23/23 the facility faxed a request to Resident #1's provider stating, " Patient is third day without Clomipramine cap 50 mg! Please sign ASAP and send a new scripts to [the pharmacy] and signed orders to [the facility] please and thank you!". An additional note written at the top of the document stated the request was faxed to the provider a second time on 11/28/23. Per record review Resident #1's November 2023 MAR the order for Clomipramine 50 mg capsules 3 capsules (150 mg) by mouth at bedtime was signed as administered every day in November of 2023 including the time period the facility's note to the prescriber indicated the medication was not available for administration. On the afternoon of 12/6/23 the LPN confirmed Resident #1's MAR was signed to indicate Clomipramine was administered every day in November 2023.	R171	#6 Resident #2 c Same correction as above applies,that it needs to be exact. Responsible DON #7 Resident #1's This has been discussed at a meeting that I had on 12/26/2023 about the multi packs and checking every pill to the MAR. As stated under #1 the checks each week to switch over the medications will be two people and detailed procedure to follow and sign off. Audit of MAR will be done weekly by RN or someone designated by RN and documented. Done by 1/19/2024. Responsible DON Tag 171- Accepted by Carol Scott, LTCM 1-5-24	

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R173	Continued From page 7	R173		
R173 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h. (1) Resident medications that the home manages must be stored in locked compartments under proper temperature controls. Only authorized personnel shall have access to the keys This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review there was a failure to ensure all medications belonging to one applicable resident (Resident #2) were stored in a locked compartment. Findings include: The facility's policies and procedures for Handling and Administration of Medications states, "Medications will be stored in a locked, secure area and under proper conditions of sanitation, temperature, light, moisture, ventilation, and segregation.". During medication administration commencing at 9:40 AM on 12/6/23 medications were observed to stored on Resident #2's night stand including Triamcinolone topical cream, 2 packages of Hydrocortisone 1% topical cream. The medications were not secured in locked compartments and were accessible to anyone entering Resident #2's room. Per record review Resident #2's medications are managed by the facility; and there are no signed prescriber's	R173	R173 #1 Resident #2 does go on trips to the store and purchases things. Staff will check after trip to store, transportation will alert nursing when ██ goes out to the store. Nursing staff will ask to check when ██ returns and if resident uncooperative RN or Administrator will speak to resident. Resident always locks his door. Any resident that has any medication or medicated ointments/cream and orders for bedside use, will have them locked secure place in their room and lock their door when they are not there. Staff on 12/26/2024 educated look for any such medications or ointments or medicated anything to report to charge. They will investigate and report to RN. Completed 12/26/2023 Pronounds removed by DLP 1/5/24 Responsible DON Tag 173- Accepted by Carol Scott, LTCM 1-5-24	

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R173	Continued From page 8 orders on file allowing Resident #2 to self administer medications or an assessment completed by the Registered Nurse indicating s/he is capable of self administration. This finding was confirmed by the Licensed Practical Nurse following the observed medication administration commencing at 9:40 AM on 12/6/23. During an interview on the morning of 12/6/23 the Manager confirmed there was a plan for the nursing staff to address the ongoing issue of Resident #2 purchasing medications in the community and storing them in his/her room.	R173		
R179 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (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	R179	R179 Inservice All mandatory Inservice training will be conducted upon hire. Staff will not be allowed to work in their department until all Inservice training is complete. Completed by 1/15/2024. Administrative Assistant to track and report to Administrator. Existing staff will be required to complete all mandatory in-services annually. Inservices will be distributed to all staff n February. They will have 30 days to complete and submit all documentation. If not completed within 30 days, staff members will be taken off the work schedule until all are complete. Completed by 3/1/2024. Administrator and Administrative Assistant will be responsible for tracking inservices. Tag 179- Accepted by Carol Scott, LTCM 1-5-24	

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R179	Continued From page 9 limited to, handwashing, 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 the Residential Care Home (RCH) failed to ensure that all staff providing direct care to residents completed the required yearly trainings. Findings include: During the course of the re-licensing survey on 12/6/23, the Manager was requested to demonstrate via training records that staff employed at the RCH who provide direct care to residents had completed the required yearly trainings. Per record review and staff interview it was noted 5 of out 7 sampled staff did complete the required yearly trainings. This finding was confirmed by the Manager at 2:51 PM on 12/6/23.	R179		
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 staff interview and record review there was a failure to ensure the required criminal background and abuse registry checks were completed for 4 out of 5 sampled staff. Findings	R190	Vermont Catholic Charities runs complete background checks for all new employees and runs background checks annually on all employees. Vermont Catholic Charities contracts with Sterling and they run complete background checks including VTAHS Adult/Child Registry checks and VCIC. Further, Vermont Catholic Charities run the VTAHS Adult/Child Registry checks and VCIC. Moving forward we will continue to run the VTAHS and VCIC internally, but we will print and scan the VTAHS Adult/Child Registry and VCIC checks to supplement the Sterling report. New hires; run immediately. Existing staff annually. In short, new and current employees (annuals) will have state checks printed and included in the background check package, then uploaded to the individual SharePoint sites Responsible party: [redacted], Manager- Office of Safe Environments Name removed by DLP 1/5/24	

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R190	Continued From page 10 include: Per record review criminal background and abuse registry checks were not completed for 4 out of 5 sampled staff as required. This finding was confirmed by the Manager at 3:02 PM on 12/6/23.	R190	Tag 190- Accepted by Carol Scott, LTCM 1-5-24	
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 there was a failure to ensure care in a safe, functional, comfortable and homelike environment. Findings include: 1. During the facility tour commencing at 9:16 AM on 12/6/23 the following environmental concerns were observed: a. The Treatment Room door on the main floor of the home near the nursing office was observed to be unattended, unlocked, and left open. A sign on the door indicated the door was to remain closed and locked when not in use. The room was observed to contain 3 cylinder oxygen tanks. Two of the tanks were not secured to prevent falls and tank damage, two were placed directly against a steam radiator, and one was stored within 1-2 feet of the radiator. The methods of storage utilized for the tanks in the treatment	R266		

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(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 room are potential risks for fire, explosion, and injury. Per the Portable Oxygen Cylinders Training and Safety Guidelines Fact Sheet on file with the facility's policies and procedures, the Oxygen Storage Guidelines state, "Keep your oxygen tanks (cylinders) away from all heat sources including radiators, heat ducts, stoves, fireplaces, matches, and lighters.". The guidelines also state cylinders are to be stored in a stand or cart. b. Blood draw and laboratory supplies including needles, and scissors were unsecured and accessible on the counter of the unlocked treatment room. One unlocked cabinet in the treatment room contained unsecured and accessible topical medications including medicated creams and powders; and another unlocked cabinet contained hazardous chemicals including three 1-gallon containers of Medline Enzymatic Detergent, two aerosol cans of Raid Ant and Roach spray, one aerosol container of WD-40, and one unlabeled bottle containing an unknown substance. The Licensed Practical Nurse on duty confirmed the room was designated to be locked and inaccessible to residents due to hazardous items stored within the room; and stated the room was left open and unlocked to provide access for a resident. On 12/06/2023 at 11:00 AM the manager confirmed that the treatment room was unlocked and unattended stating "this room is supposed to be locked at all times". 2. Unattended housekeeping carts were observed in the first and second floor hallways, leaving hazardous chemicals including disinfectants and sanitizers accessible to residents. Housekeeping staff were not observed to be in the vicinity of the	R266	A keypad lock was installed on treatment room door on 12/7/2023. All staff have been educated that the nurses station and treatment room doors must be closed when nursing staff is not in the room. Charge nurse is responsible for ensuring the doors are shut when not occupied. If door(s) are found open staff member will be given a corrective action write up. Continual offenses may lead to termination. Charge nurse is responsible for compliance. Completed by 1/8/2024. All cabinets in nurses station will be locked unless in use. Charge nurse is responsible. Completed by 1/8/24. See next page	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0155	A. BUILDING: ______ B. WING ______	C 12/06/2023

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R266	Continued From page 12 unattended carts upon checking the surrounding resident rooms and common areas. A garbage bag and cleaning chemicals were observed to be left directly in front of the doorway of resident room #113, which impeded safe entry into and exit from the room and presented a risk for falls and injury. Additionally, the second floor Maintenance Closet was observed to be unlocked and unattended with two 1 gallon containers of grout cleaner unsecured and accessible to residents. Per review of the facilities policy and procedure titled Housekeeper Checklist Residents Safety states "Housekeeping cart must be locked at all times and all chemicals must be kept locked up and out of residents reach". On the morning of 12/6/23 the Manager acknowledged the housekeeping cart containing hazardous cleaning chemicals was left unattended in areas accessible to residents, and the Maintenance Closet containing grout cleaner was left unlocked and unattended. 3. Following lunch service on 12/6/23 a large open utility can on wheels was observed to be left in the center of the elevator car, which impeded access to the elevator by residents returning to other areas of the home after lunch. Two residents, one of whom was attempting to access the elevator with a walker, were observed having difficulty entering the elevator due to the placement of the unattended can in the middle elevator car. This finding was acknowledged by the Manager on the afternoon of 12/6/23.	R266	R266 #2 and #3 Hazardous conditions • Maintenance Director will regularly check to make sure that the mop room and laundry closet are closed after each use. Maintenance Director met with housekeeping on 1/3/2024 to remind them not to leave chemicals unattended and that trash is not left where it doesn't belong, causing hazardous conditions for the residents. Trash will be placed in the blue garbage container every time it is collected. Once the container is full, the trash will be brought outside to the big receptacle. If a housekeeper fails to do his/her job as directed, a disciplinary action will be given. Completed by 1/4/2024 by Maintenance Director Maintenance Director is responsible for compliance Tag 266- Accepted by Carol Scott, LTCM 1-5-24	
R291 SS=F	IX. PHYSICAL PLANT	R291		

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	0155	A. BUILDING: ______ B. WING ______	C 12/06/2023

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R291	Continued From page 13 9.6 Plumbing 9.6.d Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure water temperatures did not exceed 120 degrees Fahrenheit in resident areas of the Residential Care Home (RCH). Findings include: During the facility tour commencing at 9:16 AM on 12/6/23 water temperatures were observed to exceed 120 degrees Fahrenheit in five resident areas of the facility including: 1. The water temperature in the shared resident restroom located on the ground level was 123.4 degrees Fahrenheit. 2. The water temperature in shared resident restroom #1 on the first floor was 127.0 degrees Fahrenheit. 3. The water temperature in shared resident restroom #2 on the first floor was 126.8 degrees Fahrenheit. 4. The water temperature in shared resident restroom #1 on the second floor was 121.6 degrees Fahrenheit. 5. The water temperature in resident restroom #2 on the second floor was 121.5 degrees Fahrenheit. At approximately 10:20 AM on 12/6/23 the	R291	R291 A new thermometer has been ordered and received. The water temperatures will be corrected and will be checked every month throughout the building (bedroom,bathroom, and shower). We will follow a checklist system that will be used monthly by the Maintenance Director and reported to the Administrator. To be completed by 1/30/2024	

Division of Licensing and Protection

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R291	Continued From page 14 facility's Maintenance Director confirmed these findings.	R291	Tag 291- Accepted by Carol Scott, LTCM 1-5-24	