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

October 27, 2022

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 **July 26, 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
	0155	A. BUILDING: _____ B. WING _____	C 07/26/2022

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: The Division of Licensing and Protection conducted an unannounced on-site complaint investigation on 7/19/22 and it was completed on 7/26/22. The following regulatory deficiencies were identified:	R100	Please see attached Plan of correction.	
R101 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.1. Eligibility 5.1.a The licensee shall not accept or retain as a resident any individual who meets level of care eligibility for nursing home admission, or who otherwise has care needs which exceed what the home is able to safely and appropriately provide. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility has retained 2 residents whose level of care needs exceed what the home is able to safely and appropriately provide (Residents #1, & #2). Findings include: 1. Resident #1 was admitted to the RCH on 1/29/22 and shortly after admission demonstrated behaviors to include agitation, resistance to care, exit seeking and elopements, indicating a high risk safety concern. As a result, on the afternoon of 2/12/22 Resident #1 was observed outside and was attempting but unable to open an exit door to return to the building. Staff were unaware of the elopement and by chance had visualized him standing outside. On 2/15/22 at approximately 2:45 PM Resident #1 was not found in his room.	R101		

R101 - R201 POC accepted 8/24/22 JEV and RN/PMC

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R101	Continued From page 1 A housekeeper observed the resident outside the fence which surrounds the facility property. The Resident was seen walking to the cemetery located adjacent to the facility. Per Nurse's Note "...Resident was undressed with only a sweatshirt. (Temperatures reported on 2/15/22 were between 2 degrees Fahrenheit (F) and 21 degree F.) It was unclear how long Resident #1 was exposed to the weather. Resident #1 had recently lost his/her spouse and believed their spouse was buried at the adjacent cemetery. On 2/25/22 Resident #1 again eloped the facility and was found on the facility property facing the adjacent cemetery. This was again repeated on 4/5/22 at 4:00 PM. Per Nursing Note dated 6/10/22 at 22:55 states: "Resident was found outside without his/her walker and s/he fell. A couple driving a truck came around the corner and saw him/her. Employee of St. Joe's was leaving for the night and walked on the scene and alerted Administrator." Despite the alarm system activated on all exit doors, it was not until the Administrator telephoned the facility, staff became aware of Resident #1's elopement and fall. The location where Resident #1 was found is a busy road which includes a dangerous curve creating limited visibility from the road. A Nurse's Note late entry dated 6/13/22 stated on 6/10/22 Resident #1 was "...practically hit by a passing pick-up truck ..." The resident was transported to the hospital and later discharged, however returned to the Emergency Department after presenting with vomiting and disorientation with a noted bruise on the crown of his/her head. On 6/11/22 at 1800, Resident was returned to the facility from the ED. Per observations throughout the day of 7/19/21 found Resident #1 in his/her suite in an isolated	R101		

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R101	Continued From page 2 area on the second floor. The room exited to a corridor which was adjacent to a stairway, easily accessible to the resident if s/he choose to leave the suite and seek an exit. Although a Care Tracker was instituted on March 1, 2022, no formal behavioral and safety plan was developed to assure the ongoing safety of the resident. In addition, during a tour with the facility Administrator commencing at 3:00 PM on 7/19/22 window screens in Resident #1's room were observed to be missing. This second floor suite was observed to have slider windows overlooking the neighboring cemetery where the resident targeted during elopements. The window was without a screen in the living room and was fully opened exposing an exit distance of approximately 35 inches high by 24 inches wide. The window lacked a restrictive device which would prevent the resident from fully opening the window. The ability to assure Resident #1's safety continues to remain a challenge and demonstrates the inability of the staff to maintain the resident in a safe setting. In addition, since admission Resident #1 has increased care needs related to behaviors, wandering, weight loss and inability to carry out activities of daily living demonstrates this resident's care needs exceed what the facility is able to provide. This was confirmed by the Administrator on 7/19/22 at 3:45 PM, recognizing the resident requires 1:1 interaction and monitoring, which staff are unable to successfully provide. 2. Resident #2 was admitted on 5/10/22 with Dementia, confusion and memory loss. Staff Notes document frequent incidents of elopement, exit seeking, wandering, and entering other resident's rooms. On 6/2/22 Resident #2 was	R101		

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R101	Continued From page 3 found walking through the common areas of the facility without his/her walker, and on 6/19/22 Resident #2 was found on the stairs with his/her walker. Both situations present high a risk for falls and injury. On the morning of 6/6/22 two of the three staff on duty searched in and around the RCH when notified Resident #1 was not in his/her room, leaving one staff to provide morning care for the 33 other residents of the home until Resident #2 was found in an unlocked boiler closet. Between 5/17/22 and 7/16/22 Resident #2 exited the facility 9 times without supervision, and made 7 additional attempts to exit the facility. On 5/17/22 Resident #2 exited the facility at approximately 4:00 AM and was unable to get back in when the locked door closed behind him. Staff was unaware s/he was outside until the fire department responded to Resident #2 pulling the alarm in the vestibule in an attempt to re-enter the building. On 7/4/22 staff noted " ...received phone call [at 11:23 PM] from the security home about door #3 alarm going on and went downstairs to check. While I was trying to turn off the alarm to go outside the building to check got another call for door #5 so I asked the aid to go check if any resident was out of the house ...found [Resident #2] walking ...asked what he was doing outside". During this incident both staff on duty were engaged in search for Resident #2 leaving no one to attend to other residents, and neither heard the door alarms as Resident #2 exited the facility. Many incidents noted occurred between 15 or 30 minute checks when staff documented Resident #2 was in his/her room. Inconsistent recording of 15 and 30 minute cheeks indicates Resident #2 primarily spends time in his room. Staff Notes indicate Resident #2 is often escorted or redirected to his/her room when in common areas of the home even during day time hours. During an interview commencing at 1:25 PM on 7/19/22	R101		

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R101	Continued From page 4 the Administrator confirmed exit seeking behaviors and elopements were increasing in frequency despite "mitigation measures in place". Please Refer to Tag 178	R101		
R129 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.d A home certified to provide assistive community care services (ACCS) shall designate a staff person responsible for case management, who shall provide at least the following case management services: maintenance and implementation of a current assessment and plan of care, and coordination of available community services. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to designate a staff member to be responsible for case management services for 28 applicable Assistive Community Care Services residents (Residents #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, and #31). Per record review there are 28 residents receiving Assistive Community Care Services (ACCS) at the Residential Care Home (RCH). During the course of the investigation the Administrator was unable to identify who is	R129		

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R129	Continued From page 5 responsible for providing case management services and coordination of community resources for the 28 applicable residents (Residents #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, and #31) receiving ACCS. At approximately 4 PM on 7/19/22 the Administrator asked if the services provided by the former Director of Nursing Services are considered case management services and confirmed there is not a designated staff member responsible for providing required services for the 28 applicable ACCS residents. The Administrator stated some of the applicable residents are provided case management by "outside agency services".	R129		
R178 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to assure that there are a sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies. Findings include:	R178		

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R178	Continued From page 6 Per review of the staff schedule for a three month period the typical staffing pattern is 2 Direct Caregivers per shift with an additional Direct Caregiver for partial day shifts 2-4 times a week. At times a third Direct Care staff is scheduled on evening and overnight shifts. A Licensed Practical Nurse (LPN) is on duty during the day shift 4-6 times per week, including the weekend days when the LPN is the second Direct Caregiver on duty. Periods of single staffing were observed on review of the schedules for May through July of 2022. Additional staff present in the facility during weekdays includes housekeeping, dietary, maintenance, and administrative staff. Per record review there are 34 residents living on 3 separate floors of the home. Per review of the resident population, there are 11 residents with Enhanced Residential Care (ERC) variances (Residents #8, #9, #10, #13, #16, #17, #18, #20, #22, #27, and #31). A Level of Care (LOC) variance indicates a resident requires more care than usual for a resident of a Level 3 residence, and the facility has applied for a variance by attesting that the facility has adequate staff to meet the resident's needs. For each resident with an ERC variance the facility must be prepared to provide 1 hour per week of nursing care per resident and 2 hours per day of Direct Caregiver care per resident. This indicates 11 hours of nursing care per week and 22 hours per day of direct caregiver care are required to meet the needs of the ERC residents living at the home in addition to the care required by the remaining 23 non-ERC residents, many of whom also have significant physical and psychological needs. Per record review two non- ERC residents (Residents #1 and #2) require significant monitoring and care due to Dementia, frequent wandering and elopements. The residence has 7	R178		

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R178	Continued From page 7 doors accessible to residents which are alarmed only during the hours of 7:30 PM - 6:00 AM. The other 12 1/2 hours of the day these doors are not alarmed. As a result of insufficient staff there was a lack of awareness and timely response when Resident #1 had a series of elopements from the facility. Per record review, Resident #1 had resided at the home since admission on 1/29/22. The resident has a diagnoses that includes Dementia and Parkinson Disease. Some of the behaviors documented for this resident included aggression, and wandering behaviors with an identified elopement risk. Since admission, the resident has had multiple elopements. During the month of February 2022, staff schedules reflect only 1 staff member on the night shift. Per Nursing's Note dated 6/10/22 at 22:55 states: " Resident was found outside without his/her walker and s/he fell. A couple driving a truck came around the corner and saw him/her. Employee of St. Joe's was leaving for the night and walked on the scene and alerted Administrator." Despite the alarm system activated on all exit doors, it was not until the Administrator telephoned the facility, staff became aware of Resident #1's elopement and fall. The location where Resident #1 was found is a busy road which includes a dangerous curve creating limited visibility from the road. A Nurse's Note late entry dated 6/13/22 stated on 6/10/22 Resident #1 was " ...practically hit by a passing pick-up truck ..." Staffing on this day included: 2 staff on evenings. Although a Care Tracker was instituted on March 1, 2022 and sporadic 30 minute checks were inconsistently recorded from 3/1/22 through 4/20/22 the residence's 7 accessible doors and limited staffing has created an environment where monitoring for elopement	R178		

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R178	Continued From page 8 behaviors has been an ongoing challenge for staff. Per review of staff night shift schedules for the month of Feburary 2022 noted only one staff member was scheduled for 14 of the 28 days. This individual would be responsible for assuring necessary care and prompt action in case of injury and/or emergencies to include monitoring of residents with a high elopement risk. Per record review Resident #2 was admitted on 5/10/22 with Dementia, confusion and memory loss. Staff Notes document frequent incidents of elopement, exit seeking, wandering, and entering other resident's rooms. On 6/2/22 Resident #2 was found walking through the common areas of the facility without his/her walker and on 6/19/22 Resident #2 was found on the stairs with his/her walker. Both situations present high a risk for falls and injury. On the morning of 6/6/22 two of the three staff on duty searched in and around the RCH when notified Resident #1 was not in his/her room, leaving one staff to provide morning care for the 33 other residents of the home until Resident #2 was found in an unlocked boiler closet. Between 5/17/22 and 7/16/22 Resident #2 exited the facility 9 times without supervision and made 7 additional attempts to exit the facility. On 5/17/22 Resident #2 exited the facility at approximately 4:00 AM and was unable to get back in when the locked door closed behind him. Staff was unaware s/he was outside until the fire department responded to Resident #2 pulling the alarm in the vestibule in an attempt to re-enter the building. On 7/4/22 staff noted " ...received phone call [at 11:23 PM] from the security home about door #3 alarm going on and went downstairs to check. While I was trying to turn off the alarm to go outside the building to check got another call for door #5 so I asked the aid to go check if any resident was out of the house ...found [Resident	R178		

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R178	Continued From page 9 #2] walking ...asked what he was doing outside". During this incident both staff on duty were engaged in search for Resident #2 leaving no one to attend to other residents, and neither heard the door alarms as Resident #2 exited the facility. Many incidents noted occurred between 15 or 30 minute checks when staff documented Resident #2 was in his/her room. Inconsistent recording of 15 and 30 minute cheeks indicates Resident #2 primarily spends time in his room. Staff Notes indicate Resident #2 is often escorted or redirected to his/her room when in common areas of the home even during daytime hours. During an interview commencing at 1:25 PM on 7/19/22 the Administrator stated "we can keep [Resident #2] safe" and confirmed exit seeking behaviors and elopements were increasing in frequency. Please Refer to Tag 101 This is a repeat citation	R178		
R213 SS=D	VI. RESIDENTS' RIGHTS 6.1 Every resident shall be treated with consideration, respect and full recognition of the resident's dignity, individuality, and privacy. A home may not ask a resident to waive the resident's rights. This REQUIREMENT is not met as evidenced by: Based on observation and a anonymous resident interviews, there was a failure of the facility to ensure each resident is treated and provided care with consideration of their dignity and privacy. Residents not identified to protect anonymity.	R213		

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R213	Continued From page 10 Findings include: 1. During a random resident interview on 7/19/22 it was disclosed a staff member who at times assists the resident with personal care was described as being "rough". During the application of orthotic shoes and compression socks, the resident reported the caregiver would not support his/her legs and would simply drop each of the resident's legs from an elevated position causing discomfort. In addition, during personal care, the caregiver would not hand a facecloth to the resident but would toss the wash cloth at the resident's face. 2. At approximately 11:35 AM on 7/19/22 Resident (A) was observed being assisted from the bathroom to their bedroom area by Resident (B). The resident who required assistance is unable to manage his/her personal care to include, at times, incontinence care and with the assistance of Resident (B) the provision of care is attempted to be provided. Due to significant physical disabilities, Resident (A)'s care needs are required for almost all Activities of Daily Living (ADLs) including receiving assistance when using the bathroom. The assistance provided by the Resident (B), although performed without coercion and with kindness, creates an environment that does not protect either resident's dignity and privacy.	R213		
R266 SS=F	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and	R266		

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R266	Continued From page 11 comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to provide care in a safe and provide a homelike environment. Findings include: A. The facility failed to assure a consistently safe environment as evidenced by: 1. Resident #1 was admitted to the RCH on 1/29/22 and shortly after admission demonstrated behaviors to include agitation, resistance to care, exit seeking and elopements indicating a high risk safety concern. As a result, on the afternoon of 2/12/22 Resident #1 was observed outside and was attempting but unable to open an exit door to return to the building. Staff were unaware of the elopement and by chance had visualized him/her standing outside. On 2/15/22 at approximately 2:45 PM Resident #1 was not found in his/her room. A housekeeper observed the resident outside the fence which surrounds the facility property. The Resident was seen walking to the cemetery located adjacent to the facility. Per Nurse's Note " ..... Resident was undressed with only a sweatshirt. (Temperatures reported on 2/15/22 were between 2 degrees Fahrenheit (F) and 21 degree F.) It was unclear how long Resident #1 was exposed to the weather. Resident #1 had recently lost his/her spouse and believed their spouse was buried at the adjacent cemetery. On 2/25/22 Resident #1 again eloped the facility and was found on the facility property facing the adjacent cemetery. This was again repeated on 4/5/22 at 4:00 PM. Per Nursing Note dated	R266		

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R266	Continued From page 12 6/10/22 at 22:55 states: " Resident was found outside without his/her walker and s/he fell. A couple driving a truck came around the corner and saw him/her. Employee of St. Joe's was leaving for the night and walked on the scene and alerted Administrator." Despite the alarm system activated on all exit doors, it was not until the Administrator telephoned the facility, staff became aware of Resident #1's elopement and fall. The location where Resident #1 was found is a busy road which includes a dangerous curve creating limited visibility from the road. A Nurse's Note late entry dated 6/13/22 stated on 6/10/22 Resident #1 was " ...practically hit by a passing pick-up truck ..." The resident was transported to the hospital and later discharged, however returned to the Emergency Department after presenting with vomiting and disorientation with a noted bruise on the crown of his/her head. On 6/11/22 at 1800, Resident was returned to the facility from the ED. Per observations throughout the day of 7/19/21 found Resident #1 in his/her suite in an isolated area on the second floor. The room exited to a corridor which was adjacent to a stairway, easily accessible to the resident if s/he choose to leave the suite and seek an exit. Although a Care Tracker was instituted on March 1, 2022, no formal behavioral and safety plan was developed to assure the ongoing safety of the resident. In addition, during a tour with the facility Administrator commencing at 3:00 PM on 7/19/22 window screens in Resident #1's room were observed to be missing. This second floor suite was observed to have slider windows overlooking the neighboring cemetery where the resident targeted during elopements. The window was without a screen in the living room and was fully opened exposing an exit distance of	R266		

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	0155	A. BUILDING: _____ B. WING _____	C 07/26/2022

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R266	Continued From page 13 approximately 35 inches high by 24 inches wide. The window lacked a restrictive device which would prevent the resident from fully opening the window. The ability to assure Resident #1's safety continues to remain a challenge and demonstrates the inability of the staff to maintain the resident in a safe setting. In addition, since admission Resident #1 has increased care needs related to behaviors, wandering, weight loss and inability to carry out activities of daily living demonstrates this resident's care needs exceed what the facility is able to provide. This was confirmed by the Administrator on 7/19/22 at 3:45 PM, recognizing the resident requires 1:1 interaction and monitoring, which staff are unable to successfully provide. 2. Per record review Resident #2 was admitted on 5/10/22 with Dementia, confusion and memory loss. Staff Notes document frequent incidents of elopement, exit seeking, wandering, and entering other resident's rooms. On 6/2/22 Resident #2 was found walking through the common areas of the facility without his/her walker, and on 6/19/22 Resident #2 was found on the stairs with his/her walker. Both situations present high a risk for falls and injury. On the morning of 6/6/22 two of the three staff on duty searched in and around the RCH when notified Resident #1 was not in his/her room, leaving one staff to provide morning care for the 33 other residents of the home until Resident #2 was found in an unlocked boiler closet. Between 5/17/22 and 7/16/22 Resident #2 exited the facility 9 times without supervision, and made 7 additional attempts to exit the facility. On 5/17/22 Resident #2 exited the facility at approximately 4:00 AM and was unable to get back in when the locked door closed behind him.	R266		

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R266	Continued From page 14 Staff was unaware s/he was outside until the fire department responded to Resident #2 pulling the alarm in the vestibule in an attempt to re-enter the building. On 7/4/22 staff noted "...received phone call [at 11:23 PM] from the security home about door #3 alarm going on and went downstairs to check. While I was trying to turn off the alarm to go outside the building to check got another call for door #5 so I asked the aid to go check if any resident was out of the house ...found [Resident #2] walking ...asked what he was doing outside". During this incident both staff on duty were engaged in search for Resident #2 leaving no one to attend to other residents, and neither heard the door alarms as Resident #2 exited the facility. Many incidents noted occurred between 15 or 30 minute checks when staff documented Resident #2 was in his/her room. Inconsistent recording of 15 and 30 minute cheeks indicates Resident #2 primarily spends time in his room. Staff Notes indicate Resident #2 is often escorted or redirected to his/her room when in common areas of the home even during day time hours. During an interview commencing at 1:25 PM on 7/19/22 the Administrator confirmed exit seeking behaviors and elopements were increasing in frequency. B. The facility failed to provide a homelike environment as evidenced by: Per observation during a tour of the facility commencing at 10:09 on 7/19/22 the following observations were noted: 1. The air temperature in all common areas of the Residential Care Home (RCH) was noted to be uncomfortably hot. The use of air conditioners is limited to offices and resident rooms, with limited	R266		

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R266	Continued From page 15 use of fans in the common areas of the home. According to the National Weather Service temperatures in Burlington Vermont ranged from 76 degrees Fahrenheit at 9 AM to 90 degrees Fahrenheit at 4 PM. The first floor hallway between the living room and bathrooms was noted as 81.3 degrees Fahrenheit at 11:00 AM with further increase to 84 degrees Fahrenheit at 3:00 PM. The living room lacked window shades to block out the heat from the sun shining into the room. At 3:00 PM the facility Administrator confirmed the air temperature in the first floor common area was 84 degrees Fahrenheit and acknowledged the failure to provide adequate climate control in the common areas of the home. 2. The first floor laundry room containing unsecured laundry cleaning supplies was unlocked and accessible to residents. During a tour of the facility on the morning of 7/19/22 the Director of Nursing stated laundry services are provided by staff. On 7/20/22 the facility Administrator confirmed there are two laundry rooms in the RCH, and both rooms did not have locks on the door. The home cares for residents with mental health and cognitive issues including residents with Dementia who wander. As noted above Resident #2 has a history of wandering into an unlocked utility area. 3. On the first and second floors the utility closets located in between two shared bathrooms had signs on the doors identifying them as a "Wash Room". Both utility rooms contained cleaning chemicals, and both were unlocked and accessible to residents. The unlocked closet on the first floor had a used toilet brush sitting in a puddle of water on the floor, and there was open access to the wiring and routers for the facility internet service with the handles of mops left	R266		

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R266	Continued From page 16 standing in a utility cart resting inches from the wires and cables. During a tour of the facility bathrooms and utility closets commencing at 3:00 PM on 7/19/22 the facility Administrator confirmed the utility closets were incorrectly identified as wash rooms, unlocked, and contained hazardous chemicals accessible to residents. 4. The first and second floor shared bathrooms were poorly maintained and in need of repairs and cleaning. Both floors have two separate shared bathrooms, one with a shower and the other with a bathtub. The bathrooms were noted to have a strong smell of urine. Discolored grout and tile near the toilets and sinks, and accumulations of dust and dirt on surfaces including the sprinkler heads and ventilation system, and a dislodged radiator end cap were noted. Cleaning chemical and personal hygiene items were observed on bathroom shelves, and toilet brushes and plungers without receptacles were observed on the floor. The bathrooms containing a tub were being used as utility rooms and for storage purposes. On the first floor there were mop buckets stored beside the tub, dirt and grime from emptying buckets in the bottom of the tub, and used mop heads drying on the handgrips on the side of the tub. The area around the tub on the second floor was used to store 5 gallon buckets and a light fixture with glass fluorescent tubes was propped against the bathroom walls. During a tour of the facility bathrooms and utility closets commencing at 3:00 PM on 7/19/22 the facility Administrator confirmed the shared bathrooms on the first and second floor of the facility were in disrepair and in need of cleaning, and the bathrooms with tubs were being used as storage and utility rooms. 5. During a tour with the facility Administrator	R266		

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R266	Continued From page 17 commencing at 3:00 PM on 7/19/22 several of the window screens in Resident #1's room were observed to be missing. Resident #1 has a diagnosis of Dementia and a history of elopement including an incident during which s/he appeared to be disoriented and attempted to visit a deceased loved one at the cemetery visible from his/her window. Resident #1 resides on the second floor of the facility and the slider window overlooking the neighboring cemetery was observed to be fully opened exposing an exiting distance of approximately 35 inches high by 24 inches wide. No screen was in this window and the window lacked a restrictive device preventing the resident from fully opening the window. The resident's bedroom windows were also without screens, and easily accessible to this resident. Also of note on 2/15/22 Resident #1 attempted to open a window while visiting on the first floor, attempting to exit to find his/her family. At 3:21 on 7/19/22 the facility Administrator confirmed there were missing window screens in Resident #1's room. 6. During the initial tour of the facility on 7/19/22 accompanied by the acting Director of Nurses (DON) staff approached the DON at 10:25 AM stating Resident # 12 had fallen in the second floor bathroom; the door was locked and the resident was unable to get up and unlock the bathroom door. Upon arrival to the 2nd floor bathroom, housekeeping staff and the DON did not have a key to unlock the bathroom and an urgent request was made to Maintenance to assist with unlocking the door. While awaiting assistance, the door handle lever was examined by the surveyor. The lever contained a screw which could be manipulated with a coin or fingernail. This locking mechanism on the door lever was turned and the door was unlocked by	R266		

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R266	Continued From page 18 the surveyor. The RCH staff who were present were unaware how to utilize the door lever lock. Upon staff opening the door, the resident was observed laying on the bathroom floor and was then assessed for injuries by the DON. Resident #1 was then transported by Emergency Services to be evaluated in the Emergency Department. Per interview in the afternoon of 7/19/22, the Administrator acknowledged staff should have known a coin is used to unlock the door when an occupant locks the door from the inside of the bathroom. This is a repeat citation.	R266		
R270 SS=D	IX. PHYSICAL PLANT 9.2 Residents' Rooms 9.2.c Each bedroom shall have an outside window. (1) Windows shall be openable and screened except in construction containing approved mechanical air circulation and ventilation equipment. (2) Window shades, venetian blinds or curtains shall be provided to control natural light and offer privacy. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to provide window screens for one applicable resident (Resident #1) findings include: During a tour with the facility Administrator commencing at 3:00 PM on 7/19/22 several of	R270		

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R270	Continued From page 19 the window screens in Resident #1's room were observed to be missing. Resident #1 has a diagnosis of Dementia and a history of elopement including an incident during which s/he appeared to be disoriented and attempted to visit a deceased loved one at the cemetery visible from his/her window. Resident #1 resides on the second floor of the facility and the window overlooking the neighboring cemetery was observed to be wide open, with a distance of approximately a two foot wide opening without a screen. No window screens were noted in the resident's bedroom which is also accessible to Resident #1. Also of note on 2/15/22 Resident #1 attempted to open a window while visiting on the first floor, attempting to exit to find his/her family. At 3:21 on 7/19/22 the facility Administrator confirmed there were missing window screens in Resident #1's room.	R270		
R281 SS=E	IX. PHYSICAL PLANT 9.3 Toilet, Bathing and Lavatory Facilities 9.3.e Resident lavatories and toilets shall not be used as utility rooms. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure bathrooms are not being used as utility rooms. Findings include: Based on observation on the first and second floor of the facility there are two separate shared bathrooms, one with a shower and the other with a bathtub. The bathrooms containing a tub were being used as utility rooms and for storage	R281		

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R281	Continued From page 20 purposes. On the first floor there were mop buckets stored beside the tub, dirt and grime from emptying buckets in the bottom of the tub, and used mop heads drying on the handgrips on the side of the tub. The area around the tub on the second floor was used to store 5 gallon buckets, and a light fixture with glass fluorescent tubes was propped against the bathroom wall. During a tour of the facility bathrooms and utility closets commencing at 3:00 PM on 7/19/22 the facility Administrator confirmed the bathrooms with tubs on the first and second floors were being used as utility rooms.	R281		

PLAN OF CORRECTION – ST. JOSEPH RESIDENTIAL CARE HOME
AUGUST 26, 2022

R101 5.1 Eligibility 5.1.a

Safety and Discharge Plan Resident 1:

1.) 30-minute checks implemented February 2022 (*See 30-minute check flow sheet)
2.) Care tracker placed on 3/1/22
3.) 15-minute check implemented March 2022 (*See 15-minute check flow sheet)
4.) Video surveillance w/ alarm installed May 2022
5.) 24/7 1:1 ancillary care retained –May 2022 - present
6.) Restrictive device was installed on Resident 1's window on 7/19/22.
7.) Admission to Hospice – 8/20/22
8.) 30-day discharge issued - 8/25/22

Safety and Discharge Plan Resident 2:

1.) 15-mintue checks implemented May 2022
2.) Care Tracker placed June 2022
3.) 24/7 1:1 ancillary care retained – June 2022-present
4.) Placement found- Discharge week of 8/29/22

- Any resident who begins exhibiting exit-seeking/elopement behaviors will immediately be placed on 15-minute checks. Staff will document by completing Frequent Check Form.
- Resident physician will be notified and consulted to establish appropriate interventions. If attempted interventions fail and it is determined that the resident is no longer appropriate for placement, a 30-day discharge notice will be issued; and in emergency situations the home will request permission for an emergency discharge or transfer as needed.
- All staff will be educated on the importance of completing 15-minute checks consistently and documenting accordingly. Education will be completed no later than 8/31/22.
- The DON or Administrator will review documentation daily to ensure compliance.
- All staff will be educated regarding emergency response to the door alarm system. This education will be completed no later than 8/31/22.

R129 5.5 General Care 5.5.d

- For all residents receiving assistive community care services (ACCS); as of 9/9/22, the DON has been identified on each resident's plan of care as the staff member responsible of case management services.
- All staff will be educated regarding this requirement no later than 8/31/22.

8/26/22

Administrator

R178 5.11 Staff Services 5.11.a

We have always had 2 nursing staff on the schedule for all shifts. If additional staff was needed, we contracted with an outside agency.

- The Home will ensure that there are always 2 qualified staff members on the schedule.
- Ancillary staff will be cross trained to assist in emergency situations as needed, including assisting with rounds, safety checks and resident needs. This training began 8/25/22 and be ongoing.
- The Administrator will conduct weekly audits of the staffing schedule to ensure that there are adequate staff present to meet the needs of the residents.
- The Administrator and the DON will have a clinical review weekly on all residents.

213 VI. Resident Rights 6.1

- Internal investigation was initiated immediately upon learning of resident's complaint. Staff member was placed on leave pending outcome of investigation.
- Self-Report to APS filed within 72 hours of report.
- The Chief Human Resource Officer investigated and found no suspected wrongdoing by accused.
- Encourage all residents to attend resident council meetings.
- Install complaint/suggestion box by 8/31/22 and communicate this to residents.
- Administrator to schedule monthly All Resident meetings to discuss information from resident council.
- All staff will be re-educated on Resident Abuse and Neglect no later than 8/31/22.

R266 - Physical Plant

9.1 Environment

9.1.a

- All missing window screens have been replaced, effective 7/19/22.
- Restrictive device was installed on Resident 1's window on 7/19/22.
- All staff will be educated regarding emergency response to the door alarm system. This education will be completed no later than 8/31/22.
- Maintenance will conduct monthly inspections of all windows to ensure that screens are present, and windows are functioning properly.

B.

- The Home will provide additional standing fans in the hallways during warm weather.
- Additional fans have been placed in the hallways effective 7/19/22.
- Climate control curtains have been installed in the living rooms effective 7/23/22.
- Locks have been installed on all laundry, cleaning and utility closets and cabinets in the home effective 7/19/22.

- Remove washroom signs from utility room closets by 7/20/22 and re-educated staff on ensuring doors are always locked.

- All staff was provided education regarding proper storage and handling of chemicals and housekeeping supplies on 7/19/22.
- Administrator or designee will conduct weekly audits for 4 weeks and then monthly to ensure that no chemicals or other housekeeping supplies are stored inappropriately.
- Administrator will conduct monthly building audits to include cleanliness inspections.
- All staff will be provided education regarding how to unlock doors using coin or fingernail in an emergency by 8/31/22.

R270 Physical Plant 9.2

- All missing window screens have been replaced, effective 07/19/22.
- Restrictive device was installed on upstairs window on 7/19/22.
- Maintenance will conduct monthly inspections of all windows to ensure that screens are present, and windows are functioning properly.

R281 Physical Plant 9.3

- Both bathrooms were updated with internal doors separating tub area from toilet and sink area. Work completed by 08/16/22.
- The internal doors will be always locked.
- Staff educated about the internal doors being always locked no later than 8/31/22.