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

February 9, 2024

Jolynn Whitten, Manager
The Village At White River Junction
101 Currier Street
White River Junction, VT 05001

Dear Ms. Whitten:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 8, 2024.** Please post this document in a prominent place in your facility.

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

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

Sincerely,

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

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
	0660	A. BUILDING: _____ B. WING _____	C 01/08/2024

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R100	Initial Comments: On 1/8/24 the Division of Licensing and Protection conducted an unannounced on-site investigation of one facility reported incident. The following regulatory deficiencies were identified:	R100	Plans of Corecction for all tags cited accepted by Jo A Evans RN on 2/5/24. See attachment to review individual accepted Plans of Correction.	
R144 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c.(1) Complete an assessment of the resident in accordance with section 5.7; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure Resident Assessments were completed in accordance with Section 5.7 of the Vermont Residential Care Home Licensing Regulations effective 10/2/2000 used in conjunction with the Vermont Assisted Living one applicable resident (Resident #1). Findings include: Per review of policies and procedures related to resident assessments provided by the Executive Director on request, the facility's Quality of Life Assessment policy was provided. This policy includes the procedure which states , "Residents shall be assessed prior to admission, on admission, and on the required schedule as stated in the Community Residency Agreement with PRN due to significant change of condition."; however the resident assessment policies and procedures provided for review do not identify the requirement for a Registered Nurse to sign and date the Resident Assessment to certify the information accurately reflects assessment	R144		

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R144	Continued From page 1 information collected/coordinated by the RN, as indicated in section N.1. on page 13 of the Vermont Resident Assessment Form. Per record review Resident #1 was admitted to the home on 10/12/23. Per review of the Resident Assessments on file for Resident #1. the Resident Assessment form completed by a Licensed Practical Nurse on the day of admission was not signed as completed by a Registered Nurse as required. Per record review resident #1 was admitted into hospice care on 12/15/23 following a significant decline in physical health. A Resident Assessment was not completed by the Registered Nurse in response to this significant change. This finding was acknowledged by the Executive Director during an interview commencing at 5:05 PM on 1/10/24. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents related to inaccurate or uncompleted assessments.	R144		
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;	R145		

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R145	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the Registered Nurse failure to ensure development of a written Plan of Care describing necessary care and services for one applicable resident (Resident #1). Findings include: The facility's Care Plans- Service Plans policy is "To develop a preliminary and comprehensive Care Plan/Service Plan for each resident that includes measurable goals and objectives, realistic approaches and interventions, timetables and evaluations to meet the resident needs." Per record review Resident #1 has diagnoses including Diabetes Mellitus with Chronic Kidney Disease; Seizures; Cardiovascular conditions and history of Stroke and Heart Attack; Dysphagia (difficulty swallowing) and history of Esophageal Obstruction; acute and chronic skin infections; Incontinence and Urinary Retention; and psychological conditions. S/he is on hospice and is prescribed antiseizure medication, nitroglycerin, and an anticoagulant medication. Resident #1's written care plan does not address: a. goals and interventions related to Diabetes Mellitus with Kidney Disease, incontinence, risk for choking, and psychosocial needs b. signs and symptoms of seizures and what to do if a seizure occurs c injury prevention and risks for bleeding associated with anticoagulant medications, and when to seek medical help d. indications and important considerations for use of nitroglycerin and when to seek medical	R145		

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R145	Continued From page 3 help e. risk for activity intolerance and risk cardiovascular event; risk for skin breakdown and infections f. hospice care including when and how to contact hospice providers. The Executive Director confirmed these findings during an interview commencing at 5:05 PM on 1/10/24. In conclusion this deficient pratice is a potential risk for more than harm to all residents due to unidentified and unmet needs for health and wellbeing.	R145		
R167 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced	R167		

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R167	Continued From page 4 by: Based on staff interview and record review there was a failure to develop written plans for the administration of 2 PRN (as needed) psychoactive medications for one applicable resident (Resident #1). Findings include: Per review of facility policies and procedures provided by the Executive Director on request, the facility has not developed policies and procedures for the administration of PRN psychoactive medications. Per record review Resident #1's physician ordered Haloperidol Lactate Oral Concentrate 2 mg/ml 0.5 ml by mouth sublingually every 6 hours as needed for agitation/delirium and Lorazepam 0.5 mg tablets One tablet by mouth/sublingually every 6 hours as needed for anxiety. During an interview commencing at 5:05 PM on 1/10/24 the Executive Director acknowledged written PRN psychoactive plans had not been developed for the administration of Haloperidol and Lorazepam to Resident #1 by staff other than a nurse. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents due to administration of PRN psychoactive medications without the appropriate monitoring for the medication's effect, and potential medication errors including misuse.	R167		
R173 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management	R173		

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R173	Continued From page 5 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 and staff interview there was a failure to ensure all medications managed by the home are stored in a locked compartment and accessible only to authorized personnel. Findings include: The facility's medication system policy states, "Compartments (including, but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications shall be locked when not in use and trays or carts used to transport medications shall not be left unattended if open or otherwise potentially available to others. " At 1:50 PM the 3rd floor Medication Room was observed with door open and unattended by staff. Unlocked cabinets and a refrigerator in the open unlocked room were observed to contain the following medications which were left unsecured and accessible to residents, visitors, and undesignated staff. 1. In the unlocked medication room cabinets: a. Bacitracin, wound cleaner spray, saline spray, Ocuvite vitamins, stool softener b. Additionally, medical supplies including	R173		

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R173	Continued From page 6 diabetic testing supplies, Urinalysis collection and other laboratory testing supplies, a Bloodborne Pathogen and Body Fluid Spill Kit, and Personal Protective Equipment were observed to be left unattended and accessible. 2. Is the unlocked medication room refrigerator: a. 4 Lispro insulin pens, 2 Novalin R insulin Flex pens, and 1 Basaglar insulin Kwikpen belonging to Resident #2. b. 1 Humalog Kwik insulin pen, 2 Lantus Solostar insulin pens, and 2 Humalog insulin Kwikpens belonging to Resident #3. c. 7 Novolog Mix 70-30 insulin Flexpen belonging to Resident #4. d. several plastic bags containing Bisacodyl rectal suppositories belonging to Resident #1, Resident #3, Resident #5, and Resident #6. e. a plastic bag containing 650 mg Acetaminophen suppositories for Resident #1. f. a House Stock supply of Aplisol 10 test 1 box = 1ml (for Tuberculosis Testing) g. Lantaprost 0.03 % solution belonging to Resident #6. h. a House Stock box of 10 Arexvy RSV vaccines These findings were confirmed by the Executive Director at 2:33 PM on 1/8/24. In conclusion this finding is a potential risk for more than minimal harm to all facility residents due to unauthorized and unsafe access to medications.	R173		
R174 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management	R174		

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R174	Continued From page 7 5.10.h. (2) Medications requiring refrigeration shall be stored in a separate, locked container impervious to water and air if kept in the same refrigerator used for storage of food. This REQUIREMENT is not met as evidenced by: Per observation and staff interview there was a a failure to ensure medications kept in the same refrigerator as food items are stored in a locked compartment that is and impervious to water and air. Findings include: The facility's medication system policy states, "The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner." and states compartments containing medications including refrigerators and boxes shall be locked; however the facility's policy does not include a statement that medications stored in a refrigerator with food items must be stored in a locked impervious container. At 2:23 PM on 1/8/24 the medication refrigerator in the 3rd floor medication room was observed to contain a Lunchables snack box, unidentified leftovers in a takeout container, and a bottle of cold pressed juice. The medication room and the refrigerator were unlocked and the medications were not contained in a locked box impervious to water and air. Instead the medications were placed directly on the refrigerator shelves in the packaging they arrived in from the pharmacy. The refrigerator shelves were observed with stickers that read "applesauce and puddings", "suppositories", and "injectable meds" indicating the shelves were intended for storage of food and	R174		

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R174	Continued From page 8 medications. These findings were confirmed by the Executive Director at 2:33 PM on 1/8/24. In conclusion this deficient practice is a potential risk for more then minimal harm due to medication contamination.	R174		
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 limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents.	R179		

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R179	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure 6 out of 7 sampled staff completed all required yearly trainings. Findings include: The facility's procedure Orientation and In-Service - Employee states, "The community should develop and implement a new employee orientation, job specific orientation, and ongoing in -service education programs consistent with Federal and State regulatory requirements. All staff members will receive in -service training on required topics ..." Per review of staff trainings, 6 out of 7 sampled residents did not complete all required yearly trainings during the previous year. This finding was confirmed by the Executive Director at 5:46 PM on 1/8/24. This deficient practice is a risk for more than minimal harm for all resident due to inadequate staff education and training to safely and effectively provide resident care.	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: 5/7 sampled staff did not complete all required	R190		

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R190	Continued From page 10 background checks confirmed with Exec. Director at 5:50 PM 1/8/24 The facility Criminal Background Check policy includes a procedure which states, "The community shall follow, at minimum, state-mandated background check guidelines. " Per review of staff criminal background and abuse registry checks, all required checks were not documented as completed for 5 out of 7 sampled staff. The Executive Director confirmed these findings at 5:50 PM on 1/8/24. In conclusion this deficient practice is potential risk for more than minimal harm for all residents, as the requirement for criminal background and abuse checks is intended to help ensure resident care and safety.	R190		
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 staff and resident interview and record review there was a failure to ensure one applicable resident was treated with consideration and full recognition of dignity and individual abilities (Resident #1). Findings include: Per review of facility policies and procedures	R213		

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R213	Continued From page 11 provided on request by the Executive Director, policies and procedures related to resident assistance with preparation for meals have not been developed by the facility . Resident #1 is dependent on staff for assistance with Activities of Daily Living including dressing, escorting to meals, and assistance with use of his/her wheelchair when moving between locations in the facility. The facility's policies for Dining Services indicates Dining Staff "anticipate your needs and act accordingly"; however the application of an apron intended for use to protect Resident #1's clothing from food spills and stains while eating was applied to Resident #1 in his/her apartment before escort to the evening meal on 11/13/23, resulting in Resident #1 being escorted through the common areas of the home and into the dining room while wearing an apron. Per Staff's written statements, on 11/13/24 after staff placed the apron on Resident #1 in preparation for escort to the dining room for dinner, the apron strings repeatedly got caught in the wheelchair which was upsetting for Resident #1. Staff stated this was a recurring safety concern. In response, Staff tied the apron strings around the wheelchair handles then in a bow around the back of the chair which was not accessible to Resident #1. While this corrective action was reportedly intended to secure the strings, it also resulted Resident #1 being tied to the wheelchair. On 11/15/23 the Director of Health Services noted, "received a report from dietary staff that [Resident #1's] apron was tied to [wheelchair] causing resident to be restrained..." Per interview with Dietary Staff commencing at 12:40 PM on 1/8/24, a resident seated at the	R213		

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R213	Continued From page 12 dining room table across from Resident #1 during dinner service on 1/13/23 alerted Staff that Resident #1 needed assistance. When the Staff asked how s/he could help, Resident #1 asked for the apron strings to be loosened. Staff stated the apron strings were wrapped tightly around the handlebars several times, and Resident #1 was tied in a manner that left him/her unable to move his/her torso forward towards the table. While Staff stated this was an unintended effect of tying Resident #1's apron strings to the wheelchair, the intervention taken to secure the strings resulted in restriction of Resident #1's movement and prohibited access to his/her food. On the afternoon of 1/8/24 the Executive Director confirmed staff tied the strings of the apron worn by Resident #1 to his/her wheelchair, resulting in Resident #1's being tied to his/her wheelchair. In conclusion this deficient practice is a potential risk for more than minimal harm to all facility residents due to the need of all resdients rights to be monitored and recognized at all times.	R213		
R222 SS=F	VI. RESIDENTS' RIGHTS 6.10 The resident's right to privacy extends to all records and personal information. Personal information about a resident shall not be discussed with anyone not directly involved in the resident's care. Release of any record, excerpts from or information contained in such records shall be subject to the resident's written approval, except as requested by representatives of the licensing agency to carry out its responsibilities or as otherwise provided by law.	R222		

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R222	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to protect the personal information of residents residing on the third floor of the home. Findings include: The facility's Protection of Privacy policy states, "The community will make every effort to protect the Personally Identifiable Information (PII) provided by the Resident to the community." and includes a procedure which states, "The Community is responsible for training and educating its employees upon hire and periodically thereafter so they are knowledgeable about safeguarding PII and reporting suspected or confirmed breaches. Employees are responsible for safeguarding PII in their custody, control or possession in both electronic and paper formats by maintaining appropriate controls at all times." At 1:50 PM on 1/8/24 the third floor Medication Room was observed to be left unattended with the door unlocked and open. An open recycle bin visible from the open doorway was observed to be filled with medication cards without the labels removed and documents on which resident Personally Identifiable Information (PII) and Protected Health Information (PHI) were visible and accessible. Per interview with two agency contracted nurses on duty at approximately 2:20 PM on 1/8/24, the nurses stated their training had not included instructions for ensuring the medication room remains locked when unattended, and for ensuring resident's personal information remains protected.	R222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0660	A. BUILDING: _____ B. WING _____	C 01/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT WHITE RIVER JUNCTION	101 CURRIER STREET WHITE RIVER JUNCTION, VT 05001

(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
R222	Continued From page 14 At 2:33 PM on 1/8/24 the Executive Director confirmed resident Personally Identifiable Information and Protected Health Information was visible and accessible in the Medication Room on the 3rd floor of the facility. In conclusion this deficient practice is a potential risk of more than minimal harm due to the accessibility of resident's personal information which is protected by the Health Insurance Portability and Accountability Act.	R222		

Plan Of Correction

R144 Resident Care and Home Services 5.9.c.(1)

Completion Date 3/5/24

Resident #1's change in condition assessment was completed by an RN on 1/22/24.

DOHS or designee will complete an audit of all current facility residents' most recent Vermont Resident Assessment to verify that a Registered Nurse (RN) signature of completion is present.

All of the most recently completed Vermont Resident Assessments that were not signed by an RN will be reviewed for accuracy and signed by an RN. If the most recent Vermont Resident Assessment is not reflective of the resident's current abilities and meets the criteria for a significant change assessment, then a change in condition assessment will be completed to reflect the resident's current abilities by the DOHS or designee.

The facility's assessment policy will be updated to reflect that a Registered Nurse will sign and date the Vermont Resident Assessment to certify the information accurately reflects assessment information.

Education will be provided to current nurses (LPNs and RNs) regarding the policy changes that reflect the requirement for a Registered Nurse to sign and date the Vermont Resident Assessment to certify that the information accurately reflects assessment information and the criteria that would indicate that a significant change in condition would need to be completed. Education to all new hire nurses will be done as part of the new hire training process.

An audit of all new Vermont Resident Assessments will be conducted monthly by the DOHS or designee for RN signature and appropriate change in condition assessment completed timely for the next 6 months.

To be presented and discussed at QAPI quarterly for the next 12 months by the DOHS or designee and then re-assessed to determine need for ongoing monitoring beyond standard DOHS oversight.

R144 Plan of Correction accepted by Jo A Evans RN on 2/5/24

R145 Resident Care and Home Services 5.9.c.(2)

Completion Date 3/5/24

Resident #1's care plan has been reviewed and updated to ensure individualized care needs were included.

DOHS or designee will audit all current residents' care plans to ensure individualized care needs are present.

Education to all current nursing staff regarding the care planning process that is based on abilities and the needs of a resident as identified in the resident assessment and that the plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being. Education to all new hire nurses will be done as part of the new hire training process.

Care Plans will be audited on a monthly basis for the next 6 months by the DOHS or designee to ensure appropriate changes were made to accurately reflect the individualized needs of each resident.

To be presented and discussed at QAPI quarterly for the next 12 months by the DOHS or designee and then re-assessed to determine need for ongoing monitoring beyond standard DOHS oversight.

R145 Plan of Correction accepted by Jo A Evans RN 2/5/24

R167 Resident Care and Home Services 5.10.d.

Completion Date 3/5/24

DOHS or designee will audit all PRN psychoactive medication orders to ensure that each order has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use.

Education will be provided to current nurses to ensure that when taking orders from providers for PRN Psychoactive medications that the order must contain a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use before the order can be transcribed and put into use. All new nurses will be educated on this as part of the new hire training process. The facility's medication management policy will be updated to reflect this process.

DOHS or designee will audit all new PRN psychoactive medication orders on a monthly basis for the next 6 months to ensure a written plan for the use of the PRN medication is present which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use.

To be presented and discussed at QAPI quarterly for the next 12 months by the DOHS or designee and then re-assessed to determine need for ongoing monitoring beyond standard DOHS oversight.

R167 Plan of Correction accepted by Jo A Evans RN on 2/5/24

R173 Resident Care and Home Services 5.10.h.

Completion Date 3/5/24

On 1/8/24, all medication room doors were checked to be closed and locked with verbal education to onsite staff and visual reminders posted on all doors that they must remain closed and locked when not in medication room. On 1/9 and 1/10/24, auto closing mechanisms and auto locking doorhandles were installed on all medication room doors. On 2/2/24, locks were placed on all medication room refrigerators.

Education will be provided to all current nursing and caregiver staff that the medication room doors are to be closed and locked when the person holding keys is not in the room. All new nursing and caregiver staff will be educated to this as part of new hire orientation training.

DOHS or designee will conduct a monthly audit of all medication room doors to ensure that the doors are closed when staff holding keys are not present for the next 6 months.

To be presented and discussed at QAPI quarterly for the next 12 months by the DOHS or designee and then re-assessed to determine need for ongoing monitoring beyond standard DOHS oversight.

R173 Plan of Correction accepted by Jo A Evans on 2/5/24

R174 Resident Care and Home Services 5.10.h. (2)

Completion Date 3/5/24

DOHS or designee will conduct an audit of all medication refrigerators to ensure that food items are not stored in medication refrigerators. Visual reminders will be placed on the outside of medication refrigerator doors. On 2/2/24, locks were also placed on all medication room refrigerators.

Education will be provided to all current nurses and medication technicians regarding no food items to be stored in the medication refrigerator. All new nurses and medication technicians will be educated to this as part of the new hire process.

DOHS or designee will conduct a monthly audit of all medication refrigerators to ensure they do not contain food items for the next 6 months.

To be presented and discussed at QAPI quarterly for the next 12 months by the DOHS or designee and then re-assessed to determine need for ongoing monitoring beyond standard DOHS oversight.

R174 Plan of Correction accpeted by Jo A Evans RN on 2/5/24

R179 Resident Care and Home Services 5.11

Completion Date 3/5/24

Business Office Manager or designee will complete an audit of all current staff education.

All current staff who have not completed mandatory training will be given until 3/1/24 to complete the training. All newly hired staff will complete the required mandatory training before working with residents.

Staff education documentation will be audited monthly for 6 months by the BOM or designee for compliance.

To be presented and discussed at QAPI quarterly for the next 12 months by the BOM or designee and then re-assessed to determine need for ongoing monitoring beyond standard BOM oversight.

R179 Plan of Correction accepted by Jo A Evans RN 2/5/24

R190 Resident Care and Home Services 5.12.b.(4)

Completion Date 3/5/24

Business Office Manager or designee will complete an audit of all current staff background check documentation.

All current staff will have the required background check documentation placed in their employee files. All new hires will have the required background check documentation on file prior to start date.

Background check documentation will be audited monthly for 6 months by the BOM or designee for compliance.

To be presented and discussed at QAPI quarterly for the next 12 months by the BOM or designee and then re-assessed to determine need for ongoing monitoring beyond standard BOM oversight.

R190 Plan of Correction accepted by Jo A Evans on 2/5/24

R213 Residents' Rights 6.1

Completion Date 3/5/24

Resident #1's care plan for feeding assistance and clothing protector use was reviewed and updated accordingly.

All staff to complete Resident Rights, Dignity, and Restraint education.

Staff to provide appropriate alternatives to items such as this clothing protector for future use.

Department Directors and nurses will perform routine rounds during assigned mealtimes to ensure compliance with residents' rights in the dining rooms.

R213 Plan of Correction accpeted by Jo A Evans RN on 2/5/24

R222 Residents' Rights 6.10

Completion Date 3/5/24

On 1/8/24, all medication room doors were checked to be closed and locked with verbal education to onsite staff and visual reminders posted on all doors that they must remain closed and locked when not in medication room. On 1/9 and 1/10/24, auto closing mechanisms and auto locking doorhandles were installed on all medication room doors. On 2/2/24, locks were placed on all medication room refrigerators.

Education will be provided to all current nursing staff regarding Protected Health Information (PHI) and the need for it to be kept secured and not accessible to unauthorized individuals. All new staff will be educated to this as part of new hire orientation training.

DOHS or designee will conduct a monthly audit of all nursing units to ensure PHI is not visible to unauthorized individuals for the next 6 months.

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To be presented and discussed at QAPI quarterly for the next 12 months by the DOHS or designee and then re-assessed to determine need for ongoing monitoring beyond standard DOHS oversight.

R222 Plan of Correction accepted by Jo A Evans RN on 2/5/24