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

September 22, 2022

Mr. Luis Marin, Manager
Vista Residential Living
5709 Us Route 4
Mendon, VT 05701

Dear Mr. Marin:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 9, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0669	A. BUILDING: _____ B. WING _____	C 08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA RESIDENTIAL LIVING	5709 US ROUTE 4 MENDON, VT 05701

(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 re-licensure survey and complaint investigation on 8/9/2022. There were no regulatory violations related to the complaint investigation. The following regulatory deficiencies were identified as a result of the re-licensure survey:	R100		
R128 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Per record review and staff interview there was a failure to have ordered medications available, administer medications as ordered and/or have complete orders for 2 Residents (Residents #1 and #2). Findings include: 1. Resident #1 was prescribed Narcan Nasal Spray One Spray in nostril for opioid (narcotic pain medication) overdose on admission. Narcan is a medication used to treat known or suspected overdose of opioids. The medication was not entered on the Medication Administration Record (MAR) or available for use as ordered. At 5:09 PM on 8/9/22 the Wellness Director confirmed the medication order for Narcan was overlooked on admission and there was no signed order to discontinue the medication. 2. Resident #2 was prescribed Calcium and	R128	**R128. Nurse will request D/C orders and parameters for all medications stated in the POC; and will review all resident's MARs to ensure each resident's medications are consistent with the physicians orders.** **All new resident's Physicians orders will be reviewed upon admission and current resident's orders will be reviewed now and every 90 days to prevent discrepancies, and will request clarification orders and parameters as needed.** **Nurse will ensure all physician's orders match the MAR and will document any changes made; Administrator will monitor all medication changes to ensure all medications remain consistent with physicians orders; and these are reflected correctly on the MAR, to prevent any medication discrepancies** **All corrections will be completed by 9/23/2022**	

R128 – R311 POC's accepted 9/14/22 J. Evans RN/PM

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R128	Continued From page 1 Vitamin D 600-200 mg twice daily. The MAR indicated the medication was prescribed and administered once daily. At 5:06 PM on 8/9/22 the Wellness Director confirmed the error in the MAR entry and subsequent medication administration errors were likely due an oversight during the admission process. 3. Resident #2 was prescribed Acetaminophen 650 mg every 6 hours as needed for pain. The entry for this medication in the MAR was incomplete did not include administration parameters for the number of hours between doses or the maximum number of doses that could safely be given in a 24 hour period of time. The resident was also prescribed scheduled doses of Acetaminophen 650 mg at 9 AM and 9 PM daily, which increases the risk of overdose due to administration of PRN (as needed) Acetaminophen without defined parameters for timing between doses. At 5:09 PM on 8/9/22 the Wellness Director confirmed the Acetaminophen PRN orders in the MAR for Resident #2 did not include the administration parameters in the provider's orders.	R128		
R134 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7 Assessment 5.7.a An assessment shall be completed for each resident within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The resident's abilities regarding medication management shall be assessed within 24 hours and nursing delegation implemented, if necessary.	R134		

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R134	Continued From page 2 This REQUIREMENT is not met as evidenced by: Per record review and staff interview there was a failure to complete an assessment of a newly admitted resident within 14 days of admission for 1 applicable resident (Resident #3). Findings include: Resident #3 was admitted to the Residential Care Home (RCH) in July of 2022 with diagnoses related to Cardiovascular, Endocrine, and Neurological disease processes. Per record review an initial assessment consistent with physician's diagnoses and orders had not been completed for Resident #3 by a Registered Nurse. On the afternoon of 8/9/22 the Wellness Director confirmed an initial assessment for Resident #3 had not been completed.	R134	**R134. All missing assessments will be completed by RN.** **RN will ensure all assessments are completed within 14 days of admission. RN will ensure to assess any new resident's medication management ability and self administration within 24 hours of admission. Nurse will document findings accordingly and will use all gathered information to formulate care plan, and implement any nursing delegations if RN deems appropriate.** **Administration and Nursing department will monitor and ensure all Admission assessments are completed within 14 days of admission; and residents ability regarding Medication Management is assessed within 24 hours of admission. Administration and management will ensure all assessments are completed and documented; and will monitor in IDT meetings to ensure the safety of our residents and maintain compliance adherence to guidelines and regulations.** **This will be corrected by 9/23/22.**	
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	R167	**R167. Care plan will be updated for Resident #2.** **A care plan will be created for any resident who is prescribed one or more PRN psychoactive medications; These will include specific behaviors, circumstances, staff eduction, side effects and/or desired effects to look for.** **Nursing department will ensure documentation is provided at the time of administration and nurse on site or delegated staff will monitor, follow up and document on effect of any PRN medications administered.** **All corrections will be completed by 9/16/20**	

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R167	Continued From page 3 medication use. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure a written care plan was developed for the use of a PRN (as needed) psychoactive medication for 1 applicable resident (Resident #2). Findings include: Resident #2 is prescribed Alprazolam 0.25 mg twice daily as needed for anxiety. Per record review a Registered Nurse had not developed a written plan for the use of this PRN psychoactive medication describing the specific behaviors this medication is intended to address, specific circumstances indicating the use of the medication, and the desired affects the staff must monitor for after administration of Alprazolam to Resident #2. Additionally, per review of Resident #2's Medication Administration Record (MAR) for August 2022 there was a failure to document the specific results observed or reported after Resident #2 was administered PRN Alprazolam at 1:00 PM on 8/6/22. At 5:12 PM on 8/9/22 the Wellness Director confirmed a written care plan for the administration of Alprazolam had not been created for Resident #2.	R167		
R173 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h.	R173		

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R173	Continued From page 4 (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 staff interview and record review there was a failure to store medications for one applicable resident (Resident # 2) in a locked compartment only accessible to authorized personnel. Findings include: During the course of the facility tour on the morning of 8/9/22 medications including a Ventolin Inhaler (for difficulty breathing) and Systane Eye Drops (for dry eyes) were observed on a table in Resident #2's room. The Wellness Director and facility Manager confirmed medications stored on the table in Resident #2's room were unsecured and accessible to other residents.	R173	**R173. All medications will be stored under a locked compartment, under proper temperature control and where only authorized personal will have access to.** **RN will make weekly walk-throughs to ensure no medications are unsecured and/or accessible to other residents. RN will inservice all staff on identifying unsecured medications and where/how to securely store all medications managed by the home. Families and residents will be educated on the safety hazard of having medications unsecured and will be trained on proper storing techniques.** **RN will train all new hires on identifying unsecured medications and proper storage techniques to ensure the safety of our residents and our home. Inservice and trainings will become a part of our yearly continued education for staff; and retraining will be offered where needed** **All corrections will be completed by 9/16/2022**	
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, the facility management failed to conduct the required criminal screenings for 5 of 5 staff members.	R190		

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R190	Continued From page 5 Findings include: Per review of personnel records on 8/9/22 of 5 staff employed at the facility noted VCIC (Vermont Crime Information Center) criminal history checks were not conducted as required. This was confirmed by the facility Manager on the afternoon of 8/9/22.	R190	**R190. Administrator will conduct personnel Criminal Record checks through VCIC for all staff members employed by Vista.** **Administrator will ensure all new hires are screened and a Criminal Record check is conducted through VCIC in accordance to the Sate of Vermont's regulations.** **All criminal records will be stored securely with the rest of the hiring packet. Hiring eligibility will be based on findings as per PP and state guidelines.**	
R249 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.d The home shall assure that food handling and storage techniques are consistent with safe food handling practices. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure facility food handling and storage techniques are consistent with safe food handling practices. Findings include: During the course of the facility tour on the morning of 8/9/22 there were expired packages of cookies dated 7/28/22 and 8/3/22 observed in the food storage area of the kitchen. An open bag of potatoes was stored directly on the kitchen floor, and there were bags of potatoes and onions stored on a shelf approximately 4 inches above the floor. According to Servsafe food storage guidelines food items should be stored at least 6 inches above the floor (https://servsafe-prep.com/servsafe-food-storage-chart/). Storage of food items 6 inches from the floor allows for proper air circulation, and reduces risk for contamination from pests and chemicals	R249	**All corrections will be completed by 9/23/2022**	

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R249	Continued From page 6 used to clean the floor. Containers of prepared food stored in the walk in cooler were observed to be missing labels identifying what was inside the containers and when the items were prepared. There were packages of unwrapped and unlabeled items on the shelves of the cooler including an open bag of sliced cheese and half of a tomato exposed to the open air. Additional items observed without labels indicating expiration dates included containers of grated cheese, yogurt, sliced turkey, mayonnaise, broth, and a mixture of hamburger and pasta shells. The walk in freezer contained a tray of unlabeled pudding in glass goblets covered with plastic wrap placed on one of the shelves. There were 3 gallon containers of ice cream including 1 opened gallon with the lid partially covering the top of the container, several boxes of bread and green peas, and an open bag of hash browns all placed directly on the freezer floor. The freezer floor was uneven due to warping of the metal floor, and areas of the floor were slippery due to ice forming on the surface. There was a small chest freezer in need of defrosting due to a build up of ice crystals that contained unlabeled packages of meat. During the course of the tour of the facility kitchen on the morning of 8/9/22 the facility Manager acknowledged the facility food storage and handling techniques are not consistent with safe food handling practices.	R249	**R249. All kitchen staff and management will be trained and/or re-trained on Safe Food Handling Practices.** **All food products will be inspected daily by kitchen manager and/or kitchen staff for labels with the date and time items were opened and stored as well as expiration date. Kitchen Manager will ensure all dry goods and vegetables that don't require refrigeration will be stored according to safe food handling practices. These will be labeled accordingly and stored on a shelf (at least 6 inches above the floor) in an open container to allow air circulation, with the rest of the dry storage goods. Kitchen Manager will ensure Walk-in freezer to be maintained clean and all food products stored in the freezer to be placed on shelves and labels will be created for all meat and/or open food products that are stored in the freezer to maintain in accordance with Safe Food Handling Practices. Kitchen Manager will ensure all food products stored inside the chest freezer are packaged and labeled in accordance to Safe Food Handling Practices. Freezer will be defrosted bi-weekly and a log will be created to ensure defrosting task is being completed by kitchen staff. Community Manager and Maintenance Department will ensure walk-in Freezer's uneven floor will be repaired and maintained clean from any ice formation to maintain the safety of kitchen staff and the proper operation of equipment.** **Community will ensure Kitchen manager enrolls and completes a management food safety course and will need to obtain a manager certification to provide safe food handling practices for our community.** **All corrections will be completed by 9/23/2022**	
R252 SS=F	VII. NUTRITION AND FOOD SERVICES	R252		

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R252	Continued From page 7 7.2 Food Storage and Equipment 7.3.b Areas of the home used for storage of food, drink, equipment or utensils shall be constructed to be easily cleaned and shall be kept clean This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure areas of the home used for storage of food drink, equipment and utensils are constructed to be easily cleaned and kept clean. Findings include: During the tour of the facility kitchen on the morning of 8/9/22 the entrance into the kitchen was noted to have broken and soiled tiles, and the stairs down into the kitchen were noted to be in disrepair. The flooring, walls, and work surfaces appeared to be worn and have significant areas of grime indicating the entire kitchen area was in need of cleaning. The cooking appliances were in disrepair with missing knobs, and areas of grease and encrusted food. The stainless steel food prep tables were cluttered with small appliances, appeared to be dirty, and had noticeable corrosion on the shelves underneath the prep surfaces. The metal floors in the walk in freezer were warped at the seams, and there was ice accumulation on the floors. A small chest freezer was noted to have build up of ice crystals and was in need of defrosting. There were several appliances and kitchen equipment items stored in the kitchen which appeared to be in disrepair that were not in use, and there was an accumulation of pest control products stored in a corner of the kitchen. During the course of the kitchen tour on the	R252	**R252. Community manager will ensure the kitchen will be restructured and deep cleaned to support all of the Community's operations.** **Community manager and Maintenance department will ensure the floor into the entrance of the kitchen will be re-done with new flooring. The room will be cleared of clutter and repainted. The stairs down into the kitchen will be tiled and sealed for better appearance. Kitchen Manager and community manager will ensure all appliances are cleaned, repaired and will replace any/all missing pieces to keep all cooking equipment in working order and safe for all kitchen staff. Community Manager and maintenance department will ensure all Stainless steel food prep tables that show any signs of corrosion will be cleaned and/or replaced to maintain adherence to safe food handling practices. Community Manager and Maintenance Department will ensure walk-in Freezer's uneven floor will be repaired and clean from any ice formation to maintain the safety of kitchen staff and the proper operation of equipment. Kitchen Manager will ensure all food products stored inside the chest freezer are packaged and labeled in accordance to Safe Food Handling Practices. Freezer will be defrosted bi-weekly and a log will be created to ensure defrosting task is being completed by kitchen staff. Kitchen manager will ensure all pest control products are removed from the kitchen and stored accordingly.** **Community will ensure Kitchen manager enrolls and completes a management food safety course and will need to obtain a manager certification to provide safe food handling practices for our community.** **All corrections will be completed by 9/23/2022**	

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R252	Continued From page 8 morning of 8/9/22 the facility Manager acknowledged the kitchen was in disrepair and in need of maintenance and cleaning.	R252		
R258 SS=D	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.h All garbage shall be collected and stored to prevent the transmission of contagious diseases, creation of a nuisance, or the breeding of insects and rodents, and shall be disposed of at least weekly. Garbage or trash in the kitchen area must be placed in lined containers with covers. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure all garbage or trash in the kitchen area is collected and stored in containers with covers. During the facility tour on the morning of 8/9/22 2 out of 3 trash receptacles were observed to be uncovered in the food prep area of the kitchen. The facility Manager confirmed the presence of uncovered trash receptacles during the tour of the facility kitchen on the morning of 8/9/22 .	R258	**R258. Garbage containers located in the kitchen have been assigned covers. Kitchen staff has been trained on keeping a clean work area to prevent any transmission of contagious diseases, creation of a nuisance, or the breeding of insects and rodents.** **Kitchen and Community manager will purchase new lined garbage containers with lids and garbage will be disposed of daily to prevent any transmission of contagious diseases, creation of a nuisance, or the breeding of insects and rodents.** **Kitchen Manager will maintain adherence to above changes by offering retraining and corrective measures for all dietary personal.** **All corrections will be completed by 9/23/2022.**	
R266 SS=E	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment.	R266		

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R266	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure care in a safe and homelike environment related to the storage of chemicals, medications and other hazardous items in the home; and missing window screens. Findings include: During the facility tour on the morning of 8/9/22 the following environmental concerns were observed and confirmed by the facility Manager in the home: 1. The windows in Resident # 3 and Resident #4's rooms were observed to be missing screens. A can of WD40 lubricating spray was observed on the window sill in Resident #3's room, which s/he stated was being used to help open the window. Resident #3's window was observed to be difficult to open. Several of the windows in the common area containing a living room and dining area of the Residential Care Home were also noted to be missing window screens. During the facility tour the facility Manager confirmed the lack of screens in the common areas of the home and in Resident #3 and #4's rooms, as well as Resident #3's use of WD40 to help open a window in his/her room. (Please refer to tag 270) 2. An unlocked closet beside a kitchenette located in the facility common area contained cleaning chemicals including bottles of disinfectant spray. Drawers in the kitchenette contained a long reach butane lighter, and an open box of chemically scented petroleum based inedible wax squares which could easily be mistaken for an edible food item due to package labeling. Cleaning chemicals were observed	R266	**R266-R270. Window screens will be replaced in all rooms being occupied by residents. New window screens will be ordered and made to fit the rest of the community's windows. Maintenance department will ensure all windows occupied by residents open freely. All chemicals located in common area closet will be stored in a secured area behind a locked door to prevent easy access to residents focusing on providing a safe environment for all. The can of WD40 lubricating spray will be removed from resident #3's room (with residents permission) and will be properly stored.** **Housekeeping manager will ensure chemicals to include disinfectant spray, butane lighters, chemically scented petroleum based inedible wax squares, and other cleaning chemicals will be removed from any resident accessible area and placed in a secured room behind a locked door to prevent any resident from easily accessing these items; only authorized personal will have access to this area. Maintenance department will ensure all window screens are manufactured and properly secured in all common area and resident's rooms windows. All window railings and opening mechanism will be maintained monthly to ensure the proper function when opening or closing. Nurse will ensure all medications for the residents of the community are kept under a locked compartment, under proper temperature control and where only authorized personal will have access to.** **Community Director will make weekly walk-throughs with housekeeping and maintenance managers to ensure compliance adherence to all changes made. Management will train staff on safety measures a creating a safety environment for residents.** **This will be completed by 10/7/22**	

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R266	Continued From page 10 placed on a counter in the kitchenette. During the facility tour the Manager confirmed the presence of unsecured hazardous items and chemicals in the common living and dining area of the home. 3. Medications including a Ventolin Inhaler (for difficulty breathing) and Systane Eye Drops (for dry eyes) were observed on a table in Resident #2's room. The Wellness Director and facility Manager confirmed medications stored on the table in Resident #2's room were unsecured and accessible to other residents. (Please refer to tag 173)	R266		
R270 SS=E	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 in the rooms of 2 applicable residents (Residents #3 and Resident #4). Findings include: During a facility tour conducted by the facility Administrator and Wellness Director on the	R270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0669	A. BUILDING: _____ B. WING _____	C 08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA RESIDENTIAL LIVING	5709 US ROUTE 4 MENDON, VT 05701

(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
R270	Continued From page 11 morning of 8/9/22 windows in Resident # 3 and Resident #4's rooms were observed to be missing screens. A can of WD40 lubricating spray was observed on the window sill in Resident #3's room, which s/he stated was being used to help open the window. Resident #3's window was observed to be difficult to open. Several of the windows in the common area containing a living room and dining area of the Residential Care Home were also noted to be missing window screens. During a tour of the facility on the morning of 8/9/22 the facility Manager confirmed the lack of screens in the common areas of the home and in Resident #3 and #4's rooms, as well as Resident #3's use of WD40 to help open a window in his/her room.	R270		
R302 SS=E	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented.	R302		

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R302	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on review of fire drill records and staff interview the facility failed to conduct quarterly fire drills including sounding of alarms, evacuation of the home with documentation of drill time and names of participating staff members. Findings include: 1. A Fire Drill Report dated 9/13/21 indicated a drill was conducted at 11:50 PM and stated the "all clear" was sounded indicating the drill was completed at the same time the drill began. No documentation was provided for additional fire drills conducted during the third quarter of 2021. 2. A Fire Drill Report dated 10/17/21 included the statement, "Took too long to put Residents in room". No documentation was provided for additional fire drills conducted during the fourth quarter of 2021. 3. A Monthly Fire Drill Recap Log indicated a fire drill was conducted on 1/13/22, however the Recap Log did not include the drill time and names of participating staff members. A Fire Drill Report was not provided for the 1/13/22 fire drill, and no documentation was provided for fire drills conducted during the first quarter of 2022. 4. Fire Drill Reports for 5/6/22 and 6/6/22 indicated staff in all areas of the home did not hear the alarm sound. No documentation was provided for additional fire drills conducted during the second quarter of 2022. At 1:11 PM on 8/9/22 the facility Manager stated only one fire drill conducted during the previous year included sounding an alarm and evacuating of the home, and confirmed the evacuation	R302	**R302 Fire Drills in the community were conducted following a format that was adopted from sister Texas communities. Fire drills will be performed as per the state of Vermont's guidelines and regulations. Appropriate documentation will be enforced and Maintenance manager will be trained to perform mandatory fire drills to ensure the safety of our residents as well as our caregivers.** **The Director will ensure Maintenance manager conducts and documents quarterly Fire Drill and complete Recap log which shows details of scheduled shifts as per state regulatory requirements. This log will guide the Maintenance Director to ensure compliance.** **The Maintenance Director will perform monthly checks to ensure proper fire drill are conducted and on the correct shifts monthly.**	

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R302	Continued From page 13 procedure in use only includes moving residents to areas behind fire walls rather than evacuating the facility. The facility Manager stated the facility had been approved to Shelter in Place which allows for evacuation to areas behind firewalls instead of evacuation to an area outside of the facility, however s/he did not provide documentation of this approval.	R302		
R311 SS=D	X. PETS 10.2.e Pet health records shall be maintained by the home and made available to the public. This REQUIREMENT is not met as evidenced by: Based on staff interview there was a failure to maintain pet health records for the cat belonging to Resident #1 that lives in the home. Findings include: During the course of the survey the facility Manager was requested to provide pet health records for the cat belonging to Resident #1. During an interview commencing at 6:45 PM on 8/9/22 the Manager confirmed the pet health records for Resident #1's cat were not maintained by the home and available for review.	R311	**R311. Resident's RP has been contacted in an attempt to obtain pet health records.** **Administration department will ensure pet records for Resident are obtained and filed accordingly to be maintained by the home and made available to the public.** **RN and Administrator will ensure all pet health records are collected upon admission for any new move-in or for residents who own a pet companion.** **This will be completed by 9/23/22**	