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

October 14, 2022

Mr. Luis Marin, Manager
Vista Senior Living
103 Us Route 4
Killington, VT 05751

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
	0664	A. BUILDING: _____ B. WING _____	08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA SENIOR LIVING	103 US ROUTE 4 KILLINGTON, VT 05751

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An announced on-site re-licensure survey was conducted of the Assisted Living Memory Care Unit on 8/9/2022 by the Division of Licensing and Protection. The following regulatory violations were identified:	R100		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and confirmed by staff there was a failure to update a care plan for 1 applicable resident who was admitted to hospice. (Resident #1) Findings include: Resident #1 was admitted to the ALR/Memory Care Unit on 10/28/20 with a diagnosis of dementia and anxiety disorder. Due to a decline in health and advancement of his/her dementia the resident was admitted to Hospice on 4/19/22. Per review of Resident #1's Care Plan initially developed upon admission, it had not been updated to reflect end of life care and collaboration with Hospice. The Director of Wellness confirmed on the afternoon of 8/9/22,	R145	**R145. Care plan will be updated for Resident #1.** **RN will update and create care plans for any residents with new diagnosis, any change of condition, and/or medication changes.** **Nurse will review careplans quarterly and/or when a change is to be made on the care plan.** **All corrections will be completed by 9/16/20**	

R145 - R270 POCs accepted 10/12/22 FMcIntosh RN/ME

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0664	A. BUILDING: _____ B. WING _____	08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA SENIOR LIVING	103 US ROUTE 4 KILLINGTON, VT 05751

(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
R145	Continued From page 1 the failure to update Resident #1's care plan.	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 by: Based on staff interview and record review, the ALR/Memory Care Unit nurse failed to develop a written plan for the use of a PRN (as needed) psychoactive medication for 1 applicable resident. (Resident #1) Findings include: Resident #1 was prescribed Lorazepam 0.5 mg orally every 6 hours on 12/18/2020 for "agitation". However, there was a failure to develop a plan that identified specific behaviors intended to be corrected with the administration of this PRN psychoactive medication and intended results.	R167	**R167. Care plan will be updated for Resident #1.** **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**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0664	A. BUILDING: _____ B. WING _____	08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA SENIOR LIVING	103 US ROUTE 4 KILLINGTON, VT 05751

(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
R167	Continued From page 2 The ALR/Memory Care nurse confirmed on the afternoon of 8/9/22 that medication delegated staff do administer Lorazepam PRN and a written plan for the use had not been developed.	R167		
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 reviewed. 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.** **All corrections will be completed by 9/23/2022**	
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	R249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0664	A. BUILDING: _____ B. WING _____	08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA SENIOR LIVING	103 US ROUTE 4 KILLINGTON, VT 05751

(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
R249	Continued From page 3 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: At the time of observations, the lunch meal was being prepared. In the food storage area there were opened packages of cookies on the counter dated 7/28/22 and 8/3/22, an open bag of potatoes stored directly on the floor, and bags of potatoes and onions stored on a shelf approximately 4 inches above 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	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**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0664	A. BUILDING: _____ B. WING _____	08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA SENIOR LIVING	103 US ROUTE 4 KILLINGTON, VT 05751

(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
R249	Continued From page 4 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		
R252 SS=F	VII. NUTRITION AND FOOD SERVICES 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.	R252	**R252. Community manager will ensure the kitchen will be restructured and deep cleaned to support all of Vista'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**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0664	A. BUILDING: _____ B. WING _____	08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA SENIOR LIVING	103 US ROUTE 4 KILLINGTON, VT 05751

(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
R252	Continued From page 5 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 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.	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.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0664	A. BUILDING: _____ B. WING _____	08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA SENIOR LIVING	103 US ROUTE 4 KILLINGTON, VT 05751

(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
R258	Continued From page 6 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 receptables during the tour of the facility kitchen on the morning of 8/9/22 .	R258		
R266 SS=F	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview, there was a failure to ensure a safe environment was provided to all residents who resided in the ALR/Memory Care Unit. Findings include: 1. Resident #1 has a diagnosis of dementia and anxiety disorder and was recently placed on Hospice services. Observation of the resident's bed noted bed rails and a hospital bed were in use. A gap of approximately 6 inches between the edge of the mattress and the bed rails was noted to exist creating a potential entrapment hazard if the resident accidentally becomes caught, stuck or wedged between the mattress bed/siderail bars. The potential for injury/harm was acknowledged by the the Wellness Director and ALR manager. The use of the bed rails for Resident #1 was not assessed to determine to	R266	**R266. RN will complete a bed rail assessment for all residents using bed rails; and RN will train direct care staff on safe practices with residents using bed rails. A foam wedge will be cut to size and placed in the space between the bed and the mattress to prevent any bed rail related injury.** **Assessment will be completed and properly documented by nurse within 24hrs upon admission or when a resident has need for a bed with bed rails to ensure a safe environment is provided. Care plans will be updated accordingly. Closets leading to electrical panels and/or harmful chemicals will be maintained locked at all times to provide a safe environment for the residents as well as maintaining the laundry room door locked throughout the day.** **RN and community manager will ensure assessments are completed within 24hrs and staff are using appropriate measures to ensure a safe environment such as using pillows or foam wedges to fill any gaps between mattress and rails. RN and community manager will complete daily walk-throughs to ensure all doors leading to electrical panels, harmful chemicals, and laundry room are kept locked throughout the day.** **This will be completed by 10/7/22**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0664	A. BUILDING: _____ B. WING _____	08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA SENIOR LIVING	103 US ROUTE 4 KILLINGTON, VT 05751

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R266	Continued From page 7 be necessary or if there were known risks to Resident #1. In addition, bed rails were observed in use for Residents #2, 3, 4, 5, 6 who are all vulnerable to possible injury due to age and experiencing various stages of dementia. The bedrails extended approximately 1/3 of the length of the beds. It was confirmed by the Wellness Director, on 8/9/22 at 9:45 AM there was a failure to assess the safe use of the bed rails to determine if each of the residents identified were presently utilizing the side rails for mobility and were properly installed without risk for entrapment. 2. During a tour of the ALR/Memory Care Unit on 8/9/22 at 9:30 AM the following observations were made and confirmed by the ALR manager and Wellness Director: a. a closet containing electrical panels within the recreation area was unlocked and accessible to residents; b. a location (described as a nurse's station & nutrition station) situated between the living and dinning room had a unlocked lower cabinet containing cleaning spray, air freshener spray, disinfectants and a cigarette lighter was noted to be in a drawer above the lower cabinet. At 12:30 PM during meal time, Resident #4 was observed wheeling him/herself over to this location and taking a ball point pen, at the time staff were busy with delivering lunch and feeding residents. Eventually a staff member removed the resident from the nurse/nutrition station and returned Resident #4 to their dinning room table. c. the laundry room was observed to be open and accessible to wandering residents. Liquid detergent containers and two 1 gallon containers	R266		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0664	A. BUILDING: _____ B. WING _____	08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA SENIOR LIVING	103 US ROUTE 4 KILLINGTON, VT 05751

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R266	Continued From page 8 of bleach were accessible. ALR manager confirmed the room should be locked. However, at 5:10 PM the laundry room was again observed to be unlocked and door was ajar. d. cleaning products were observed in Resident #2's room; e. disinfectant spray was noted in the bathroom of resident #7; f. Resident #5 had a tube of Aspercream and Soothing Eye drops at bedside.	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 ensure window screens were utilized in residents' rooms who reside on the ALR/Memory Care Unit, a residence for individuals with Alzheimer's disease and other forms of dementia. Findings include: During a tour of the Memory Care Unit accompanied by the ALR Manager and Wellness	R270	**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.** **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.** **Community Director will make weekly walk-throughs with maintenance manager to ensure all windows open freely and all screens are installed after fabrication.** **This will be completed by 10/7/22.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0664	A. BUILDING: _____ B. WING _____	08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA SENIOR LIVING	103 US ROUTE 4 KILLINGTON, VT 05751

(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 9 Director on 8/9/22 at 9:45 AM window screens were missing in rooms 157, 161 and in the living room where residents reside during the day and evening. When opened, the unscreened windows failed to protect against insects entering and/or create a potential exit for a wandering resident. The ALR Manager acknowledged the lack of screens.	R270		