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

July 26, 2024

Ms. Tonia Trask
Wintergreen Residential Care - North
360 New Road
Brandon, VT 05733

Dear Ms. Trask:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 4, 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
	0619	A. BUILDING: _____ B. WING _____	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINTERGREEN RESIDENTIAL CARE - NORTH	360 NEW ROAD BRANDON, VT 05733

(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: On 6/4/24 the Division of Licensing and Protection conducted an unannounced on-site re-licensure survey. The following regulatory deficiencies were identified:	R100		
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 staff interview and record review the Registered Nurse failed to complete resident assessments for 2 out of 3 sampled residents (Residents #1, and #2) in accordance with section 5.7 of the Vermont Residential Care Home Licensing Regulations effective 10/3/2000 to include completion of an assessment consistent with the physician's diagnoses and orders within 14 days of admission to the home; and completion of a reassessment at any point in which there is a change in the resident's physical or mental condition. Findings include: The home's policies and procedures include Section G. Assessment Procedure which states, "The RN will assess the resident within 14 days using the assessment form provided by the licensing agency. This assessment will be consistent with MD diagnosis/orders, dietary issues, allergies, bladder/bowel function, psychosocial concerns and therapies. The RN is responsible for the ongoing assessments for any	R144	- The action we will take to correct the deficiency will be the RN will complete the resident assessments with-in the 14 days after admission date. - The R.N will make a updated assessment schedule to do all assessments on-time to ensure the deficient practice does not recur. - The manager will also keep track of the 14 day time period after admission to help the RN make sure the deficient practice does not re cur.	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Donna Brook — 7/21/24 — Manager

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R144	Continued From page 1 changes with medication [sic]". Per record review the following Resident Assessments on file for 2 out of 3 sampled residents (Residents #1, and #2) were not completed in accordance with Section 5.7 of the Vermont Residential Care Home Licensing Regulations effective 10/3/2000: 1. Per record review Resident #1 was admitted to the home on 7/15/22. His/her admission assessment was signed as completed on 8/15/22, which is not within the required 14 day completion period. Resident #1 was admitted into hospice care on 5/10/23. A significant change assessment was not completed in response to this significant change in Resident #1's condition. These findings were confirmed by the Manager of the home at 4:25 PM on 6/4/24. 2. Per record review, Resident #2 was admitted to the home on 2/22/24. Resident #2's admission assessment was signed by the RN as complete on 2/29/24, which is within the required 14 day time frame for completion of a resident's admission assessment; however the information reported in Resident #2's admission assessment is not consistent with Resident #2's diagnosis of Cognitive Dysfunction at the time of admission. Resident #2's admission assessment indicates his/her short term and long term memory are intact; s/he is independent in his/her ability to make consistent/reasonable decisions regarding tasks of daily life; s/he has no difficulty remembering and does not require directions or reminding from others. During an interview at 4:47 PM the Owner and Manager of the home confirmed the information	R144	The date the corrective action will be completed will be 7/26/24 Tag-144-Accepted-7-26-24 by C. Scott LTCM	

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R144	Continued From page 2 related to in Resident #2's cognitive function in his/her admission assessment is inaccurate and inconsistent with his/her diagnosis. In conclusion this deficient practice is a risk for more than minimal harm to all facility residents resulting from the failure to ensure the Registered Nurse's accuracy during the assessment process; and the failure to ensure the facility's assessment process is consistent with the licensing requirements.	R144		
R164 SS=F	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: (2) A registered nurse must delegate the responsibility for the administration of specific medications to designated staff for designated residents This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the Registered Nurse responsible for nursing supervision and oversight at the home failed to delegate the responsibility of administering specific medications by designated staff to designated residents of the home. Findings include: The home's Policies and Procedures Manual effective October 2009 includes a Nursing Overview section which states, "Our staff includes a RN [sic], who is responsible for training,	R164	The action we will take to correct the deficiency will be the RN will meet will the staff and delegate the responsibility to administer medications to residents. The manager will remind each new R.N. to re-delegate to staff for administration of medications.	

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R164	Continued From page 3 delegating and monitoring the staff who will be administering medications." On the morning of 6/4/24 the Manager of the home was requested to provide documentation of the delegation of facility staff who administer medications to residents of the home under the supervision and licensure of the current Registered Nurse on staff at the home. At 11:54 AM on 6/4/24 the Manager confirmed the requested documentation was not on file and available for review as the current Registered Nurse had not delegated the staff who administer medications at the home under his/her supervision and nursing license. The Manager of the home confirmed the current Registered Nurse was hired approximately one year prior to the survey conducted on 6/4/24. In closing this deficient practice is a potential risk for more than minimal harm for all facility residents resulting from the failure to ensure staff who administer medications have been properly trained to safely and accurately administer medications and informed regarding each individual resident's specific needs related to their specific medications.	R164	- The manager will work with the RN to be sure all staff has been trained to delegate medications - The date corrective action will be Completed will be 7/26/24 Tag-164-Accepted-7-26-24 by C. Scott LTCM	
R167 SS=F	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	R167		

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R167	Continued From page 4 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 there was a failure to ensure development of written plans for the administration of PRN (as needed) psychoactive medications by staff other than a nurse for all applicable residents of the home. Findings include: The home's effective October 2009 includes a section entitled PRN/PRN Psychoactive Medications which states staff who meet the criteria to administer PRN medications may do so only when a written plan for the use of the medication has been developed and addresses the following: "a. Description or statement of specific behaviors that the medication will address or correct b. Description of the circumstances that will indicate the use of medication and that, c. Staff is knowledgeable about the desired effects and side effects of the medication d. Documentation of the time the medication was administered, the reason for the medication and the effect of the medication each time the medication is administered." On the afternoon of 6/4/24 the Manager of the home was requested to provide copies of the	R167	The action we will take to correct the deficiency for Medication management will be the RN will write out plans for the administration of PRN psychoactive medications by staff for all applicable residents. to ensure that the deficient practice doesn't recur the RN and manager will work together and make a list of all residents with PRN psychoative medications to keep track of them. We will also have more	

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R167	Continued From page 5 facility's written plans for the administration of PRN psychoactive medications to applicable facility residents for review. At 1:54 PM on 6/4/24 the Manager of the home confirmed written plans for the administration of psychoactive PRN medications by staff other than a nurse were not on file and available for review as the plans had not been developed. 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 monitoring the medication's effect, and due to potential medication errors including misuse.	R167	Staff training on the PRN psychoactive medications. The RN will monitore the medications & Med book weekly to ensure PRN psychoactive meds are given according to the written plans. The Corrective action will be completed by 7/26/24 Tag-167- Accepted-7-26 -24 by C. Scott LTCM	
R174 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 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: Based on observation and staff interview there was a failure to ensure all medications stored in the same refrigerator with foods and beverages are stored in a separate locked container which is impervious to water and air. Findings include: The policies and procedures provided by the Manager for review on request did not include policies and procedures that govern storage of	R174		

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R174	Continued From page 6 medications in a refrigerator which is also used to store food and beverages; however the home's Medication Storage Policies and Procedures state, " All medications, either prescribed or over-the-counter are kept in a locked cabinet only accessible by staff who have been delegated to administer medications to residents according to doctors written order [sic]". During a tour of home commencing at 10:40 AM on 6/4/24, medications including bottles of Latanoprost Ophthalmic Solution (for ocular hypertension) and Glycerin Suppositories (for constipation) were observed to be stored in a produce drawer in Fridge #1 located in the kitchen of the home which is used for storage of food and beverages. While the refrigerator drawer contained a locked box for medication storage, the medications listed above were not stored within the locked medication box. This finding was confirmed by the Manager of the home at 1:05 PM on 6/4/24. In conclusion this deficient practice is a potential risk for more than minimal harm to all facility residents due to the improper storage of medications in a refrigerator also used for food storage, and the failure to ensure accessibility to resident's medications is limited to authorized staff.	R174 Tag-174-Accepted-7-26-24 by C. Scott LTCM	The action we will take to correct the deficiency of storing medications in the same refrigerator will be put all medications to be stored in a frige in a seperate lock box and in a seperate area unused by food. More training for staff on how to properly store medication to be refrierated will be done, the lock box will be stored awaey from food.	
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	R179		

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R179	Continued From page 7 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. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure 5 out of 5 sampled staff completed all required yearly trainings. Findings include: The home's Policies and Procedures Manual effective October 2009 includes Staff Member Expectations which state, "Each staff member must ... complete at a minimum, the standard annual requirements (12 hours annually) in order to received continuum." An additional Staff Education policy provided by the Manager of the home for review on 6/4/24 states, "The manager will be responsible for staff	R179	The manager will monitor to make sure medications to be stored in the refrigerator are in a Seperate box with a lock and not Stored near food. The date Corrective action will be completed will be 7/26/24 R179 The action we will take to correct the deficiency for staff trainings will be completed by all staff a minimum of	

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R179	Continued From page 8 training programs to assure at least 12 hours per year of education. Included will be reporting of abuse neglect and exploitation, fire &safety, resident rights, and infection control [sic]". This policy does not include a complete list of the yearly trainings required by the licensing agency. Per record review 5 out of 5 sampled staff did not complete all required yearly trainings. All 5 sampled staff had not completed Emergency Response and First Aid training; and 2 out of 5 sampled staff had not completed any of the required yearly trainings. This finding was confirmed by the Manager of the home at 2:31 PM on 6/4/24. This deficient practice is a potential risk for more than minimal harm for all facility residents due to inadequate staff education and training to safely and effectively provide resident care.	R179 Tag-179-Accepted 7-26-24 by C. Scott LTCM	(12) hours a year. Also upon hiring new staff we will have them read all Staff trainings before working alone, The manager will make sure to have all staff have completed all 12 hrs of trainings or they will not be able to work. The date Corrective action will be completed on 7/26/24	
R181 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement,	R181		

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R181	Continued From page 9 including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure the decision to hire one applicable staff with a substantiated Vermont Criminal Information Center (VCIC) criminal record check finding. Findings include: The home's Policies and Procedures Manual effective October 2009 does not include policies and procedures that govern the hiring of staff with substantiated criminal record findings. Per record review 1 out of 5 sampled staff's VCIC criminal record contained a substantiated finding of a criminal conviction. A letter stating the decision to hire this applicable employee did not pose a threat to the residents of the home had not been written by the administrative staff and was not on file in the applicable employee's personnel file as required. This finding was confirmed by the Manager of the home at 2:39 PM on 6/4/24. In conclusion this deficient practice is a potential risk for harm to all facility residents due to the failure to conduct a review of criminal background checks and document an administrative decision was made that the substantiated findings did not pose a threat to the safety and well-being of facility residents.	R181 Tag-181-Accepted 7-26-24 by C. Scott LTCM	the action we will take to correct the deficiency of hiring staff with a Criminal background will be not hiring anyone and terminated the employee with a criminal background immediately. upon interviewing we will do the background check and if a Criminal background is seen. the individual will not be hired. The manager will not let the individual work at the facility. R181 The manager will check =	

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R190	Continued From page 10	R190	the background paper along with the owner to ensure this practice doesnt recur.	
R190 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure all required criminal record and abuse registry checks were completed for 5 out of 5 sampled staff as required. Findings include: The home's Policies and Procedures Manual effective October 2009 includes Staff Member Expectations which state the following checks are needed for employment: "* Criminal Records check *Abuse, Neglect, and Exploitation Records check *Child Abuse Registry check * Driver's Record check" Per record review all required criminal record background and abuse registry checks were not completed as required for 5 out of 5 sampled staff. This finding was confirmed by the Manager of the home at 3:10 PM on 6/4/24. In conclusion this deficient practice is a potential risk for more than minimal harm for all residents, as the requirement for criminal background and abuse checks is intended to ensure all residents are free from the risk of harm.	R190 Tag-190 Accepted 7-26-24 by C.Scott LTCM	the date the corrective action will be completed on 7/26/24 R190 → The action we will take to correct the deficiency will be to do background checks on everyone upon interviewing The manager will check employee files to ensure all are up to date and continue to do	

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R200	Continued From page 11	R200	background check every 12 months.	
R200 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to develop policies and procedures that govern all areas of service provided by the home. Findings include: Per review, the home's Policies and Procedures Manual effective October 2009 does not include policies and procedures governing the following areas of service: * Hiring of staff with substantiated criminal record findings * Regulation of water temperatures in resident accessible areas of the home * Storage and labeling of perishable foods and beverages *Maintenance of a safe, functional, comfortable, and homelike living environment *Resident's Right to privacy On the afternoon of 6/4/24 the Manager confirmed policies and procedures governing all areas of service provided by the home had not been developed. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents due to failure to provide accessible	R200 Tag-200-Accepted-7-26-24 by C. Scott LTCM	the manager will monitor all employees charts to ensure the deficient practice does not recur. The Corrective action will be completed on 7/26/24 R200→ The action we will take to correct this deficiency is to write up Policies + Procedures that govern all Services provided in the home.	

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R200	Continued From page 12 information and clear instructions related to tasks staff are required to perform.	R200 →	to ensure this doesn't happen again the owner will write up all policies + procedures for services provided in the home along with the manager. The owners will be monitoring more closely to ensure all written policies + procedures are completed. The corrective action will be completed on 7/26/24 Tag-213-Accepted-7-26-24 by C. Scott LTCM	
R213 SS=F	VI. RESIDENTS' RIGHTS 6.1 Every resident shall be treated with consideration, respect and full recognition of the resident's dignity, individuality, and privacy. A home may not ask a resident to waive the resident's rights. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure residents are treated with consideration, respect and full recognition of the resident's dignity, individuality, and privacy. THIS REQUIREMENT WAS NOT MET AS EVIDENCED BY: During a tour of the home commencing at 10:40 AM on 6/4/24 the following resident right concerns were observed: 1. The doors of the home are locked with a security mechanism which requires a code or key to exit the building. On the morning of 6/2/24 an employee of the home was observed asking another employee to enter a code on the keypad of locking mechanism to let him/her out of the home; and on the afternoon of 6/4/24 a visitor who was observed asking a staff member to let him/her out of the home stated, " I know I can't have the code". During an interview commencing at 11:51 AM on	R213		

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R213	Continued From page 13 6/4/24, Staff on duty confirmed the doors are locked to prevent exit of the facility, and the code is only given to resident's family members who the administrative staff have determined can be trusted with this information. The Staff stated none of the residents are given the code, and recently the code was changed when one of the residents gained access to the code. During an interview at 12:55 PM on 6/4/24 the Owner and Manager confirmed the doors of the home are locked to prevent resident's from exiting the home. The Manager confirmed the home is licensed as a Level III Residential Care Home and does not have a license or variance to operate as a secured (locked) facility or a Special Care Unit. On the afternoon of 6/4/24 the Owner of the home stated the home has been locked to prevent residents from exiting since an incident occurred "years ago" (in 2021) when a resident eloped from the building and was not located for several hours. Per the Owner, locking the doors to prevent residents from exiting the building was initiated in response to this incident in an effort to keep this type of incident from happening again. This deficient practice is a risk for more than minimal harm to all facility residents and visitors due to impeding ability to freely exit the home as each individual has a right,	R213	The action we will take to correct the deficiency will be to take dee the locks preventing residents from leaving will be removed immediately. The facility will add regular locks for residents availability to exit. The facility will add a door bell to each door so we can monitor when a resident goes outside for their safety. The date corrective action will be completed will be 7/26/24	
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	R222		

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R222	Continued From page 14 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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure the right to privacy for all facility residents related to storage of resident records and personal information in areas of the home which are unsecured and accessible to all who enter the home. Findings include: Per review, the home's Policies and Procedures Manual effective October 2009 does not include policies and procedures to ensure all resident records and personal information are stored in secured areas to prevent access by unauthorized individuals. During a tour of the home commencing at 10:40 AM on 6/4/24, resident records and resident's personal information were observed to be stored in areas of the home that are visible, unsecured, and accessible including an unlocked cabinet in the dining room, on a countertop and in unlocked cabinets in an open office area located in the dining room, and on top of the medication cart adjacent to the living room. An empty medication card without the identifying labels removed was observed in an open trash can in the kitchen, and the home's fax machine utilized to send and receive private communications related to resident's records and private information was observed on a countertop in the dining room. Controlled substance administration records and	R222	The action we will take to correct the deficiency will be. all personal information involving residents will be locked up where theyre not visible or accessible to anyone other then employees. R222 we will offer more trainings for staff regaurding personal information and privacy The manager will make sure to remove all personal files into the office. manager will monitor the facility daily to ensure this practice doesnt recur. The date corrective action will be completed is 7/26/24	

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R222	Continued From page 15 resident service records were observed to be accessible and unprotected in binders left on the top of the medications cart in an area adjacent to the living room where visitors and resident gather. At 12:37 PM on 6/4/24 the Manager of the home confirmed resident records and personal information were unsecured and accessible throughout the home, and acknowledged the failure to ensure resident's right to privacy. In conclusion this deficient practice is a risk for more than minimal harm to all facility residents due to access to all resident's personal information by people who the resident's or their guardians have not granted access.	R222	Tag-222-Accepted-7-26-24 by C. Scott LTCM	
R247 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure all perishable foods and beverages are labeled and dated with the dates the perishable items were opened or prepared. Findings include: Per review, the home's Policies and Procedures Manual effective October 2009 does not include policies and procedures to ensure all perishable	R247	The action we will take to correct the deficiency will be to label, date and take the temp of all food. offer more trainings regaurding proper food safety will ensure that this practice does n happen again.	

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R247	Continued From page 16 foods and beverages are labeled and dated with the dates the items were opened or prepared. During a tour of the facility commencing at 10:40 AM on 6/4/24 the following perishable foods and beverages were observed without labels indicating the dates the items were opened or prepared: In the pantry: 5 boxes of cereal, oils, sugars, flour, boxes of crackers, bags of chips, and containers of nuts. In Fridge #1: Prunes, dried apricots, condiments, lemon juice, chocolate syrup, milk, 3 unlabeled pitchers prepared beverages, one bottle fruit juice, bags of cheese, unsealed deli turkey and chicken slices, 2 Liter sodas and an open unsealed can of soda. The freezer in this refrigerator contained opened undated containers of ice cream and waffles. In Fridge #2: unsealed single serving containers of pudding, bottles of dressings and sauces, jars of jams and jellies, whipped topping, sour cream, parmesan cheese, milk, 2 bottles of juice and a pitcher of a prepared beverage, a container of leftovers without an identifying label, chocolate sauce, pancake syrup, and a mason jar with an unidentified liquid inside. These findings were confirmed by the Manager of the home at 12:35 PM on 6/4/24. In conclusion, this deficient practice is a potential risk for more than minimal harm due to food borne illness for all facility residents.	R247	The manager will monitor daily and check for labels, dates and temps so the practice does not recur. The date the corrective action will be completed will be 7/26/24 Tag-247-Accepted-7-26-24 by C. Scott LTCM	

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R266	Continued From page 17	R266	The flooring will be replaced as its a safety risk the screen will be replaced in the window, bed rails will be removed off all residents beds. All cleaning supplies will be locked up and out of the Kitchen. Bathrooms will all be secured with locked Cabinets to ~~ensure~~ correct this deficiency. The manager will ensure this deficiency doesn't happen again by monitoring weekly.	
R266 SS=F	IX. PHYSICAL PLANT	R266		

9.1 Environment

9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview there is a failure to ensure care in a safe, functional, comfortable and homelike environment for all residents of the home. Findings include:

1. Per review of the policies and procedures provided on request by the Manager of the home for review, policies and procedures to ensure a safe, functional, comfortable and homelike environment in the home have not been developed.

2. The flooring in the dining area and living room was observed to be in poor repair with areas of the laminate flooring chipped, cracked, and with gaps between the planks which are a risk for trips, falls, and injuries particularly for residents who use walkers and canes to ambulate. On the afternoon of 6/4/24 the Owner of the home confirmed the flooring in the dining and living areas of the home were in poor repair and acknowledged the risk for falls and injuries due to the condition of the flooring.

This deficient practice is a risk for more than minimal harm to all facility residents due to the uneven and unsafe walking surface resulting from poorly maintained flooring in the common areas

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R266	Continued From page 18 of the home. 3. The main entryway of the home; which is open to the kitchen, dining and living areas of the home, was observed with one missing window screen and one ripped window screen which allows insects to enter the home when the windows are opened for circulation of fresh air. The Manager of the home confirmed the missing and torn window screens in the entryway of the home following the tour of the home commencing at 10:40 AM on 6/4/24. 4. There were unsecured bed assist side rails in Resident Rooms #2 and #3 of the home. The rails were observed without straps securing the metal bars to the bed, which allows the rails to pull away from the frame and mattress, and the mattress to be pulled off the box springs, with minimal force applied to the assistive devices. Additionally, in Resident Room #3 a metal handle was attached to and protruding from the wall along one of the beds located in this room. The metal handle extends approximately 2 inches from the wall and is attached to the wall in close proximity to the head of the bed 1-2 feet above the mattress. The metal object protruding from the wall along the side of the bed is a risk for injury resulting from contact with the metal object. This deficient practice is a risk for more than minimal harm to all facility residents due to the failure to recognize potential safety issues and risks for injury when installing assistive devices for residents. 5. The following hazardous cleaning products, household chemicals, and health and beauty products containing toxic substances were observed to be unsecured and accessible to	R266	The manager will monitor to ensure this deficient practice does not recur. The date for corrective action will be completed on 7/26/24 Tag-266-Accepted-7-26-24 by C. Scott LTCM	

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R266	Continued From page 19 residents of the home who have varying ability to safely manage access to these products: a. Under the unlocked kitchen sink: Easy Off Heavy Duty Oven Cleaner, Cascade Power Dry Dishwasher Rinse Aid, multiple bottles of dish detergent, and an unsealed container of Dishwashing Pods. Additionally, a bottle of WD40 was observed in the kitchen pantry. b. In an unlocked cabinet in the dining area: Bottles of rubbing alcohol, hydrogen peroxide, fingernail polish remover, petroleum jelly, sunscreen; and a bag of Epsom Salts. c. In an unlocked cabinet in the shared bathroom across from the Manager's office: Health and Beauty aids including multiple bottles of body wash, shampoo, conditioners, Axe Body Spray, perfumes, denture cleaning tablets, deodorants, hair gel, and hair spray. An additional unlocked cabinet in this bathroom contained several used electric and disposable razors stored uncovered in a drawer together which is a risk for injury and an infection risk. A second drawer in this cabinet contained denture adhesive, denture cleaning tabs, 4 opened tubes of toothpaste, and 6 toothbrushes including 2 which were uncovered and exposed to the unclean drawer and other items stored in the drawer which is a risk for infection. This deficient practice is a potential risk for more than minimal harm for all facility residents due to potential access and exposure to poisonous compounds. At 12:46 PM the Manager confirmed the environmental hazards listed above and	R266		

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R266	Continued From page 20 acknowledged the failure to ensure a safe, functional, homelike and comfortable living environment in the home. In conclusion these deficient practices are a potential risk for more than minimal harm to all facility residents due to exposure to unsafe and unsanitary conditions.	R266		
R291 SS=F	IX. PHYSICAL PLANT 9.6 Plumbing 9.6.d Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure water temperatures in resident accessible areas of the home remain at or below 120 degrees Fahrenheit. Findings include: Per review, the home's Policies and Procedures Manual effective October 2009 does not include policies and procedures to ensure water temperatures in areas of the home accessible to residents are maintained below 120 degrees Fahrenheit. During a facility tour commencing at 10:40 AM on 6/4/24 the water temperatures in both resident accessible bathrooms in the home were observed with water temperatures above 120 degrees. The water temperature in the shared resident bathroom located near resident rooms #2-#4 was observed to be 125.4 degrees Fahrenheit;	R291	The action we will take to correct this deficiency will be check the hot water more regularly on a weekly basis. A weekly schedule will be posted so the water temp will be tested and adjusted correctly.	

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R291	Continued From page 21 and the water temperature in the shared bathroom located near the Manager's office was observed to be 126.7 degrees Fahrenheit. These findings were confirmed by the Manager of the home at 2:21 PM on 6/4/24. Following adjustments made to the home's water boiler on the afternoon of 6/4/24, the water temperatures in all areas of the home accessible to residents were observed to be sustained between 105 - 106 degrees Fahrenheit. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents due to the risk for burns associated with water temperatures above 120 degrees Fahrenheit and increased risk for burns with injuries resulting for vulnerable adults.	R291 Tag-291-Accepted-7-26-24 by C. Scott LTCM	The manager will be monitoring water temps weekly as well to ensure this practice doesn't recur. the Corrective action will be completed on 7/26/24	
R999 SS=F	MISCELLANEOUS 4.12 License Certificate The home's current license certificate shall be protected and appropriately displayed in such a place and manner as to be readily viewable by persons entering the home. Any conditions which affect the license in any way shall be posted adjacent to the license certificate. This regulatory requirement is NOT MET as evidenced by: Based on observation, staff interview and record review there was a failure to notify the licensing agency regarding a change in the individual(s) appointed by the Licensee as the Manager(s) of the home; and a failure to request and post a new license which accurately reflects the current Manager appointed by the home's Licensees as	R999 R999	The action we will take to correct the deficiency will be moving the Licence Certificate so its appropriately displayed for persons entering the facility, also	

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R999	Continued From page 22 the individual responsible for the daily management of the home including supervision of employees and residents. Findings include: On 2/14/24 the Division of Licensing and Protection granted a license to the home's Licensees to operate a Residential Care Home effective 2/1/24- 1/31/25 following submission of an application which indicated a second Manager had been appointed as responsible for the daily management of the home including supervision of the employees and residents. The license granted lists the names of two Managers. During the tour of the home commencing at 10:40 AM on 6/4/24 the licensed posted in the home was observed to be the same license issued to the Licensee on 2/14/24, which listed the names of both Managers identified in the license application. At 11:53 AM on 6/4/24 Staff reported the home was managed by only one individual identified as a Manager on the license issued on 2/14/24. Staff stated the second Manager identified on the application, and on the license issued to the Residential Care Home on 2/14/24, had not been employed at the facility since February of 2024. At 12:13 PM on 6/4/24 the home's current Manager confirmed the second Manager's employment at the home had ended on 2/28/24. The current Manager confirmed the license posted at the home during the survey on 6/4/24 did not accurately identify current information regarding the appointed Manager of the home. The Manager stated s/he was not aware the license posted listed both Managers, and s/he was not aware of the requirement to notify the licensing agency when the second Manager	R999	if any changes occur with the licence it will be updated correctly. The manager will ensure that the deficient practice does nit recur by monitoring The date action will be completed is 7/26/24 Tag-999-Accepted-7-26-24 by C. Scott LTCM	

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R999	Continued From page 23 resigned.	R999		