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 10, 2024

Tara Hill, Manager
Wintergreen Residential Care - North
360 New Road
Brandon, VT 05733

Dear Ms. Hill:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 16, 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

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 _____	C 09/16/2024

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 9/16/24 the Division of Licensing and Protection conducted an unannounced on-site investigation of two complaints. The following regulatory deficiencies were identified:	R100	During the time that the Violations occurred, Wintergreen was under a previous Manager who is no longer the Manager. Current Management will assure that all regulatory requirements will be followed	9/16/24
R114 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.3 Discharge and Transfer Requirements 5.3.a Involuntary Discharge or Transfer of Residents (2) In the case of an involuntary discharge or transfer, the manager shall: i. Notify the resident, and if known, a family member and/or legal representative of the resident, of the discharge or transfer and the specific reasons for the move in writing and in a language and manner the resident understands at least 72 hours before a transfer within the home and thirty (30) days before discharge from the home. If the resident does not have a family member or legal representative and requests assistance, the notice shall be sent to the Long Term Care Ombudsman, Vermont Protection and Advocacy or Vermont Senior Citizens Law Project. ii. Use the form prescribed by the licensing agency for giving written notice of discharge or transfer and include a statement in large print that the resident has the right to appeal the home's decision to transfer or discharge with the appropriate information regarding how to do so. iii. Include a statement in the written notice that the resident may remain in the room or home	R114	Current Management understands all discharge and transfer regulations and has reviewed these regulations with the owners and will follow all discharge and transfer regulations in the future to include: notifying the resident, their family or legal representative of the transfer or discharge, the reasons for and within the regulation time frames. If needed, for the reasons outlined in the regulations, notice will be sent to the Long Term Care Ombudsman, the Vermont Protection and Advocacy, and the Vermont	9/16/24

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R114	Continued From page 1 during the appeal. iv. Place a copy of the notice in the resident's clinical record. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the former Manager and Owner of the home failed to comply with licensing requirements related to discharge notifications and the discharge process for one applicable resident (Resident #1). Findings include: The home's policies and procedures governing resident discharges are congruent with the licensing regulations. 1. Per record review the former Manager of the home failed to notify Resident #1, the family member that serves as the resident's DPOA, and the licensing agency prior to the resident's discharge from the home on 7/13/24. While the home had previously issued a 30 day discharge notice to Resident #1 on 6/20/24 with a discharge date of 7/20/24, followed by notice of an emergency discharge effective 6/26/24, these discharges were appealed and the home was notified on 7/12/24 these discharges were not permitted as the information provided for review did not meet the licensing requirements for discharge. One day following this notification by the licensing agency the former Manager discharged the resident without notice. This finding was confirmed by the former Manager at 2:28 PM on 9/16/24. 2. Per record review, the discharge notification letters provided to Resident #1 by the Owner of	R114	Senior Citizens Law Project. Residents will be notified by using the appropriate form and proper delivery requirements of their right to appeal the homes decision to Transfer and/or discharge. Appropriate information regarding how to appeal will be provided to the resident in a manner in which they understand and required in the regulations. Residents will be provided a written notice that they may remain in the home during the appeal. A copy of this notice will be placed in the residents clinical record. R 114 Plan of Correction accepted by Jo A Evans RN on 10/10/24.	9/16/24

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R114	Continued From page 2 the home dated 6/20/24 regarding the 30 day discharge and dated 6/27/24 regarding the emergency discharge were not provided using the form prescribed by the licensing agency to include ensuring the use of large print for the statement regarding the resident's right to appeal the discharge. This finding was confirmed by the former Manager at 2:25 PM on 9/16/24. 3. Per review of documents in Resident #1's record, the letter dated 6/27/24 for the emergency discharge of Resident #1 on 6/26/24 was not maintained on file and available for review. The former Manager of the home was requested to also review Resident #1's record to determine of the document was maintained on file. At 2:25 PM on 9/16/24 the former Manager confirmed the emergency discharge notification letter dated 6/27/24 was not on file and available for review in Resident #1's record .	R114		
R118 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.3 Discharge and Transfer Requirements 5.3.d A home must provide sufficient preparation and orientation to residents to ensure a safe and orderly transfer or discharge from the home. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to provide one applicable resident (Resident #1) sufficient preparation to ensure a safe and orderly discharge from the home. Findings include: The home's discharge policies and procedures	R118	Current management understands the regulation that the home needs to provide sufficient preparation and orientation to the resident to ensure a safe and orderly transfer or discharge from the home and will do so in the future so that an inappropriate transfer or discharge does not recur. 9/16/24	

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R118	Continued From page 3 are congruent with the licensing regulations. Per review of Progress Notes, on 7/13/24 Resident #1 was in cleared for discharge back the home following an evaluation in the Emergency Room. A Progress Note dated 7/13/24 indicated the Emergency Room staff did not evaluate Resident #1 "for mental" and stated the "ER is trying to figure out another place for [Resident #1] to go as [s/he] is too much for our facility". This note was signed by the former Manager of the home. An undated and unsigned note follows this note in Resident #1's record and states, "Resident left our facility as we could not take care of [his/her] needs". On 4/18/24 the home was granted a variance by the licensing agency to retain Resident #1 at the former Manager's request. The variance approval was based on the former Manager's attestation the home was able to meet Resident #1's needs which exceeded the home's level of licensure. During an interview commencing at 1:07 PM on 9/16/24, the former Manager stated Resident #1 was awaiting approval for Enhanced Residential Care and Assistive Community Care Services funding when s/he was discharged without notification to the resident, a family member who serves as his/her Durable Power Of Attorney (DPOA), and the licensing agency. When discussing Resident #1's discharge without notice, the former Manager stated Resident #1 "had no funds to go into another facility and no one would take [him/her], we were stuck ...". On the afternoon of 9/16/24 the former Manager conveyed Resident #1's needs exceeded the home's ability to care for him/her and interfered with the Staff's ability to care for other residents. Per review of Staff schedules for June and July of 2024, the home's established pattern of single	R118	All resident's needs will continually be assessed by the home and Management will assure Compliance with all Variances. If a resident's needs exceeds the level of Wintergreen's licensure, the transfer or discharge of the ~~fed~~ resident will comply with all the regulations and requirements as outlined by the state. R 118 Plan of Correction accepted by Jo A Evans RN on 10/10/24.	9/16/24 Ongoing

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R118	Continued From page 4 staffing was not increased to meet the needs of the facility's residents including Resident #1. The variance notification letter issued to the former Manager included notification of the home's responsibility to ensure adequate staffing levels to include a sufficient number of qualified personnel available at all times to provide necessary care. Per record review, the home issued a 30 day discharge notice to Resident #1 on 6/20/24 with a discharge date of 7/20/24 followed by notice of an emergency discharge effective 6/26/24. On 7/12/24 the State Long Term Care Manager issued a letter notifying Resident #1, a family member who serves as the resident's DPOA, and the Owners of the home regarding the results of an appeal of the 30 day and emergency discharges. This letter indicated regulatory requirements for a 30-day discharge and emergency discharge had not been met, and stated the home was not permitted to proceed with discharge. This letter provided instructions for an appeal of this decision, and included the statement, "Please note that per the Residential Care Home Regulations Section 5.3. d A home must provide sufficient orientation to residents to ensure a safe and orderly transfer or discharge from the home." One day after this letter was issued Resident #1 was discharged from the home without notice, preparation for discharge, and arrangements for alternate placement. Resident #1 was left in the Emergency Room, and the responsibility for his/her care and placement in another facility was left to the hospital and a local mental health agency. During the interview commencing at 1:07 PM on 9/16/24 the former Manger of the home stated the decision was made to discharge Resident #1 from the home regardless of the consequences; and at 1:56 PM on 9/16/24 the former Manger	R118	Adequate staffing levels of Wintergreen has been assessed and additional staff have been hired to meet the needs of all residents. Management is now more involved in the day to day operations of the home and oversight of the staffing needs to meet the needs of the residents and comply with all regulations and requirements. Staffing will continually be assessed, so that all residents needs are met and requirements are followed.	9/16/24 Ongoing

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R118	Continued From page 5 confirmed Resident #1 was discharged from the home on 7/13/24. This findings is cited at actual harm level due to Resident #1's discharge resulting in the loss of his/her home.	R118		
R129 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.d A home certified to provide assistive community care services (ACCS) shall designate a staff person responsible for case management, who shall provide at least the following case management services: maintenance and implementation of a current assessment and plan of care, and coordination of available community services. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to designate a staff person responsible for providing case management services to the 4 applicable residents (Residents #2, #3, #4, and #5) of the home receiving Assistive Community Care Services (ACCS). Findings include: Policies and procedures governing provision of care and services provided to residents receiving Assistive Community Care Services (ACCS) have not been developed by the home. Per record review Residents #2, #3, #4, and #5 were receiving ACCS as of 9/16/24. During an	R129	Current management have reviewed the case manager requirements of all ACCS residents as well as the current assessment and plan of care of each, and is currently updating each assessment and plan of care with the home's RN. this will be completed by 10/18/24. Manager will continually update each assessment and plan of care as required and as needed so the violation of this regulation does not recur.	10/18/24 ongoing

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R129	Continued From page 6 interview commencing at 11:56 AM on 9/16/24 the Manager and Finance Manager confirmed a Staff person had not been designated to provide case management for the 4 residents of the home receiving ACCS.	R129	Wintergreen will develop policies and procedures relevant to the care and services of residents receiving ACCS and will include this in Wintergreens Policies and procedures by 10/18/24. 10/18/24 R129 Plan of Corrections accepted by Jo A Evans RN on 10/10/24	
R178 SS=K	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review there was a failure to ensure adequate staffing to meet resident needs and ensure a safe environment. Findings include: Policies and procedures governing staffing patterns to include maintaining adequate staffing levels to meet resident care needs and maintain a safe environment have not been developed by the home. 1. Per interviews with the Owner, former and current Managers, and Staff on duty the use lever locks on the home's exterior doors to prevent residents from exiting the facility was in effect to prevent residents from exiting the home during periods of single staffing. On the morning of 9/16/24 the exterior doors of the home were observed with locking	R178	Staffing needs have been and will continue to be assessed to meet the needs of all residents. Additional staff have been recruited and hired and recruitment and hiring of staff will continue. 9/16/24 ongoing Current Management is More present in the home to increase staffing levels as well and policies, and procedures are being developed regarding staffing levels to meet all resident needs and will be included in the homes Policies and procedures Manual by 10/18/24	

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R178	Continued From page 7 mechanisms installed on the interior handles of the doors to prevent residents from exiting the facility. The licensing agency previously required the removal of digital locks placed on the home's exterior doors to prevent residents from exiting the home when this regulatory deficiency was identified during a survey of the home on 6/4/24. Per record review home is licensed as a Level III Residential Care Home and is not approved to operate as a special care unit. The home's license does not permit the facility to operate as a locked facility At 10:50 AM on 9/16/24 the Owner of the home confirmed locking mechanisms were installed on the exterior doors of the home to prevent residents from exiting when the single staff on duty is providing personal care to residents. Per review of the Treatment Administration Records on file for September 2024 all residents are provided a shower or sponge bath daily. During an interview commencing at 11:56 AM on 9/16/24 the current Manager of the home confirmed this finding and stated all residents of the facility require assistance with personal hygiene. At 1:11 PM on 9/16/24 the former Manager of the home stated the locking mechanisms were installed for when Staff are giving showers so the residents who were "taking off" wouldn't leave the home, and confirmed the locking mechanisms were put on for when a single staff was busy helping residents. Staff members on duty on 9/16/24 stated the locks were in use at all the times to prevent residents from leaving the facility grounds. One Staff stated s/he has to chase after residents if the lock is not used, and another Staff stated residents are constantly attempting to exit the facility.	R178	All interior locking Mechanisms on doors used for exiting the home have been removed and door alarms are being used instead to ensure residents ability to exit the building while still accounting for their safety. These changes and requirements have been reviewed with Staff and will become part of the Home's Policies and procedures by 10/18/24 Staffing levels have been assessed and additional Staff have been employed to meet the needs of all residents while ensuring their Safety	9/16/24

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R178	Continued From page 8 2. The residence is home to 9 residents who require care and services related to their individual physical condition, cognitive function, ability to independently perform activities of daily living. Per record review for a sample of 3 residents (Residents #5, #6, and #7) the following care needs were identified in the applicable resident's Resident Assessment and Care Plan which indicate need for Staff support: a. Resident #5 is living with Non-Alzheimer's Dementia. Per record review his/her ability to make decisions about tasks of daily life is severely impaired. S/he requires oversight and cueing for tasks, wanders daily and is not easily redirected. S/he requires cueing for safety related to risk for falls. At times s/he requires a one-person physical assist for mobility in bed and transfers. S/he is dependent on staff for dressing, toileting, and personal hygiene, requires a scheduled toileting plan, is incontinent of urine several times a day and experiences occasional fecal incontinence. b. Resident #6 is living with significant cognitive impairment resulting from Vascular Dementia. Per record review s/he wanders daily, is at risk for falls and requires cueing for safety. S/he requires supervision on stairs, cueing for bed mobility, oversight and cueing when eating, and is totally dependent on Staff for assistance with toileting personal hygiene bathing. S/he has multiple episodes of urinary incontinence daily, occasional bowel incontinence, and requires a toileting schedule. c. Resident #7 is living with advanced Dementia. Per record review s/he has a history of multiple falls prior to admission with injuries including a subdural hematoma, and an ankle injury. His/her	R178	The need for additional Staffing levels was assessed and additional Staff have been employed and trained to provide adequate Staffing levels for the Safety of all residents. 9/16/24 ongoing Current Manager as of 9/1/24 is on site on a regular basis to assist and continually assess Staffing levels. Wintergreen will continue to employ and train Staff to meet the needs of the residents and the required Staffing levels In addition, Volunteers and interns are being recruited to assist in Meeting the needs of residents and requirements	

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R178	Continued From page 9 ability to make decisions regarding tasks of daily living is severely impaired and s/he has difficulty understanding. S/he is dependent on Staff for dressing, personal hygiene, bathing, and toileting. S/he requires supervision when eating, is dependent on Staff for bed mobility and locomotion in the home, requires extensive assistance with transfers, and has an unsteady gait. S/he has multiple daily episodes of urinary incontinence and daily incident of fecal incontinence, and requires a scheduled toileting plan. Per review of Staff schedules for June-September 2024 all shifts were documented as single staffed. During an interview on 9/16/24, Staff confirmed all shifts are single staffed with brief periods of overlap during shift changes. On the afternoon of 9/16/24 the Manager confirmed this finding; and stated since s/he became the Manager of the home on 9/1/24 Administrative Staff had been on site daily; however they do not have set schedules or document their hours on the Staff schedule. Additionally, residents of the home have varying ability to exit the home during an emergency requiring evacuation. The facility's emergency response plan includes evacuation of residents to the parking lot of a health care office located on a property near the facility, which would required a minimum of 2 staff on duty to ensure supervision of residents within the home and en route to the evacuation site. The facility's practice of single staffing poses immediate threat to the health and safety of all facility residents. Due to the scope and severity of this finding the current Manager of the home was required by the licensing agency to submit and	R178	Staff schedules have been updated to more accurately account for staffing levels. Additional staff have been added to the shifts to provide for the safety of the residents. Part-time staff have been hired in addition to full time staff to meet the safety needs of the residents and to comply with requirements	9/16/24 ongoing

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R178	Continued From page 10 implement a plan of immediate corrective actions effective 9/16/24. The corrective action plan signed and submitted by the current Manager on the afternoon of 9/16/24 included the immediate removal of the door locking mechanisms, use of door alarms at all times, and implementation of staffing levels to maintain two staff on duty at all times in order to ensure the safety of all residents.	R178	R 178 Plan of Correction accepted by Jo A Evans RN on 10/10/24.	
R199 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.14 Restraints 5.14.f A home may not install a door security system which prevents residents from readily exiting the building without prior approval of the licensing agency. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review there was a failure to obtain prior approval from the licensing agency before installing locking mechanisms on the home's exterior doors which prevent residents of the home from readily exiting the building. Findings include: Policies and procedures to ensure the home's doorways are accessible and remain unimpeded had not been developed by the home as of 9/16/24. This finding was confirmed by the home's Manager on the afternoon of 9/16/24. On the morning of 9/16/24 the exterior doors of the home were observed with door lever locking mechanisms installed on the interior side of the doors, which are outfitted with lever handles. The	R199	All locks preventing residents from leaving the building have been removed. Door alarms are installed instead to ensure the safety of residents. This regulation has been reviewed with staff and will be added to the home's policies and procedures by 10/18/24 so this violation does not recur. 9/16/24 R 199 Plan of Correction accepted by Jo A Evans RN on 10/10/24.	

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R199	Continued From page 11 lever locking mechanisms installed on both of the home's exterior doors block the handles from moving up or down to prevent the doors from opening. Per record review the home has not obtained approval from the licensing agency to install the locking mechanism on the exterior doors, which prevent residents from readily exiting the facility. At 10:50 AM on 9/16/24 the Owner of the home confirmed the door handle lever locking mechanisms were installed to prevent residents from exiting the home following the removal of digital locking mechanisms which were required by the licensing agency to be removed as a corrective action when the doors were found to be locked to prevent residents from exiting the home during a relicensure survey conducted on 6/4/24. The corrective actions submitted by the previous Manager of the home in response to the identification of this deficient practice during the relicensure survey on 6/4/24 included the statement that all locks preventing residents from leaving the facility would be removed immediately.	R199		
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: care and services provided to residents receiving	R200		

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	0619	A. BUILDING: _____ B. WING _____	C 09/16/2024

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R200	Continued From page 12 Assistive Community Care Services (ACCS) have not been developed by the home. Based on staff interview and record review there was a failure to ensure development of policies and procedures governing all services provided by the home. Findings include: On 9/16/24 the Manager of the home was requested to provide policies and procedures related to deficient practices identified during the investigation survey. On the afternoon of 9/16/24 the Manager confirmed policies and procedures governing the following areas of service had not been developed by the home: a. Resident Assessments and Care Planning b. Staffing patterns to include maintaining adequate staffing to meet resident care needs and maintain a safe environment c. Maintaining accessible exits and entryways d. Treatment of residents with respect for individuality, dignity, and respect e. Posting of required documents f. Care and services provided to residents receiving Assistive Community Care Services (ACCS), including designation of a staff person responsible for providing Case Management for residents receiving ACCS.	R200	Wintergreen's policies and procedures manual is being updated to address the deficiencies listed in this report. This will include: ACCS Casemanagement requirements Resident Assessments and Care Planning Staffing patterns and Maintenance of appropriate staffing levels to meet resident care needs and a safe environment Maintaining accessible exits and entrances The treatment of residents with respect for individuality, dignity, and respect. The posting of all required documents. These policies and procedures will be reviewed by staff on a regular basis to ensure compliance.	10/18/24
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.	R213		

R 200 Plan of Correction accepted by Jo A Evans RN on 10/10/24.

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R213	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure treatment with consideration, respect and full recognition of the resident's dignity and individuality related to the right to access outside areas without locked doors prohibiting exit for all residents. Findings include: Policies and procedures related to ensuring the home's residents right to access outside areas without locked doors prohibiting exit have not been developed by the home. On the morning of 9/16/24 the exterior doors of the home were observed with door lever locking mechanisms installed on the interior side of the doors, which are outfitted with lever handles. The lever locking mechanisms block the handles from moving up or down to prevent the doors from opening. Per record review the home is a Level III Residential Care Home which is not licensed as a Special Care Unit. The licensing regulations for the home's type and level of licensure do not permit the home to operate as a locked facility. The application of locks and barriers to prevent residents from exiting the home during an emergency and at will is a safety hazard and a violation of the residents' right to go outside. At 10:50 AM on 9/16/24 the Owner of the home confirmed the door handle lever locking mechanisms were installed to prevent residents from exiting the home. At 2:29 PM on 9/16/25 the previous Manager confirmed the new locking mechanisms were installed residents would not get out when the facility is single staffed.	R213	Management will continue to ensure that residents can access outside areas by not installing any locking devices preventing them from doing so. 9/16/24 R 213 Plan of Correction accepted by Jo A Evans RN on 10/10/24.	

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R999	Continued From page 14	R999		
R999 SS=F	MISCELLANEOUS R 999 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 post the license which accurately reflects the current Manager appointed by the home's Licensees as the individual responsible for the daily management of the home including supervision of employees and residents. Findings include: On 9/9/24 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 indicating a new Manager had been appointed as responsible for the daily management of the home including supervision of the employees and residents. During the tour of the home on the morning of 9/16/24/24 the licensed posted in the home was observed to be the previous license issued to the Licensee, which did not identify the current Manager of the home. At 12:52 PM on 9/16/24 the Manager of the home confirmed the current license provided to the home by the licensing agency was not displayed in the home.	R999	On 9/9/24 the updated License Certificate was Mailed to the owners home address. On 9/16/24, the owner was contacted about the updated license and he confirmed he had recently received it in the Mail. The current license was retrieved from the owner on 9/16/24 and immediately posted. The current Manager will ensure the most updated license, and any other required postings will be posted immediately upon receiving the documents to ensure this violation does not recur .R 999 Plan of Correction accepted by Jo A Evans RN on 10/10/24.	9/16/24 ongoing

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R999	Continued From page 15 This is a repeat citation.	R999		