VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

October 27, 2015

Ms. Celine Blondel, Manager
Next Door
847 Pine Street
Burlington, VT 05401-4924

Dear Ms. Blondel:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 17, 2015.** 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
Licensing Chief

PRINTED: 06/29/2015
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	0530		06/17/2015

NAME OF PROVIDER OR SUPPLIER: NEXT DOOR

STREET ADDRESS, CITY, STATE, ZIP CODE: 847 PINE STREET, BURLINGTON, VT 05401

(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
T 001	Initial Comments An unannounced onsite re-licensure survey was completed on 6/17/15 by the Vermont Division of Licensing and Protection. The following regulatory violations were found.	T 001		
T 015 SS=D	V.5.3.b.1.2.3.4.5 Resident Care and Services 5.3 Intake 5.3 b The intake process shall be completed no later than seven (7) days from the date of admission and shall include a comprehensive assessment focusing on the following: (1) Early history in brief summary; (2) Review and written summary of current adjustment in major areas of life function - personal, social, familial, educational and vocational with an identification of major dysfunctions leading to the need for residential treatment. (3) As recent a medical report as possible to include orders for medications, cautions on adverse reactions and symptoms to watch for. (4) Review of specific substance abuse if applicable. (5) Appropriate abstracts from agencies, institutions, and programs previously used by the individual.	T 015	all POCs accepted per addendum(s) 10/26/15 Meg Buttram C. Blondel	7/12/15

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

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T 015	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the intake for 1 of 3 residents in the total sample was not completed within 7 days of admission to the home as required. (Resident #2). Findings include: Per review on 6/17/15, the medical record for Resident #2, who was admitted on 5/27/15, did not include a brief early history, a written summary of adjustment in major areas of life function and appropriate abstracts from agencies, institutions and programs previously used by the individual. The lack of a completed intake was confirmed during interview with the Administrator at 5 PM on 6/17/15.	T 015		
T 032 SS=D	V.5.7.b Resident Care and Services 5.7 Treatment Plan 5.7.b The residence shall ensure that the treatment plan reflects steps to be taken to solve identified problems, either by direct service at the residence or indirectly by referral to a community resource. The treatment plan shall be completed within fourteen (14) days of admission. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to assure that the treatment plan for 1 of 3 residents in the total sample was completed within 14 days of admission to the home. (Resident #2). Findings include:	T 032		

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T 032	Continued From page 2 Per record review on 6/17/15, Resident #2 was admitted to the home on 5/27/15, and as of the date of survey, there was no treatment plan developed to include the steps to address resident identified needs, specific goals and interventions/steps to attain those goals. This finding was confirmed with the Administrator at 5 PM on 6/17/15.	T 032		
T 035 SS=D	V.5.8.a.1.2.3.4.5.6.7.8 Resident Care and Services 5.8 Medication Management 5.8.a Each therapeutic community residence must have written policies and procedures describing the residence ' s medication practices. The policies must cover at least the following: (1) If a therapeutic community residence provides medication management, it shall be done under the supervision of a registered nurse. (2) Who will provide the professional nursing delegation if the residence administers medications to residents unable to self-administer and how the process of delegation is to be carried out in the residence. (3) Qualifications of the staff who will be managing medications or administering medications and the residence's process for nursing supervision of the staff.	T 035		

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T 035	Continued From page 3 (4) How medications shall be obtained for residents including choices of pharmacies. (5) Procedures for documentation of medication administration. (6) Procedures for disposing of outdated or unused medication, including designation of a person or persons with responsibility for disposal. (7) Procedures for monitoring side effects of psychoactive medications. (8) Procedures for assessing a resident ' s ability to self-administer and documentation of the assessment in the medical record This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility to assure that there was a written procedure to monitor for potential adverse side effects of psychoactive medication use for 2 of 2 applicable residents in the sample. (Residents #2 and #3). Findings include: Per review of the medical records for Residents #2 and #3, there was no evidence of routine monitoring for signs of adverse side effects for the use of psychoactive medications, including benzodiazepine and anti-psychotic medications. The lack of documented monitoring and development of a policy/procedure to address this process was confirmed with the Administrator and the Registered Nurse (RN) on 6/17/15 at 5 PM. Refer also to 0044.	T 035		

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T 036	Continued From page 4	T 036		
T 036 SS=D	V.5.8.b Resident Care and Services	T 036		
	5.8 Medication Management			
	5.8.b The manager of the residence is responsible for ensuring that all medications are handled according to the residence's policies and that designated staff are fully trained in the policies and procedures. The manager shall assure that all medications and drugs are used only as prescribed by the resident's physician, properly labeled and kept in a locked cabinet at all times or, when a program of self-medication is in effect, otherwise safely secured.			
	This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to assure that there were medication policies/procedures to address all issues related to medication administration for residents of the home. All residents of the home are potentially affected. Findings include:			
	Per observations in the office area of the home on 6/17/15 at 11:35 AM, a resident of the home had requested medication from the resident assistant on duty and while pouring the packet of medications due at that time, one pill fell onto the floor. The staff member picked up the pill from the floor and was preparing to give it to the resident. When asked by the surveyor what was the home's procedure for addressing a medication dropped to the floor, the staff member did not recall receiving any training on this issue. Per interview with the RN on the afternoon of the same day, the RN was not aware of any policy/procedure to address this potential concern. The lack of a policy was also confirmed			

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T 036	Continued From page 5 with the Manager of the home at 5:50 PM the same day.	T 036		
T 040 SS=D	V.5.8.5 Resident Care and Services 5.8 Medication Management 5.8.5 Staff other than a nurse may administer PRN psychoactive medications only when the residence 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 home failed to assure that staff other than a nurse who administer PRN (as needed) psychoactive medications have a specific written plan which describes the behaviors the medication is intended to treat, specifies when the medication is to be used, educates staff about desired effects and potential adverse side effects to monitor for and documents the time of, reason for use and effect of the medication. This deficiency affected 1 of 3 residents in the total sample. (Resident #3). Findings include: Per review of the physician orders for Resident #3, the resident had current orders for PRN (as needed) psychoactive medications, (Lorazepam and Seroquel) which were administered by	T 040		

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T 040	Continued From page 6 non-licensed staff and there was no required PRN Psychoactive Care Plan to direct staff on the reasons for the use of each of these medications. The Care Plan must include the behaviors being treated, when to administer the medication, the desired effects and possible adverse side effects to monitor for. Although some staff did document the effectiveness of the medication on the MAR (Medication Administration Record), it was inconsistently documented per review of the May and June, 2015 MARs. These findings were confirmed during interview with the RN overseeing medication administration for the home at 5:30 PM on 6/17/15.	T 040		
T 044 SS=D	V.5.8.g.1.2.3.4.5.6. Resident Care and Services 5.8 Medication Management 5.8.g Residences must establish procedures for documentation sufficient to indicate to the health care provider, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include: (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, including the reason why and the actions taken by the residence; (3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect;	T 044		

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T 044	Continued From page 7 (4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; (5) For residents receiving psychoactive medications, a record of monitoring for side effects; and (6) All incidents of medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to assure that there was documentation of monitoring for side effects of psychoactive medications for 2 of 2 residents in the applicable sample. (Residents # 2 and #3). Findings include: Per review of the medical records for Residents #2 and #3 on 6/17/15, there was no written evidence of monitoring for potential adverse side effects for these residents. The residents received psychoactive medications daily, including medication classifications, benzodiazepines and anti-psychotics. During interview with the Registered Nurse (RN) providing oversight and medication training to staff in the home, the RN verified that he/she was not aware of this requirement and had not provided psychoactive medication monitoring. Refer also to 0035.	T 044		
T 046 SS=D	V. 5.8.h.1 Resident Care and Services 5.8 Medication Management	T 046		

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T 046	Continued From page 8 5.8.h.1 Resident medications that the residence manages must be stored in double-locked compartments under proper temperature controls. Only authorized personnel shall have access to the keys. This REQUIREMENT is not met as evidenced by: Based on observation, the home failed to assure that medication requiring refrigeration was kept in a double locked compartment under proper temperature controls. Findings include: Per observations in the lower level of the home, in a room off the recreation room, a refrigerator held extra insulin for one the the home's residents. There was no thermometer in the refrigerator and staff present during the tour indicated that they were not aware of any process to assure that the temperature range was safe for storage of insulin. During interview on the afternoon of the same day, the RN and Manager confirmed that there was no process to assure that the medication was stored at a safe temperature, per manufacturer's recommendations.	T 046		
T 052 SS=E	V.5.9.b.1.2.3.4.5.6.7 Resident Care and Services 5.9 Staff Services 5.9.b. The residence must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not	T 052		

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T 052	Continued From page 9 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, hand washing, 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, the facility failed to assure that all staff completed the 7 Vermont mandated annual staff training programs, as stated in the Licensing and Operating Regulations for Therapeutic Community Residences (TCRs) for, 5 of 5 staff in the applicable sample. Findings include: Per review on 6/17/15, the Vermont annually mandated staff trainings for 5 of the 5 staff in the total sample were incomplete. None of the 5 staff had completed all of the trainings required. During interview at 3:30 PM, the Manager stated that some of the training occurred during staff	T 052		

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T 052	Continued From page 10 meetings. However there was no documentation of the trainings and no sign-off sheets to show which staff may have attended. The lack of required staff training was confirmed with the Manager after completion of the document reviews.	T 052		
T 071 SS=C	V.5.13 Resident Care and Services 5.13 Policies and Procedures Each residence must have written policies and procedures that govern all services provided by the residence. A copy shall be available for review at the residence upon request. This REQUIREMENT is not met as evidenced by: Based on staff interview, there was no written policy/procedure to address staff's implementation of the emergency process of calling 911 Emergency Services. All residents of the home are potentially affected. Findings include: Per interview with a staff member on duty on 6/17/15 regarding resident emergency processes, staff indicated that in an emergent medical situation posing a risk of significant imminent harm to a resident, they had been trained to call 911 Emergency Services. During interview with the Manager of the home later the same day, he/she stated that this was the process for staff to follow and confirmed that there was no written policy/procedure regarding implementation of this emergency response.	T 071		

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T 115	Continued From page 11	T 115		
T 115 SS=A	VII.7.1.a.3 Nutrition and Food Service 7.1 Food Services 7.1.a Menus and Nutritional Standards 7.1.a.3 The current week's regular and therapeutic menu shall be posted in a prominent public place for residents and other interested parties. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure that weekly menus for 3 meals daily for the current week were posted for residents and interested parties. Findings include: Per observation during the initial tour of the home on 6/17/15 at 9:40 AM, the menu posted included lunch and supper meals only, with no listed foods/plans for the daily breakfast meal. This observation was confirmed with the staff member present who was in charge at the time of survey. The staff member stated that there was a variety of foods available every day for breakfast and that residents had a daily choice of what they would like to eat for breakfast.	T 115		
T 127 SS=D	VII.7.2.b 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 temperature. Hot foods shall be kept hot at 135 degrees F and cold foods shall be kept at 41 degrees F or cooler.	T 127		

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T 127	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure that all perishable foods were held at the proper temperature in all areas of the home. Findings include: Per observation of the recreation room on the lower level of the home on 6/17/15 at 10:30 AM, the refrigerator temperature was 45 degrees F. (Fahrenheit). The safe temperature range for storage of cold foods is 41 degrees F or cooler. When asked if there was a system to monitor the temperature of the home's refrigerators and freezers, the supervisor confirmed that there was no process to assure that the cold foods were stored at safe temperatures.	T 127		
T 134 SS=E	VII.7.3.b Nutrition and Food Services 7.3 Food Storage and Equipment 7.3.b Areas of the residence 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, all areas used for food and equipment storage were not kept clean at all times. Findings include: Per observations of the kitchen areas on 6/17/15 at 10:10 AM, the following areas were not clean and sanitary:	T 134		

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T 134	Continued From page 13 a. The Lazy Susan corner storage cabinet in the kitchen had soiled shelves, with dust and crumbs visible. b. The drawers (3) used to store silverware and utensils were visibly soiled with dust and food particles. c. Upper cabinet door finishes were worn, with untreated wood exposed and some soiling visible. The surfaces were not easily cleanable.	T 134		
T 146 SS=F	IX.9.1.a Physical Plant 9.1 Environment 9.1.a The residence 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 and staff interview, the facility failed to assure that all areas of the home were maintained in a safe, functional and sanitary manner. Findings include: Per observations of the home throughout 6/17/15, the following areas were not maintained in a safe, functional and sanitary manner: a. The upper floor resident smoking area had an open metal pail to hold cigarette butts that had a hole approximately 5 inches in diameter in the bottom of it. Extinguished smoking materials were observed sitting directly on the wood floor of the porch due to the hole in the bottom of the pail.	T 146		

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T 146	Continued From page 14 This posed a significant risk for fire. On the main level porch., the pail used to hold extinguished smoking materials was made of hard plastic, not safe or suitable for containing flammable materials. A resident of the home was observed throwing a lighted cigarette on the first floor wood porch floor at 1:45 PM. This was reported to staff immediately. During interview with the staff on duty, they were not aware of any process to monitor the smoking areas regularly to assure that smoking items are properly and safely disposed of. The supervisor later confirmed that there was no staff assigned to check this area regularly throughout the day. b. The upstairs hallway bathroom had a very worn and stained floor, with evidence of water leakage around the base of the toilet; the wall and floor adjacent to the tub area was heavily soiled with a build up of black material. c. In the basement laundry room, the opening by the washing machine door was heavily soiled with a build up of black material around the rubber flange at the opening. These observations were confirmed with the supervisor at the completion of the tour.	T 146		
T 187 SS=C	IX.9.11.c Physical Plant 9.11 Disaster and Emergency Preparedness 9.11.c Each residence shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of	T 187		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	0530		06/17/2015

NAME OF PROVIDER OR SUPPLIER
NEXT DOOR

STREET ADDRESS, CITY, STATE, ZIP CODE
847 PINE STREET
BURLINGTON, VT 05401

(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
T 187	Continued From page 15 day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to include the names of all staff members present for each of the fire drills conducted in the previous 12 months. Findings include: Per review of the fire drills conducted during the previous 12 months, the home failed to include the names of all staff present who participated in each drill, as required by Vermont TCR regulations. The lack of staff names completing the drills was confirmed with the Manager at 5:30 PM on 6/17/15.	T 187		

NextDoor Program
Plan of Correction 2015
REVISED

Resident Care and Services

T015 - 5.3 Intake – Staff will complete the intake history including a brief early history, written summary of adjustment in major areas of life function, and discharge summaries from previous care. Intakes will be reviewed and signed off by house manager within 7 days of admission, and place in client chart. Chart audits for completeness will every 6 months by designated staff assigned by house manager.

T032 – 5.7 Treatment Plan – A client specific treatment plan will be initiated and developed upon admission and completed within 14 days and will include resident identified needs, specific goals and interventions/steps to obtain these goals. Staff and resident will review and sign the plan, and will be reviewed and signed by house manager within 14 days. This plan will be placed in client chart.

T035 – 5.8 Medication Management – Psychoactive medication orders, including benzodiazepines and anti-psychotics will address targeted behaviors as evidenced by client specific symptoms including the monitoring for signs of adverse side effects specific to the medication administered. The program nurse will be responsible for signing off on all new and on-going orders to ensure the inclusion of the above on the physician's orders and MAR.

T036 – 5.8b Medication Management – An addendum to the current medication policy will include addressing medication contamination (i.e. a pill falling on the floor) and reference to this policy will be part of the standard medication delegation by the program nurse, effective immediately.

T040 – 5.8.5 Medication Management – A resident care plan will include a written plan which describes the behaviors the PRN medication is intended to treat, specifying when the medication is to be used, and desired effects and potential adverse effects that will be monitored and documented on the MAR. The specific PRN MAR will also include reason for use and effectiveness of the medication. A PRN medication policy is now included in the current policy and procedures manual.

T044 – 5.8g Medication Management – Psychoactive medication orders, including benzodiazepines and anti-psychotics will address targeted behaviors as evidenced by client specific symptoms including the monitoring for signs of adverse side effects specific to the medication administered. The program nurse will be responsible for signing off on all new and on-going orders to ensure the inclusion of the above on the physician's orders and MAR.

NextDoor Program
Plan of Correction 2015
REVISED

Resident Care and Services

T015 - 5.3 Intake –
Action Taken - NextDoor staff have completed the intake history including a brief early history, written summary of adjustment in major areas of life function, and discharge summaries from previous care for resident #2.

Measures put in place to ensure the deficiency does not recur - will include chart audits for completeness every 6 months by designated staff assigned by house manager.

Monitoring – House manager will provide oversight of intakes and will be reviewed and signed off on within 7 days of admission.

Completion – this was done on July 1, 2015.

POC accepted as revised 10/26/15 [illegible]

T032 – 5.7 Treatment Plan –
Action Taken - A client specific treatment plan has been completed for Resident #2 and includes resident identified needs, specific goals and interventions/steps to obtain these goals.

Measures put in place to ensure the deficiency does not recur – The program will work with our Health Information to design an online care plan with built in reminders.

Monitoring – oversight of care plans will be done by the RN.

Completion – the treatment plan was done on July 1, 2015.

POC accepted as revised 10/26/15 [illegible]

T035 – 5.8 Medication Management –
Action Taken – The RN will incorporate the AIMS test for resident #2 and #3.

Measures put in place to ensure the deficiency does not recur – The RN will review and update the AIMS test every year or as needed.

Monitoring – The RN will provide oversight on the AIMS test.

Completion – The AIMS test will be done for ALL residents including resident #2 and #3 by August 10, 2015.

POC accepted as revised 10/26/15 [illegible]

T036 – 5.8b Medication Management –
Action Taken - An addendum to the current medication policy now includes addressing medication contamination (i.e. a pill falling on the floor).

Measures put in place to ensure the deficiency does not recur - reference to this policy will be part of the standard medication delegation by the RN.

Monitoring – The RN will provide the education which includes medication contamination to all staff on a yearly basis.

Completion – The RN addressed this with all staff during staff meeting on July 29, 2015.

T040 – 5.8.5 Medication Management –
Action Taken – The RN has developed a PRN Plan for Resident #3 which includes identifying use of anti-psychotic or psychotropic medications for specific behaviors and highlights adverse side effects to monitor for.

Measures put in place to ensure the deficiency does not recur – This will be included on the RN checklist for new residents.

Monitoring – the house manager and RN will review medication charts for completeness on a monthly basis.

Completion – this has been completed

T044 – 5.8g Medication Management –
Action Taken – A problem list will be developed for each medical diagnosis and medications to be administered. It will include potential adverse side effects to watch for. The RN will also incorporate the AIMS test for resident #2 and #3 to measure and monitor.

Measures put in place to ensure the deficiency does not recur – The RN will review and update the problem list and AIMS test every year or as needed. This will also be reviewed in staff meetings.

Monitoring – The RN will provide oversight of the problem list and any complimenting medications, including yearly follow up with the AIMS test.

Completion – The AIMS test will be done for ALL residents including resident #2 and #3 by August 17, 2015.

T046 – 5.8.h.1 Medication Management –
Action Taken - A new thermometer has been placed in the medication refrigerator.

Measures put in place to ensure the deficiency does not recur – This has been added to the Awake Overnight Checklist for daily monitoring.

Monitoring - Staff will notify the house manager of any unacceptable temperature ranges, and house manager will review overnight records of temperatures recorded.

Completion – this has been completed.

POC accepted 10/26/15 Mary Bolton RN

T052 – 5.9.b Staff Services – State mandated trainings including Resident rights, Fire
Action Taken – Training records from HR, on-line, and staff meetings are being compiled into one notebook

Measures put in place to ensure the deficiency does not recur – House manager and RN will document trainings from staff meetings.

Monitoring – House manager and RN will review training logs on a monthly basis.

Completion – Trainings will be caught up by the end of the year

POC accepted 10/26/15 Mary Bolton RN

T071 – 5.13 Policies and Procedures –
Action Taken – The policy and procedures manual has currently been amended to include emergency services protocol regarding appropriateness of dialing 9-1-1, or use of panic button.

Measures put in place to ensure the deficiency does not recur – This will be part of on-going training during staff meetings

Monitoring – House manager and RN will review training logs on a monthly basis

Completion – This has been completed.

POC accepted 10/26/15 Mary P. Bolton RN

<u>Nutrition and Food Service</u>

T115 – 7.1.a.3 Menus and Nutritional Standards –
Action Taken – Staff will post breakfast items available on the menu effective immediately.

Measures put in place to ensure the deficiency does not recur – Staff will discuss in weekly staff meeting what items are available for the menu.

Monitoring – House manager and RN will review menus

Completion – This has been completed

T127 – 7.2.b Food Safety and Sanitation –
Action Taken – New thermometer has been purchased for the ~~[illegible]~~ recreation room resident fridge.

Measures put in place to ensure the deficiency does not recur – An addendum will be added to the Awake-Overnight checklist for staff to monitor and record the temperature of all fridges daily, this includes broken or missing thermometers.

Monitoring – House manager will review checklists daily.

Completion – This has been completed

T134 – 7.3.b Food Storage and Equipment
Action Taken – Staff have cleaned the Lazy Susan, drawers, and upper cabinet.

Measures put in place to ensure the deficiency does not recur – The cleaning checklist now includes cleaning the Lazy Susan, the drawers, and upper cabinet doors.

Monitoring – House manager will review checklist and areas for cleanliness

Completion – This has been completed

Physical Plant

T146 – 9.1.a Environment
(a)
Action Taken – Metal buckets and sand were purchased the day of the inspection for cigarette disposal.

Measures put in place to ensure the deficiency does not recur – This has been added to the daily cleaning checklist. All staff will monitor smoking areas daily and dispose of butts from cans.

Monitoring – House manager will review checklist and do visual inspection for safety.

Completion – This has been completed

(b)
Action Taken – Floors have been cleaned to the best of our ability.
(Facilities has been notified regarding replacement of flooring).

Measures put in place to ensure the deficiency does not recur – Daily cleaning and visual inspection has been added to the daily checklist.

Monitoring – House manager will review checklist and visual inspection for cleanliness

Completion – This has been completed

(c)
Action Taken – NextDoor staff cleaned around the rubber flange

Measures put in place to ensure the deficiency does not recur – Weekly visual inspection has been added to the daily checklist. Staff will use washing machine cleaner on a monthly basis.

Monitoring – House manager will review checklist and visual inspection for cleanliness

Completion – This has been completed.

POC accepted 10/26/15 Meg Bolton RN

T187 – 9.11.c Disaster and Emergency Preparedness –
Action Taken – House manager notified all staff of the need to include staff names present for the drills

Measures put in place to ensure the deficiency does not recur – a line has been added to the monthly drill sheet

Monitoring – House manager will review drill sheets monthly

Completion – This has been completed

POC accepted 10/26/15 Meg Bolton RN