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

February 6, 2025

Martha Ilsley, Manager
The Village At White River Junction
101 Currier Street
White River Junction, VT 05001

Dear Ms. Ilsley:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 23, 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
	0660	A. BUILDING: _____ B. WING _____	C 12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT WHITE RIVER JUNCTION	101 CURRIER STREET WHITE RIVER JUNCTION, VT 05001

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R100	Initial Comments: An unannounced onsite relicensure survey, two complaint investigation and a facility reported incident investigation was conducted by the Division of Licensing and Protection on 12/23/24. Regulatory deficiencies were identified as a result. Findings include:	R100	The facility neither admits nor denies The Deficiencies set forth in this Statement of Deficiencies. The facility alleges compliance	
R128 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Per record review, the Medication Administration Record (MAR) for Resident #4 was documented to not have administered medications as prescribed per the order, at varying times on September, October, November and December 2024. Per staff interview, MAR's are documented by staff by a code assigned by staff, if medication is not administered or refused, there is a present code that is to be selected by the med staff, that would then be documented on the MAR. Per review of the MAR and interview, Staff confirmed the following codes "DNA" to mean Drug Not Available, "DNG" to mean Drug not Given, "REF" to mean refused and "OTH" to mean Other. The September 2024 MAR indicated the medication order for Diltiazem ER 180 mg Cap,	R128	With all deficiencies cited by The Division of Licensing and Protection by the alleged completion Date. R128 Each residents medication, treatment and dietary services Will be consistant with the physician orders. An investigation was performed into the medications Diltiazem, Metoprolol, Mirtazapine, And Escitalopram. It was determined that [redacted] Hospice only renews medication on a 14 day cycle.	

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R128	Continued From page 1 give 1 capsule by mouth daily to not have been documented with code DNA Drug Not Available on 9/1/24. The MAR record administration notes written on 9/1/24 at 7:43 AM said "faxed to pharmacy". The resident progress notes written on 9/1/24 states "Phone call to Bayada Hospice. Informed [name] is out of Diltizem and Metoprolol. Req. delivery. States [s/he] is unsure if they are able to deliver. Questions if staff can go pick up. Advised I have no staff available to that task. Stats [sic] [s/he] will talk to their pharmacy and see what they can do." The October MAR indicated the medication Escitalopram 5 mg, take 1 tablet by mouth daily was documented with code DNA Drug Not Available two times, on 10/13/24 and 10/14/24. The MAR administration note written on 10/13/24 at 11:07 AM, "awaiting pharmacy delivery" and on 10/14/24 at "awaiting a new script". The resident progress notes do not include additional documentation of the missed doses occurring on 10/13/24 and 10/14/24. The October 2024 MAR indicated the medication prednisoLONE Acetate Ophthalmic Suspension 1% , 1 millimeter into eye(s) one time per daily in the AM every day, was documented with code DNA on 10/27/24, 10/28/24, 10/29/24. The MAR administration notes written on 10/27/24 at 1:07 PM, 10/28/24 at 11:21 AM and on 10/29/24 at 11:25 AM only include a puncuation mark, without providing reasoning for the DNA (drug not available) documentation code. Per staff interview on 12/23/24 at 1:30 PM, a Med	R128	The facility pharmacy deliveries are based on a 30 day supply of routine Medications. R128 In meeting with [redacted] Hospice, hospice residents going forward will be on a 30 day supply of medications to coincide with the other residents medication delivery dates. An audit will be conducted of all residents who self medicate to ensure there is an adequate supply of medications available until the next delivery date by the pharmacy. This audit will be conducted weekly for 3 months, and presented to the	

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R128	Continued From page 2 staff explained when docuemnting medications as DNA, DNG, REF, OTH a prompt appears to provide additioanl documententation to provide reasoning for the indicated code utilized. The additional documentation is then included on the MAR. The Med Staff confirmed the documentation on 10/27/24, 10/28/24 and 10/29/24 only is documented with a punctuation mark and does not include a reason for the documentation code DNA. The resident progress note written on 10/28/24 at 9:03 AM states ".. .[provider name] who prescribes [resident] Prednisolone eyedrops, which [resident] is out of, they said they are faxing [pharmacy name] today. " On 10/29/24 at 3:21 PM, a progress noted written states " The provider at [office name] did not send a re-order script to the Pharmacy. [Provider Name] was notified and the script was sent to the local pharmacy and was picked up this afternoon. [resident name] made aware of the issues with the med scripts." The October 2024 MAR indicated Mirtazapine 7.5 mg, 1 tablet by mouth at bedtime , documented with code DNG Drug not Given on 10/26/24. Per review of the printed MAR administration notes and resident progress notes, there are no further noted documentation to account for reasoning the medication was not given. The December 2024 MAR indicated the medication prednisoLONE Acetate Ophthalmic Suspension 1% , 1 millimeter into eye(s) one time per daily in the AM every day, was documented with code DNA on 10/10/24. The MAR administration note written on 12/10/24 at 10:19 AM, states "waiting for a new script". The progress note written on 12/10/24 at 10:37	R128	Quality Assurance Performance Improvement Committee for further monitoring and action. The Director of Health Services or Designee will monitor 1/13/25 The order for the medication Prednisolone Acetate Ophth. Suspension prescription had not been renewed and was unable to be refilled by pharmacy. R128 Attempts were made to refill the prescription through the Primary care physician office who referred to the Ophthalmologist office for prescription renewal.The prescriptions had renewal orders for only 30 days at a time. This has now been changed with a renewal for one year.	

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R128	Continued From page 3 AM, states "Res. is currently receiving [pronoun] script for prednisoLONE eyedrops out of [provider office name]. I called them, they are sending the script to [pharmacy name] today." Per interview on 12/23/24 at 11:30 AM, the Director of Health Services (DOHS) confirmed Resident #4 had missed medication in the last few months due to medications not being available. The DOHS explained receiving prescriptions from the prescribing provider in delay caused a lapse in medication dispensing and resulting in missed administrations.	R128	Resident has an adequate supply of the ophthalmic suspension with the renewal prescriptions. The Opthalmic Suspension with other medications will be audited weekly to ensure adequate supply with the other medications. The Health Services Director Or designess is monitoring.	1/13/25
R175 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (3) Residents who are capable of self-administration may choose to store their own medications provided that the home is able to provide the resident with a secure storage space to prevent unauthorized access to the resident's medications. Whether or not the home is able to provide such a secured space must be explained to the resident on or before admission. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the ALR failed to ensure residents who are capable of self-administration may choose to store their own medications provided that the home is able to provide the resident with a secure storage space to prevent unauthorized access. Findings include:	R175	R175 Residents who are capable of self-administration may choose to store their own medications provided the resident has a secure storeage space to prevent unauthorized access to the residents medications.	

R128 Accepted
Jenielle Shea, RN
2/6/25

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R175	Continued From page 4 Per record review Resident #2 and Resident # 3 were approved to self administer medications by the facility Registered Nurse. In observation and interview with Resident # 2, medications in the resident's apartment were stored in an unsecure manor. Resident #2 moved into the facilty on 11/26/24. S/he explaind during the admission process, they were directed to store medications in the mounted medicine storage box on the wall. In observation and interview, Resident # 2 medication were stored within the mounted box however the box locking mechnism was not operable. Resident #2 at the time of observation, confirmed to not have been directed to secure the medications or provided a method to secure the medications. In observation and interivew with Residetnt # 3 medications in the resident's apartment were stored in an unsecure manor. The medications were observed to be stored with the mounted box and on the bathroom vanity, shelving area. Resident # 3 at the time of observation and interview, confirmed "sometime back" the white boxes were mounted to the wall, "We were told to store the medications there and were told to lock the box. We never received keys to lock or a way to secure the medications within the mounted box." In review of the facility policy and procedures, the policy does not include how the home will provide the resident with a secure storage space to prevent unauthorized access to the resident's medications.	R175	. The secured space is explained to the residents on or before admission. Residents were re-educated regarding medication storeage at Resident Council on January 10, 2025. The Facility will ensure that Residents who are capable of self administration have in place a secured storeage space and that residents are storing medications securely. 1/13/25 R175 An audit will be conducted weekly of all residents who self administer their medications to ensure their medications are securely stored.	

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R175	Continued From page 5 Per interview on 12/23/24 at 3:30 PM, the Regsitered Nurse confirmed the policy does not include how the facility will provide secured storage space. The RN noted Resident # 2 and # 3 typically lock there entry doors, the RN confirmed staff have ability to enter the units and all staff are not authorized to have access of medications. This is a repeat Citation.	R175	The results of this audit will be monitored by the Quality Assurance Performance Improvement Committee for further review and action. This audit will occur weekly x 3 months and will be monitored By the Director of Health services or designee	1/13/25
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 record review and staff interview, the ALR failed to ensure criminal background checks were available for review. Per record review 4 out of 5 staff of the applicable staff records did not include the initial or annual background checks completed for Vermont Criminal Information Center (VCIC) and/or Abuse registry checks. The facility policy titled Criminal Background Checks: Monitoring, Evaluation, and Approval Process (HR011PP) states " .. The community shall follow, at minimum, state-mandated background check guidelines."	R190	R175 Accepted Jenielle Shea, RN 2/6/25 R 190 The facility will conduct New hire background checks toi include adult and child abuse checks as well as the Vermont criminal checks conducted by the Vermont Criminal Information Center (VCIC). In addition to conducting these checks prior to hire they	

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R190	Continued From page 6 Per interview on 12/23/24 at 1:10 PM the Manager confirmed VCIC and/or AHS (Agency of Human Services) adult and child abuse checks were not available for review for 4 out of 5 staff and annual checks for 1 our 5 staff were not completed for VCIC and abuse registry of the applicable staff.	R190	will be completed on an annual basis. These checks will be audited by the Human Resource Director and presented to The Quality Assurance Performance Improvement Committee for further monitoring and action. These audits will be conducted monthly for 3 months and annually thereafter.	1/20/25
R207 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.b The licensee and staff are required to report suspected or reported incidents of abuse, neglect or exploitation. It is not the licensee's or staff's responsibility to determine if the alleged incident did occur or not; that is the responsibility of the licensing agency. A home may, and should, conduct its own investigation. However, that must not delay reporting of the alleged or suspected incident to Adult Protective Services. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to report an incident of a contracted staff member's physical abuse of one applicable resident (Resident #1) to the licensing agency. Findings include: The facility's Reporting Suspected Resident Abuse, Neglect or Exploitation policy effective 10/25/18 does not specify the requirement to report suspected abuse to the licensing agency. Per record review, on 10/3/24 two staff members reported observing a contracted agency Licensing Practical Nurse (LPN) engaging in a	R207	R 207 All suspected or reported Incidents of abuse, neglect or Exploitation will be reported to Adult Protective Services and to the Licensing Agency. Staff have been re-educated Regarding abuse, abuse prevention, reporting of abuse, neglect and exploitation as well the correct agencies to report to.	

R190 Accepted
Jenielle Shea, RN
2/6/25

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R207	Continued From page 7 verbal altercation with a Resident #1 followed by the LPN bumping his/her body into Resident #1, knocking him/her backwards into a chair. The facility's Executive Director reported this incident to the Adult Protective Services the following day, however the incident was not reported to the licensing agency as required. This finding was confirmed by the Executive Director on the afternoon of 12/23/24. See tag 224	R207	The contracted agency staff member was immediately suspended after the reported incident and reported to the Contracting Agency, and reported to Adult Protective Services. The contracted agency staff did not return to the facility after the Suspension. This will be monitored and audited by the Executive Director or designee and reported on to the Quality Assurance Performance Improvement Committee for further Review , monitoring and action Executive Director or designee To monitor R207 Accepted Jenielle Shea, RN 2/6/25	1/13/25
R208 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.c Incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse, or if an injury requiring physician intervention results, or if there is a pattern of abusive behavior. All resident-to-resident incidents, even minor ones, must be recorded in the resident's record. Families or legal representatives must be notified and a plan must be developed to deal with the behaviors This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure one applicable resident's pattern of abusive behaviors directed towards residents and staff was reported to the licensing agency (Resident #1). Findings include: The facility's Reporting Suspected Resident Abuse, Neglect or Exploitation policy effective	R208	R 208 Incidents involving Resident to Resident abuse will be reported to the Licensing Agency. Staff have been re-educated	

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R208	Continued From page 8 10/25/2018 is consistent with this regulatory requirement. Per record review, Resident #1 presented with abusive behaviors directed towards other residents and/or staff on multiple occasions between 8/2/24 and 11/21/24. Resident #1's Progress Notes document incidents of abusive behaviors which occurred on 8/2/24, 8/17/24, 9/21/24, 10/4/24, 11/12/24, and 11/21/24. During an interview commencing at 4:12 PM on 12/23/24 the Director of Memory Care confirmed a pattern of multiple incidents of abusive behaviors is documented in Resident #1's record. Documentation of reporting to the licensing agency regarding Resident #1's pattern of abuse was not provided by the Director of Memory Care on request on the afternoon of 12/23/24. The failure to report Resident #1's pattern of abuse to the licensing agency was acknowledged by the Executive Director, Director of Health Services, and Director of the Memory Care Center on the afternoon of 12/23/24.	R208	regarding reporting of abuse, neglect or exploitation and reporting to the correct licensing Agency. The policy regarding suspected abuse will be consistent with this requirement. A discussion was held with Resident #1 Durable Power of Attorney for Health Care regarding residents pattern of abusive Behaviors towards others, and a psyche evaluation is pending. All reports of abuse will be Monitored by the Executive Director or designee and will Be reported on to the Quality Assurance Performance Committee for further monitoring and action. Executive Director or designee To monitor R208 Accepted Jenielle Shea, RN 2/6/25	1/13/25
R224 SS=D	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there	R224		

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R224	Continued From page 9 was a failure to ensure one applicable resident (Resident # 1) remained free of physical abuse by staff. Findings include: The facility's policies and procedures are consistent with this regulatory requirement. Per record review on 10/3/24 two Direct Care Staff in the facility's memory care center reported witnessing an agency contracted Licensed Practical Nurse (LPN) engage in a verbal altercation with Resident #1 after the resident repeatedly asked questions about the medications the LPN was attempting to administer to the resident. Both Staff who witnessed the incident reported observing the LPN move towards Resident #1 and bump his/her body into the resident, causing Resident #1 to fall backwards into a chair. Per interview commencing at 12:31 PM on 12/23/24, a Direct Care Staff who witnessed this incident stated s/he observed the LPN approach and bump his/her belly into Resident #1's body during the verbal altercation, causing Resident #1 to fall into the chair behind him/her. The Direct Care Staff stated Resident #1 appeared shocked immediately after falling backwards into the chair, and stated the resident did not appear to be injured as a result of the physical contact and fall. During the interview commencing at 12:31 PM on 12/23/24, the Direct Care Staff who witnessed the incident described the LPN's verbal response to Resident #1 during this incident as unkind and not respectful, and described the LPN's physical contact with Resident #1 during this incident as abusive. The Direct Care Staff stated s/he immediately reported the incident to the Interim Director of Health Services. Per record review the agency LPN was immediately suspended and	R224	R 224 Residents shall be free From mental , verbal, physical Abuse, neglect and exploitation. The contracted staff was immediately suspended upon receiving the report by staff members and did not return to the facility. Staff have been re-educated regarding resident rights, abuse, neglect and exploitation and reporting of abuse. This Will be monitored by the Executive Director or designee and reported On to the Quality Assurance Performance Improvement Committee for further monitoring and Action 1/13/25 R 224 Accepted Jenielle Shea, RN 2/6/25	

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R224	Continued From page 10 his/her contracted employment ended. On the afternoon of 12/23/24 the Executive Director, current Director of Health Services, and Memory Care Center Director acknowledged the finding of LPN's treatment of Resident #1 as physically abusive.	R224	R 246 The facility will procure Food from sources that comply with all laws relating to food and food labelling. Cans with dents, swellings or leaks will be rejected and kept separate until returned to the supplier. 1. All dented cans were immediately removed on 12/23/24. 2. The walk in wilted Culinary herbs were immediately Disposed of 12/23/24 3. The thawed turkey was removed from the tray and the area was thoroughly cleansed and disinfected. The cranberry sauce was disposed of. 12/23/24	
R246 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.a Each home must procure food from sources that comply with all laws relating to food and food labeling. Food must be safe for human consumption, free of spoilage, filth or other contamination. All milk products served and used in food preparation must be pasteurized. Cans with dents, swelling or leaks shall be rejected and kept separate until returned to the supplier. This REQUIREMENT is not met as evidenced by: Based on observation there is a failure to ensure all foods are free of spoilage and procured from sources that comply with food and food labeling laws; and a failure to ensure cans with dents and damaged cans are kept separate until returned to the supplier or discarded. Findings include: The facility's Food and Beverage Services - Sanitation and Infection Control Standards policy includes food storage and food contamination/ spoilage prevention procedures. 1. During a tour of the facility's kitchen and dining areas commencing at 9:08 AM on 12/23/24 dented cans were observed to be stored with	R246		

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(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
R246	Continued From page 11 canned items to be served to residents including seven cans of various food items, and 6 dented and rusted small cans of condensed milk. This finding was confirmed by the Director of Culinary services at 9:30 AM on 12/23/24. In the walk-in refrigeration unit adjacent to the main kitchen, wilted and discolored culinary herbs were observed to be stored. A bottom shelf in this refrigeration unit was observed with a large tray on which a frozen turkey had been thawing for 4 days. The turkey and other foods stored on the tray were submerged in the fluids that had drained from the thawed turkey. A container of cranberry sauce dated as opened or prepared on "11/22" was also observed to be stored in this refrigeration unit. These findings were confirmed by the Director of Culinary Services at approximately 9:45 AM on 12/23/24. 2. In the Memory Care Center home canned goods were observed to be stored in the refrigeration units including a mason jar of pickled cabbage in the food service kitchen, and 4 small mason jars of what appeared to be jelly in the activities kitchen. These findings were confirmed by the Direct Care Staff on duty in the Memory Care Center on the morning of 12/23/24.	R246	4. The memory care unit mason jar of cabbage and small jars of jelly were immediately disposed of. Dietary staff have been re-educated Regarding food safety and sanitation. An audit of the main kitchen and Memory care kitchen will be Conducted 3x weekly for 3 months To ensure noted area are in compliance. The results of these audits will be Submitted to the Quality Assurance Performance Improvement Committee For further action and review. This will be monitored by the Food and Beverage Manager or Designee.	1/15/25
R266 SS=F	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment.	R266		

R 246 Accepted
Jenielle Shea, RN
2/6/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0660	A. BUILDING: _____ B. WING _____	C 12/23/2024

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R266	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure care in a safe, functional, sanitary, homelike and comfortable environment. Findings include: The facility's Environmental Services policies and procedures state the health and well-being of staff and residents will be maintained throughout the community, and the community will comply with all State and Federal regulations. During a tour of the home commencing at 8:42 AM on 12/23/24 the following environmental deficiencies were identified: 1. Hazardous chemicals including sanitizers, disinfectants, Health and Beauty Products, Acetone Nail Polish Remover, Spot Remover, and other hazardous products were observed to be unsecured and accessible to residents in the home's unlocked Spa and Salon. The facility's Environmental Services policy and procedures manual states all chemicals will be stored in locked rooms. 2. Dirty laundry was observed to be stored directly on the shower floor in a memory care center resident's room. 3. Unsecured disposable razors were observed to be accessible in 2 resident rooms in the home's Memory Care Center. A tube of Prevident fluoride toothpaste, which is available by only by prescription due to the amount of fluoride in this medication, was also observed to be stored in the same basket as a disposable razor on the bathroom counter in one of the resident rooms. A container of Clorox wipes was observed to be	R266	R266 The facility will ensure care Is provided in a safe, functional, sanitary Homelike and comfortable environment. Hazardous chemicals including sanitizers, disinfectants, health and beauty products, acetone nail polish remover, spot remover and other hazardous products will be securely stored and inaccessible to residents. Staff have been re-educated regarding proper storeage of the above, as well as proper storeage of dirty laundry. The unsecured razors, prescription Toothpaste, clorox wipes, liquor, chemicals, were immediately removed. 12/23/24 The dirty laundry stored directly on the shower room floor in the apartment of a resident was immediately removed.The facilities spa and salon are locked when not in attendanceb	

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R266	Continued From page 13 unsecured and accessible in a memory care center resident's room. 4. On the 5th floor of the home a bar adjacent to the movie theater was observed with multiple bottles of liquor left unsecured and accessible on the counter. Additional bottles of liquor were observed to be unsecured and accessible under the bar sink along with hazardous cleaning chemicals. 5. The sink in the bar is outfitted with a drainage system that allows the water from the sink to drain into an open basin underneath the sink. This basin was observed to be malodorous and coated with a dark gelatinous substance. These findings were confirmed by the Executive Director during an interview commencing at 11:33 AM on 12/23/24.	R266	By a staff member. 12/23/24 An audit will be conducted weekly of random resident rooms and of the spa and salon to ensure that hazardous materials, dirty laundry, and disposable razors are secure and inaccessible to residents and that dirty laundry is stored appropriately. The results of these audits will be monitored by the Quality Assurance Performance Improvement Committee for further	
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 water temperatures were observed to be maintained above 120 degrees Fahrenheit in resident accessible areas of the home. Findings include: During the facility tour commencing at 8:42 AM on 12/23/24 water temperatures were observed to be maintained above 120 degrees Fahrenheit	R291	Review and action Health Services Director or designee Will monitor The drainage system under the sink In the bar has been cleaned, Disinfected and covered. This area Will be audited weekly to ensure It is cleaned and disinfected on a	1/13/25

R 266 Accepted
Jenielle Shea, RN
2/6/25

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
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R291	Continued From page 14 in the following resident accessible areas: 1. In the Memory Care Center: Resident Room 2004 129.6 degrees Resident Room 2009 138 degrees Resident Room 2014 134.4 degrees 2. On the 3rd floor of the home: Resident Salon 124 degrees Resident Room 3217 121.3 degrees Public bathroom by elevator 123.6 degrees 3. 4th floor public bathroom 135.9 degrees 4. 5th floor public bathroom 133.9 degrees These findings were confirmed by the Executive Director during an interview commencing at 11:33 AM on 12/23/24. Following an adjustment to the water heating system on the afternoon of 12/23/24, water temperatures in the resident accessible areas identified above were observed to be maintained at or below 120 degrees Fahrenheit.	R291	Weekly basis. The Maintenance Supervisor or designee will monitor R291 Hot water temperatures Will not exceed 120 degrees F in resident areas. The water system was adjusted and the rooms as mentioned were at or below 120 degrees F on 12/23/24. An audit is being conducted 3 x weekly for 3 months of public bathrooms and random resident rooms on all floors to ensure water temps are at or below 120 degrees F. These audits Will be reiewed and monitored R 291 Accepted Jenielle Shea, RN 2/6/25	1/13/25