VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
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AGENCY OF HUMAN SERVICES

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

January 6, 2026

Cassandra Quesnel, Manager
Shard Villa
1177 Shard Villa Road
Salisbury, VT 05769-9588

Dear Ms. Quesnel:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 8, 2025.** 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
	0152	A. BUILDING: _____ B. WING _____	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARD VILLA	1177 SHARD VILLA ROAD SALISBURY, VT 05769

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R100	Initial Comments On 12/8/25 the Division of Licensing and Protection conducted an unannounced on-site annual re-licensure survey. The following regulatory deficiencies were identified:	R100	Corrective actions for all tags cited accepted by Jo A Evans RN on 1/3/26. Please see the attached document to review the accepted Plan of Correction.	
R105 SS=F	5.2.a Uniform Consumer Disclosure-Admit Agreements The licensee upon initial licensure must state the services it can and will provide, the public programs or benefits that it accepts or delivers, the policies that affect a resident's ability to remain in the home, and any other relevant information. (1) The uniform consumer disclosure must be completed on a form provided by the licensing agency and must be kept on file by the licensee. (2) The uniform consumer disclosure must include a statement describing the daily, weekly or monthly rate to be charged, a description of the services that are covered in the rate and all other applicable financial issues. (3) The uniform consumer disclosure must include a statement that rates are subject to change, including rate changes due to increased care needs,and describe the situations in which the changes (s) could occur. (4) The uniform consumer disclosure must be provided; i. to residents prior to or at admission and at any time it is changed or is requested by the resident; and ii. to the public upon request (5) The availability of a uniform consumer disclosure must be noted prominently in all marketing brochures and written materials.	R105		

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R105	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to complete the Uniform Consumer Disclosure Form provided by the licensing agency and to ensure this statement is provided to residents of the home as required. Findings include: Policies and procedures governing Uniform Consumer Disclosure have not been developed by the home. At 10:37 AM the Interim Manager was requested to provide a copy of the home's completed Uniform Consumer Disclosure statement. Per the Interim Manager and per record review, a completed Uniform Consumer Disclosure statement was not on file and available for review at the home. This finding was confirmed by the Manager during the interview commencing at 10:48 AM on 12/8/25.	R105		
R113 SS=F	5.2.c (7) Uniform Consumer Disclosure- Admit Agreements In addition to general resident agreement requirements, agreements for all ACCS participants must include: A home certified to provide assistive community care services (ACCS) must designate a staff person responsible for case management.	R113		

Cassi Smith RN, Director

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R113	Continued From page 2 Residents must be informed upon admission, and any time there is a change, of the name of the staff person responsible for case management. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to designate a Case Manager for residents of the home receiving Assistive Community Care Services (ACCS). Policies and procedures related to Assistive Community Care Services have not been developed by the home. Per interview with the Interim Manager and the Administrative Assistant commencing at 12:51 PM , and per record review, the home cares for 9 residents who receive Assistive Community Care Services. At 3:23 PM on 12/8/25 the Manager and Administrative Assistant confirmed a staff member has not been designated to be the Case Manager for residents receiving Assistive Community Care Services.	R113		
R196 SS=F	5.10.d (5) Medication Management Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; identifies any known triggers for the behaviors; 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	R196		

Cassie Quesnel RN, Director

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R196	Continued From page 3 the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to ensure written plans are developed for the administration of PRN (as needed) psychoactive medications by staff other than a nurse for all applicable residents of the home. Findings include: Policies and procedures governing the administration psychoactive medications by staff other than a nurse have not been developed by the home. Per the Interim Manager who also serves as the Registered Nurse responsible for nursing oversight at the home, and per record review, written plans for the PRN administration of psychoactive medications by staff other than a nurse have not been developed for all applicable residents of the home. This finding was confirmed by the Interim Manager at 1:35 PM on 12/8/25.	R196		
R203 SS=F	5.10.h (1) Medication Management All drugs, medicines and chemicals used in the home must be labeled in accordance with currently accepted professional standards of practice. Medication must be used only for the resident identified on the pharmacy label. (1) Resident medications that the home manages must be stored in locked compartments under proper temperature controls. Only authorized personnel must have access to the keys.	R203		

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R203	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure unsecured medications are not accessible to resident of the home and a failure to ensure only authorized personnel have access to the medication cart keys. Findings include: 1. Based on observation and staff interview there is a failure to ensure unsecured medications are not accessible to resident of the home. Findings include: Policies and procedures governing secure storage of medications have not been developed by the home. During a tour of the home commencing at 10:50 AM on 12/8/25 the following unsecured medications were observed to be unsecured and accessible to residents of the home: a. Oral syringes used to administer Lorazepam solution were were observed to be stored on top of the med cart in a paper cup. The unsecured used syringes contained a small amount of the controlled substance administered, which commonly occurs when administering medications via oral syringe. This is a risk for diversion of the residual controlled substance left in the syringe and an infection risk. b. Derma Phor topical ointment prescribed by Resident #2's provider was observed to be stored on a shelf in this Resident's bathroom. These findings were confirmed by the Interim Manager during the tour of the home commencing at 10:50 AM on 12/8/25.	R203		

Cassie Quesnel, RN Director

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R203	Continued From page 5 c. During an observed med pass at approximately 12:15 PM on 12/8/25 a bottle of Vicks Vapo Rub and an unlabeled medication cup containing one pill was observed on top of the dresser in Resident #3's room. The Interim Manager stated the single pill in a cup on Resident #3's dresser is the medication Baclofen and confirmed Resident #3 is permitted to keep a single dose of Baclofen at their bedside for self administration. These findings were confirmed by the Interim Manager following the observed med pass on the afternoon of 12/8/25. 2. Based on observation and staff interview there is a failure to ensure only authorized personnel have access to the medication cart keys. Findings include: Policies and procedures governing access to the medication cart keys have not been developed by the home. During a tour of the home commencing at 10:50 AM on 12/8/25, keys to the medication cart were observed to be stored in an unlocked drawer beside the medication cart. At 11:21 AM the Interim Manager confirmed this finding.	R203		
R206 SS=F	5.10.h (4) Medication Management Medications left after the death or discharge of a resident, or outdated medications, must be promptly disposed of in accordance with the home's policy and applicable standards of practice.	R206		

Cassie Calvert, Pro Director

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R206	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure prompt disposal of outdated medications, Findings include: Policies and procedures governing medication disposal have not been developed by the home. The following outdated medications were observed to be stored in the home's medication cart: 1. Desitin Diaper Rash Paste expired on 8/20/24 2. Hydrogen Peroxide 3% Solution expired 10/3/25 3. Lemon Glycerin Swab Sticks expired 3/2025 4. Single Dose Bacitracin Ointment packets expired 7/2024 5. Additionally, an Osam Covid-19 Home Test Kit which expired on 3/13/25 was stored in the medication cart. The Manufacturer's website states, "Do not use kit past its expiration date" and does not include an expiration extension date for the Lot Number on the expired test observed in the med cart. These findings were confirmed by the Interim Manager following a review of medication storage areas conducted by the survey team on the afternoon of 12/8/25.	R206		
R210 SS=F	5.11.c Staff Services The home must provide, or arrange for the	R210		

Cassi Cressul, RN Director

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R210	Continued From page 7 provision of, at least twelve (12) hours of training upon hire and each year to each staff person providing direct care to residents. The manager may give credit towards the required 12 hours of training upon hire, for any formal training received in the twelve months preceding the date of hire, provided the home maintains documentation of the training and ensures competency in the subject matter. The training must include, but is not limited to, the following: (1)Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; (7) General supervision and care of residents; (8)Communication strategies, person-centered care, challenging behaviors and understanding dementia; (9) Recognition of and sensitivity to different cultures, belief systems, abilities, gender identities, sexual orientation; and (10) Trauma-informed care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to ensure trainings were completed as required for 5 out of 5 sampled staff. Findings	R210		

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R210	Continued From page 8 include: Policies and procedures governing completion of staff training required by the licensing agency have not been developed by the home. On the afternoon of 12/8/25 the Interim Manager was requested to provide documentation of trainings completed by 5 sampled staff. Per review of the documentation provided, the required trainings were not completed by 5 out of 5 sampled staff. This finding was confirmed by the Interim Manager at 3:32 PM on 12/8/25.	R210		
R342 SS=F	5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy must be available at the home for review upon request by residents and their representatives, advocacy organizations and the licensing agency. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to develop policies and procedures governing all areas of service provided by the home: and a failure to ensure the home's policies and procedures are accessible to all residents and visitors on request. Findings include: 1. At 10:48 AM on 12/8/25 the Interim Manager confirmed the home's policy and procedures manual is located in the administrative office and is not accessible to residents and visitors of the home at all times.	R342		

Jessie Russell, RN Director

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R342	Continued From page 9 2. Throughout the survey conducted at the home on 12/8/25, the Interim Manager and Administrative Assistant were requested to provide copies of policies and procedures governing the areas of services related to potential deficiencies identified during the survey process. Policies and procedures governing the following areas of service were not on file and available for review, or had not been developed by the home: a. Assistive Community Care Services b. Uniform Consumer Disclosure c. Staff completion of trainings required by the licensing agency d. Residents right to privacy and safeguarding resident's personal health information e. Secure storage of medications and ensuring only authorized personnel have access to the medication cart keys f. Food safety and sanitation including, but not limited to, storage temperatures for perishable foods and beverages g. Storage of poisonous compounds including, but not limited to, secure separate storage within areas where food is stored h. Medication Disposal i. Care for the home's pets including designated feeding areas j. Obtaining level of care variances to admit or retain residents who require nursing home level of care k. Secure storage of hazardous items On the afternoon of 12/8/25 the Interim Manager confirmed policies and procedures governing all areas of service have not been developed by the home.	R342		

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R358	Continued From page 10	R358		
R358 SS=F	6.10 Resident's Rights The resident's right to privacy extends to all records and personal information. Personal information about a resident must not be discussed with anyone not directly involved in the resident's care. Release of any record, excerpts from or information contained in such records are subject to the resident's written approval, except as requested by representatives of the licensing agency to carry out its responsibilities or as otherwise provided by law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, there is a failure to ensure the right to privacy for all residents of the home related to the storage of personal health information. Findings include: While the home does provide staff a handout which explains the Health Information Portability and Accountability Act, policies and procedures governing how the home ensures the resident's right to privacy and safeguards resident's personal health information have not been developed by the home. During a tour of the home commencing at 10:50 AM on 12/8/25 the following resident personal health information was observed to be unprotected and accessible: a. Oral syringes used to administer Lorazepam oral solution to Resident #1 with identifying labels including the Resident #1's name and the medication name and dose were observed to be	R358		

Cassie Shuval, RN Director

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R358	Continued From page 11 visible and accessible on top of the home's med cart. Per the Interim Manager's confirmation, the syringes observed on the cart were used to administer medication the two previous evenings. This was confirmed by the Interim Manager at 11:22 AM on 12/8/25 b. The home's multi-dose medication packages used to store and administer medications for all residents of the home were observed to be discarded in a trash receptacle without removing personal health information including the resident's name and the dose and name of the medications contained within the packaging. This was confirmed by the Interim Manager at 11:24 AM on 12/8/25.	R358		
R381 SS=F	7.2.a Food Safety and Sanitation Each home must procure food from sources that comply with all laws relating to food and food labeling. The home must ensure that all food is 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 must be rejected and kept separate until returned to the supplier. This STANDARD is not met as evidenced by: Based on observation and staff interview there is a failure to ensure food safe for human consumption and free of contamination related to food storage areas adjacent to the kitchen. Findings include:	R381		

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R381	Continued From page 12 Policies and procedures related to food safety and sanitation have not been developed by the home. During a tour of the home commencing at 10:50 AM the following food safety issues were observed: 1 In the food storage area adjacent to the kitchen the following risks for food contamination and spoilage were observed: a. A packaged whole raw chicken in a thin plastic produce bag was observed to be placed on a counter in the food storage area within 1-2 inches of baked goods and a package of english muffins which surrounded the chicken, and approximately 8 inches from a folded towel placed on the counter with stacks of hard plastic cups used to serve beverages to residents. This is a risk for cross contamination and food-borne illness. b. A package of ant bait was observed on a shelf with food in this food storage area, which is a risk for food contamination. c. The refrigerated mild dispenser in this food storage area was observed to dispense milk at 43 degrees Fahrenheit which is a risk for spoilage. 2. A refrigerator in a second food storage area was observed with an undated Ziploc bag containing shrimp which was observed to be malodorous. The shrimp was placed directly on a shelf beside a bin of tomatoes and avocados which are typically served raw; and on a shelf located directly above a shelf containing open bins of vegetables and 2 vented zip lock bags of grapes including one which was open. This is a risk for cross contamination of food items and	R381		

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R381	Continued From page 13 food-borne illness. 3. A litter box for the home's pet cat was observed to be stored in a third storage area with food items stored on the floor including a bag of flour covered with plastic wrap and a ventilated bag of potatoes. This area is also used to store food packaging, insulated beverage dispensers, small appliances and equipment used for food preparation. This is a risk for food contamination. During the tour of the home commencing at 10:50 AM on 12/8/25 the Interim Manager confirmed these findings.	R381		
R382 SS=F	7.2.b Food Safety and Sanitation 7.2.b All perishable food and drink must be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. (3) Staff must monitor the temperature of temperature-controlled food storage areas. Staff must conduct regular temperature checks of prepared food to ensure proper food safety and must document the time and results of each check. The U.S. Department of Agriculture provides guidance for time and temperature curves to ensure prepared foods remain outside of the 'danger zone' for food safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to home's refrigerated milk dispenser holds milk at to below 40 degrees Fahrenheit.	R382		

Cassie Quesnel, RN Director

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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
R382	Continued From page 14 Findings include: Policies and procedures governing perishable food and beverage storage temperatures have not been developed by the home. During a tour of the home commencing at 10:50 AM on 12/8/25 the milk stored in the refrigerated milk dispenser was observed to be dispensed at 43 degrees Fahrenheit. This finding was confirmed by the Interim Manager at 10:58 AM on 12/8/25.	R382		
R394 SS=F	7.3.i Food Storage and Equipment Poisonous compounds (such as cleaning products and insecticides) must be labeled for easy identification and must not be stored in the food storage area unless they are stored in a separate, locked compartment within the food storage area. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure insecticides are not stored on the same shelf as food items. Findings include: Policies and procedures governing storage of poisonous compounds within food storage areas have not been developed by the home. During a tour of the home commencing at 10:50 AM on 12/8/25 a package of ant bait insecticide was observed to be stored on the same shelf as food items in the food storage area adjacent to the kitchen. This finding was confirmed by the Interim Manager during the tour of the food	R394		

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	0152	A. BUILDING: _____ B. WING _____	12/08/2025

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R394	Continued From page 15 storage area.	R394		
R403 SS=F	9.1.c Environment The home must ensure that the resident environment remains as free of accident hazards as possible. Maintaining a safe environment must include the safe storage and clear labeling of chemical agents, which must include secure storage of such agents if the home has residents with cognitive impairment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure the home is free of hazardous items in resident accessible areas. Findings include: Individuals with varying abilities to safely manage access to hazardous items, including residents with cognitive impairment, reside at this Residential Care Home. Policies and procedures governing storage of hazardous items have not been developed by the home. During a tour of the home commencing at 10:50 AM on 12/8/25 the following hazardous items were observed to be unsecured and accessible to residents: 1. The kitchen doors which open to resident accessible areas of the home were observed to remain open throughout the survey. including periods of time when staff were not present in this area of the home. The open kitchen doorways also allow residents access to the food storage areas adjacent to kitchen. A spray bottle of	R403		

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R403	Continued From page 16 disinfectant observed to the stored on the shelf under the stainless steel prep table in the kitchen. The administrative and kitchen staff were notified of this safety concern at approximately 10:55 AM; however, this spray bottle was observed to remain accessible to residents throughout the entire survey conducted on 12/8/25. Additionally, a box of liquid ant bait was observed to be accessible to residents in the food storage area adjacent to the kitchen. 2. Unsecured chemicals observed in Resident #4's room included spray bottles of insect repellant, furniture polish, and anti-fog lens cleaner. Additionally, a package of disposable razors was observed to be stored on a shelf in Resident #4's bathroom. 3. A bottle of ethyl alcohol-based hand sanitizer was observed to be stored in a shared bathroom on the second floor of the home. While ensuring resident access to hand sanitizers is an important infection control intervention, and it is important to acknowledge the Material Safety Data Sheet for the specific brand of hand sanitizer observed indicates this product is safe for use as intended, the hand sanitizer placed on the window of the second floor shared bathroom was packaged in a plastic honey bear shaped squeeze bottle typically used to store honey, syrups and other food items. This poses a risk for consumption, particularly for residents living with cognitive impairment. This brand of hand sanitizer is available in other forms of packaging. During the tour commencing at 10:50 AM on 12/8/25 the Interim Manager confirmed unsecured hazardous items were accessible to residents of the home; and at 12:01 PM on 12/8/25 the Interim Manager confirmed	R403		

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R403	Continued From page 17 unsecured chemicals are not permitted to be stored in resident rooms.	R403		
R453 SS=F	10.2.f Pets Pets, owned by a resident or the home, may reside in the home providing the following conditions are met The home must maintain a separate area for feeding cats and dogs other than the kitchen or resident dining areas. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure the home's cat is fed in an area other than the kitchen. Findings include: Policies and procedures governing care of the home's pets have not been developed by the home. Per observation during the tour of the home commencing at 10:50 AM on 12/8/25, the home's pet cat is fed in the kitchen where the resident's food is prepared. This finding was confirmed by the Interim Manager on the afternoon of 12/8/25.	R453		
R463 SS=D	12.1.a Nursing Home Level of Care The provision of nursing home level of care means the provision of services that require specialized knowledge, judgment and skill, all of which meet the standards of nursing as set forth in 26 V.S.A. Chapter 28. A home that wishes to admit or retain a resident who requires nursing home level of care must obtain prior written approval from the licensing agency in the form of a variance and must demonstrate to the licensing	R463		

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R463	Continued From page 18 agency's satisfaction that it has the capacity to provide the necessary care and services. Enhanced Residential Care providers must provide the services agreed to in the Enhanced Residential Care provider agreement with the state of Vermont and outlined in their Admissions Agreements with ERC residents This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to obtain a level of care variance prior to admitting one applicable resident (Resident #5) who required nursing home level of care on admission. Findings include: Policies and procedures governing level of care variances for residents of the home who meet nursing home level of care have not been developed by the home. Per record review Resident #5 was admitted to the home on 9/2/25. The Admission Assessment signed as completed on 9/9/25 by the Registered Nurse, who currently also serves as the home's Interim Manager, indicates Resident #5 required a nursing home level of care on admission as evidenced by: 1. Total dependence on staff for all transfers, locomotion, mobility in bed including all position changes, dressing, toileting, bathing and personal hygiene. 2. Need for extensive assistance required with eating. 3. Cognitive impairment which impacts this Resident's short term memory and results in moderately impaired ability to make decisions	R463		

Cassie Quesnel, RN Director

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R463	Continued From page 19 regarding tasks of daily life. 4. Bowel and urinary incontinence with a scheduled toileting plan. 5. Resident #5's recent admission into hospice services, which the Interim Manager stated occurred approximately one week prior to the survey conducted on 12/8/25. At approximately 5:00 PM on 12/8/25 the Interim Manager confirmed the home has not obtained a level of care variance from the licensing agency to admit or retain Resident #5.	R463		

Deficiency Statement Plan of Correction (POC)

Survey Date:12/8/2025

Facility Name: Shard Villa Residential Care Home

Deficiency Tag	How the deficiency was corrected	How other potential residents identified, and corrective action taken	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R105 Plan of Correction accepted by Jo A Evans RN on 1/3/26	A copy of Uniform Consumer Disclosure was obtained and immediately completed.	Copies of disclosure have been made available to all current residents and families. All future admission packets have been updated to include Consumer disclosure	12/20/2026	A copy of Uniform Consumer disclosure will be completed included in all future new admission packets. It will be reviewed annually and as needed to confirm services and rates documented reflect the most current information.	Management
R113 Plan of Correction accepted by Jo A Evans RN on 1/3/26	All ACCS residents Care plans were updated to name the designated RN as Case Manager.	An audit of all residential charts was completed to identify ACCS residents and update charts to formally identify the assigned case manager.	12/20/2025	Updated admissions check list will designate case manager for all future admissions.	Management
R196 Plan of Correction accepted by Jo A Evans RN on 1/3/26	All PRN psychoactive medications on file have been identified. MARS have been revised to include specific behaviors and circumstances where these medications are indicated for.	A review of all current MARS of residents was completed to identify all PRN psychoactive medications and complete any missing information.	12/30/2025	MAR standards were reviewed and revised to clearly require specific behavioral/ clinical indication prior to administration. Time of administration, dosage and monitoring of	Nursing

				intended effects/side effects.	
R203 Plan of Correction accepted by Jo A Evans RN on 1/3/26	A. Used Oral syringes were removed immediately and secured in locked med cabinet. B. Resident #2 Dermaphor was immediately removed from room and secured in med cart. C. Vicks Vapo rub and Baclofen at bedside of resident #3 were immediately removed and secured in med cart. 2. Spare med cart keys removed from side cart storage and secured in management office.	A sweep of all rooms was completed. Any medication or OTC products that were found were removed and secured in med storage.	12/10/2025	Policy of secure medication storage and access to med cart keys developed and reviewed annually to ensure compliance. Education review with staff regarding medication storage and designated spare key location procedure to obtain spare keys from management .	Management
R206 Plan of Correction accepted by Jo A Evans RN on 1/3/26	All medications identified as expired/out of date at time of survey were immediately removed and disposed of.	An inventory sweep of medication cart and cabinet was completed. No other medications observed expired at this time.	12/18/2025	Current P&P for medication disposal was updated and reviewed with med techs to ensure prompt disposal of outdated medications.	Nursing
R210	Direct care staff identified as incompliant during survey	An audit of all direct care staff was completed, all staff	12/30/25	A spread sheet of Direct caregiving staff has been created to track and ensure	Nursing

Plan of Correction accepted by Jo A Evans RN on 1/3/26	completed their missing education hours.	identified as incompliant were set to complete education hours with RN.		compliance of all education hours are met.	
R342 Plan of Correction accepted by Jo A Evans RN on 1/3/26	The binders containing the facility's Policies and Procedures is located at the entrance of staff offices and accessible to residents and families at all times and upon request. Following the survey some P&Ps that were unable to be located at the time were found to have been developed but filed in a separate binder. Those Policies and Procedures were reviewed and relabeled for quick locating. P&Ps for ACCS, Uniform Consumer disclosure, Staff education, Secure Storage of medication, safe Storage of chemicals/hazardous waste, Pet Maintenance, and obtaining level variances have been developed.	Policy and procedures that govern services provided by the facility have been reviewed, updated and placed at visitor entrance near resident 1st floor hall for public access.	12/10/2025	A notice was created and posted at all visitor entrances identifying location of facility P&P binders Management to review Policies and Procedures annually and as needed to ensure compliance.	Management
R358 Plan of Correction accepted by Jo A Evans RN on 1/3/26	A. Oral syringes on med cart that were labeled with resident personal and medical information were immediately removed	An inspection of all residential and communal areas was completed to ensure no other violations.	12/8/2025	Management developed a policy and procedure for safeguarding residents personal medical information. This Policy and procedure have been	Nursing

	from atop med cart and secured in designated locked cabinet and disposed. B. Education provided to medication aides regarding personal information. New instructions given to use Sharpy marker to cover personal information & or removal of information and shred following med administration.	All staff educated on residents right to privacy and responsibility of protecting private health information.		included in staff trainings and med tech course all medication aides are required to take. Will be reviewed annually during each individual's skill check.	
R381 Plan of Correction accepted by Jo A Evans RN on 1/3/26	A. Chicken was immediately removed from counter, placed in a pan and into refrigerator at time of survey. Staff sanitized counter area to prevent cross contamination/infection. B. Ant bait was removed immediately and secured where facility chemical/ hazardous materials are stored in locked cabinet. 2. Shrimp was discarded, later identified as staff members from from home. Education provided to staff. 3. Cat litter box removed from back dry storage area.	A review of the kitchen was completed. Kitchen staff to ensure labels/dates and safe storage practices are observed when bringing food in from home. Policy and Procedure regarding safe storage of food and chemicals reviewed.	12/08/25	Kitchen staff are to conduct daily checks and cleaning of refrigerators to prevent contamination and risk for infection. All cooks will complete safe serve training and certification. A policy and procedure was developed and	Kitchen Services

				implemented for care of pets in residential care home.	
R382 Plan of Correction accepted by Jo A Evans RN on 1/3/26	A. Milk Dispenser was turned down to keep milk temperature below 40º and new thermometer obtained.	Control source is located on the Milk dispenser. Every other day temps have been taken at various times to ensure consistent and accurate readings	12/11/25	A policy and procedure for perishable food and beverage temperatures developed.	Kitchen Services
R394 Plan of Correction accepted by Jo A Evans RN on 1/3/26	Ant Bait was discarded and area sanitized.	Panty was checked to ensure no other hazardous products on shelving where food is stored.	12/08/2025	P&P of storage of poisonous compounds was developed.	Kitchen Services
R403 Plan of Correction accepted by Jo A Evans RN on 1/3/26	Chemicals were removed from kitchen and resident #4 room and placed in designated locked storage. The hand sanitizer from the second-floor bathroom was discarded.	All direct caregiving and kitchen staff were educated of the dangers of cleaning chemicals left accessible to residents.	12/10/2025	A P&P of storage of poisonous compounds has been developed Staff will provide a daily scan of resident rooms for potentially hazardous materials.	Management
R453 Plan of Correction accepted by Jo A Evans RN on 1/3/26	Cat food dish was removed from the kitchen.	Kitchen staff educated on infection risk and educated on appropriate designated feeding station.	12/08/2025	A P&P was developed for pet care and maintenance of animals within the facility	Management
R463 Plan of Correction accepted by Jo A Evans RN on 1/3/26	Resident #5 was reassessed and Variance completed for submission to retain individual.	RN educated on Facility level of licensing and requirements to obtain variances for both private and ERC residents to ensure compliance.	12/31/2025 (Variance approval received)	Evaluation need for variances have been incorporated as part of the resident assessment at admission and reassessment with health status change.	Administrator