VERMONT

**Department of Disabilities, Aging and Independent Living**
**Division of Licensing and Protection**
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
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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 12, 2026

Wanda King, Manager
Fairwinds Residential Care Home
108 Mechanic Street
North Bennington, VT 05257

Dear Ms. King:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 19, 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

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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| | 0031 | A. BUILDING: _____ B. WING _____ | 11/19/2025 |

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| FAIRWINDS RESIDENTIAL CARE HOME | 108 MECHANIC STREET NORTH BENNINGTON, VT 05257 |

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| R100 | *Initial Comments*<br><br>On 11/19/25 the Division of Licensing and Protection conducted an unannounced on-site annual re-licensure survey. The following deficiencies were identified: | R100 | Corrective action for all deficiencies cited accepted by Jo A Evans RN on 1/11/26.<br><br>Please see the attached document to review the accepted corrective actions. | |
| R105 SS=F | 5.2.a Uniform Consumer Disclosure-Admit Agreements<br><br>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.<br><br>(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.<br>(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.<br>(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.<br>(4) The uniform consumer disclosure must be provided;<br>i. to residents prior to or at admission and at any time it is changed or is requested by the resident; and<br>ii. to the public upon request<br>(5) The availability of a uniform consumer disclosure must be noted prominently in all marketing brochures and written materials. | R105 | | |



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wanda J. Kelly — TITLE: Owner-Manager — (X6) DATE: 1/6/2026

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| R105 | Continued From page 1<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review there is a failure to complete and maintain on file a Uniform Consumer Disclosure Statement.<br>Findings include:<br><br>Policies and procedures governing Uniform Consumer Disclosure have not been developed by the home.<br><br>Per record review Resident #1 was admitted to the home on 10/25/25. Per record review and interview with the Manager, a completed Uniform Consumer Disclosure Statement was not provided to Resident #1 during their admission process as required.<br><br>During an interview commencing at 11:37 PM on 11/19/25 the Manager of the home was requested to provide a copy of the home's completed Uniform Consumer Disclosure form for review. At 1:15 PM the Manager confirmed they were not aware of the requirement to complete and maintain this form on file and available for review on request. | R105 | | |
| R191 SS=D | 5.10.c Medication Management<br><br>Staff must not administer any medication, prescription or over-the-counter medications for which there is not a written, signed order from a licensed health care provider and a supporting | R191 | | |

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| R191 | Continued From page 2<br>diagnosis or problem statement in the resident's record.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review there is a failure to obtain written signed orders for medications administered to one applicable resident (Resident #2). Findings include:<br><br>Policies and procedures governing written signed orders were not provided for review on request.<br><br>Per review of the November 2025 Medication Administration Record (MAR) and signed orders on file, written signed orders were not obtained for the following medications listed on Resident #2's November 2025 Medication Administration Record:<br><br>a. "Ventolin HFA solution (aerosol) 108/90 mcg 2 Puffs Q 3 hrs PRN [sic]" is listed on Resident #2's November 2025 MAR; however, a current order for this medication is not included on the two most recent med lists reviewed and signed by Resident #2's providers. On the afternoon of 11/19/25 the Manager stated they forgot to include this medication on the med list they prepared for Resident #2's provider to sign on 9/19/25.<br><br>b. Written signed orders to discontinue scheduled doses of Clonazepam 0.5 mg administered twice daily on 11/4/25 and to begin administration of Clonazepam 0.5 mg as a PRN (as needed) medication were not included in Resident #2's record.<br><br>c. Written signed orders to discontinue scheduled | R191 | | |

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| R191 | Continued From page 3<br><br>doses of Olanzapine 2.5 mg administered once daily every morning on 11/4/25 and to begin administration of Olanzapine 2.5 mg as a PRN (as needed) medication were not included in Resident #2's record<br><br>At 4:07 PM on 11/19/25 the Manager stated the orders to change scheduled Clonazepam and Olanzapine to PRN medications were received as a telephone order, however there is no documentation of these orders being taken as telephone order from Resident #2's provider and as of the date the annual survey was conducted on 11/19/25 15 days had passed since this change was made in the November 2025 MAR without the home obtaining a signed copy of this order. Additionally, the PRN orders for Clonazepam and Olanzapine were written over the orders for these meds to be given as scheduled twice daily instead of documenting the scheduled orders as discontinued and creating a new entry for the PRN orders. This is a risk for med errors.<br><br>d. Resident #2's November 2025 MAR lists Seroquel 50 mg to be given three times daily; however, a written signed order for this dose of Seroquel has not been obtained for Resident #2. The most recent signed order on file for Seroquel is for a 25 mg dose.<br><br>These findings were confirmed by the Manager at 4:17 PM on 11/19/25. | R191 | | |
| R196 SS=D | 5.10.d (5) Medication Management<br><br>Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN | R196 | | |

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| R196 | Continued From page 4<br><br>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 the time of, reason for and specific results of the medication use.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview there is a failure to develop a written plan for the administration of psychoactive PRN (as needed) medications by staff other than a nurse for one applicable resident (Resident #2). Findings include:<br><br>Policies and procedures governing the administration of PRN psychoactive medication were not provided for review on request.<br><br>Per review of the November 2025 Medication Administration Record, Resident #2 is prescribed the psychoactive medications Clonazepam (treats anxiety) and Olanzapine (antipsychotic) as needed (PRN). Per record review, written plans for the administration of these PRN medications by staff other than a nurse have not been developed as required. This finding was confirmed by the Manager at 4:35 PM on 11/19/25. | R196 | | |
| R197 SS=D | 5.10.d (5)(i) Medication Management<br><br>Unlicensed staff must not administer anti-psychotic medications on a PRN or "as needed" basis, unless the delegating registered | R197 | | |

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| R197 | Continued From page 5<br>nurse gives verbal permission prior to administration for each dose, which must be documented.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review there is a failure to ensure the Registered Nurse gives verbal permission to unlicensed staff prior to their administration of PRN (as needed) psychoactive medications to one applicable resident (Resident #2). Findings include:<br><br>Per review of the November 2025 Medication Administration Record, the following psychoactive medications were administered to Resident #2 as needed:<br><br>a. Olanzapine 2.5 mg was given as needed once daily from 11/11/25 - 11/17/25.<br>b. Clonazepam 0.5 mg was given as needed once daily from 11/5/25 - 11/10/25, on 11/12/25 and from 11/14/25 - 11/18/25.<br><br>At 4:35 PM on 11/19/25 the Manager stated they were not aware of this licensing requirement and confirmed the home's Registered Nurse is not contacted by unlicensed staff for permission prior to administering psychoactive PRN medications. | R197 | | |
| R202 SS=D | 5.10.g Medication Management<br><br>Homes must establish procedures for documentation sufficient to indicate to the licensed health care provider, registered nurse, | R202 | | |

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| R202 | Continued From page 6<br>manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this must include:<br>(1) Documentation that medications were administered as ordered;<br>(2) All instances of refusal of medications, including the reason why and the actions taken by the home;<br>(3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect;<br>(4) A current list of who is administering medications to residents, including staff to whom a registered nurse has delegated administration; and<br>(5) For residents receiving psychoactive medications, a record of monitoring for side effects.<br>(6) All incidents of medication errors.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review there is a failure to ensure medications were administered as ordered for one applicable resident (Resident #2); and there is a failure to establish and implement procedures for documentation of the reason for and effects of PRN medication administration for all residents of the home. Findings include:<br><br>Policies and procedures governing medication administration and documentation were not provided for review on request.<br><br>1. Per record review, Resident #2's November 2025 Medication Administration Record lists an order for Milk of Magnesia 60 ml every 2 hours as | R202 | | |

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| R202 | Continued From page 7<br>needed, which is not consistent with the prescriber's orders for Milk of Magnesia 60 ml every 24 hours as needed for constipation. This finding was confirmed by the Manager at 4:17 PM on 11/19/25.<br><br>2. Per review, the home's Medication Administration Records do not include documentation of the reason for giving PRN medications and the effects of PRN medication administration. The Medication Administration Records do not have a designated area for documenting this information. At 4:40 PM on 11/19/25 the Manager confirmed the reason for giving a PRN medication and the effects of PRN medication administration is not documented in individual resident's records including resident's Medication Administration Records. Per the Manager, sometimes this information is noted in the "day book" which is a shared communication log for documenting information related to all residents of the home. | R202 | | |
| R209 SS=D | 5.11.b Staff Services<br><br>The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and record review an Owner of the home failed to demonstrate competency in the skills of respectful and effective interactions with residents and effective redirection of a Resident without use of physical contact. Findings include: | R209 | | |

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| R209 | Continued From page 8<br><br>Policies and procedures governing staff competencies in effective interactions and communications with residents are not on file and available for review.<br><br>Per record review Resident #2 is living with advanced Dementia and often requires redirection and assistance. Throughout the survey conducted on 11/19/25 Resident #2 was frequently observed seeking validation and attention from staff, and making attempts to engage in interactions with others.<br><br>At 2:48 PM on 11/19/25, an Owner of the home was observed talking on the phone when Resident #2 approached and attempted to engage them in conversation. The Owner was observed responding to Resident #2's attempt to talk with them by placing their hand against the front of the Resident's right shoulder and applying pressure in a manner that appeared to be an effort to redirect the resident away from them with a subtle push. Additional staff came to assist and were observed redirecting the Resident #2 away from the situation without difficulty and without making physical contact with the resident. The Surveyor met with both Owners of the home immediately after observing the Owner's use physical contact to direct Resident #2 away from them. The applicable Owner confirmed their use of physical contact when Resident #2 attempted to engage them while they were on the phone and at 2:51 PM both Owners, to include the Manager and the Owner who made physical contact with Resident #2, confirmed this method of redirecting Resident #2 did not demonstrate competency in skills the applicable Owner is frequently required to perform. | R209 | | |

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| R210 | Continued From page 9 | R210 | | |
| R210 SS=F | 5.11.c Staff Services<br><br>The home must provide, or arrange for the 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:<br><br>(1)Resident rights;<br>(2) Fire safety and emergency evacuation;<br>(3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid;<br>(4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation;<br>(5) Respectful and effective interaction with residents;<br>(6) Infection control measures, including but not limited to, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions;<br>(7) General supervision and care of residents;<br>(8)Communication strategies, person-centered care, challenging behaviors and understanding dementia;<br>(9) Recognition of and sensitivity to different cultures, belief systems, abilities, gender identities, sexual orientation; and<br>(10) Trauma-informed care.<br><br>This REQUIREMENT is not met as evidenced | R210 | | |

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| R210 | Continued From page 10<br>by:<br>Based on staff interview and record review there is a failure to ensure the required staff training was completed by 5 out of 5 sampled staff. Findings include:<br><br>Policies and procedures governing staff training were not provided for review on request.<br><br>On the morning of 11/19/25 the Manager of the home was requested to provide documentation of the required trainings completed by 5 sampled staff. Per review of the documentation provided by the Manager, 5 out of 5 sampled employees did not complete trainings as required. The Manager confirmed this finding at 2:34 PM on 11/19/25. | R210 | | |
| R225 SS=F | 5.12. b (4) Records/Reports<br><br>The home must keep and maintain the following records:<br><br>The results of the criminal record and adult abuse registry checks for all staff:<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review there is a failure to complete criminal record and abuse registry checks as required for 5 out of 5 sampled staff. Findings include:<br><br>Policies and procedures governing staff criminal record and abuse registry checks were not provided for review on request.<br><br>On the morning of 11/19/25 the Manager of the home was requested to provide documentation of | R225 | | |



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| R225 | Continued From page 11<br>criminal record and abuse registry checks completed for a sample a 5 staff. Per review of the documentation provided by the Manager, the facility failed to complete the required background checks for 5 out of 5 sampled employees. This finding was confirmed by the Manager at 2:11 PM on 11/19/25. | R225 | | |
| R342 SS=F | 5.15 Policies and Procedures<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review there is a failure to ensure policies and procedures governing all areas of service provided by the home are developed and maintained on file and available for review. Findings include:<br><br>On 11/19/25 the Manager was requested to provide policies and procedures governing areas of service related to deficiencies identified throughout the survey. Per review of the policies and procedures maintained on file at the home, and by confirmation of the Manager at approximately 5:20 PM on 11/19/25, policies and procedures governing the following areas of service have not been developed by the home:<br><br>a. Staff training<br>b. Staff competencies in the skills they are required to perform | R342 | | |

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|---|---|---|---|---|
| R342 | Continued From page 12<br>c. Staff criminal record and abuse registry background checks<br>d. Treatment of Residents with dignity and respect<br>e. Administration of PRN psychoactive medications by staff other than a nurse<br>f. Medication orders<br>g. Documentation of medication administration<br>h. Completion and provision of the Uniform Consumer Disclosure Form provided by the licensing agency<br>i. Pet records | R342 | | |
| R349 SS=D | 6.1 Resident's Rights<br><br>Every resident must be treated with consideration, respect and full recognition of the resident ' s dignity, individuality, and privacy. Care provided to residents must be person-centered. A home may not ask a resident to waive the resident's rights.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview an Owner of the home who also works as a Direct Care Staff failed to treat one applicable resident (Resident #2) with dignity and respect. Findings include:<br><br>Per record review Resident #2 is living with advanced Dementia and often requires redirection and assistance. Throughout the survey conducted on 11/19/25 Resident #2 was frequently observed seeking validation and attention from staff, and making attempts to engage in interactions with others. | R349 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0031 | A. BUILDING: _____ B. WING _____ | 11/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FAIRWINDS RESIDENTIAL CARE HOME | 108 MECHANIC STREET NORTH BENNINGTON, VT 05257 |

| (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 |
|---|---|---|---|---|
| R349 | Continued From page 13<br><br>At 2:48 PM on 11/19/25, an Owner of the home was observed talking on the phone when Resident #2 approached and attempted to engage them in conversation. The Owner was observed responding to Resident #2's attempt to talk with them by placing their hand against the front of the Resident's right shoulder and applying pressure in a manner that appeared to be an effort to redirect the resident away from them with a subtle push. Additional staff came to assist and were observed redirecting the Resident #2 away from the situation without difficulty and without making physical contact with the resident. The Surveyor met with both Owners of the home immediately after observing the Owner's use physical contact to direct Resident #2 away from them. The applicable Owner confirmed their use of physical contact when Resident #2 attempted to engage them while they were on the phone. At 2:51 PM on 11/19/25 the Owner who is the Manager of the home confirmed Resident #2 was not treated with dignity and respect by the Owner who redirected them using physical contact. | R349 | | |
| R450 SS=F | 10.2.d Pets<br><br>Pets, owned by a resident or the home, may reside in the home providing the following conditions are met:<br><br>Pets must be free from active disease, receive regular veterinarian care and are vaccinated against common communicable diseases.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review there is a failure to ensure veterinary records for the | R450 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0031 | A. BUILDING: _____ B. WING _____ | 11/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FAIRWINDS RESIDENTIAL CARE HOME | 108 MECHANIC STREET NORTH BENNINGTON, VT 05257 |

| (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 |
|---|---|---|---|---|
| R450 | Continued From page 14<br>home's cat include documentation of current vaccinations against common communicable diseases.<br><br>The home's Policy and Procedure for Pets Visiting or Living in Fairwinds states the animals in the home must be properly inoculated and the home "will maintain and keep all vaccination records and veterinary care [sic]."<br><br>On the afternoon of 11/19/25 the Manager was requested to provide veterinary records for the home's cat. Per review, the veterinary records provided by the Manager did not include documentation of the current vaccinations for communicable diseases other than rabies. The Manager confirmed this finding at 1:24 PM on 11/19/25. | R450 | | |

Fairwinds Residential Care Home
108 mechanic street
North Bennington,VT.05257
802-442-4067

Plan of Corrections for survey done on November 19,2025

R105

5.2a Uniform Consumer Disclosure -Admit Agreements

1. A uniform consumer Disclosure form has been printed and filled out for each resident ,given to each responsible party and placed in each resident's file.11/21/25
2. A copy has been placed on our bulletin board for public viewing if needed.11/21/25
3. Going forward the uniform consumer disclosure will be placed with the admission packet and the manager will be responsible for making sure the responsible party is provided a copy and a copy placed in the residents file with the admission agreement.11/21/2025
4. The manager will be responsible for keeping copies in our admission packet . Also for making sure the responsible party is provided with a copy of the uniform disclosure and placed in the residents file.11/21/25

R105 Plan of Correction accepted by Jo A Evans RN on 1/11/26.

R191

5.10.c Medication Management

Pronouns redacted by DLP 1-7-25

1.The R.N. will be responsible for calling the Dr.for physician orders and they will be faxed to [redacted] and [redacted] will place them in the residents chart prior to the administration of any medications.12/11/2025

2.The R.N.placed a call to the physicians office for clarification on resident #2's medication list .The list was forwarded to Fairwinds and placed in the residents chart.12/11/25

3. Corrections were made in resident #2's chart by the L.P.N.and R.N.12/11/25

4. An appointment was scheduled for 12/11/2025 to review resident #2's medications and provide written changes for the residents records.

5. Corrections were made to the Medication administration record by the L.P.N.and reviewed by the R.N. to match the physician orders.12/11/25

6.A meeting was held with the R.N. and the L.P.N to address the mistakes made on resident #2's MAR and physician orders.and come up with a plan to address the mistakes that occurred on the MAR and the physician orders.The physician orders will be reviewed by both R.N. and L.P.N. along with the manager to prevent these errors from reoccuring. .All orders will be reviewed when a resident has a physician appointment and weekly thereafter by the L.P.N and R.N.along with the manager to maintain compliance.12/11/2025.

R191 Plan of Correction accepted by Jo A Evans RN on 1/11/26.

R196 5.10(5)
Medication Management

1.The R.N.will be responsible for training the staff on all newly ordered medication The nurse will train staff on changes in medication.,the residents condition,what behaviors the medication should be used for,the desired effects and the negative side effects the staff should be watching for .The nurse will monitor the documentation the staff has provided for administering the medication the, time medication was given ,the reason for giving the medication and the specific results the medication has had for the resident . Staff will be responsible for demonstrating that they can provide the accurate information pertaining to the ordered medication,the reason they should administer the medication ,the effects the medication has or has not had on the resident positive and/or negative,and the ability to know where to document the time given , the reason for giving the medication,the specific results the medication has had on the resident positive and or negative.If there are questions that arise the nurse is available by messaging or calling .If there is a need for the nurse to visit ,the visit will happen as soon as possible.The manager and or staff may contact the nurse at any time throughout the day..12/1/2025.

2..Anytime a psychoactive PRN medication is ordered by the physician ,the R.N will develop a written plan for the individual resident which will include the specific medication being used for the resident, the specific dose of the medication,the reason the medication is being used,the behaviors that may

require giving a PRN psychoactive medication,the nonpharmaceutical interventions that should be tried prior to contacting the R.N for permission to administer the PRN .The contact information for reaching the R.N.
The documentation that needs to be provided after administering the PRN psychoactive medication.
The written plan will be placed in the MAR with the individuals medication documentation.This will prevent errors and maintain compliance for giving PRN psychoactive medication.1/5/26

3.All staff members will be trained on all medications including PRN's and PRN psychoactive medication and the staff will be delegated for giving medications by the R.N. after they have demonstrated the ability and skills required to give medications ,including what the medication is used for,the Effects the medication has had on the resident, positive or negative,capable of identifying the right resident ,right medication ,right dose, right time and right route.11/20/25

4.The staff delegation will be documented and signed by the R.N. and staff members and kept in a file labeled medication administration and kept in a locked cabinet with the resident files.11/20/25

5..All medication errors have been identified and corrected by the R.N.and L.P.N.
The L.P.N. and R.N.will review the medication orders weekly and if there is a change in medication orders or a hospitalization occurs.11/20/25
The R.N and L.P.N.will review the residents chart containing physician orders and the Medication Administration Record on a weekly basis or when there is a change in medication orders or a hospitalization occurs.11/20/25
6 . The manager will review and keep track of the physician orders and notify the Nurses of any medication changes,Dr.'s appointments or hospitalizations that need to be addressed and documented.11/20/2025.
7.. The R.N. and L.P.N will document all changes in the nurses notes and make necessary changes on the medication administration record.11/20/25
A policy was developed for administering psychoactive medication,identifying the behaviors that may require administering a prn psychoactive medications, a policy requiring the notification of the R.N. prior to giving a psychoactive medication following the nurses orders for giving the P.R.N.,documenting with initials in the medication

administration record,documenting on the progress notes added to the MAR for giving P.R.N.psychoactive medication.The documentation will include the 3 non pharmaceutical interventions tried, the medication and dose given ,the time and date medication was given,the effect the medication did or did not have. Also document side effects if any .signed by the staff administering the medication.11/21/25.

8.The R.N. and L.P.N.will continue to educate staff on the interventions to be used and identifying the behaviors that may require using a PRN.11/21/25 .

9. The manager will be responsible for identifying staff members that need to be delegated to,notifying the R.N. that the delegation is needed,reviewing the documentation and making sure it is up to date to maintain compliance. 11/21/25.

R196 Plan of Correction accepted by Jo A Evans RN on 1/11/26.

R197

5.10.d(5)(i) Medication Management

1. A policy was written for giving PRN psychoactive medications on 11/20/2025.
2. The R.N. has met with all the staff to go over the policies and procedures pertaining to giving PRN psychoactive medications .12/1/25.&12/22/25.
3. This includes the procedure for giving the meds ,which includes using 3 non pharmaceutical interventions ,documenting them and then calling the R.N. for permission to administer the PRN medication.The person administering will sign the progress notes which have been added to the MAR documenting which 3 nonpharmaceutical interventions have been tried,documentation of the medication given ,the dose ,the time ,the reason for giving the medication and the effect the medication has had on the resident if any..The notes will be signed and dated by the staff that has administered the medication.11/20/25.
4. The R.N. will document in the nurses notes the time , the date,the medication, the dose given ,the reason given ,the nonpharmaceutical interventions used and that verbal permission was given to the administering staff member.This will be documented by the R.N. any time a PRN psychoactive medication is given,this will prevent further errors from occurring and maintain compliance.1/4/26.

5. The R.N. provided the staff with education on when to use the prn psychoactive medication, the policy that was developed for giving prn psychoactive medications.,and when and why they should call the nurse for permission to give the medication and documentation after giving the medication. The R.N. will monitor the medication administration records and the progress notes on a weekly schedule to assure administration and documentation of the psychoactive medications is being done accurately.12/1/2025.&12/22/25.
6. The manager will be responsible for notifying the R.N of any medication changes ,side effects of the medication and if the medications are being effective.
7. If the medication has side effects or is not being effective the Nurse will be responsible for contacting the physician and notifying the staff of changes.Changes will be documented in the nurses notes and the administration record, by the L.P.N.and R.N. at the time of the change.This will keep us in compliance12/125
8. .

4.A training on the impact of antipsychotics on geriatric patients,including efficacy,dosing and compliance was provided by our R.N. and a test was given to every staff member which was helpful to everyone.this will be done again on 1/ 2/2026..

R197 Plan of Correction acceped by Jo A Evans RN on 1/11/26.

R202

5.10.g Medication Management

1. A progress note form for giving PRN's has been added to the medication administration record for each resident.
2. When administering any PRN medications including the psychoactive medications the medication administration record will be signed by the staff member giving the medication with initials and time given. Another note will be documented on the progress notes ,which will include non pharmaceutical interventions tried,what medication was given ,the dose given ,the reason given,the time given and the effect the medication has had for the resident.These notes will be signed and dated by the person giving the medication.The R.N. will be responsible for reviewing the Medication record and progress notes on a weekly schedule to assure that the psychoactive medications are being given and documented properly.11/20/25.
3. The manager will be responsible for notifying the nurse of any problems or changes that occur.11/20/25.
4. This procedure will be continued to be followed to prevent further errors from recurring.11/20/25
5. New medication sheets have been done on the computer to make them more legible and prevent documentation errors due to penmanship.The med sheets will be reviewed by the R.N. and the L.P.N.on a weekly basis to prevent further errors from recurring and maintain compliance .11/20/25..
6. The R.N. will review the medication records on a monthly basis or if needed due to changes in medication,Dr's

appointments or hospitalization occurs ,to maintain compliance.11/20/25

R202 Plan of Correction accepted by Jo A Evans RN on 1/11/26.

R209

5.11.b Staff Services

1. An inservice addressing interactions with dementia residents in an anxious or agitated state was held by the L.P.N on 5/25/2025.
2. The R.N and the L.P.N met separately with the staff member involved to go over interventions and procedures to deal with a dementia resident in an anxious or agitated state.11/21/25.
3. Another inservice will be held in January of 2026.for the entire staff.1/10/25.
4. A policy is being developed to address effective interactions and communication with residents and added to our policies and procedures This will aid and educate the staff in dealing with dementia residents in an appropriate manner and prevent the recurrence of this particular situation. 12/31/25.
5. The manager will be responsible for addressing staff and redirecting on a daily basis to assure this practice does not recur .11/20/25.
6. The manager will be responsible for meeting with the nurses and keeping them informed of resident behaviors that may need to be addressed.The nurses will be responsible for going over behaviors

and interventions with the staff that should be used to deal with the resident behaviors ..12/1/2025

7. The manager will be responsible for making sure all residents are being treated with dignity and respect.
8. The manager will be responsible.for coordinating training with the nurse to maintain compliance with resident rights and treating the residents with dignity and respect.11/20/25.

R209 Plan of Correction accepted by Jo A Evans RN on 1/11/26.

R210

5.11.c Staff Services

1. Training is held on a monthly basis but many of the required training had been missed.
2. Both of our nurses have agreed to provide 2 trainings per month to allow us to catch up on the new required trainings including resident rights ,resident emergency response,policies and procedures regarding abuse ,neglect and exploitation,respectful and effective interaction with residents ,infection control measures,general supervision and care of residents,communication strategies,person centered care, challenging behaviors and understanding dementia,recognition of sensitivity to different cultures belief systems,abilities,gender identities and sexual orientation.and trauma informed care.12/31/25.

The nurses are going to provide 2 hours of training weekly to educate staff on the remainder of the trainings.12/31/25

3. The nurses will coordinate an hour of training with the manager to be done on a monthly basis to maintain compliance with our yearly trainings.12/1/2025
4. Additional trainings will be added at the nurses convenience.12/31/25
5. Credit will be given for formal training accessed outside of the home with the proof of documentation and placed in the individual's file for training completed.12/1/25.
6. Training will be documented on the training forms signed by the R.N. and kept in a file labeled medication delegation.
7. The manager will be responsible for making sure the training are being coordinated with the nurses and documentation is being done to maintain compliance.12/1/25.

R210 Plan of Correction accepted by Jo A Evans RN on 1/11/26.

R225

5.12.b (4) Records/Reports

1. When a person is being considered for employment the form will be filled out for VCIC and the Abuse/ child registry.12/2/25
2. Upon the return the person will be considered for hire.
3. Yearly checks on all employees will be done.12/2/25

4. Checks will be done by mail or online (if accessible)
5. Criminal checks will be kept in the criminal check folder in the locked cabinet with resident files .12/2/25
6. Applied on-line with both VCIC and Vermont adult abuse and child registry to allow us to do these criminal checks on-line.12/2/2025
7. .No response for on-line checks therefore we have sent paper copies .12/31/2025.
8. The manager will be responsible for submitting the background checks before hire and on a yearly schedule to maintain compliance.12/2/25
9. The manager will be responsible for submitting the record checks prior to the expiration of the last recorded record check to maintain compliance.12/2/25.
10. The manager will be responsible for filing the record checks in a file for criminal background checks to maintain compliance..These will be kept in a locked cabinet with resident and employee files.12/2/25

R225 Plan of Correction accepted by Jo A Evans RN on 1/11/26.

R342 5.15 Policies and Procedures

1.Developing policies and procedures has been an ongoing learning and developmental project .We have developed numerous policies and procedures.The nurse and manager are continuing to implement these.

(a) Staff training 12/12/25

(b) Staff competencies in the skills they are they are required to perform (to be finished 12/29/25

(c) Staff criminal record and abuse registry background checks12/29/25.

(d) Administration of PRN psychoactive medications by staff other than the nurse.11/21/25.

(e) Medication orders 12/29/25

(f) Documentation of medication administration is included in our medication management and charting procedures which was developed in 2023 .We will review to check for necessary clarifications and we will make corrections if needed to maintain compliance.12/29/25.

(g) Completion of uniform disclosure form 11/21/25.

(h) Pet records policy was developed in 2023 with a signature form to be signed by anyone bringing in a pet visitor. We have reviewed it and the policy contains all necessary information.11/21/25.

2.The manager has printed the regulations and placed them in a folder in an area that is available upon request by the resident,residents representative,advocacy groups or licensing agency.

3. The R.N. and manager are reviewing the regulations to identify the policies and procedures needed to meet the standard policy requirements. We are implementing these to maintain compliance.12/31/25

4. The manager will be responsible for reviewing the policies and procedures on a monthly schedule to maintain compliance.12/31/25.

R342 Plan of Correction accepted by Jo A Evans RN on 1/11/26.

R349 6.1 Resident Rights

1. At the time of hire staff members will be trained on the Residents Rights and center around the residents right to be treated with consideration,dignity and respect as well as individuality,and privacy.It will be the managers responsibility to ensure that the residents rights are being implemented and followed on a daily basis to prevent further recurrence and to maintain compliance with the licensing regulations.

2.Residents Rights are reviewed and an inservice is provided yearly.12/29/25

3.A policy will be implemented and taught by the R.N. to deal with the difficult situations we encounter with dementia residents on a daily basis.12/29/25

4.It has been and always will be our policy to use only verbal redirection,walk away and reapproach or to have another employee step into redirect if the resident is not responding . This will continue to be our policy .

5. We are very conscientious about how our residents are cared for and the way they are treated .12/29/25

6. We will develop a policy and both nurses will continue to educate the staff on dealing with dementia residents, and interventions that should be used.This will be included in our training education at least but not limited to 2 times per year.12/29/25

The manager will be responsible for notifying the nurses of problematic resident behaviors .The nurse will be

responsible for educating the staff on behaviors and interventions to deal with the resident behaviors. 11/21/25.

R349 Plan of Correction accepted by Jo A Evans RN on 1/11/26.

R450 10.2d.Pets

1. Our cat is vaccinated ,the rabies vaccine was good until 12/10/2026.
2. Once the vet and ourselves were made aware of the many tests and vaccinations now required to do we took the cat to the vet on 11/20/25 and 12/11/25 to finish all required vaccinations and testing.

3. All vaccination records are kept in a file labeled pet records and kept in a locked cabinet with the other charts. 11/20/25.
4. The manager will be responsible for reviewing pet records periodically to assure the records are kept up to date and maintain compliance.12/11/25.

R450 Plan of Correction accepted by Jo A Evans RN on 1/11/26.