VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
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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

June 8, 2026

Billie Jo Abbott, Manager
Maple Lane Retirement Home
33 Maple Lane
Barton, VT 05822-9494

Dear Ms. Abbott:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 11, 2026.** 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
	0140	A. BUILDING: _____ B. WING _____	C 05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE LANE RETIREMENT HOME	33 MAPLE LANE BARTON, VT 05822

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments On 5/11/2026 the Division of Licensing and Protection conducted an unannounced on-site annual survey and an investigation of one complaint. The following deficiencies were identified:	R100	Tags-141, 172, 203, 210, 225, 366, 369, 382, 401, 403, 434 have been accepted by C. Scott LTCM on 6-8-26	
R141 SS=D	5.5c General Care Each resident's medication, treatment, and dietary services must be consistent with the licensed health care provider's order, the written plan of care, and the resident's preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review there is a failure to administer an antibiotic medication to one applicable resident (Resident #1) as ordered by a licensed healthcare provider. Findings include: The home's Administering Medications policy states, "Medications are administered in a safe and timely manner, and as prescribed." Per record review Resident #1 was prescribed the antibiotic medication Augmentin to treat Diverticulitis on discharge from the emergency department on the afternoon of 5/9/2026. The medication was ordered twice daily for ten days. Per observation, staff interview, and record review Resident #1 returned from the hospital with the medication on 5/9/2026; however, the medication was not administered until the morning of 5/11/2026. At approximately 10:40 AM on 5/11/2026 the Med Tech on duty was observed entering the medication orders received from the	R141		

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R141	Continued From page 1 emergency department on 5/9/2026 into Resident #1's Medication Administration Record. At 10:55 AM on 5/11/26 the Med Tech was observed administering the first dose of the Augmentin Resident #1 received at the home following their visit to the emergency department on 5/9/2026. This medication error was confirmed by the Campus Administrator of the home at 3:28 PM on 5/11/2026. Please refer to tag 172	R141		
R172 SS=D	5.9.c.(15) Nursing Services For each resident requiring nursing overview, administration of medication, or nursing care, the registered nurse must: Assume responsibility for staff performance in the administration of or assistance with resident medication in accordance with the home?s policies. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review the Registered Nurse failed to assume responsibility for staff performance in the administration of one applicable resident's (Resident #1's) medication in accordance with the home's policies. Findings include: The home's Delegating New Medications policy effective 4/1/2025 states, "All newly prescribed medications and medicated treatments must be delegated to all staff members before administration." Procedures included in this policy	R172		

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R172	Continued From page 2	R172		

state, "The RN must be notified immediately when new orders arrive. A message will be sent to the team notifying everyone of a new medication. Staff are responsible for contacting the RN, either by virtual phone call or in person. All staff must be delegated by 2 PM that day. Once delegated on new medication, there will be a flow sheet staff need to sign." This procedure further states, "Any medication added from Emergency Department visit outside of business hours, will be delegated starting at 7 am before morning medication passes begin."

The home's Medication and Treatment Orders policy effective 4/1/2025 includes procedures which state the nurse is responsible for assuring "changes in orders are addressed in the resident's service/care plan and are communicated to the other staff".

The home's Administering Medications policy states, "Medications are administered in a safe and timely manner, and as prescribed."

Per record review Resident #1 was prescribed the antibiotic medication Augmentin to treat Diverticulitis on discharge from the emergency department on the afternoon of 5/9/2026. The medication was ordered twice daily for ten days. Per observation, staff interview, and record review Resident #1 returned from the hospital with the medication on 5/9/2026; however, the medication was not administered at the home until the morning of 5/11/2026. At approximately 10:40 AM on 5/11/2026 the Med Tech on duty was observed entering the medication orders received from the emergency department on 5/9/2026 into Resident #1's Medication Administration Record; and at 10:55 AM on 5/11/26 the Med Tech was observed

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R172	Continued From page 3 administering the first dose of the Augmentin Resident #1 received at the home following their visit to the emergency department on 5/9/2026. This medication error was confirmed by the Campus Administrator of the home at 3:28 PM on 5/11/2026. On the afternoon of 5/11/2025 the Campus Administrator confirmed they are one of two Registered Nurses currently responsible for nursing oversight of the home. Please refer to tag 141.	R172		
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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure only authorized personnel can access the keys to the medication refrigerator. Findings include: The home's Medication Storage policy effective 4/1/2025 states medications will be kept securely stored and only authorized staff will have access to stored medications. Per observation, the home's kitchen is divided	R203		

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R203	Continued From page 4 from the common areas of the home by a door which does not have a doorknob and cannot be locked, leaving the kitchen accessible at all times. At 10:28 AM on 5/11/2026 a set of keys was observed hanging inside an unlocked cabinet in the kitchen, which included the key to open the medication refrigerator which is stored in the kitchen. Upon accessing the key and opening the medication fridge in the kitchen, the Surveyor observed multiple injectable medications stored in this refrigerator. The Campus Administrator confirmed this finding during an interview commencing at 2:25 PM on 5/11/2026.	R203		
R210 SS=F	5.11.c Staff Services 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: (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,	R210		

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R210	Continued From page 5 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 5 out of 5 sampled staff did not complete yearly trainings as required. Findings include: Policies and procedures governing staff trainings were not provided for review on request. Per review of trainings completed by 5 sampled staff, all 5 sampled staff did not complete the required trainings. This finding was confirmed by the Business Office Manager/HR Director at 6:10 PM on 5/11/2026.	R210		
R225 SS=F	5.12. b (4) Records/Reports The home must keep and maintain the following records: The results of the criminal record and adult abuse registry checks for all staff: This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there	R225		

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R225	Continued From page 6 is a failure to complete the require yearly background checks for one applicable staff. Findings include: The policy and procedures governing completion of staff background checks provided for review does not address completion of yearly background checks. Per review of criminal record and abuse registry checks completed for 5 sampled staff, yearly checks were not completed as required for 1 sampled staff. This finding was confirmed by the Business Office Manager/HR Director at 6:10 PM on 5/11/2026.	R225		
R366 SS=F	6.18 Resident's Rights The enumeration of residents ' rights will not be construed to limit, modify, abridge or reduce in any way any rights that a resident otherwise enjoys as a human being or citizen. A copy of the Residents Rights set forth in this section must be written in clear language, large print (font size 18), given to residents on admission, and posted conspicuously in a public place in the home. The home's grievance procedure and directions for contacting the Office of the Long-Term Care Ombudsman and Disability Rights Vermont also must be written in the same font size, provided to each resident, and posted in the same location as the statement of Residents ' Rights. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is	R366		

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R366	Continued From page 7 a failure to post the home's grievance procedures in the same location as the statement of Resident Rights. Findings include: Policies and procedures governing documents required to be posted at the home were not provide by the home on request. At 11:32 AM on 5/11/2026 the home's Grievance Procedure and the enumeration of Resident Rights were observed to be posted in different areas of the room that includes the dining room, reception area, and medication closet. This finding was confirmed by the Campus Administrator at 3:45 PM on 5/11/2026.	R366		
R369 SS=F	7.1.a.(1) Menus and Nutritional Standards The home must provide each resident with a nourishing, palatable, well-balanced diet that meets their daily nutritional and special dietary needs, taking into account the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, and interviews conducted with residents and staff, there is a failure to serve palatable meals that meet resident's needs and take into account the personal preferences of each resident. Findings include: The home's Resident Food Preferences Policy Statement effective July 2017 and provided for review on 5/11/2026 includes, but is not limited to, the following statements: a. Individual food preferences will be assessed	R369		

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R369	Continued From page 8 upon admission and communicated to the interdisciplinary team. b. If the resident refuses or is unhappy with his or her diet, the staff will create a care plan that the resident is satisfied with. c. The facility's Quality Assessment and Performance Improvement (QAPI) Committee will periodically review issues related to food preferences and meals to try to identify more widespread concerns about meal offerings, food preparation, etc. 1. Meals served at the home are prepared at the skilled nursing facility managed by the same organization located on the same campus. The meals are delivered to the home and served by the residential care staff. Per observation during lunch service on 5/11/2026, and per resident interviews, multiple residents indicated the food served at the home is poorly prepared, not palatable, inconsistent with their dietary needs and preferences, and served cold. Per resident and staff interviews, the residents have repeatedly expressed concerns about the food they are served directly to staff employed by the organization that manages the home and during Resident Council meetings; however the residents have not received written responses to their complaints and effective changes have not been implemented to improve the home's food service. 2. A sample plate was requested for Surveyor review during lunch service on 5/11/2025. The Surveyor's observations of the food served on the sampled plate included:	R369		

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R369	Continued From page 9 a. The food item listed on the menu as meatloaf appeared to have been prepared without ingredients typically used as binding agents to create a "loaf" consistency and was observed to be clumps of cooked beef with an oily appearance and texture. The food item listed on the menu as "cream gravy" was observed to be a thin, watery liquid that was not consistent with the typical color and texture of cream gravy. b. Per the Surveyor's taste test of the food items on the sample plate the meatloaf, cream gravy, and a bowtie pasta dish served during lunch service were observed to lack flavor. At 2:46 PM on 5/11/2026. the Campus Administrator acknowledged the food served at the home is not consistent with this licensing requirement.	R369		
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.	R382		

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R382	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure food served to residents of the home at or above 140 degrees Fahrenheit. Findings include: Policies and procedures governing the temperatures of food served at the home were not provided for review on request. 1. During interviews conducted on 5/11/2026 two Residents stated meals at the home are cold when served. 2. Per observation of a sample plate provided on request on 5/11/2026, food items were served at temperatures lower than the required 140 degrees Fahrenheit during lunch service on 5/11/2026 including: a. Corn 108.5 degrees b. Cream Gravy 111.0 degrees c. Rice 123.6 degrees d. Meatloaf 115.2 degrees e. Gluten free pasta with chicken/red sauce 126.3 degrees f. Pasta with Sausage and Chicken: sausage 109.8 degrees and pasta with sauce 96.4 degrees At 2:46 PM on 5/11/2026. the Campus Administrator confirmed the temperatures of food items on a sample plate served during lunch on 5/11/2025 were below 140 degrees Fahrenheit.	R382		
R401 SS=F	9.1.a Environment	R401		

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R401	Continued From page 11 The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This includes outdoor areas that are used by residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure care in a safe, sanitary, comfortable and homelike environment. Findings include: The home's Environment policy effective 4/1/2025 states the purpose of the policy is to "maintain a safe, functional, sanitary, homelike, and comfortable environment as free of accident hazards as possible." Per this policy, monthly rounds will be conducted to ensure there are no areas that create a potential hazard to residents of the facility; and "areas of concern identified will be repaired timely according to level of urgency of the problem [sic]." 1. At 9:40 AM on 5/11/2026 the wooden exterior handicap ramp leading to the entrance of the home was observed to be cracked and splintering in areas where hands are placed when using the rails. Screws in the railings were observed to be rusted, with one rusted screw was protruding from the rail and almost completely exposed. Painted areas of the ramp were observed with paint that was cracked and chipping away. This finding was confirmed by the Campus Administrator during a review of findings commencing at approximately 2:25 PM on 5/11/2026. 2. At 10:40 AM on 5/11/2026 a resident's	R401		

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R401	Continued From page 12 personal compression stockings were left drying draped over the side of a sink in the common area where the dining room tables, medication room, and reception desk are located. The stockings were observed to remain draped across the area of the sink during the afternoon. At 2:35 PM on 5/11/2026 the Manager confirmed this finding and stated residents' compression stockings should be washed in resident bathrooms and hung to dry in the applicable resident's room. 3. At 11:05 AM on 5/11/2026 the area adjacent to the living room where 3 single occupancy resident rooms are located was observed with a strong odor of urine. During the tour of this area the odor was observed to be coming from the bathroom at the end of the hallway. At 3:21 PM on 5/11/2026 the Campus Administrator confirmed this finding.	R401		
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 secure storage of cleaning chemicals. Findings include: Policies and procedures governing secure storage of cleaning chemicals and other	R403		

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R403	Continued From page 13 hazardous items were not provided for review on request. The home's Environment policy effective 4/1/2025 states the purpose of the policy is to "maintain a safe, functional, sanitary, homelike, and comfortable environment as free of accident hazards as possible.". Per this policy, monthly rounds will be conducted to ensure there are no areas that create a potential hazard to residents of the facility; and "areas of concern identified will be repaired timely according to level of urgency of the problem [sic]." Residents of the home have varying abilities to safely manage access to cleaning chemicals. 1. Per observation. the home's kitchen is divided from the common areas of the home by a door which does not have a door knob and cannot be locked, leaving the kitchen accessible to residents at all times. At 10:28 AM on 5/11/2026 a set of keys was observed hanging inside an unlocked cabinet in the kitchen, which included the key to open the kitchen storage closet. Cleaning chemicals observed to be accessible in this closet included oven cleaner, bathroom disinfectant, multi-surface disinfectant, germicidal sani-cloth wipes, boxes of scented dryer sheets, concentrated carpet and upholstery cleaner, spot and stain floor cleaner, and stainless steel cleaner. 2. An unsecured spray bottle of Rapid Multi-Surface Disinfectant Cleaner was also observed to be unsecured and accessible in the unlocked cabinet under sink in home's reception area at 10:40 AM on 5/11/2026. These findings were confirmed by the Campus	R403		

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	0140	A. BUILDING: _____ B. WING _____	C 05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE LANE RETIREMENT HOME	33 MAPLE LANE BARTON, VT 05822

(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
R403	Continued From page 14 Administrator during a review of findings commencing at approximately 2:25 PM on 5/11/2026.	R403		
R434 SS=F	9.8.a Heating Each home must be equipped with a heating system which is of sufficient size and capability to maintain sufficient heat in all areas of the home used by residents, and which complies with applicable fire and safety rules. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews there is a failure to maintain sufficient heat in all areas of the home used by residents. Findings include: Policies and procedures governing the heating resident accessible areas of the home were not provided for review on request. 1. During interviews conducted on 5/11/2026, Residents indicated the home was insufficiently heated during the winter including statements that the residents had to wear coats inside, it was really cold in the home for what seemed like weeks, the floor is cold, and the wind blows right in through the windows. 2. Per observation, the home is constructed with a foyer between the main entrance and the dining room. At 3:07 PM on 5/11/2026 the Campus Administrator confirmed the door between the foyer and the dining room where residents frequently congregate has to be kept open during the winter to prevent the pipes in the foyer from	R434		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0140	A. BUILDING: _____ B. WING _____	C 05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE LANE RETIREMENT HOME	33 MAPLE LANE BARTON, VT 05822

(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
R434	Continued From page 15 freezing, which allows cold air flow from the exterior of the home into the areas of the home used by residents. The Administrator confirmed residents discussed this issue during a Resident Council meeting. 3. During the interview commencing at 7:58 AM on 5/12/2026 the Staff identified by the Campus Administrator as a supportive manager stated there is a wall heater in the foyer between the front door and the dining area. This Staff also confirmed the pipes in the foyer will freeze if the door between the foyer and the dining room is not left open when it gets cold during the winter. Per this Staff, during the winter the heater installed in the foyer was functioning properly, but it was not able to keep up well enough to prevent the pipes in that area from freezing when the door between the foyer and the dining room was closed. During the interview on the morning of 5/12/2026 the Staff stated additional space heaters were not placed in the dining room or the foyer to ensure the areas of the home used by residents were adequately heated; and confirmed many residents complained about the home being too cold including at the Resident Council Meeting. On the morning of 5/12/2026 the Staff identified as the supportive manager confirmed the heating issues in the home were an ongoing baseline issue during the winter. During interviews conducted on 5/11/2026 and 5/12/2026, the Campus Administrator and the Staff identified as a supportive manager both confirmed resident's complaints about the heating issues expressed during the Resident Council meeting were reported directly to the leadership team.	R434		

R141

How the deficiency was corrected

Resident #1 received the full course of antibiotic prescribed without negative effects identified related to the alleged deficient practice.

How other potential residents identified, and corrective action taken

Residents receiving new medication orders have the potential to be affected by the alleged deficient practice.

1. The facility has implemented the use of a back up medication kit to be used in the event a medication is not available.
2. Staff have been educated regarding the backup medication process.
3. Staff have been educated to contact the RN when a resident returns from the ER or other provider appointment to determine if new medications were ordered and available.

Date corrected

6/12/2026

System changes to ensure compliance of the regulation

Audits will be done weekly by the Registered Nurse to monitor effectiveness of the plan.

Who will monitor to ensure compliance

Registered Nurse

R172

How the deficiency was corrected

Resident #1 received the full course of antibiotic prescribed without negative effects identified related to the alleged deficient practice.

How other potential residents identified, and corrective action taken

Residents receiving new medication orders have the potential to be affected by the alleged deficient practice.

1. The facility has implemented the use of a backup medication kit to be used in the event a new medication is not available.
2. Staff have been educated regarding the backup medication process.
3. Staff have been educated to contact the RN when a resident returns from the ER or other provider appointment to determine if new medications were ordered and available.

System changes to ensure compliance with the regulation

Audits will be conducted weekly by the Registered Nurse to ensure medications are received as ordered.

Date corrected

6/12/2026

Who will monitor to ensure compliance

The Registered Nurse

R203

How the deficiency was corrected

The identified key that unlocks the medication refrigerator was immediately removed from the key ring at the time of survey and the remaining keys were relocated to the office area that is not accessible to residents.

How other potential residents identified, and corrective action taken

Residents able to access unlocked areas have the potential to be affected by the alleged deficient practice.

1. Staff have been educated to keep keys in the office area where they are not accessible to residents

System changes to ensure compliance with the regulation

Observation audits will be conducted weekly by the Manager or designee to ensure no residents have access to keys.

Date corrected

6/12/2026

Who will monitor to ensure compliance

The Facility Manager

R210

How the deficiency was corrected

The identified staff have completed required training courses.

How other potential residents identified, and corrective action taken

Residents residing in the facility have the potential to be affected by the alleged deficient practice.

1. Facility administration has reviewed the requirement for required training.
2. Staff working in the facility will complete required training courses upon hire prior to working on their own and annually thereafter.

System changes to ensure compliance with the regulation

The Facility Manager will conduct audits upon hire and annually of employees based on hire dates to ensure required training courses are complete.

Date corrected

6/12/2026

Who will monitor to ensure compliance

The Facility Manager

R225

How the deficiency was corrected

There were no negative effects to residents residing in the facility related to the alleged deficient practice. The 1 identified staff member has completed background checks and no issues were identified.

How other potential residents identified, and corrective action taken

Residents residing in the facility have the potential to be affected by the alleged deficient practice.

1. Facility management is aware of the requirement for annual background checks.
2. An audit has been completed to ensure other employees have had annual background checks and no others were found to be out of compliance.

System changes to ensure compliance with the regulation

The Facility Manager will conduct audits upon hire and annually thereafter to ensure required background checks are complete for employees.

Date corrected

5/11/2026

Who will monitor to ensure compliance

The Facility Manager

R366

How the deficiency was corrected

The grievance procedures were located in the common area upon entrance to the facility. The grievance procedure poster has been relocated to be next to the statement of resident rights that is also in the common area.

How other potential residents identified, and corrective action taken

Residents residing in the facility have the potential to be affected by the alleged deficient practice if they are unable to locate the grievance procedure poster.

1. Facility administration has reviewed the requirements for the grievance procedures to be posted in the same location as the statement of resident rights.
2.

System changes to ensure compliance with the regulation

The Facility Manager will monitor with daily checks to ensure the posters remain in the same location.

Date corrected

6/12/2026

Who will monitor to ensure compliance

The Facility Manager

R369

How the deficiency was corrected

The Certified Dietary Manager for the organization has provided education to staff responsible for cooking the meals following the recipe book to provide meals that are visually appealing and palatable.

How other potential residents identified, and corrective action taken

Residents consuming the food prepared have the potential to be affected.

1. Education has been provided regarding utilizing the recipe book to prepare the food.

System changes to ensure compliance with the regulation

The Facility Manager will conduct interviews with residents weekly regarding the quality of the food and implement further action as necessary.

Date corrected

6/12/2026

Who will monitor to ensure compliance

Facility Manager

R382
How the deficiency was corrected

A chart was provided for staff to indicate the required temperatures for food.
The facility would like to note that at the time of service to the residents the temperatures taken of the food were within normal limits.

How other potential residents identified, and corrective action taken
Residents consuming the food in the facility have the potential to be affected.

1. Education has been provided to staff regarding the process of keeping accurate temperature of food during service and the required temperatures.

System changes to ensure compliance with the regulation

The Facility Manager or designee will conduct twice weekly audits of food temperatures and once weekly interviews with residents to ensure satisfaction with meal service.
Date corrected

6/12/2026

Who will monitor to ensure compliance

The Facility Manager

R401
How the deficiency was corrected

The handicap ramp has been assessed for areas of splintering, peeling paint, and rusty/protruding screws as part of the summer maintenance program.
The identified bathroom has been thoroughly cleaned and odors addressed
The identified compression stockings were removed from the sink in the common area

How other potential residents identified, and corrective action taken

Residents residing in the facility have the potential to be affected by the alleged deficient practice.

1. All identified areas related to the handicap ramp will be repaired to ensure no splinters, peeling paint, or rusty protruding screws.
2. Staff will be educated regarding the procedure for rinsing compression stockings.

3. Staff will be educated regarding the cleaning of bathrooms in the facility and procedure to follow if odors are present.

System changes to ensure compliance with the regulation

Maintenance will include the handicap ramp in their monthly environmental rounds to ensure the handicap ramp remains in good repair once repairs are complete.

Cleanliness of the bathrooms to include odors will be checked daily by PCA staff working in the facility.

The Facility Manager will conduct weekly audits to ensure cleanliness of the bathrooms free from odors and appropriate care of compression stockings.

Date corrected

Handicap ramp: 7/5/2026

Bathroom odors and Compression Stocking care: 6/12/2026

Who will monitor to ensure compliance

Maintenance Director and Facility Manager

R403

How the deficiency was corrected

The identified set of keys were relocated to the office area that is secure
The identified spray bottle of Disinfectant Cleaner was relocated to a secure location not accessible by residents. This was done at time of survey.

How other potential residents identified, and corrective action taken

Residents residing in the facility have the potential to be affected by the alleged deficient practice.

1. Education will be provided to staff regarding the requirements for security of chemicals.

System changes to ensure compliance with the regulation

Audits will be conducted weekly by the facility manager or designee to ensure security of chemicals.

Date corrected

6/12/2026

Who will monitor to ensure compliance

Facility Manager

R434

How the deficiency was corrected

The facilities furnace was replaced within the last 2 years with identified sufficient BTU's to maintain temperatures within a required range. In February of 2026 there was an issue identified with the furnace that was addressed within 3 hours and the issue did not return.

The frozen pipes were addressed by Blanchard Oil at the time of the event.

The majority of the windows in the facility have been replaced. The windows will be assessed and repaired if needed to prevent drafts during colder months.

There is no immediate correction at this time due to warmer weather, and the heating is not an issue currently

How other potential residents identified, and corrective action taken

Residents residing in the facility during colder months have the potential to be affected by the alleged deficient practice.

System changes to ensure compliance with the regulation

As part of the summer maintenance program and prior to cooler weather, the facility will contact Blanchard Oil to assess the furnace and likelihood of frozen pipes and address repairs or changes if needed. The facility will request this preventative assessment be completed by end of September 2026.

PCA staff will include in their daily checks of the facility ambient room temperatures to ensure temperatures remain in the acceptable range. They will be educated on the process to follow if there are issues or complaints identified related to temperatures within the facility.

The facility environmental rounds performed by maintenance will include windows to ensure they are in good repair and free from significant drafts during cooler weather.

Date corrected

6/12/2026

Who will monitor to ensure compliance

Maintenance Director and Facility Manager