VERMONT

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

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

February 11, 2025

Liza Rixon, Manager
Sterling House At Richmond
61 Farr Road
Richmond, VT 05477-9301

Dear Ms. Rixon:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 14, 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
	0591	A. BUILDING: _____ B. WING _____	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE AT RICHMOND	61 FARR ROAD RICHMOND, VT 05477

(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 1/14/25 the Division of Licensing and Protection conducted an unannounced on-site annual relicensure survey. The following regulatory deficiencies were identified:	R100		
R179 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b 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. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not 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, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there	R179	See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0591	A. BUILDING: _____ B. WING _____	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE AT RICHMOND	61 FARR ROAD RICHMOND, VT 05477

(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
R179	Continued From page 1 was a failure to ensure 1 out of 5 sampled staff completed the required yearly trainings. Findings include: The home's Orientation and Staff Training policy is consistent with this regulation. During the survey on 1/14/25 the Manager was requested to provide documentation of the required yearly trainings for a sample of 5 staff. On review of the staff training documents provided, 1 out of 5 sampled staff did not complete all required yearly trainings. This finding was confirmed by the Manager at 5:30 PM on 1/14/25.	R179		
R200 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review policies and procedures governing the secure storage of chemicals have not been developed by the home. Findings include: On the afternoon of 1/14/25 the Manager of the home was requested to provide the home's policies and procedures governing the secure storage of chemicals. The home's Physical Plant policies and procedures provided in response to	R200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0591	A. BUILDING: _____ B. WING _____	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE AT RICHMOND	61 FARR ROAD RICHMOND, VT 05477

(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
R200	Continued From page 2 this request did not include policies and procedures governing secure storage of chemicals. This finding was confirmed by the Manager on the afternoon of 1/14/25.	R200		
R221 SS=F	VI. RESIDENTS' RIGHTS 6.9 Residents may manage their own personal finances. The home or licensee shall not manage a resident's finances unless requested in writing by the resident and then in accordance with the resident's wishes. The home or licensee shall keep a record of all transactions and make the record available, upon request, to the resident or legal representative, and shall provide the resident with an accounting of all transactions at least quarterly. Resident funds must be kept separate from other accounts or funds of the home. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to maintain a record of all transactions and provide an accounting of transactions at least quarterly for all residents for whom the home provides management of personal finances. Findings include: The home's Resident Funds and Property policy and procedures are consistent with these regulatory requirements. Per record review the home manages personal funds for 3 applicable residents (Residents #1, #2, an #3). A record transactions maintained by	R221		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0591	A. BUILDING: _____ B. WING _____	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE AT RICHMOND	61 FARR ROAD RICHMOND, VT 05477

(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
R221	Continued From page 3 the home did not include all transactions and an accounting of all transactions was not provided on at least a quarterly basis for all 3 applicable residents. Per interview with the Manager on the afternoon of 1/14/25, Resident #1 had not been provided a quarterly statement since March or 2024, Resident #2 had not been provided a quarterly statement since July of 2024, and the date of the last quarterly statement provided for Resident #3 was unknown. Additionally, the written requests to manage personal funds on file for Residents #1, #2, and #3 were without a date indicating when the written requests were made. These findings were confirmed by the Manager of the home on the afternoon of 1/14/25.	R221		
R266 SS=F	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure care in a safe environment related to unsecured cleaning chemicals stored in resident accessible areas of the home. Findings include: The home's Physical Plant policy and procedures provided for review on 1/14/25 does not include	R266		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0591	A. BUILDING: _____ B. WING _____	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE AT RICHMOND	61 FARR ROAD RICHMOND, VT 05477

(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
R266	Continued From page 4 policies governing secure storage of cleaning chemicals in resident accessible areas. During the facility tour commencing at 10:45 AM on 1/14/25 unsecured cleaning chemicals were observed to be stored in the home's unlocked Salon, in resident room #107, and in the shared first floor bathroom. Cleaning products accessible to residents in these areas included Woolite laundry detergent, Lysol disinfectant spray, Scrubbing Bubbles Bathroom Disinfectant spray, Mr. Clean multi-purpose cleaning spray, Lysol toilet disinfecting gel, and Lysol All Purpose cleaning spray. These findings were confirmed by the Manager of the home on the morning of 1/14/25.	R266		
R291 SS=F	IX. PHYSICAL PLANT 9.6 Plumbing 9.6.d Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure water temperatures are maintained at or below 120 degrees Fahrenheit. Findings include: Policies and procedures developed by the home governing maintenance of water temperatures in resident accessible areas are consistent with this regulation. During the facility tour commencing at 10:45 AM	R291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0591	A. BUILDING: _____ B. WING _____	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE AT RICHMOND	61 FARR ROAD RICHMOND, VT 05477

(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
R291	Continued From page 5 on 1/14/25 the water temperature in the second floor bathroom for resident rooms #204 A and B was observed to be 130.5 degrees Fahrenheit. This finding was confirmed by the Manager during the facility tour on the morning of 1/26/25. Following adjustments made to the home's water heating system by a contracted company the water temperatures in this area were confirmed to be maintained at or below 120 degrees Fahrenheit at 3:53 PM on 1/14/25.	R291		

Deficiency Statement Plan of Correction (POC)

Survey Date: January 14,2025

Facility Name: Sterling House at Richmond

Deficiency Regulation	How the deficiency was corrected	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R179 Plan of Correction accepted by Jo A Evans RN on 2/10/25	Employee was provided required yearly training. Documentation completed.	1/31/2025	Summary checklist of education will be completed for each employee. Back up documentation will be maintained with checklist.	Manager will review quarterly for compliance
R221 Plan of Correction accepted by Jo A Evans RN on 2/10/25	Resident Funds log was updated with current transactions and statements were provided to resident/responsible persons	2/4/2025	Accounting of transactions will be reviewed monthly to ensure completion. Quarterly statements have been sent & will be sent and summarized on a check sheet.	Manager will monitor monthly for compliance
R266 Plan of Correction accepted by Jo A Evans RN on 2/10/25	Chemicals were removed from unsecured areas. An audit was completed in each resident's room for any other chemicals, resident/families updated. Environment Policy and Procedure was revised to include secure storage of chemicals.	2/5/2025	Locks have been added to areas that store chemicals. Notice to residents/families has been provided about securing chemicals if they would like them in the resident's room. Random rounds will be conducted weekly x4weeks. Safety rounds will be conducted quarterly.	Manager will review results of rounds to ensure compliance
R291 Plan of correction accepted by Jo A Evans RN on 2/10/25	Water temp was corrected that day by contracted company.	1/14/2025	Monthly water temps will be conducted and recorded on preventative maintenance sheets	Manager will review PM sheets for compliance.

Environmental manager 2/5/2025