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 25, 2025

Amy Visser-Lynch, Manager
Historic Homes Of Runnemede-Evarts House
40 Maxwell Perkins Lane
Windsor, VT 05089

Dear Ms. Visser-Lynch:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 22, 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
	0374	A. BUILDING: _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HISTORIC HOMES OF RUNNEMEDE-EVARTS HOUSE	40 MAXWELL PERKINS LANE WINDSOR, VT 05089

(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: An unannounced onsite relicensure survey and complaint investigation was conducted by Division of Licensing and Protection 1/22/25. The complaint investigation resulted in substantial compliance with regulatory requirements. The relicensure survey identified regulatory deficiencies. Findings include:	R100		
R147 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (4) Maintain a current list for review by staff and physician of all residents' medications. The list shall include: resident's name; medications; date medication ordered; dosage and frequency of administration; and likely side effects to monitor; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the RCH failed to ensure medication orders provided specific dosage and/or frequency of administration for 2 out 3 residents of the applicable sample. Per record review the standing medication orders, for Residents #1 and #2 include directions of use to indicate range dosage and/or frequencies for medications: Mucinex 1 or 2 tablets, by mouth every 12 hours as needed for cough, Mylanta 15 cc-30 cc every 4 hours for indigestion, Tums 2 tablets every 2-3 hours for indigestion. Additionally, Resident #1 has a prn medication order, Trazodone 25 mg take 1 and 1/2 tablets by	R147		

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R147	Continued From page 1 mouth twice daily as needed for depression. The order does not include an identified time frequency in between administrations in which the medication may be administered. Per interview on 1/22/25 at 12:40 PM, the Manager confirmed the standing orders include range dosages and frequencies.	R147		
R161 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.b The manager of the home is responsible for ensuring that all medications are handled according to the home's policies and that designated staff are fully trained in the policies and procedures. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the Manager failed to ensure medications were handled according to the home's policies. Per record review Resident #1, #2 and Resident # 3 Medication administration record were not appropriately documented to account for the administration of medications. The facility policy states, "Medications administered will be documented on the resident's individual medication record, PRN (as needed) medications will be documented as to date, time, reason for and effect." Per interview on 1/11/25 at 1:45 PM, Med Staff confirmed the Medication Administration Record	R161		

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R161	Continued From page 2 to have a reference legend staff are to utilize in documenting medications, to account for refused or medications not given. The Medication Administration Record (MAR) for January 2025 were reviewed and had the following medication not documented to account for the administration of the medications. Resident #1 the medications include Vitamin B-12, Vitamin D3, Alphagan eye drops, Tylenol, DSS capsules (docusate sodium), and Trazodone. Resident #2 the medications include Tylenol and Sodium Chloride. Resident #3 the medications include Asmanex, Omperazole, ondansetro, Acetaminophen, and Lantus. Also, Resident #3 has an order to obtain blood glucose every AM, the documentation occurs on the MAR and blood glucose recording sheet. The MAR was not documented to occur on January 14-16th. The blood glucose log was not documented with recordings on January 5,7,10, 14,15,17,18,19. An interview on 1/22/25 at 1:30 PM, the Manager confirmed the MARs for Resident #1, #2, #3 and the incomplete documentation to account for administrations.	R161		
R167 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer	R167		

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R167	Continued From page 3 medications under the following conditions: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; 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. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the Registered Nurse (RN) failed to develop written care plans to demonstrate the use of as needed (PRN) psychoactive medications for 1 out 4 residents of the applicable sample. Findings include: Per record review Residents #1 was prescribed psychoactive medication to be administered as needed to modify behaviors. Resident #1 orders include prescribed Trazodone 50 mg, take 75 mg (1 and 1/2 tablets) by mouth twice daily as needed for depression. Per interview on 1/22/25 at 12:15 PM the Manager, confirmed a care plan has not been developed for unlicensed staff to reference prior to the administration of the PRN psychoactive medication for Resident #1.	R167		
R179 SS=D	V. RESIDENT CARE AND HOME SERVICES	R179		

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R179	Continued From page 4 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 was a failure to ensure 1 out of 5 sampled staff completed all required yearly trainings. Findings include: The home's policies and procedures governing staff training are consistent with this regulatory requirement.	R179		

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R179	Continued From page 5 On the morning of 1/22/25 the Manager was requested to provide documentation of training completed for a sample of 5 staff. Per review of the staff training records provided for review, 1 out of 5 sampled staff did not complete all the required yearly trainings. Per interview on 1/22/25 at 1220 PM, the Manager confirmed the staffing educations records, acknowledging 1 staff had not completed all of the required annual.	R179		
R250 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.e The use of outdated, unlabeled or damaged canned goods is prohibited and such goods shall not be maintained on the premises. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the RCH failed to ensure food items stored within the refrigerator were labeled and dated to indicate when items are to be used by. Per observation on 1/22/25 at 9:50 AM the kitchen refrigerator was observed to store varying containers of prepared food and deli meats that were unlabeled and not dated to indicate the date of preparation and/or use by dates. The facility's policy and procedure for Food Services does not establish a procedure for labelling and dating foods, with use by dates of perishable and/or prepared foods.	R250		

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R250	Continued From page 6 Per interview on 1/22/25 at 11:20 AM the Manager confirmed kitchen services are provided by a vendor and would review the requirement to ensure proper labeling and dating occurs on perishable food items.	R250		
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 interviews, the RCH failed to ensure a safe environment within the kitchen area of the facility. Per observation during the facility tour of the kitchen at approximately 9:50 AM, a portable steam table was observed stored on the counter of the kitchen. Upon inspection the 3 of the lids were hot to touch, upon lifting the lid, water was observed in a rolling boil. Through further observation, the kitchen has two points of entry, in which each entry the doors remained open. The kitchen was observed to be unsupervised by staff for periods of time throughout the onsite visit. Per interview on 1/22/25 at 12:40 PM, staff confirmed the kitchen doors remain open and are not closed or secured, allowing access to the kitchen by residents.	R266		

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R266	Continued From page 7 On 1/22/25 at 10:30 PM, the Manager confirmed the observations identified. The Manager was unable to provide a policy that would indicate the facility practice providing safety with use of the steam table in the Kitchen area.	R266		
R302 SS=F	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that fire drills were conducted at specific rotating times of the day per regulations. Findings include: During review of the fire drill logs kept by the facility, 2 fire drills were documented as completed within the last year. The facility's policy and procedure for Fire Drills identifies the requirement per regulation.	R302		

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R302	Continued From page 8 Per interview on 1/22/25 12:10 PM, the Manager confirmed the documentation of 2 completed drills on 11/21/24 and 11/22/24. The Manager confirmed no additional fire drills have been completed.	R302		

Deficiency Statement Plan of Correction (POC)

Survey Date: 1/22/2025

Facility Name: Historic Homes of Runnemede – Evarts House

Deficiency Regulation	Tag	How the deficiency was corrected	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
1. Based on record review and staff interviews, the RCH failed to ensure medication orders provided specific dosage and/or frequency of administration for 2 out 3 residents of the applicable sample. Per record review the standing medication orders, for Residents #1 and #2 include directions of use to indicate range dosage and/or frequencies for medications: Mucinex 1 or 2 tablets, by mouth every 12 hours as needed for cough, Mylanta 15 cc-30 cc every 4 hours for indigestion, Tums 2 tablets every 2-3 hours for indigestion. Additionally, Resident #1 has a prn medication order, Trazodone 25 mg take 1 and 1/2 tablets by mouth twice daily as needed for depression. The order does not include an identified time frequency in between administrations in which the medication may be administered.	R147 5.9.c (4)	During medication administration record review and new order transcription, nursing staff will not accept any range orders. They will be addressed with the ordering provider for clarification prior to transcription.	2/11/2025	Process in place to review and clarify medication orders.	Nursing staff will complete regular chart reviews and correct any issues noted monthly at a minimum. Nursing will report findings of reviews to administration and nursing leadership for management. R147 Accepted Jenielle Shea, RN 2/24/25
2. Based on record review and staff interview, the Manager failed to ensure medications were handled according to the home's policies. Per record review Resident #1, #2 and Resident # 3 Medication administration record were not appropriately documented to account for the administration of medications. The facility policy states, "Medications	R161 5.10.b	Nursing staff are to review MAR at set intervals for completeness and provide feedback, education, and guidance to medication administration PCAs on proper medication administration documentation.	2/12/2025	Process in place to review and rectify medication administration documentation.	Nursing staff will complete regular MAR reviews and address deficiencies weekly at a minimum. Nursing will report findings of reviews to administration and nursing leadership for management.

administered will be documented on the resident's individual medication record, PRN (as needed) medications will be documented as to date, time, reason for and effect." Per interview on 1/11/25 at 1:45 PM, Med Staff confirmed the Medication Administration Record to have a reference legend staff are to utilize in documenting medications, to account for refused or medications not given. The Medication Administration Record (MAR) for January 2025 were reviewed and had the following medication not documented to account for the administration of the medications. Resident #1 the medications include Vitamin B-12, Vitamin D3, Alphagan eye drops, Tylenol, DSS capsules (docusate sodium), and Trazodone. Resident #2 the medications include Tylenol and Sodium Chloride. Resident #3 the medications include Asmanex, Omperazole, ondansetro, Acetaminophen, and Lantus. Also, Resident #3 has an order to obtain blood glucose every AM, the documentation occurs on the MAR and blood glucose recording sheet. The MAR was not documented to occur on January 14-16th. The blood glucose log was not documented with recordings on January 5,7,10,14,15,17,18,19.					R161 Accepted Jenielle Shea, RN 2/24/25
3. Based on staff interview and record review the Registered Nurse (RN) failed to develop written care plans to demonstrate the use of as needed (PRN) psychoactive medications for 1 out 4 residents of the applicable sample. Findings include: Per record review Residents #1 was prescribed psychoactive medication to be administered as needed to modify behaviors.	R167 5.10.d	Nursing staff are to review behavior tracking sheets for psychoactive medications at set intervals for completeness and provide feedback, education, and guidance to medication administration PCAs on proper documentation of behaviors.	2/28/25	Process in place to review behavior documentation. Audit of residents on psychoactive medications and existing care plans is underway.	Nursing staff will complete regular psychoactive medication behavior tracking sheet and care plan reviews and address deficiencies weekly at a minimum. Nursing will report findings of reviews to administration and

Resident #1 orders include prescribed Trazodone 50 mg, take 75 mg (1 and 1/2 tablets) by mouth twice daily as needed for depression. Per interview on 1/22/25 at 12:15 PM the Manager, confirmed a care plan has not been developed for unlicensed staff to reference prior to the administration of the PRN psychoactive medication for Resident #1.		On admission, as needed [based upon behavior documentation & other data collected], and at least annually RN nursing staff will initiate and / or update written care plans for all residents on psychoactive medications.		Care plans will be updated as needed by the nursing staff.	nursing leadership for management. R167 Accepted Jenielle Shea, RN 2/24/25
4. Based on staff interview and record review there was a failure to ensure 1 out of 5 sampled staff completed all required yearly trainings. Findings include: The home's policies and procedures governing staff training are consistent with this regulatory requirement. On the morning of 1/22/25 the Manager was requested to provide documentation of training completed for a sample of 5 staff. Per review of the staff training records provided for review, 1 out of 5 sampled staff did not complete all the required yearly trainings.	R179 5.11.b	Standardized education program to include 7 core elements plus other pertinent topics has been adopted. (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.	3/31/25	Process to assign and track completion of the standardized education program on hire and annually to be developed.	Administration and nursing leadership to assign, track compliance, and provide disciplinary actions as needed for non-compliance. R179 Accepted Jenielle Shea, RN 2/24/25
5. Per observation on 1/22/25 at 9:50 AM the	R250 7.2.e	Policy / procedure on labeling and dating of food items to be	2/28/2025	On-going education and practice auditing	Administration or their delegees will audit food storage locations

kitchen refrigerator was observed to store varying containers of prepared food and deli meats that were unlabeled and not dated to indicate the date of preparation and/or use by dates. The facility's policy and procedure for Food Services does not establish a procedure for labelling and dating foods, with use by dates of perishable and/or prepared foods.		revised to include specific guidance. Staff members who handle resident food items will be educated on the revised policy / procedure.		processes will be established and maintained.	at regular intervals to ensure proper dating of food items. Remedial education will be provided as needed. R250 Accepted Jenielle Shea, RN 2/24/25
6. Per observation during the facility tour of the kitchen at approximately 9:50 AM, a portable steam table was observed stored on the counter of the kitchen. Upon inspection the 3 of the lids were hot to touch, upon lifting the lid, water was observed in a rolling boil. Through further observation, the kitchen has two points of entry, in which each entry the doors remained open. The kitchen was observed to be unsupervised by staff for periods of time throughout the onsite visit.	R266 9.1.a	Educate staff operating the steam table on the manufacturer's instructions for use. Post safety and operating instructions at the point of use. Set policy that the kitchen must be monitored while the steam table is in use.	2/19/2025	Establish training and safe operation standards for use of the steam table.	Administration or their delegees will monitor adherence of safe steam table operation. Remedial education will be provided as needed. R266 Accepted Jenielle Shea, RN 2/25/24
7. Based on staff interview and record review, the facility failed to ensure that fire drills were conducted at specific rotating times of the day per regulations. Findings include: During review of the fire drill logs kept by the facility, 2 fire drills were documented as completed within the last year. The facility's policy and procedure for Fire Drills identifies the requirement per regulation.	R302 9.11.c	Facility personnel will conduct periodic fire drills at rotating times of the day a minimum of four times yearly.	2/19/2025	Fire drills will be scheduled monthly at rotating times of day to ensure all shifts are drilled with regularity. R302 Accepted Jenielle Shea, RN 2/24/25	Administration or their delegees will monitor completion of planned fire drills to ensure the minimum required drills are performed at rotating times within a calendar year. Adjustments to scheduled drills will occur to ensure compliance with the minimum standard as needed.