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

March 11, 2025

Kathleen Michaels, Manager
Our Lady Of Providence
47 West Spring Street
Winooski, VT 05404-1397

Dear Ms. Michaels:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 28, 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
	0198	A. BUILDING: _____ B. WING _____	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PROVIDENCE	47 WEST SPRING STREET WINOOSKI, VT 05404

(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 1/28/25 the Division of Licensing and Protection conducted an unannounced on-site annual relicensure survey. The following regulatory deficiencies were identified:	R100	Please refer to the attached document to review corrective actions for all tags.	
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 5 out	R179	R179 Plan of Correction accepted by Jo A Evans RN on 3/7/25.	

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R179	Continued From page 1 of 5 sampled staff did not complete all required yearly trainings. Findings include: The home's policies and procedures governing staff training provided for review on 1/28/25 do not identify the required yearly trainings to be completed. Per review of training records on file for a sample of 5 staff, the required yearly trainings were not completed as required by 5 out of 5 sampled staff. This finding was confirmed by the Administrator at 2:55 PM on 1/28/25.	R179		
R190 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) 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 was a failure to complete all required criminal record and abuse registry background checks for 5 out of 5 sampled staff. Findings include: The home's policies and procedures governing staff background checks are not consistent with the current regulatory requirements. Per review of criminal record and abuse registry checks on file for a sample of 5 staff, all required background checks were not completed as required for 5 out of 5 sampled staff. This findings was confirmed by the Administrator at 1:22 PM on 1/28/25.	R190	R190 Plan of Correction accepted by Jo A Evans RN on 3/7/25	

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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 there was a failure to ensure policies and procedures have been developed governing environmental maintenance and safety; and a failure to ensure policies and procedures related to staff trainings and background checks, and completion of fire drills are consistent with regulatory requirements. Findings include: During the survey conducted on 1/28/25 the Administrator confirmed policies and procedures related to maintenance of the residential living environment, ensuring hazardous chemicals are stored in locked compartments in resident accessible areas, and ensuring water temperatures in resident accessible areas of the home are maintained at or below 120 degrees Fahrenheit had not been developed by the home. Additionally, the Administrator confirmed policies and procedures on file and available for review related to staff yearly trainings, staff criminal record and abuse registry background checks, and completion of fire drills were not consistent with the regulatory requirements.	R200	R200 Plan of Correction accepted by Jo A Evans RN on 3/7/25.	
R247 SS=F	VII. NUTRITION AND FOOD SERVICES	R247		

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R247	Continued From page 3 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall 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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure all perishable foods and beverages are labeled indicating the date the items were opened or prepared. Findings include: The home's policies and procedures governing storage and labeling of perishable foods and beverages are consistent with this regulatory requirement. During the tour of the home commencing at 10:30 AM on 1/28/25 the following perishable foods and beverages were observed in the dining room kitchenette and main kitchen without labels indicating the dates the items were opened or prepared: 1. In the Dining Room Kitchenette Refrigerator: dairy products, condiments, apple sauce, whipped cream without a lid, chocolate sauce, small containers of a brown sauce without an identifying label, and an undated opened 3 gallon container of ice cream. 2. In the reach-in refrigerator in the kitchen: an unlabeled tub of chopped potatoes in water, milk, large containers of sour cream and cottage cheese, condiments, sauces, stock, cheese, and an unlabeled stainless steel tray of prepared rice.	R247	R247 Plan of Correction accepted by Jo A Evans RN 3/7/25.	

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R247	Continued From page 4 These findings were confirmed by the Director for Dining Services on the morning or 1/28/25.	R247		
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, comfortable and homelike environment. Findings include: Policies and procedures governing maintenance of the home's living environment and governing secure storage of hazardous chemicals were not on file and available for review on request. During a tour of the home commencing at 10:35 AM on 1/28/25 the following environmental concerns were observed: 1. The cabinets and hood above the oven in the kitchenette near the serving area of the dining room were in need of cleaning. A drawer in this resident accessible area was observed to contain several small sharp knives which the Director of Dining Services stated are not permitted to be stored in resident accessible areas. 2. There were unsecured hazardous chemicals	R266	R266 Plan of Correction accepted by Jo A Evans RN on 3/7/25.	

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R266	Continued From page 5 observed to be stored in open areas of the kitchen prep and dishwashing room adjacent to the dining room including detergents, glass cleaner, oven cleaner, and disinfectant sprays. This area of the home was accessible to residents via open doorways from dining room and the first floor hallways. 3. In the walk-in freezer adjacent to the kitchen there was a build-up of ice that had fallen to the floor in chunks. Ice was observed covering the freezer ceiling, walls, and shelves. Ice build-up was also observed covering boxes of food and inside open boxes containing food. These findings were confirmed by the Director of Dining Services during the tour of the food service areas of the home on the morning of 1/28/25. 4. Damaged ceiling tiles were observed throughout the home. Examples include the end of the East wing hallway and the west wing laundry room on the second floor where ceiling tiles were observed with areas that were stained, swelling ,cracked, broken and with sections of tile that were poorly articulating with the metal framework that holds the tiles in place. 5. An unlocked maintenance closet on the second floor of the East wing was observed with paint, cleaning supplies, disinfectant spray, Goof Off Heavy Duty Remover spray for dissolving pain and adhesives, and a 5 gallon container containing a corrosive chemical. There findings were confirmed by the Licensed Practical Nurse during the tour of the home on the morning of 1/28/25.	R266		

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R291	Continued From page 6	R291		
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 thee is a failure to ensure water temperatures are maintained at or below 120 degrees Fahrenheit in areas of the home accessible to residents. Findings include: Policies and procedures governing water temperatures in resident accessible areas have not been developed by the home. During a tour of the home commencing at 10:35 AM on 1/29/25 water temperatures were observed to be maintained above 120 degrees Fahrenheit in the following resident accessible areas: 1. First Floor Bathroom East Wing #1 121.5 Degrees 2. First Floor Bathroom East Wing #2 125 Degrees 3. First Floor Tub room East Wing 122 Degrees 4. First Floor Laundry Room East Wing 123 Degrees 5. Resident Room 212 123.5 Degrees 6. Resident Room 213 129 Degrees 7. Resident Room 215 123 Degrees 8. Resident Room 224 131.5 Degrees 9. Resident Room 237 125.5 Degrees	R291	R291 Plan of Correction accepted by Jo A Evans RN on 3/7/25.	

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R291	Continued From page 7 10. Resident Room 252 125 Degrees These findings were confirmed by the Licensed Practical Nurse during the tour of the home on the on the morning of 1/28/25. Following adjustments to the boiler made by facility staff, water temperatures were confirmed by the Director of Facilities to be maintained at or below 120 degrees Fahrenheit in the resident accessible areas listed above. The Director of Facilities stated the facility created a plan on 1/28/25 for water heating system repairs to be completed.	R291		

Deficiency Statement Plan of Correction (POC)

Survey Date: 1/28/2025

Facility Name: Our Lady of Providence

Deficiency Regulation	How the deficiency was corrected	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R179 SS=F 5.11.b (1-7)	ORIENTAION AND TRAINING POLICY RE-WRITTEN AND CLEARLY IDENTIFY YEARLY TRAININGS TO BE COMPLETED. STAFF WERE REMINDED OF ANNUAL TRAININGS DUE AND SCHEDULED TIME TO COMPLETE.	2/10/2025	POLICY AND PROCEDURE UPDATED IN POLICY AND PROCEDURE BINDER AND SAVED TO STAFF SHARED DRIVE. MONTHLY REMINDERS AND QUARTERLY REVIEW OF STAFF TRAINING WILL BE COMLETED TO ENSURE COMPLETION OF TRAINING AND CONTINUED COMPLIANCE. STAFF HAS BEEN ASKED TO COMPLETE OVERDUE RESIDENT EMERGENCY RESPONSE AND FIRST AID TRAINING AND RESIDENT RIGHTS TRAINING BY 3/10/2025.	ADMINISTRATOR, DIRECTOR OF NURSING, DIRECTOR OF FACILITIES
R190 SS=F 5.12.b(4)	BEORE A POTENTIAL EMPLOYEE IS HIRED WE WILL RUN THE 4 MANDATED BACKGROUND CHECKS.	2/10/2025 - 2/19/2025	THE NURSE COORDINATOR WILL RUN THE BACKGROUND CHECKS AND WILL BE RERUN YEARLY DURING THE MONTH OF JANUARY.	ADMINISTRATOR
R200 SS=F 5.15	POLICIES AND PROCEDURES WERE UPDATED.	2/13/2025	UPDATED POLICIES AND PROCEDURES MADE AVAILABLE IN RECEPTION UPON REQUEST.	DIRECTOR OF FACILITIES
R200 SS=F 5.15	TIME OF FIRE DRILLS WILL BE ADJUSTED ACCORDINGLY.	2/13/2025	TIME OF FIRE DRILLS WILL BE WITHIN EACH SHIFT, AT LEAST TWICE PER SHIFT, A DRILL CONDUCTED AT LEAST QUARTERLY AND NO LESS THAN 6 DRILLS PER YEAR.	DIRECTOR OF FACILITIES
R247 SS=F 7.2 b	ALL PERISHABLE FOOD AND DRINK HAVE BEEN PROPERLY LABELED, DATED AND ARE HELD AT PROPER TEMPERATURES.	1/29/2025	THERE IS A CHART TO FILL OUT EVERY DAY THAT HAS TEMPERATURE READING AND IS POSTED NEXT TO WALK-IN. IT HAS TO BE UPDATED EACH DAY. ANY AND ALL FOOD NOT LABELED WILL BE DISPOSED OF. ALL ITEMS ARE TO BE LABELED AND DATED WHEN OPENED.	DIRECTOR OF DINING, CO-DIRECTOR OF DINING, DISH STAFF
R247 SS=F 7.2 b (1)	ALL THE ITEMS IN DINING ROOM KITCHEN REFRIGERATOR HAVE BEEN LABELED AND DATED AND A NOTICE HAS BEEN PUT ON REFRIGERTAOR.	1/29/2025	PUT UP NOTICE ON THE REFRIGERATOR STATING THAT ALL FOOD MUST BE LABELED AND DATED AND CHECKED BY STAFF EACH DAY.	DIRECTOR OF DINING
R247 SS=F 7.2 b (2)	REACH-IN REFRIGERATOR IN KITCHEN HAS BEEN LABELED AND DATED. ALL	2/1/2025	WEEKLY MEETINGS WILL BE HELD WITH ALL THE KITCHEN STAFF.	DIRECTOR OF DINING

Kathleen Mchall 3/4/25

R179, R190, R200, R247, R266, and R291 Plans of Correction accepted by Jo A Evans RN on 3/7/25.

	OPEN UNLABELED ITEMS HAVE BEEN DISPOSED OF.			
R266 SS=F 9.1. a	POLICIES AND PROCEDURES WERE UPDATED.	2/13/2025	UPDATED POLICIES AND PROCEDURES MADE AVAILABLE IN RECEPTION UPON REQUEST.	DIRECTOR OF FACILITIES
R266 SS=F 9.1.a (1)	CABINETS AND HOOD HAVE BEEN CLEANED AND PUT ON A WEEKLY CLEANING SCHEDULE. ALL SMALL SHARP KNIVES HAVE BEEN REMOVED.	2/12/2025	MEETING WITH ALL KITCHEN STAFF ON INSTRUCTING HOW TO CLEAN AND STORE AND TO FOLLOW CLEANING SCHEDULE.	DIRECTOR OF DINING, CO-DIRECTOR OF DINING
R266 SS=F 9.1.a (2)	ALL CLEANING ITEMS HAVE BEEN REMOVED AND STORED IN A LOCKED CABINET. NOTICE PUT UP STATING TO KEEP CHEMICALS IN LOCKED CABINET.	2/11/2025	NOTICE WAS PUT UP AND STAFF HAS BEEN INSTRUCTED OF PROTOCALS.	DIRECTOR OF DINING, CO- DIRECTOR OF DINING
R266 SS=F 9.1.a (3)	ALL BUILT-UP ICE IN WALK-IN FREEZER HAS BEEN REMOVED. ALL BOXES THAT WERE COVERED WITH ICE BUILD-UP HAVE BEEN DISPOSED OF.	2/15/2025	KITCHEN STAFF WILL CHECK EACH DAY TO SEE THAT N BOXES ARE LEFT OPEN AND ANY ICE BUILD-UP WILL BE REMOVED. FREEZER WILL BE CLEANED WEEKLY.	DIRECTOR OF DINING, CO-DIRECTOR OF DINING
R266 SS=F 9.1.a (4)	DAMAGED CEILING TILES WERE REPLACED.	2/13/2025	DAMAGED CEILING TILES WILL BE REPLACED OR REPAIRED AS STAINS OR DAMAGE OCCUR.	DIRECTOR OF FACILITIES
R266 SS=F 9.1.a (5)	UNSECURED CHEMICALS WERE MOVED TO A LOCKED CLOSET.	1/28/2025	HAZARDOUS CHEMICALS WILL BE STORED IN A LOCKED AREA AWAY FROM IMMEDIATE REACH OF RESIDENTS.	DIRECTOR OF FACILITIES
R291 SS=F 9.6.d (1-10)	REPAIR SERVICES PREFORMED ON FAULTY MIXING VALVE.	1/28/2025	TEMPERATURES WILL CONTINUE TO BE MONITORED ON A WEEKLY BASIS AND LOGGED IN LOGBOOK.	DIRECTOR OF FACILITIES

ADMINISTRATOR, KATHLEEN MICHAELS K Michaels 3/4/25

REVISED 3/03/2025

R179, R190, R200, R247, R266, and R291 Plans of Correction accepted by Jo A Evans RN on 3/7/25.