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

Kate Driver, Manager
Homestead Senior Living
64 Harborview Drive
St Albans, VT 05478-4477

Dear Ms. Driver:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 12, 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
	0605	A. BUILDING: _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD SENIOR LIVING	64 HARBORVIEW DRIVE ST ALBANS, VT 05478

(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 2/12/25 the Division of Licensing and Protection conducted an unannounced on-site annual re-licensing survey and an investigation of one complaint. There were no regulatory deficiencies identified during the complaint investigation. The following regulatory deficiencies were identified during the annual survey:	R100	Please see attached document to review the accepted corrective actions for each individual citation.	
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 NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.e The use of outdated, unlabeled or damaged canned goods is prohibited and such goods shall not be maintained on the premises.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 and staff interview there was a failure to ensure dented cans are not maintained on the premises. Findings include: The facility's policy for storage and disposal of dented cans is consistent with this regulatory requirement. During a tour of the facility's food storage area on the morning of 2/12/25 dented cans were observed to be stored with foods to be served to residents including eight #10 dented cans of fruit and vegetables, and eight 14 oz cans of sweetened condensed milk. This finding was confirmed by the Executive Director at 10:23 AM on 2/12/25.	R250	R250 Plan of Correction accepted by Jo A Evans RN on 3/6/25.	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Kate Bonn TITLE Executive Director (X6) DATE 3/4/25

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R266	Continued From page 1	R266		
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 is a failure to ensure care in a safe, functional, sanitary, homelike and comfortable environment related to the condition of the facility carpeting. Findings include: On the morning of 2/12/25 the carpeting in the dining room was observed to be in poor repair with multiple areas where the carpeting is fraying and worn away, discolored due to extensive staining, and rippled which is a risk for falls and injury. During observation of lunch service one resident expressed concerns about the safety of the carpeting, and 2 other residents seated at the same table expressed concerns about the staining and fraying of the carpeting. Facility Staff reported attempts to clean the carpeting to remove the stains have not changed the appearance of the carpet. While other areas of the carpeting throughout the home were also observed with staining and wear, the dining room carpet was observed to have the most significant damage. These findings were confirmed by the Executive Director on the afternoon of 2/12/25. This is a repeat citation.	R266	R266 Plan of Correction accepted by Jo A Evans RN on 3/6/25.	

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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 record review and staff interview there was a failure to document the time drills were conducted. Findings include: The facility's Fire Safety Training and Drills policy is consistent with this regulatory requirement. On the morning of 2/12/25 the Executive Director was requested to provide documentation of fire drills conducted at the facility during the previous year. Per review of the fire drill records provided for review, the form used by the facility to document the drills conducted did not include a place for the staff to document the time fire drills are conducted. Due to the failure to document the timing of fire drills, the facility was unable to demonstrate compliance with the regulatory requirement to conduct at least one yearly fire drill	R302	R302 Plan of Correction accepted by Jo A Evans RN on 3/6/25.	

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R302	Continued From page 3 during the morning, afternoon, evening, and night. This finding was confirmed by the Executive Director at 1:50 PM on 2/12/25.	R302		

Deficiency Statement Plan of Correction (POC)

Survey Date: February 12, 2025

Facility Name: Homestead Senior Living

Deficiency Regulation	How the deficiency was corrected	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R250 7.2 7.2e	All dented cans were removed and returned to vendor. R250 accepted by Jo A Evans RN on 3/6/25.	2/12/2025	Physical and visual confirmation of each can upon receipt from vendor from ED and DSD. Educated DSD about dented can policy and signed off.	ED & DSD to weekly audit to confirm practice in place for 3 months. Monitor in QA monthly for 6 months.
R302 9.11 9.11.c	Going forward all Fire Drills are done in military time and reflected in TELs system. R302 accepted by Jo A Evans RN on 3/6/25.	2/12/2025	ED & DOF will utilize military time for paper tracking and the TELs system is utilized for all monthly tracking of Fire Drills. Educated new DOF on Fire Drill protocol in TEL's	ED and DOF will monitor monthly to ensure military time and TEL's system is updated for 12 months. Monitor in QA monthly for 6 months.
R266 9.1 9.1.a	Carpets are being quoted for replacement. R266 accepted by Jo A Evans RN on 3/6/25.	2/17/2025	Carpets are cleaned before and after each meal service. Management Company is procuring measurements for replacement.	ED follows up weekly with Management Company on carpet replacement timeline. Monitor in QA monthly for 6 months.
R100	No deficiency found			