VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
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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

August 22, 2025

Luis Marin, Manager
Vista Senior Living
103 Us Route 4
Killington, VT 05751

Dear Mr. Marin:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 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
	0664	A. BUILDING: _____ B. WING _____	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA SENIOR LIVING	103 US ROUTE 4 KILLINGTON, VT 05751

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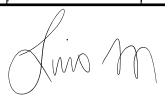
R100	Initial Comments On 7/28/25 the Division of Licensing and Protection conducted an unannounced on-site annual survey. The following regulatory deficiencies were identified:	R100		
R105 SS=F	5.2.a Uniform Consumer Disclosure-Admit Agreements The licensee upon initial licensure must state the services it can and will provide, the public programs or benefits that it accepts or delivers, the policies that affect a resident's ability to remain in the home, and any other relevant information. (1) The uniform consumer disclosure must be completed on a form provided by the licensing agency and must be kept on file by the licensee. (2) The uniform consumer disclosure must include a statement describing the daily, weekly or monthly rate to be charged, a description of the services that are covered in the rate and all other applicable financial issues. (3) The uniform consumer disclosure must include a statement that rates are subject to change, including rate changes due to increased care needs,and describe the situations in which the changes (s) could occur. (4) The uniform consumer disclosure must be provided; i. to residents prior to or at admission and at any time it is changed or is requested by the resident; and ii. to the public upon request (5) The availability of a uniform consumer disclosure must be noted prominently in all marketing brochures and written materials.	R105	Deficiency Tag: R105 – Uniform Consumer Disclosure How the deficiency was corrected: The facility immediately obtained and completed the official Vermont “Residential Care Home Uniform Consumer Disclosure” form, as issued by the Division of Licensing and Protection. As of July 30, 2025, this form is included in every new resident admission packet and is publicly available upon request. Printed copies are also available at the front desk for residents, families, and the public. How other potential residents were identified and corrective action taken: No retroactive updates will be made to past resident files; however, the form will be consistently provided to all new admissions moving forward and will remain available upon request to any current resident or member of the public.Notice of these forms will be noted in our weekly newsletters. System changes to ensure compliance: Revised the Admissions Checklist to require completion of the official state form before admission is finalized. Established an annual review process to ensure the form reflects current services, rates, and policies. Implemented a process to update both printed copies and the website version simultaneously whenever changes occur. Who will monitor to ensure compliance: Executive Director will conduct quarterly audits of three random new admission files to confirm inclusion of the form. Marketing & Admissions Coordinator will verify website posting monthly. Date corrected: Aug 30, 2025 R 105 Plan of Corrections accepted by Jo A Evans RN on 8/22/25	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE Executive Director (X6) DATE 8/21/2025

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R105	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to provide the required Uniform Consumer Disclosure Statement provided by the licensing agency to residents of the home. Findings include: Policies and procedures governing provision of the required Uniform Consumer Disclosure Statement have not been developed by the home. Per record review, the Admission Agreement utilized by the Assisted Living Residence does not include the Uniform Consumer Disclosure Statement form provided by the licensing agency as required. This finding was confirmed by the Executive Director at 11:57 AM on 7/28/25.	R105		
R162 SS=E	5.9.c (5) Nursing Services For each resident requiring nursing overview, administration of medication, or nursing care, the registered nurse must: Maintain a current list for review by staff and physician of all residents' medications. The list must include: resident's name; medications; date medication ordered; dosage and frequency of administration; and likely side effects to monitor;	R162		

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R162	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to ensure medication orders for one applicable resident (Resident #1) include a specific dose to be administered and frequency of administration. Findings include: Policies and procedures governing prescriber's orders for medications have not been developed by the home. Per review of Resident #1's July 2025 Medication Administration Record the following medication orders do not include a specific dose to be administered and/or frequency of administration to include the specific amount of time between doses of PRN (as needed) medications: 1. "Ammonium Lactate 12% LOTN". 2. Cyclobenzaprine HCl 5 mg tablets 1 tab by mouth three times a day as needed for muscle spasms. 3. Diclofenac Sodium 1% gel Apply 2 grams to upper extremities four times daily as needed. 4. Oxycodone HCl 5 mg tabs ½ tab by mouth twice a day as needed for pain. 5. Tylenol Extra Strength 500 mg tabs 2 tablets by mouth twice daily for pain. These findings were confirmed by the Director of Nursing at 3:53 PM on 7/28/25.	R162	R162 – Nursing Services: complete med orders (5.9.c(5)) MARs will reflect complete prescriber orders (dose, frequency, PRN intervals). Written and signed clarification orders requested from prescribing provider to include dose and specific amount of time between doses of PRN medications. A full review of all resident records, agreements, service plans, and medication logs was completed to identify any impact. Staff observations and interviews confirmed consistent practice, and no other residents were affected. All staff have been re-educated on regulatory requirements, with procedures reinforced to ensure compliance. Wellness Director will perform complete medication order audits for order completeness on all residents. Will ensure to clarify hour interval between doses where needed and request written and signed orders. Wellness Director will verify order completeness prior to entering in EMAR system; PRN interval prompts embedded in MAR process. Completion date: 09/01/2025 Responsible: Wellness Director R162 Plan of Correction accepted by Jo A. Evans on 8/22/25	
R184 SS=F	5.10.a (6) Medication Management Each home must have written policies and procedures describing the home's medication	R184		

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R184	Continued From page 3 management practicies. The policies must cover at least the following: Procedures for monitoring side effects of psychoactive medications. This REQUIREMENT is not met as evidenced by: Based on staff interviews there is a failure to develop written policies and procedures to ensure monitoring for side effects of psychoactive medications for all applicable residents of the Assisted Living Residence. Findings include: During an interview commencing at 11:11 AM on 7/28/25 the Director of Nursing confirmed the home has not developed and implemented procedures to monitor for side effects of psychoactive medications for all applicable residents of the home. On the afternoon of 7/28/25 the Executive Director confirmed policies and procedures governing monitoring for the side effects of psychoactive medications have not been developed by the home.	R184	Type text here R184 — Medication Management (5.10.a(6)) Deficiency Summary: The home did not have written policies or procedures to monitor for side effects of psychoactive medications. Corrective action for deficiency identified: A policy addressing the monitoring of side effects for psychoactive medications will be developed and implemented into the community's Policies & Procedures. Identification of others potentially affected & corrections: All residents had the potential to be affected. The policy will be reviewed with staff to ensure understanding and consistent application. Measures/System changes to prevent recurrence: The policy will remain part of the community's Policies & Procedures and will be included in staff training. Monitoring/Oversight: The Wellness Director will provide ongoing oversight to ensure staff follow the policy as written. Completion date: September 1 2025 Responsible: Wellness Director R184 Plan of Correction accepted by Jo A Evans RN on 8/22/25	
R202 SS=F	5.10.g Medication Management Homes must establish procedures for documentation sufficient to indicate to the licensed health care provider, registered nurse, manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this must include: (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications,	R202		

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R202	Continued From page 4 including the reason why and the actions taken by the home; (3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect; (4) A current list of who is administering medications to residents, including staff to whom a registered nurse has delegated administration; and (5) For residents receiving psychoactive medications, a record of monitoring for side effects. (6) All incidents of medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review there is a failure to administer medications as ordered for 3 out of 3 sampled residents (Residents #1, #2, and #3). Findings include: Policies and procedures to ensuring medications are maintained in stock and available for review have not been developed by the Assisted Living Residence. Per review of the July 2025 Medication Administration Record (MAR) the following medications were not administered as ordered: 1. Resident #1 is prescribed scheduled doses of 1,000 mg of Tylenol twice daily for pain. Resident #1's MAR documents 19 missed doses of this scheduled medication during the month of July 2025 due to this over the counter medication not being in stock and available for administration. Additionally, Resident #1 was not administered 9 scheduled doses of Finasteride (medication to regulate hormones) 5 mg tablets and 10	R202	R202 — Medication Management Documentation (5.10.g) Corrective action for residents identified: All medications were checked to confirm adequate on-hand supply for scheduled administrations; any low or out-of-cycle items were requested per Procedure F-196. Identification of others potentially affected & corrections: The Wellness Director reviewed all residents who are not on pharmacy cycle delivery with our preferred pharmacy. Reorder prompts were set so refills are requested before supply runs out. Staff were re-educated on the proper timeline for initiating a reorder consistent with Procedure F-196. Measures/System practices to prevent recurrence: Procedure F-196 is utilized to maintain on-hand supply and documentation. At each shift change, a med-cart count and delivery check confirms supply; any low or out-of-cycle items are reordered before depletion per F-196. For residents not on cycle delivery, reorder reminders are set ≥7 days before expected depletion. Staff verify all storage locations, including overstock, before marking a dose as missed. Any “med not available” triggers immediate notification to the Wellness Director Monitoring/Oversight: Wellness Director or designee will continue audits EMAR Daily for administration timeliness, refusals, PRN effectiveness, and any “med not available” notations per company policy F-196. Completion date: 09/1/2025 Responsible: Director of Nursing R202 Plan of Correction accepted by Jo A Evans RN on 8/22/25	

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R202	Continued From page 5 scheduled doses of Carboxymethylcellulose 0.5% Ophthalmic Solution for dry eyes during the month of July 2025 because the medication was not in stock. 2. Resident #2 was not administered 2 scheduled doses of Torsemide 20 mg tablets (medication to treat edema associated with high blood pressure) during the month of July 2025 due to the medication not in stock. 3. Resident #3 was not administered the medication Levothyroxine Sodium 112 mcg tablets on 7/3/25 to treat hypothyroidism as ordered. The MAR indicated the reason for this missed medication as "Med not available". During an interview on the afternoon of 7/28/25 the Director of Nursing stated the medication was in stock in the medication cart and the Med Tech did not recognize the medication. The Director of Nursing confirmed these findings at 3:53 PM on 7/28/25.	R202		
R203 SS=E	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:	R203		

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R203	Continued From page 6 Based on observation and staff interview there is a failure to ensure medications managed by the home are inaccessible to residents and secured in locked compartments. Findings include: Policies and procedures governing secure storage of medications have not been developed by the home. During a tour of the home commencing at 10:15 AM on 7/28/25 medications were observed to be unsecured and accessible to residents of the home including 2 packages of cough drops in Room 162 and a bottle of Aspirin 81 mg tablets in Room 166. These findings were confirmed by the Director of Nursing during the tour of the home on the morning of 7/28/25. The home is a special care unit for residents who are living with cognitive decline and have varying ability to safely manage access to medications. During an interview commencing at 11:11 AM on 7/28/25 the Director of nursing confirmed the home manages medications for all residents of the home.	R203	R203 — Medication Storage & Security (5.10.h(1)) Deficiency summary: Resident medications managed by the home were observed unsecured/inaccessible to residents. Corrective action for residents identified: All resident medications, including OTC items, are maintained in the locked med room/cart. Any items found in resident rooms were removed and placed in secure storage per VSL procedure F-190. Identification of others potentially affected & corrections: A room-by-room sweep was completed to confirm no resident-managed meds exist in this special care setting. Any discovered items were logged and secured. Measures/System changes to prevent recurrence: Staff retrained to ensure all medications are stored securely. Staff is instructed that resident rooms must remain free of unsecured medications. Monitoring/Oversight: The Wellness Director or designee will routinely check for compliance during rounds. Any unsecured medications will be addressed immediately, Completion date: 09/1/2025 Responsible: Director of Nursing R203 Plan of Correction accepted by Jo A Evans RN on 8/22/25	
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 is a failure to complete the required staff criminal record and abuse registry checks for 5 out of 5	R225		

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R225	Continued From page 7 sampled staff. Findings include: On 7/28/25 the Executive Director was requested to provide documentation of criminal record and abuse registry checks completed for a sample of 5 staff. Per review of the documentation provided by the Executive Director, background checks were not completed as required for 5 out of 5 sampled staff. This finding was confirmed by the Executive Director at 2:16 PM on 7/28/25.	R225	R225 — Personnel Records: Criminal Record & Abuse Registry Checks (5.12.b(4)) Deficiency summary: Files reviewed lacked documentation of required Vermont criminal record and adult abuse registry checks. Corrective action for staff identified: Required checks for sampled staff are documented in the personnel files. Any outstanding verifications will be obtained and filed. Identification of others potentially affected & corrections: Executive Director reconciled all current staff files against a checklist verifying completion of checks prior to working. Any missing documentation will be obtained and recorded. Measures/System changes to prevent recurrence:	
R342 SS=F	5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy must be available at the home for review upon request by residents and their representatives, advocacy organizations and the licensing agency. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to develop policies and procedures governing all areas of service provided by the home. Findings include: During the annual survey conducted at the home on 7/28/25 the Executive Director was requested to provided policies and procedures governing the following areas of service: a. Secure storage of medications b. Monitoring for side effects of psychoactive medications c. Variances for residents who require nursing home level of care d. Maintaining water temperatures at or below	R342	A one-page hiring packet checklist is used at onboarding to confirm both checks before a start date is scheduled. HR maintains a roster that displays verification dates and renewal timelines. Monitoring/Oversight: Annual file spot-audit for verification presence. Results are recorded on the Background Check Compliance Log. Completion date: 09/15/2025 Responsible: Executive Director / HR Designee R225 Plan of Correction accepted by Jo A Evans RN on 8/22/25	

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R342	Continued From page 8 120 degrees Fahrenheit in resident accessible areas e. Bed rail installation and monitoring for safety f. Ensuring required documents are posted in areas accessible to residents and visitors of the home g. Staff criminal record and abuse registry checks h. Uniform Consumer Disclosure Statements i. Management of Resident's personal funds j. Posting of required documents k. Prescriber's orders for medications At 4:35 PM on 7/28/25 the Executive Director confirmed the requested policies and procedures listed above had not been developed by the organization that manages the home.	R342	R342 — Policies & Procedures (5.15) Deficiency Summary: The home did not have written policies and procedures governing all required service areas. Corrective action for areas identified: Policies and procedures were already in place for several service areas. A full review will be completed and additional written policies will be formalized to ensure all required areas are addressed. Identification of others potentially affected & corrections: All residents had the potential to be affected by incomplete policy coverage. A full review of services and policies was completed, and staff were re-educated to ensure consistent application. Measures/System changes to prevent recurrence: Policy manual updated to include all required areas. Existing practices incorporated into written policy. Policies reviewed with staff. Monitoring/Oversight: Executive Director will verify annually that all required policies are present, current, and accessible. Completion date: 9/1/2025 Responsible: Executive Director R342 Plan of Correction accepted by Jo A Evans RN on 8/22/25	
R357 SS=F	6.9 Resident's Rights Residents may manage their own personal finances. The home or licensee must 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 must keep a record of all transactions and make the record available, upon request, to the resident or legal representative and must 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 is a failure to ensure a written request is obtained	R357		

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R357	Continued From page 9 for the home's management of resident's personal funds, a record of all transactions involving resident's personal funds is maintained, and a quarterly accounting of personal funds is provided to the resident or their representative on at least a quarterly basis for all residents with personal funds managed by the home. Findings include: Policies and procedures governing management of resident's personal funds have not been developed by the home. On the afternoon of 7/28/25 the Director of Nursing was requested to provide documentation of written requests for management of personal funds, a record of transactions and documentation of quarterly accounting of resident's personal funds provided to the applicable residents or their responsible parties. At 2:45 PM on 7/28/25 the Director of Nursing confirmed written requests are not obtained for management of resident's personal funds, the required documentation of transactions is not complete, and the home does not provide quarterly accounting of personal funds to residents or their responsible parties.	R357	R357 — Resident Personal Funds (6.9) Deficiency summary: Quarterly accounting and receipt practices for resident funds were not demonstrated as required. Corrective action for residents identified: Any resident personal funds previously held by the home were reconciled and returned to the resident or legal representative with a receipt. Identification of others potentially affected & corrections: Wellness Director verified that no resident has funds on deposit with the home; confirmations are filed. Measures/System practices to prevent recurrence: The home does not accept or hold resident personal funds. Residents/representatives maintain their own funds and manage purchases directly. When assistance is requested, staff facilitate communication with the representative; no funds are deposited with or disbursed by the home. As a result, ledgers and internal resident-fund accounting are not utilized. Monitoring/Oversight: Wellness Director confirms quarterly that no funds are held by the home. Completion date: by 09/1/2025 Responsible: Wellness Director / Executive Director R357 Plan of Correction accepted by Jo A Evans RN on 8/22/25	
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	R366		

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R366	Continued From page 10 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 a failure to post copies of the Resident's Rights, the home's grievance procedures, and directions for contacting the Office of the Long Term Care Ombudsman and Disability Rights Vermont conspicuously in a public place in the home. Findings include: Policies and procedures governing posting of required documents conspicuously is a public area have not been developed by the home. During a tour of the Assisted Living Residence commencing at 10:15 AM on 7/28/25 copies of the Resident's Rights, the home's grievance procedures, and directions for contacting the Ombudsman and Disability Rights Vermont were observed to not be posted in a public area of the home. These findings were confirmed by the Executive Director at approximately 1:30 PM on 7/28/25.	R366	R366 — Posting of Required Documents (6.18) Deficiency summary: Consumer rights and grievance information were not posted in resident-accessible areas with required elements/format. Corrective action for residents/visitors: Resident Rights, Ombudsman contact, and Disability Rights Vermont contact are posted at the main entrance and the ALR common area in at least 18-point font. The same materials are included in the admission packet. Identification of other areas & corrections: A walkthrough confirmed postings in all resident-facing common areas; duplicates are placed where missing. Measures/System changes to prevent recurrence: A Posting Checklist is part of monthly safety rounds, confirming presence, legibility, and current contact info. Monitoring/Oversight: ED/designee verifies postings monthly and documents on the Posting Checklist retained in the Safety binder. Completion date: By 09/1/2025 Responsible: Executive Director R366 Plan of Correction accepted by Jo A Evans RN on 8/22/25	
R401 SS=F	9.1.a Environment The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This includes outdoor areas that are	R401		

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	0664	A. BUILDING: _____ B. WING _____	07/28/2025

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R401	Continued From page 11 used by residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview there is a failure to provide care in a safe, sanitary, comfortable, homelike environment. Findings include: The home's Internal Environmental Services policy states, "The residence will be kept clean and well-maintained. This will be accomplished through a regular cleaning schedule, a preventative maintenance program, and repair or enhancement of exiting structures, systems and fixtures." 1. During a tour commencing at 9:15 AM the following environmental concerns were observed in the common areas of the facility shared with a Residential Care Home managed by the same organization that manages the Assisted Living Residence: a. The doors between the first floor shared common areas of the facility and areas of the facility intended to be inaccessible to residents including the kitchen where resident meals are prepared, administrative offices, a laundry room, and staff living quarters were left unlocked. The doors were equipped with combination locking systems that were not in use to prevent access to these areas. The flooring along the threshold of one of the doors was in poor repair with missing and damaged tiles, which is a trip hazard. Unsecured cleaning chemicals including	R401		

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R401	Continued From page 12 detergents, dryer sheets, sanitizing spray, and toilet cleaner were observed to be unsecured and accessible to residents in the laundry room in this area of the home. The laundry room did not have a door. b. The baseboard heaters in the men's and women's bathrooms adjacent to the shared main lobby and activity area were observed to be in poor repair. The radiator in the men's bathroom was missing an end cap leaving sharp edges on the ends of the radiator covers exposed. This bathroom was also observed to be in need of cleaning. The radiator along the floor of the women's bathroom was without a cover, leaving pipes through which hot water flows to heat the room exposed. Additionally, there were 2 rectangular pieces of metal and bolts jutting upwards approximately 1-2 inches from the floor in front of the radiator. The condition of the radiators and the exposed metal on the floor are a potential risk for injury. c. The suspended ceiling in a food storage area of the kitchen was observed to be in poor repair including a damaged ceiling time drooping from the suspended ceiling above a dry goods storage shelf. The food stored on the shelf was exposed to insulation and debris from the damaged tile and the area above the suspended ceiling. 1. During a tour of the Assisted Living Residence (ALR) commencing at 10:15 AM the following environmental concerns were observed: a. Hazardous items were observed to be unsecured and accessible to residents of the home including disposable razors, lens cleaner, and wound cleaner in resident rooms; and cleaning chemicals including sanitizer and bleach	R401	R401 – Environment (9.1) Corrective Action: All environmental and safety issues identified during survey (e.g., unsecured chemicals, repair needs, cleanliness concerns) were corrected promptly. Identification of Others: A walkthrough of the entire building was completed to identify and correct any additional hazards or environmental issues. System Changes: Staff have been retrained to keep hazardous items secured and to promptly report any safety or maintenance concerns. Monitoring/Oversight: The Executive Director or designee will routinely observe the environment to ensure the home remains safe, sanitary, and homelike, with issues corrected as they arise. Completion date: By 09/1/2025 Responsible: Executive Director R401 Plan of Correction accepted by Jo A Evans on 8/22/25	

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R401	Continued From page 13 in an unlocked cabinet in the coffee area between the living room and dining room of the home. The ALR is operating as a special care unit for residents living with cognitive decline who have limited ability to safely manage access to hazardous items. b. In a resident room wound care supplies and an unsealed package of petroleum jelly left open were stored on the vanity beside the sink where they were exposed to open air and water. Per interview with the Director of Nursing the resident was receiving in home wound care from a home health agency. c. The ceilings in the ALR were observed to be in poor condition with numerous broken, cracked, and displaced ceiling tiles and cracked ceiling light covers. These findings were confirmed by the Director of Nursing and Executive Director during the facility tour and on the afternoon of 7/28/25.	R401		
R430 SS=F	9.6.d Plumbing Hot water temperatures must not exceed 120 degrees Fahrenheit in resident areas. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure water temperatures are maintained at or below 120 degrees Fahrenheit in a shared bathroom in the home's Memory Care center. Findings include: Policies and Procedures governing maintenance	R430		

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R430	Continued From page 14 of water temperatures at or below 120 degrees Fahrenheit in resident accessible areas have not been developed by the home. During a tour of the Assisted Living Residence memory care center commencing at 10:15 AM on 7/28/25 the men's shared bathroom adjacent to the living room was observed with a water temperature of 122.5 degrees Fahrenheit. This finding was confirmed by the Director of Nursing during the tour of the Assisted Living Residence. Following adjustment made to the water heating system by the Executive Director, water temperatures were confirmed by the Executive Director to be sustained below 120 degrees Fahrenheit.	R430	R430 – Hot water temperatures must not exceed 120 degrees Fahrenheit in resident areas 9.6.d Corrective action for affected residents: Adjusted hot water system to keep temperatures within safe limits. Identification of others potentially affected: All resident-accessible faucets tested for compliance. System changes: Routine hot water testing is part of the maintenance schedule. Monitoring: Maintenance logs reviewed monthly for compliance. Completion date: 07/28/2025 R430 Plan of Correction accepted by Jo A Evans RN on 8/22/25	
R481 SS=D	13.4.a (1)(2) Resident Care and Services-Eligibility 13.4.a Eligibility. The licensee may accept and retain any individual 18 years old or older, including those whose needs meet the definition of nursing home level of care if those needs can be met by the assisted living residence, with the following exceptions: (1) The licensee may not admit any individual who has a serious, acute illness requiring the medical, surgical, or nursing care provided by a general or special hospital; and (2) The licensee may not admit any individual who has the following equipment, treatment, or care needs: ventilator, stage III, or IV pressure ulcer, nasopharyngeal, oral or tracheal suctioning or two-person assistance to transfer from bed or chair or to ambulate. A current resident of the facility who develops a	R481		

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R481	Continued From page 15 need for equipment, treatment, or care as listed above in (2) or who develops a terminal illness may remain in the residence so long as the licensee can safely meet the resident ' s needs and/or the resident ' s care needs are met by an appropriate licensed provider. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to obtain a level of care variance to admit one applicable resident (Resident #2) who was receiving hospice care and required two person assistance with transfers on admission to the home. Findings include: Policies and procedures governing level of care variances have not been developed by the home. Per record review Resident #2 was admitted to the home on 5/7/25 while receiving hospice care initiated prior to admission. Resident #2's Admission Assessment signed as completed by the Director of Nursing on 5/16/25 indicates Resident #2 required a "Two plus physical assist" with transfers including transfers from bed or chair on admission to the Assisted Living Residence. During an interview commencing at 11:11 AM on 7/28/25 the Director of Nursing confirmed Resident #2 was admitted to the Assisted Living Residence on hospice and confirmed the home had not obtained a Level of Care Variance from the licensing agency to admit Resident #2.	R481	Deficiency Tag: R481 – Resident Care & Services: Eligibility How the deficiency was corrected: Resident #2, admitted on hospice and requiring two-person transfers, was reviewed. Care needs were confirmed as being met safely through hospice partnership and trained staff. A Level of Care Variance request was submitted to the Division immediately following survey. How other potential residents were identified and corrective action taken: Any future admissions requiring more than minimal assistance will be pre-screened and flagged for variance before move-in. System changes to ensure compliance: Admissions process updated to include a “Variance Verification Step” requiring ED approval before admission if a resident presents with: hospice enrollment, two-person assist, ventilator, advanced wound care, or other excluded criteria. Training was completed with admissions and nursing staff. Who will monitor to ensure compliance: Wellness Director will review all admission assessments prior to move-in. Quarterly chart audits will confirm resident eligibility and/or approved variance. Date corrected: 09/1/2025 R481 Plan of Correction accepted by Jo A Evans on 8/22/25	

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R999	Continued From page 16	R999		
R999 SS=F	Miscellaneous This REQUIREMENT is not met as evidenced by: 4.12 License Certificate The home's current license certificate must be protected and appropriately displayed in such a place and manner as to be readily viewable by persons entering the home. Any conditions which affect the license in any way must be posted adjacent to the license certificate. This licensing requirement is NOT MET as evidenced by: Per observation on 7/18/25 the license posted in the Assisted Living Residence was observed to have expired on 11/30/2024 and the current license issued on 12/1/2024 was not posted in an area readily viewable by persons entering the home as required. This finding was confirmed by the Executive Director at approximately 1:30 PM on 7/28/25.	R999	R999 – License Posting Corrective action for affected residents/visitors: The current license is posted where visitors and inspectors can see it immediately upon entry. Identification of others potentially affected: Posting locations checked to confirm visibility and accuracy. System changes: Upon receipt of a new license, the old one is immediately replaced. Monitoring: Annual posting review or as soon as a new license is issued by Executive Director. Completion date: 07/28/2025 R 999 Plan of Corrections accepted by Jo A Evans RN on 8/22/25	