VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
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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

September 29, 2025

Wendy Audette, Manager
Heaton Woods
10 Heaton Street
Montpelier, VT 05602-2480

Dear Ms. Audette:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 2, 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
	0297	A. BUILDING: _____ B. WING _____	C 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATON WOODS	10 HEATON STREET MONTPELIER, VT 05602

(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 8/28/25 and 9/2/25 the Division of Licensing and Protection conducted an unannounced on-site investigation of one facility reported incident. This investigation resulted in the need of an immediate plan of correction which was submitted by the facility and approved on 9/3/25. The following deficiencies were identified:	R100	Plan of Correction accepted by Jo A Evans RN on 9/26/25 Please refer to the attached document to review the accepted Plan of Correction.	
R161 SS=L	5.9.c (4) Nursing Services For each resident requiring nursing overview, administration of medication, or nursing care, the registered nurse must: Provide instruction and oversight to all direct care personnel regarding each resident's health care needs and nutritional needs. Delegate nursing tasks as appropriate, following the Board of Nursing?s recommended practices, with adequate documentation of delegation; This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the residence's current Director of Nursing (DON) failed to provide instruction, oversight and appropriate delegation to staff responsible for medication administration in response to diversion of one applicable resident's (Resident #1) narcotic medication by an unidentified staff. Findings include: 1. Policies and procedures governing medication diversion have not been developed and implemented by the residence's current Director of Nursing who is also the residence's Executive Director.	R161		

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R161	Continued From page 1 Per record review, on 7/29/25 the residence received delivery of 2 medication cards each containing sixty 2 mg tablets of Hydromorphone for Resident #1. Hydromorphone is a narcotic pain medication which is required by the licensing agency to be stored in a locked compartment and accounted for every shift. The Hydromorphone tablets stored in the medication cards received on 7/29/25 were individually packaged in 60 sealed single dose compartments. Per staff interviews and record review, on the evening of 8/18/25, one of Resident #1's Hydromorphone medication cards was discovered to have been tampered with. Per review of the residence's internal investigation documents, 21 Hydromorphone tablets were determined to have been diverted by breaking the individual medication card compartment seals and replacing the narcotic medication taken from the individual compartments with "look alike" medications prescribed to other residents and stored in the same medication cart. The Hydromorphone tablets were replaced with multiple medications of similar appearance including: a. Hydroxyzine 25 mg tablets (antihistamine prescribed for anxiety) b. Fludrocortisone 0.1 mg tablets (steroid prescribed to maintain blood pressure and fluid balance) c. Amlodipine Besylate 2.5 mg tablets (prescribed for high blood pressure) d. Levothyroxine 50 mcg tablets (prescribed for Hypothyroidism) The back of the compromised medication card was found to have pieces of medical tape concealing the broken seals of the individual compartments from which the Hydromorphone	R161		

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R161	Continued From page 2 tablets were taken. Five of the 21 compromised medication compartments had remnants of medical tape on them but were empty, indicating Resident #1's Hydromorphone was not administered as ordered on the dates and times the pills stored in the 5 empty compartments were accounted for in the Medication Administration Record and on the Controlled Substance Count Sheets. These findings were acknowledged by the recently hired Director of Nursing who is still in training, and confirmed by a Registered Nurse employed at the residence during staff interviews conducted on 8/28/25. 2. The residence's Guidelines for Medication Assistance/Administration Delegation policy developed in August 2025 states, "The Director of Nursing (DON) has the authority and responsibility of implementing and monitoring the delegation process to ensure safe, accurate medication administration by trained unlicensed medication technicians." Per interview with the DON/Manager of the home on 9/2/25, this policy has not been implemented by the current Director of Nursing as of 9/2/25. The facility's current Director of Nursing reported narcotic diversion to the local police and the licensing agency; however, as of 9/2/25 the Director of Nursing had not implemented adequate interventions to include staff instruction, oversight, and appropriate medication delegation to ensure safe and effective medication administration for all residents of the facility. During an interview commencing at 3:03 PM on 9/2/25 the DON confirmed the staff responsible for diverting Resident #1's Hydromorphone and replacing it with other medications had not been	R161		

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R161	Continued From page 3 identified and only additional daily medication counts by a staff RN and the new DON were being implemented. This was determined by the licensing agency's investigation team to be an immediate threat to health and safety for all residents due to the responsible staff's continued access to all resident's medications and ability to administer to residents. During the interview commencing at 3:03 PM on 9/2/25, the current DON was asked to describe actions they had taken since the diversion was discovered on 8/18/25 to prevent further misappropriation of resident medications. The current DON stated they had implemented daily random audits of the medication carts, during which a Registered Nurse counts and observes all controlled substances. While the random audits provide nursing oversight of controlled substances administered to residents, this intervention does not provide increased nursing oversight of other medications administered to residents as the current DON confirmed the random med cart audits are only conducted for controlled substances. During this interview the current DON also indicated additional steps would likely be taken after the investigation being conducted by the facility was completed; and described possible interventions for securing and monitoring medication carts which had not been implemented as of 9/2/25. These findings were confirmed by the current Director of Nursing on the afternoon of 9/2/25. 3. The residence's Management of Controlled Medications policy developed in August 2025 outlines procedures for medication administration requiring Med Techs to inspect the medications and packaging to ensure they are intact. This	R161		

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R161	Continued From page 4	R161		

policy also outlines procedures for controlled substance counts to ensure outgoing staff passing off the med cart keys and incoming staff accepting the keys review every controlled medication stored in the cart and all medication inventory sheets to confirm the quantity matches. This policy states both Med Techs performing a med check "need to agree that the medication quantity is accurate, the medications are intact, and that the packaging they are in is intact as well." This policy had not been implemented by the current DON as of 9/2/25. On the afternoon of 9/2/25, a Registered Nurse described a controlled substance count conducted the previous day during which both Med Techs did not appear to be viewing the medication card and the controlled inventory sheets together to ensure the count was correct. Per interview on 9/2/25, the staff RN described their intervention by providing oversight and education at that time to those staff members to help them understand the importance of ensuring medications are accurate when taking over a medication cart. The RN stated intervening in this manner should be common practice for a RN to ensure medication delegated staff understand their role as administrators of medications for resident protection.

During interviews conducted on the afternoon of 8/28/25, Med Techs delegated by the DON confirmed their job duties include providing instruction and supervision to trainees regarding essential nursing tasks that ensure safe and effective medication administration. Three out of three Med Techs interviewed on 8/28/28 confirmed that trainees routinely prepare and administer medications to residents under the supervision and monitoring of delegated Med Techs prior to the current DON delegating the trainee to administer medications. Med Techs

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R161	Continued From page 5 interviewed on 8/28/25 also confirmed they are responsible for instructing trainees on how to perform nursing tasks including how to perform controlled substance counts. On 8/28/25 staff confirmed when the Hydromorphone was diverted, the applicable medication cards were stored in the medication cart with the backs of the cards facing each other and a rubber band placed around both cards. When medication cards are stored in this configuration the individual single dose compartments seals are not visible without separating the cards and turning them over to visualize the backs. On 9/2/25 the current DON indicated Resident #1's Hydromorphone cards didn't feel different because there were 2 cards stored back to back, and stated the Med Techs were not checking the backs of the med cards before administering the medication. On the afternoon of 9/2/25 the current Director of Nursing confirmed they had not redelegated the 10 Med Techs employed at the residence to perform essential nursing tasks following the diversion of Resident #1's Hydromorphone. The DON also confirmed they had not implemented applicable policies and procedures developed in July and August of 2025 to ensure safe and effective medication management and administration practices. The current Registered Nurse stated they were waiting for the newly hired Director of Nursing to perform these re-delegation tasks once they assume the responsibilities of the overseeing Registered Nurse following the completion of the controlled substance investigation. 4. In response to the licensing agency's determination that these deficient practices posed an immediate threat to all resident's health and	R161		

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R161	Continued From page 6 safety, on 9/3/25 the current Director of Nursing submitted a plan of immediate corrective actions to provide appropriate education and delegation to all Med Techs related to medication administration, documentation, controlled substance management. The immediate plan also indicated corrective actions to be taken include implementation of monitoring and supervision to ensure safe and effective mediation management and administration for Residents. The plan of immediate corrective actions submitted by the current DON was accepted by the State Long Term Care Manager on 9/3/25.	R161		
R194 SS=F	5.10.d (3) Medication Management The registered nurse must accept responsibility for the proper administration of medications, and is responsible for: i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects; ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications; iii. Assessing the resident's condition and the need for any changes in medications; and iv. Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions regarding medication administration and documentation. v. Ensuring that all applicable staff are trained and delegated before the staff are permitted to administer any newly prescribed medication to any resident.	R194		

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R194	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews there is a failure for the Registered Nurse responsible for proper administration of medications to teach designated staff techniques for medication administration. Findings include: The residence's Medication Delegation Training policy was developed in August 2025 and has not been implemented by the current Director of Nursing. Per review, this policy does not specify the Registered Nurse's responsibility to teach designated staff proper techniques for medication administration. The residence's Guidelines for Medication Assistance/Administration Delegation policy and procedures developed in August 2025 states, "Only designated employees who have received training from the RN may assist with medication assistance/administration." . This policy also has not been implemented by the current Director of Nursing.. Policies and procedures consistent with this licensing requirement developed prior to August of 2025 were not on file and available for review. On 8/28/25 interviews were conducted with 3 Med Techs who confirmed during the medication administration training process trainees routinely administer medications to residents under the supervision of Med Techs prior to the Director of Nursing completing an observed med pass and delegating the trainee to administer medications. Additionally, 3 out of 3 Med Techs confirmed during medication administration training process	R194		

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R194	Continued From page 8 trainees are instructed by Med Techs on how to perform tasks including controlled substance counts; and 2 out of 3 Med Techs confirmed trainees dominions subcutaneous injections including insulin under the supervision of Med Techs during their training process. During an interview commencing at 3:03 PM on 9/2/25 the Executive Director, who also currently serves as the Director of Nursing (DON), confirmed Med Techs are responsible for teaching medication administration skills to trainees, and trainees administer medications to residents under the supervision of Med Techs prior to completion of their medication administration delegation process.	R194		
R196 SS=F	5.10.d (5) Medication Management 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; identifies any known triggers for the behaviors; 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 there is a failure to develop written plans for the administration of psychoactive PRN (as needed) medications by staff other than a nurse for all applicable residents of the home. Findings	R196		

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R196	Continued From page 9 include: Policies and procedures governing development of written plans for the administration of PRN psychoactive medications by staff other than a nurse have not been developed by the home. During Staff interviews conducted in the medication room on the morning of 9/2/25, members of the residence's Nursing and Med Tech Staff were unaware of written plans for the administration of psychoactive PRN medications on file at the residence. During an interview conducted on the afternoon of 9/2/25, the former Interim Director of Nursing stated written plans for the administration of psychoactive PRN medications are included in the care plans developed for applicable residents. Per record review conducted with the former Interim Director of Nursing, written plans for the administration of psychoactive PRN medication were not observed to be included in applicable resident's care plans. At 3:51 PM on 9/2/25 the former Interim Director of Nursing confirmed written plans for the administration of PRN psychoactive medications by staff other than a nurse had not been developed for all applicable residents of the home.	R196		
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:	R202		

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R202	Continued From page 10 (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, 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 ensure medications were administered as ordered to 7 applicable residents (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, and Resident #7). Findings include: The residence's Guidelines for Medication Assistance/Administration Delegation policy developed in August 2025 states, "The Director of Nursing (DON) has the authority and responsibility of implementing and monitoring the delegation process to ensure safe, accurate medication administration by trained unlicensed medication technicians." This policy has not been implemented by the current Director of Nursing. Policies and Procedures for administration of various types of medications developed in July 2025 instructs the staff administering medication	R202		

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R202	Continued From page 11 to perform 3 checks to ensure the right medication, right dose, right time, right route, right resident, and right documentation when administering medications. These policies and procedures have not been implemented by the current Director of Nursing. During the investigation conducted on 8/28/25 and 9/2/25 the following incidents of medications not being administered as ordered were identified: 1. Medications not administered as ordered for Resident #1: a. Per Medication Error Report review, on 7/8/25 at 11:50 PM and 7/9/25 at 5:30 AM Resident #1 was given 0.5 mg doses of the PRN (as needed) anxiety medication Lorazepam instead of the prescribed 2 mg scheduled doses of the of the narcotic pain medication Hydromorphone. b. Per record review, on 7/29/25 the residence received delivery of 2 medication cards each containing sixty 2 mg tablets of Hydromorphone for Resident #1. Hydromorphone is a narcotic pain medication which is required by the licensing agency to be stored in a locked compartment and accounted for every shift. The Hydromorphone tablets stored in the medication cards received on 7/29/25 were individually packaged in 60 sealed single dose compartments. Per staff interviews and record review, on the evening of 8/18/25, one of Resident #1's Hydromorphone medication cards was discovered to have been tampered with. Per review of the residence's internal investigation documents, 21 Hydromorphone tablets were determined to have been diverted by breaking the individual medication card compartment seals and replacing the narcotic	R202		

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R202	Continued From page 12 medication taken from the individual compartments with "look alike" medications prescribed to other residents and stored in the same medication cart. The back of the compromised Hydromorphone medication card was found to have pieces of medical tape concealing the broken seals of the individual compartments from which the Hydromorphone tablets were taken. Five of the 21 compromised medication compartments had remnants of medical tape on them but were empty, indicating Resident #1's Hydromorphone was not administered as ordered on the dates and times the pills stored in the 5 empty compartments were accounted for in the Medication Administration Record and on the Controlled Substance Count Sheets. These medication errors occurred between 7/29/25 when the medication card was received from the pharmacy and 8/18/25 when the diversion of Resident #1's Hydromorphone was discovered. 2. Medication not administered as ordered for Resident #2: Per review of the August 2025 Medication Administration Record, Resident #2 was not administered their daily dose of Fludrocortisone 0.1 mg tablet on 8/18/25, 8/19/25 and 8/20/35 as ordered due to the medication being out of stock prior to the scheduled routine delivery of a 28-day supply of this medication. 3. Medications not administered as ordered for Resident #3: a. Per review of the August 2025 Medication Administration Record, Resident #3 was not	R202		

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R202	Continued From page 13 administered their daily dose of Amlodipine Besylate 2.5 mg tablet on 8/17/25, 8/18/25, 8/19/25 and 8/20/35 as ordered due to the medication being out of stock prior to the scheduled routine delivery of a 28-day supply of this medication. b. Per Medication Administration Record review, a total of 20 nightly doses of Methocarbamol 500 mg tablets were not administered as ordered to Resident #3 from 7/31/25 - 8/19/25. There is no documentation in Resident #3's record indicating the Registered Nurse responsible for medication administration oversight identified this issue and took actions to obtain this medication. 4. Medication not administered as ordered for Resident #4: Per review of Progress Notes, on 6/27/25 Resident #4's order for Lasix was increased from 40 mg once daily to 40 mg twice daily. When the new order was entered in the Medication Administration Record (MAR) the previous order was not discontinued and remained in the MAR. On 6/28/25, 6/29/25, and 6/30/25 the resident was given 80 mg of Lasix in the morning and 40 mg of Lasix in the evening instead of the ordered dose of 40 mg twice daily. 5. Medication not administered as ordered for Resident #5: Per review of the August 2025 Medication Administration Record, Resident #5 was not administered 3 consecutive nightly 10 mg doses of the antipsychotic medication aripiprazole (Abilify) on 8/29/25, 8/30/25 and 8/31/25. due to	R202		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0297	A. BUILDING: _____ B. WING _____	C 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATON WOODS	10 HEATON STREET MONTPELIER, VT 05602

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R202	Continued From page 14 this medication being out of stock. The website for the pharmaceutical company that manufactures this medication states, "If you miss several doses, talk to your doctor right away" (Abilify.com). There is no documentation in Resident #5's record indicating the prescribing physician was notified regarding missed doses of this medication. Per record review, this medication was documented as "ordered 8/31" at 7:29 PM on 8/31/25. 6. Medications not administered as ordered for Resident #6: a. A Medication Error Report dated 6/25/25 states Resident #6 was administered Morphine Sulfate Oral Solution 0.1 ml (2 mg) when Morphine Sulfate Oral Solution 0.2 ml (4 mg) was ordered. The Medication Error Report indicates the wrong dose was given to Resident #6 due to the Med Tech administering a pre-filled syringe that remained in the medication cart from a previous order. b. A Medication Error Report dated 7/4/25 states on 7/2/25 a delivery of a medication card containing Eliquis 2.5 mg tablets for Resident #6 was accepted from the pharmacy and stored in the medication cart, however this medication was no longer prescribed for the Resident. On 7/4/25 it was discovered a tablet was missing from the card and potentially administered to Resident #6. 7. Medications not administered as ordered for Resident #7: a. Per Medication Error Report review, Resident # 7 was given two doses Magnesium Oxide and	R202		

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R202	Continued From page 15 Sodium Chloride in error 8/29/25 when these medications were ordered to be given once daily. b. On 8/28/25 the Director of Nursing in training acknowledged medications were not administered as ordered to facility residents. On the afternoon of 9/2/25 the former Interim Director of Nursing and the Executive Director who serves as the current Director of Nursing confirmed medications were not administered as ordered to facility residents. On 8/28/25 the Director of Nursing in training acknowledged medications were not administered as ordered to facility residents. On the afternoon of 9/2/25 the former Interim Director of Nursing and the Executive Director who serves as the current Director of Nursing confirmed medications were not administered as ordered to facility residents.	R202		
R210 SS=F	5.11.c Staff Services The home must provide, or arrange for the provision of, at least twelve (12) hours of training upon hire and each year to each staff person providing direct care to residents. The manager may give credit towards the required 12 hours of training upon hire, for any formal training received in the twelve months preceding the date of hire, provided the home maintains documentation of the training and ensures competency in the subject matter. 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,	R210		

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R210	Continued From page 16 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, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; (7) General supervision and care of residents; (8)Communication strategies, person-centered care, challenging behaviors and understanding dementia; (9) Recognition of and sensitivity to different cultures, belief systems, abilities, gender identities, sexual orientation; and (10) Trauma-informed care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to ensure completion of all required trainings for 5 out of 5 sampled staff. Findings include: The residence's Staff Training for Health Related Services Policy is consistent with the licensing rules. Per review of the documentation of completed trainings on file and available for review for a sample of 5 staff, all required trainings were not completed by 5 out of 5 sampled staff. This finding was confirmed by the former Interim Director of Nursing at 1:22 PM on 9/2/25.	R210		

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R225	Continued From page 17	R225		
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 ensure all background checks were completed as required for 3 out of 5 Staff. Findings include: The residence's background check policy is consistent with the licensing rules. On 9/2/25 documentation of criminal record and abuse registry checks on file at the residence was reviewed for a sample of 5 staff. Per record review, yearly background checks were not completed as required for 3 out of 5 sampled staff. This finding was confirmed by the residence's former Interim Director of Nursing at 1:38 PM on 9/2/25.	R225		

Deficiency Statement Plan of Correction (POC)

Survey Date: 9/2/2025

Facility Name: Heaton Woods Residence

Deficiency Tag	How the deficiency was corrected	How other potential residents identified, and corrective action taken	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R161 Plan of Correction accepted by Jo A Evans RN on 9/26/25	Focused education on new controlled substance management including inspection of packaging, controlled substance counting when changing staff, and new auditing of controlled substance drawer. Medication carts will be secured to one location on 9/3/25. 24/7 video monitoring and recording of medication cart will be implemented. Implementation of auditing of controlled substance monitoring including spot checking of controlled substances and controlled substance counting between shifts	Investigation into all controlled substances. New policies implemented and all medication delegated staff redelegated.	Completed 9/10/25	Education with administration and DON on regulations. Create a new quality assurance auditing policy. New controlled substance management policy.	DON
R194 Plan of Correction accepted by Jo A Evans RN on 9/26/25	Education with RN to all current medication delegated staff on appropriate medication administration and documentation. Implementation of routine auditing of medication passing. All current medication delegated staff re-delegated and signed off on by RN.	Education provided to all medication delegated staff and all medication delegated staff redelegated.	Completed 9/10/25	Education with administration and DON on regulations. Implementing new medication delegation policy and new medication delegation sign off. Create a new quality assurance auditing policy.	DON

R196 Plan of Correction acccepted by Jo A Evans RN on 9/26/25	Review and implementation of psychoactive care plans for all residents receiving psychoactive medications.	Internal review of all resident care plans for individuals receiving psychoactive medications and new care plan policy implemented.	10/26/25	Education with DON and RNs on regulations. Implementing of new care plan policy regarding psychoactive medications.	DON
R202 Plan of Correction accepted by Jo A Evans RN on 9/26/25	Education with RN to all current medication delegated staff on appropriate medication administration and documentation. Implementation of routine auditing of medication passing. All current medication delegated staff re-delegated and signed off on by RN.	Prior medication errors reviewed. Education to RNs and all medication delegated staff. All medication delegated staff redelegated.	Completed 9/10/25	Education with administration and DON on regulations. Implementing new medication delegation policy and new medication delegation sign off. Create a new quality assurance auditing policy.	DON
R210 Plan of Correction accepted by Jo A Evans RN on 9/26/25	All staff mandatory in-services will be reviewed to ensure completion. All outstanding in-services will be completed.	All staff mandatory in-services will be reviewed to ensure completion. All outstanding in-services will be completed	10/26/25	Staff in-services will be completed upon hire and then annually per policy.	Director of operations
R225 Plan of Correction accepted by Jo A Evans RN on 9/26/25	A new process is implemented to ensure all new hire and annual background checks are completed. Internal audit performed for all current employees	Internal audit performed for all current employees. A new process is implemented to ensure all new hire and annual background checks are completed.	10/26/25	Staff background checks will be completed upon hire and then annually per policy.	Director of operations