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

December 11, 2025

Carl Erickson, Manager
Riverview Life Skills Center
197 Highlander Drive
Jeffersonville, VT 05464-9591

Dear Mr. Erickson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 10, 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 |
|---|---|---|---|
| | 0214 | A. BUILDING: _____ B. WING _____ | 11/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| RIVERVIEW LIFE SKILLS CENTER | 197 HIGHLANDER DRIVE JEFFERSONVILLE, VT 05464 |

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| R100 | Initial Comments<br><br>On 11/10/25 the Division of Licensing and Protection conducted an unannounced on-site annual re-licensure survey. The following deficiencies were identified: | R100 | | |
| R151 SS=D | 5.7.c Assessment<br><br>Each resident must also be reassessed annually and at any point in which there is a significant change in the resident's physical or mental condition, as defined in the instructional guide with the assessment instrument, available on the DLP website.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review there is a failure to complete an annual assessment for one applicable resident (Resident #9). Findings include:<br><br>Policies and procedures governing Resident Assessments were not provided for review on request.<br><br>Per record review, the most recent Resident Assessment on file for Resident #9 was signed as completed by a Registered Nurse on 4/13/24. Resident #9's annual Resident Assessment for 2025 was due on 4/13/25 and had not been completed as of 11/10/25. This finding was confirmed by the Manager at 3:24 PM on 11/10/25. | R151 | | |
| R191 SS=E | 5.10.c Medication Management | R191 | | |

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| R191 | Continued From page 1<br>Staff must not administer any medication, prescription or over-the-counter medications for which there is not a written, signed order from a licensed health care provider and a supporting diagnosis or problem statement in the resident's record.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review there is a failure to ensure written, signed provider's orders are on file and available for review for medications listed on the November 2025 Medication Administration Record for 2 out of 3 sampled residents (Residents #6 and #8). Findings include:<br><br>Policies and procedures governing medication orders were not provided for review on request.<br><br>Per record review written, signed provider's orders were not on file and available for review for the following medications listed on the November 2025 Medication Administration Record:<br><br>1. For Resident #6:<br>a. Polyethylene Glycol Power 3350<br><br>2. For Resident #8<br>a. Baclofen 10 mg tabs<br>b. Carbodopa/Levadopa ER 50-200 mg tabs<br>c. Daily-Vite tabs<br>d. Naproxen 375 mg tabs<br><br>These findings were confirmed by the Manager at 4:56 PM on 11/10/25. | R191 | | |

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| R193 | Continued From page 2 | R193 | | |
| R193 SS=F | 5.10.d (2) Medication Management<br><br>A registered nurse must delegate the responsibility for the administration of specific medications to designated staff for designated residents. Delegation must be resident (1) specific for each medication.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and record review there is a failure to ensure the Registered Nurse currently employed at the home has delegated the responsibility for the nursing task of medication administration to designated staff. Findings include:<br><br>Per the Manager, the Registered Nurse currently responsible for nursing oversight at the home was re-hired on 9/8/25. A binder provided by the Manager for review contained documentation of the delegation of nursing tasks including medication administration completed by the home's 2 previous Registered Nurses; however, documentation of the current Registered Nurse's delegation of staff responsible for administering specific medication to designated residents was not included in this binder.<br><br>During an interview commencing at 12:32 PM on 11/10/25, the Manager stated the Registered Nurse was not available for interview. Per interviews conducted at 11:05 AM and 3:35 PM on 11/10/25, two Med Techs on duty at the home confirmed they had not been delegated to perform the nursing task of medication administration by the home's current Registered Nurse since 9/8/25. | R193 | | |

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| R193 | Continued From page 3<br><br>At 4:24 PM on 11/10/25, the Manager confirmed documentation of the current Registered Nurse's delegation of the responsibility for medication administration for all Med Techs responsible for performing this nursing task was not on file and available for review, and stated the Registered Nurse "hasn't had time to do it". | R193 | | |
| R196 SS=F | 5.10.d (5) Medication Management<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on Staff interview and record review there is a failure to ensure development of written plans for the administration of PRN (as needed) psychoactive medications by staff other than the Registered Nurse for all applicable residents of the home. Findings include:<br><br>Policies and procedures governing administration of PRN psychoactive medications were not provided for review on request.<br><br>Per record review, plans for the administration of PRN psychoactive medications by staff other than a nurse are not on file and available for review at | R196 | | |

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| R196 | Continued From page 4<br>the home. During an interview commencing at 3:35 PM on 11/10/25, a Med Tech confirmed plans for the administration of PRN psychoactive medications are not on file or in use at the home. The Manager of the home acknowledged these findings on the afternoon of 11/10/25. | R196 | | |
| R202 SS=F | 5.10.g Medication Management<br><br>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:<br>(1) Documentation that medications were administered as ordered;<br>(2) All instances of refusal of medications, including the reason why and the actions taken by the home;<br>(3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect;<br>(4) A current list of who is administering medications to residents, including staff to whom a registered nurse has delegated administration; and<br>(5) For residents receiving psychoactive medications, a record of monitoring for side effects.<br>(6) All incidents of medication errors.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and record review there is a failure to document administration of medications as ordered for 2 applicable residents | R202 | | |

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| R202 | Continued From page 5<br>(Residents #6 and #8); and a failure to establish and implement procedures for monitoring all applicable residents for the potential side effects of psychoactive medications. Findings include:<br><br>Policies and procedures governing medication administration and monitoring for the side effects of psychoactive medications were not provided for review on 11/10/25.<br><br>1. Per record review there is a failure to ensure the following medications are administered as ordered:<br><br>a. Per review of signed medication orders on file, Resident #6's physician ordered APAP (acetaminophen) 325 mg tabs 2 tabs to be given every 4 hours as needed for pain/fever. Per record review, Resident #6's November 2025 Medication Administration Record listed an order for "APAP 325 mg tabs take one tablet by mouth every 6 hours as needed" for which a signed medication order is not on file in Resident #6's record.<br><br>b. Per record review, Resident #8's November 2026 Medication Administration Record lists an order for Baclofen 100 mg tab One tablet by mouth every 8 hours. The medication administration times entered for this order are not consistent with the order listed in the MAR, as this medication is scheduled to be given at 8 AM, 12 PM and 8 PM indicating the first two doses are scheduled to be given 4 hours apart.<br><br>The Manager confirmed the finding of resident medications which were not administered as ordered at 4:56 PM on 11/10/25. | R202 | Type text here | |

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| R202 | Continued From page 6<br><br>2. During an interview commencing 12:32 PM on 11/10/25 the Manager stated they were unsure if the residents of the home prescribed psychoactive medications are monitored for the side effects of these medications. During this interview, the Manager stated the Registered Nurse was not available for interview.<br><br>Per record review, documentation of monitoring for the side effects of psychoactive medications was not on file in the home's Medication Administration Record and resident records. This finding was confirmed by a Med Tech during an interview commencing at 3:35 PM on 11/10/25 who stated the only monitoring they are aware of is documented on Behavior Sheets in the Medication Administration Records for applicable residents. The Behavior Sheets utilized by the home are a tool for monitoring resident behaviors rather than the side effects of psychoactive medications. A binder provided by the Manager for review contained documentation of AIMS (Abnormal Involuntary Movement Scale) testing, which is an assessment tool commonly used to check for the presence and severity of uncontrolled involuntary movement resulting from the use of antipsychotic medications. This binder was observed to be without documentation of AIMS testing completed after 2020.<br><br>On the afternoon of 11/10/25 the Manager acknowledged the lack of current documentation indicating residents of the home prescribed psychoactive medications are being monitored for the side effects of these medications. | R202 | | |
| R206 SS=F | 5.10.h (4) Medication Management<br><br>Medications left after the death or discharge of a | R206 | | |

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| R206 | Continued From page 7 | R206 | | |

resident, or outdated medications, must be promptly disposed of in accordance with the home's policy and applicable standards of practice.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview there is a failure to ensure outdated medications belonging to 5 applicable Residents (Residents #1, #2, #3, #4 and #5) were disposed of promptly. Findings include:

Policies and procedures governing disposal of outdated medications were not provided for review on request.

During a review of the medications stored in the medication cart in the basement residential area of the home on the morning of 11/10/25, outdated medications belonging to 5 residents of the home including Resident #1, Resident #2, Resident #3, Resident #4 and Resident #5 were observed to have not been disposed of promptly including:

1. For Resident #1:
a. Trazodone 50 mg tabs expired 8/3/25
b. Acetaminophen 325 mg tabs expired 4/21/25
c. Ibuprofen 400 mg tabs expired 3/2/25

2. For Resident #2:
a. Acetaminophen 500 mg tabs expired 7/16/25
b. Diphenhydramine 25 mg capsules expired 3/24/25

3. For Resident #3
a. Melatonin 5 mg soft gels expired 8/5/25
b. Acetaminophen 500 mg tabs expired 1/25/25

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| R206 | Continued From page 8<br>c. 2 cards of Acetaminophen 500 mg tabs expired 7/16/25<br>d. 2 cards of Omeprazole 20 mg caps expired 5/14/25<br>e. Mucus Relief Tab ER 600 mg tab expired 6 30/25<br>f. Baclofen 20 mg tabs expired 1/28/25<br>g. Zonisamide 100 mg caps 7/16/25<br>h. Loperamide 4 mg caplets expired 8/2025<br>i. Calcium Antacid 500 mg tabs expired 7/16/25<br>j. Tramadol HCl 50 mg tabs expired 9/6/25<br><br>4. For Resident #4<br>a. Hydroxyzine HCl 25 mg tabs expired 2/27/25<br>b. Guaifenesin 200 mg tabs expired 8/7/25<br>c. Methocarbamol 500 mg tabs expired 1/16/25<br>d. Methocarbamol 500 mg tabs expired 7/16/25<br>e. Acetaminophen 500 mg tabs expired 7/7/25<br><br>5. For Resident #5<br>a. Ibuprofen 400 mg tabs expired 3/25/24<br>b. Ibuprofen 400 mg tabs expired 5/4/25<br>c. Fiber (Reguloid) 500 mg caps expired 8/17/25<br>d. Acetaminophen 500 mg tabs expired 5/21/24<br>e. Loperamide 2 mg tabs expired 7/15/25<br>f. Loperamide 2 mg tabs expired 8/16/25<br>g. Lactase 3,000 unit Dairy Aid expired 8/1/25<br><br>At 12:31 PM on 11/10/25 the Manager of the home confirmed the failure to promptly dispose of outdated medications belonging to multiple residents of the home. | R206 | | |
| R210 SS=F | 5.11.c Staff Services<br><br>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 | R210 | | |

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| R210 | Continued From page 9<br>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:<br><br>(1)Resident rights;<br>(2) Fire safety and emergency evacuation;<br>(3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid;<br>(4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation;<br>(5) Respectful and effective interaction with residents;<br>(6) Infection control measures, including but not limited to, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions;<br>(7) General supervision and care of residents;<br>(8)Communication strategies, person-centered care, challenging behaviors and understanding dementia;<br>(9) Recognition of and sensitivity to different cultures, belief systems, abilities, gender identities, sexual orientation; and<br>(10) Trauma-informed care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review there is a failure to ensure 5 out of 5 sampled staff completed the required trainings. Findings include:<br><br>Policies and procedures governing staff training | R210 | | |

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| R210 | Continued From page 10<br>were not provided for review on request.<br><br>At 9:59 AM on 11/10/25 the Manager was requested to provide documentation of trainings completed by 5 sampled staff for review. Per the documentation provided by the Manager for review, 5 out of 5 sampled staff did not compete the required trainings. This finding was confirmed by the Manager at 12:25 PM on 11/10/25 and re-confirmed on exit at approximately 5:15 PM on 11/10/25. | R210 | | |
| R225 SS=F | 5.12. b (4) Records/Reports<br><br>The home must keep and maintain the following records:<br><br>The results of the criminal record and adult abuse registry checks for all staff:<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review there is a failure to ensure the required criminal record and abuse registry checks were competed for 3 out of 5 sampled staff. Findings include:<br><br>Policies and procedures governing staff background checks were not provided for review on request.<br><br>At 9:59 AM on 11/10/25 the Manager 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 Manager, background checks were not completed as required for 3 out of 5 sampled staff. This finding was confirmed by the Manager at 12:12 PM on | R225 | | |

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| R225 | Continued From page 11<br>11/10/25. | R225 | | |
| R342 SS=F | 5.15 Policies and Procedures<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review there is a failure to ensure policies and procedures governing all areas of service have been developed by the home, are available for review, and are provided on request. Findings include:<br><br>At 9:35 AM on 11/10/25 the Manager of the home was provided a list of Entrance Requests including a request for access to a paper or electronic copy of the current facility policies and procedures manual. During the survey the Manager was requested to provide policies and procedures governing areas of service which were identified as areas of potential deficiency based on observation, staff interviews, and record review. Policies and procedures were not provided for review on request.<br><br>At 1:25 PM on 11/10/25 the Manager was asked where the home's policies and procedures manual was stored. The Manager responded there was one official up to date copy of the home's policies and procedures manual and confirmed it was not kept in a common area of the home. Additional statements made by the | R342 | | |

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| R342 | Continued From page 12<br><br>Manager in response to inquiry about the home's policies and procedures manual included that it was usually stored in the office.The Manager stated they were unsure where the manual was at the moment, and indicated it may be downstairs but could not find the homes policies and procedures.<br><br>The Manager failed to provide policies related to the areas of care and service identified as potential deficiencies during and following the survey conducted on 11/10/25. Information provided by the Manager regarding requested policies and procedures was limited to confirmation at 4:10 PM on 11/10/25 that the home's grievance procedures were not posted in the home as required because policies and procedures governing this area of service had not been developed by the home. | R342 | | |
| R356 SS=F | 6.8 Resident's Rights<br><br>A resident may complain or voice a grievance without interference, coercion or reprisal. Each home must establish a written grievance procedure for resolving residents ' concerns or complaints that is explained to residents at the time of admission. The grievance procedure must include at a minimum, time frames, a process for responding to residents in writing, and a method by which each resident filing a complaint will be made aware of the role and contact information of the Office of the Long-Term Care Ombudsman and Disability Rights Vermont as an alternative or in addition to the home's grievance mechanism.<br><br>This REQUIREMENT is not met as evidenced by: | R356 | | |

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| | 0214 | A. BUILDING: _____ B. WING _____ | 11/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| RIVERVIEW LIFE SKILLS CENTER | 197 HIGHLANDER DRIVE JEFFERSONVILLE, VT 05464 |

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| R356 | Continued From page 13<br><br>Based on observation and staff interview there is a failure to develop written policies and procedures for resolving resident's concerns or complaints. Findings include:<br><br>During a tour of the home on the morning of 11/10/25 the Surveyor observed the home's Grievance procedures were not posted in the home as required. At 4:10 PM on 11/10/25 the Manager confirmed procedures for response to Grievances had not been developed by the home. | R356 | | |
| R381 SS=F | 7.2.a Food Safety and Sanitation<br><br>Each home must procure food from sources that comply with all laws relating to food and food labeling. The home must ensure that all food is safe for human consumption, free of spoilage, filth or other contamination. All milk products served and used in food preparation must be pasteurized. Cans with dents, swelling or leaks must be rejected and kept separate until returned to the supplier.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview there is a failure to ensure opened lunch meat is safe for consumption and free of spoilage. Findings include:<br><br>During a facility tour commencing at 10:00 AM on 11/10 25 the refrigerator in the basement residential living area was observed with opened containers of sliced turkey deli meat with labels indicating the containers were opened on 10/26/25 and 10/28/25. The label on the containers states "use within 5 days after opening". One container had been open for 13 | R381 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| R381 | Continued From page 14<br>days, and the other container had been open for 15 days.<br><br>The Manager was alerted to this finding during the tour of the basement residential living area, and upon viewing the opened packages of turkey the Manager confirmed the opened containers of deli meat were not safe for consumption due to the length of time they had been stored in the refrigerator. | R381 | | |
| R382 SS=F | 7.2.b Food Safety and Sanitation<br><br>7.2.b All perishable food and drink must be labeled, dated and held at proper temperatures:<br>(1) At or below 40 degrees Fahrenheit.<br>(2) At or above 140 degrees Fahrenheit when served or heated prior to service.<br>(3) Staff must monitor the temperature of temperature-controlled food storage areas. Staff must conduct regular temperature checks of prepared food to ensure proper food safety and must document the time and results of each check. The U.S. Department of Agriculture provides guidance for time and temperature curves to ensure prepared foods remain outside of the 'danger zone' for food safety.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview there is a failure to ensure perishable foods and drinks requiring refrigeration are held at or below 40 degrees Fahrenheit. Findings include:<br><br>Policies and procedures governing the storage of perishable food and drinks were not provided for | R382 | | |

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| R382 | Continued From page 15<br>review on request.<br><br>Per observation during a tour of the home's second floor living environment commencing at 10:00 AM on 11/10/25, the thermometer in the fridge closest to the kitchen sink indicated the food inside this fridge was held at 47 degrees Fahrenheit. Upon notification of this observation the Manager confirmed this finding and stated the temps in this fridge had recently been an issue. A thermometer was moved from a second fridge in the second floor kitchen to the fridge closest to the kitchen sink, and was observed approximately 15 minutes later to also indicate the food in this fridge was held at 47 degrees Fahrenheit.<br><br>Following adjustment to the temperature control setting in the applicable fridge the temperature of the applicable refrigerator was rechecked by the Surveyor at 3:50 PM and observed to be 44 degrees Fahrenheit. This finding was confirmed by the Staff on duty present with the Surveyor to conduct the recheck at 3:50 PM. The Manager confirmed this finding at approximately 4:00 PM on 11/10/25. | R382 | | |
| R454 SS=D | 11.1 Resident Funds and Property<br><br>A resident's money and other valuables must be in the control of the resident, except where there is a guardian, or attorney in fact (power of attorney), who requests otherwise. The home may manage the resident ' s finances only upon the written request of the resident. There must be a written agreement stating the assistance requested, the terms of same, the funds or property and persons involved.<br><br>This REQUIREMENT is not met as evidenced | R454 | | |

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| R454 | Continued From page 16<br>by:<br>Based on staff interview and record review there is a failure to obtain a written request to manage personal finances for one applicable resident (Resident # 8). Findings include:<br><br>Policies and procedures governing management of resident's personal funds were not provided for review on request.<br><br>Per interview with the Manager commencing at 12:32 PM on 11/10/25, and per record review, Resident #8's personal finances are managed by the home. At 1:08 PM on 11/10/25 the Manager confirmed a signed request for management of Resident #8's personal finances had not been obtained by the home. The Manager stated they "should have had that on file". | R454 | | |
| R455 SS=F | 11.2 Resident Funds and Property<br><br>If the home manages the resident's finances, the home must keep a record of all transactions, provide the resident with a quarterly statement, and keep all resident funds separate from the home or licensee's funds.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review there is a failure to keep a record of all transactions for one applicable resident (Resident #6) and a failure to provide adequate documentation of quarterly statements provided to 4 applicable residents for whom personal finances are managed by the home (Resident #3, Resident #6, Resident #7 and Resident #8). Findings include:<br><br>Policies and procedures governing management | R455 | | |

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| R455 | Continued From page 17<br>of resident's personal funds were not provided for review on request.<br><br>1. Per record review Resident #6's personal finances are managed by the home. At 1:14 PM on 11/10/25 the Manager confirmed a record of all financial transactions is not kept for Resident #6.<br><br>2. Per interview with the Manager commencing at 12:32 PM on 11/10/25, the home manages personal funds for Resident#3, Resident #6, Resident #7 and Resident #8. On the afternoon of 11/10/25 the Manager was requested to provide copies of quarterly statements of Resident's funds provided to the applicable Residents and/or their guardians for review. The document provided by the Manager in response to this request was a paper that stated, "Client fund registry quarterly update (report) sent to guardians on 10/21/25". The Manager stated a copy of this document was stored in folders maintained for each applicable Resident along with a record of financial transactions and copies of the same document listing previous dates. The Manager stated the Residents and/or their guardians were provided a copy of a list of transactions each quarter; however, documentation of individual quarterly statements provided to the applicable Residents and/or guardians referenced in the document provided by the Manager was not on file and available for review on 11/10/25.<br><br>At approximately 1:20 PM on 11/10/25 the Manager acknowledged the document stating "Client fund registry quarterly update (report) sent to guardians on 10/21/25" does not meet the minimum standard for quarterly reporting of Resident's personal finances. | R455 | | |

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| R461 SS=D | 11.8 Resident Funds and Property<br><br>The licensee, the licensee's relative or any staff member must not be the legal guardian, trustee or legal representative for any resident other than a relative. The licensee or any staff of the home are permitted to act as the resident's representative payee according to Social Security rules provided the resident or the resident ' s legal representative agrees in writing to this arrangement and all other provisions of these rules related to money management are met.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review there is a failure to ensure all provisions of the licensing rules for management of a resident's personal funds are met for one applicable resident (Resident #6) who receives representative payee services from the Manager. Findings include:<br><br>Policies and procedures governing representative services provided for Residents of the home, and governing management of personal finances for residents of the home, were not provided for review on request on 11/10/25.<br><br>Per interview with the Manager commencing at 12:32 PM on 11/10/25, and per record review, the Manager serves as the representative payee for Resident #6. At 1:14 PM on 11/10/25 the Manager confirmed a written record of financial transactions is not kept for Resident #3, and Resident #3 is not provided with an accounting of their personal funds on a quarterly basis. | R461 | | |

## Deficiency Statement Plan of Correction (POC)

**Survey Date: November 11,2025**

**Facility Name: Riverview Life Skills Center**

| 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 |
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| R151<br>Plan of Correction accepted by Jo A Evans RN 12/10/25 | All previously missing signed physicians orders pertaining to client #6 and client #8 have been successfully obtained and filed. These documents are now incorporated into the respective client medical records ensuring complete and compliant charting. | To ensure this deficiency does not impact any other clients, a full audit of all client medical records was conducted 11/19/2025 to verify that signed physician orders were present, complete and properly filed. | 11/19/2025 | To mitigate the recurrence of documentation gaps, the following quality assurance protocol will be instituted: The RN will systematically audit client charts to confirm that all active medication orders are appropriately signed, current and filed within the clients medical records (chart). | Registered Nurse |
| R191<br>Plan of Correction accepted by Jo A Evans RN 12/10/25 | Client #6 missing medication order has been obtained, signed by primary physician and filed into the clients chart. Client # 8 missing medication orders have been obtained and signed by primary physician. Signed orders have been placed in clients chart.<br>Policy and Procedure governing medication orders are in Policy and procedure binder. | RN and administrator immediately conducted a 100% audit of all client charts and the MARs to verify that a current, signed medication order was present and properly filed for every medication being administered. | 11/27/2025 | To mitigate the recurrence of documentation gaps, the following quality assurance protocol will be instituted: The Registered Nurse will systematically audit client records to confirm that all active medication orders are appropriately signed, current and filed within the clients medical record.<br>Policy and Procedure regarding medication orders will be reviewed annually | Registered Nurse<br><br>Manager. |
| R193 | The current registered nurse completed the | The RN conducted a 100% audit to verify that | 11/17/2025 | Human resources/employee binder shall maintain the | Registered Nurse |

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| Plan of Correction accepted by Jo A Evans RN 12/10/25 | necessary delegation protocol immediately upon hire. Medication delegation for the designated staff members has been officially finalized, documenting their training and competency. All associated documentation regarding this delegation is complete, formally filed and readily available for audit and compliance verification. | all necessary RN delegation tasks (specifically for medication administration and specific treatments) were completed. All audit results are documented and signed by the RN and are current for all staff providing care. All personnel files to ensure that documentation for RN delegation of staff competency for all designated care providers are complete, current and filed according to policy. | | training log for all delegation-related training records. RN will conduct annual audits of delegated medication tasks to ensure medication delegation compliance. | Manager |
| R196<br><br>Plan of Correction accepted by Jo A Evans RN 12/10/25 | A full audit of all current residents prescribed PRN psychoactive medications was completed. For each applicable resident, a written PRN medication plan was developed and placed in their record. Plans include: Specific behaviors the medication is intended to address, Known behavior triggers, Circumstances warranting medication use, desired effects and potential side effects to monitor, and documentation protocols for time, reason, and results of administration. | All residents now have a complete, current, and physician-approved written PRN medication plan in their record, ensuring this deficiency is corrected for all residents. Riverview has implemented a mandatory protocol to ensure that any client newly prescribed A PRN psychoactive medication is automatically identified, and the required comprehensive PRN plan is initiated before the first dose is administered. | 11/26/2025 | A standardized PRN Psychactive Medication is in place. All direct care staff received training on regulatory requirements for PRN psychoactive medications, how to interpret and follow written PRN plans, Proper documentation procedures. Riverview's medication policy and procedure has be revised to reflect the regulatory requirements and include clear Procedures for PRN administration by non-nursing staff. | Registered Nurse<br><br>Administration |

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| Type text here<br>R202<br><br>Plan of Correction accepted by Jo A Evans RN 12/10/25 | RN has reviewed Resident #6's medical record and obtained a signed physicians order for the "APAP 325 mg tab". This order has been placed in the residents chart.<br>Resident #8 RN has compared the physician's order for Baclofen 100mg tab against the current MAR. The MAR has been corrected to reflect the physicians order: "8am, Noon and 8pm". RN has conducted competency check with all staff administering medications accurately documenting administration times based on physician order.<br>Monitoring for Side Effects of Psychoactive Medications: The RN will conduct a comprehensive review of the records of all residents receiving psychoactive medications to ensure a current, documented plan for monitoring side effects is in place for each resident. All | The RN and administration audited 100% of all current MARs against the corresponding current signed physician orders to identity and correct any discrepancies in medication, dosage, time or route for all residents.<br>The RN conducted a 100% comprehensive review of all residents currently receiving psychoactive/psychotropic medications to confirm that a specific, written plan for monitoring side effects and target behaviors is in place for each resident, with documentation protocols clearly defined. | 12/03/2025 | Riverview's Policy and Procedures governing medication administration and monitoring for side effects of psychoactive medications have been reviewed and revised to align with current Vermont state regulations.<br>RN<br>will review policies regarding obtaining and filing signed physician orders before administering any medication, accurate scheduling of "every X hours" medications, required documentation of all medication administration, including PRN medications, specific , documented monitoring for psychoactive medication side effects. | Registered Nurse<br><br>Administrator |

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| | medication administration delegated staff will be re-educated on where to document this monitoring (MAR Behavioral/Intervention Monthly Flow Record). | | | | |
| R206<br><br>Plan of Correction accepted by Jo A Evans RN 12/10/25 | All expired medications have been removed and properly destroyed. New physician orders have been obtained for all appropriate current medications and placed in appropriate client charts. Medication is up-to-date and contains only valid, current prescriptions. | RN conducted a 100% audit of all medications storage areas (Lock medication carts) to identify and ensure the removal and proper destruction of all expired, discontinued, or improperly labeled medications. RN audited 100% of all current client charts against their MARs to confirm that every medication currently being administered has a corresponding valid, current, and signed physician's order in the chart. | 11/19/2025 | Effective immediately, a comprehensive , joint monthly audit of the medication carts inventory and operational compliance will be conducted. This audit will be performed collaboratively by the RN and a trained medication-delegated staff member. | RN and trained medication delegated staff member. |
| R210<br><br>Plan of Correction accepted by Jo A Evans RN 12/10/25 | All staff who were deficient in their annual training have been immediately scheduled to complete all required trainings. The trainings will cover all 10 mandatory topics listed in the regulation. Riverview's administrators have reviewed and organized | The administrator, RN and HR have conducted a 100% audit of all current staff training files to verify that every employee has or will receive required annual and mandated in-service training topics within the regulatory timeframe. The audit identified specific staff needing | 11/21/2025 | Riverview has officially designated a Training Compliance Manager who will be responsible for overseeing, tracking and maintaining all staff training records. The Training compliance manager will create a master schedule to ensure all direct care staff complete their 12 hours of annual training (Monthly trainings). Riverview | Administration Registered Nurse |

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| | all training records for 2025. Copies of the completed training will be placed in the Staff Training Binder with each of the required training topics. | training. All staff are currently. Trainings have been schedule all will be completed and documented. | | administration will review the status of 100% of direct care staff training records to ensure full compliance with the 12 annual requirement. | |
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| R225<br><br>Plan of Correction accepted by Jo A Evans RN 12/10/25 | Obtained and filed criminal record and adult registry checks for the 3 staff members Identified. Verified that all current staff have completed background checks as well and state criminal and national criminal background checks completed and filed. Developed and implemented a written policy outlining procedures for obtaining, verifying, and storing background checks. | Conducted a full audit of all staff files to ensure compliance. Suspended unsupervised resident contact for any staff pending verification. Reinforced hiring protocols to prevent onboarding with completed checks. | 11/14/2025 | Created a standardized checklist for new hire onboarding that includes criminal record and abuse registry verification. Integrated background tracking in HR software with alerts for missing or expired documentation. Policy added to Policy and Procedure manual and reviewed during orientation. | Administrator |
| R342<br><br>Plan of Correction accepted by Jo A Evans RN 12/10/25 | Riverview compiled and reviewed all existing policies and procedures governing services including staffing, care delivery, emergency response, grievance handling and record review. A complete and current policies and procedures manual was printed and placed in a designated common | All current residents and their representatives were notified in writing that the new manual is now available upon request and in the designated location. Staff were instructed to offer access to the manual during resident admission and care planning meetings. | 11/20/2025 | A new policy was implemented requiring quarterly review and policy and procedures manual. A signage protocol was established to ensure grievance procedures and policy access instructions are posted to common areas. A request log was created to track all requests for policy access and ensure timely fulfillment. | Administrator |

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| | area accessible to residents, representatives and staff. | | | | |
| R356<br><br>Plan of Correction accepted by Jo A Evans RN 12/10/25 | Grievance policy and procedures were developed in written form and posted in a prominent location within the home. The policy outlines resident's rights to file complaints without interference, coercion or reprisal. It includes time frames for response, a written reply process, and contact information for the Long Term Care Ombudsman and Disability Rights Vermont | All current residents received a copy of the procedure and were informed of their rights during a group meeting. Staff reviewed the policy with each resident individually to ensure understanding. New admissions now receive the grievance procedure as part of the intake packet. | 11/14/2025 | The grievance policy is now included in the admissions agreement. A framed copy is posted in main common area near the resident rights postings. A quarterly review of grievance postings is added to the internal compliance audit. Staff orientation now includes training on grievance handling and resident rights. | Administrator |
| R381<br><br>Plan of Correction accepted by Jo A Evans RN 12/10/25 | The expired turkey deli meat was immediately discarded. Staff were re-educated on food labeling and discard timelines for opened products. | All refrigerators in residents accessible areas were inspected. No other expired or improperly labeled food items were found. | 11/13/2025 | Revised for storage protocol was implemented, including a daily refrigerator log and discard systems, i.e., all deli meat from the previous week is to be discarded each Saturday and replaced with newly purchased deli items. | Administrator |
| R382<br><br>Plan of Correction accepted by Jo A Evans RN 12/10/25 | Refrigerator temperature was adjusted and rechecked to meet the required standard of 40 degrees Fahrenheit. Staff will continue to monitor and document temperatures once daily. Once of the upper floor refrigerators was | All refrigerators in resident areas were inspected and recalibrated. Once refrigerator will be replaced. Delivery date for new refrigerator is 12/11/2025. Staff were retrained on food safety protocols. Unsafe food items were discarded. | 11/13/2025 | A written policy was update and added to policy and procedure manual. Monthly audits of food storage area were implemented. | Administrator |

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| | recording a temperature of 47 degrees Fahrenheit even after adjusting the temperature controls and changing thermometers. A new refrigerator has been purchased and will be delivered on 12/11/2025. | | | | |
| R454<br><br>Plan of Correction accepted by Jo A Evans RN 12/10/25 | A signed written request was obtained from Resident #8 authorizing the home to manage personal finances. A standardized agreement template was created and implemented to document all future financial assistance arrangements. | All residents receiving financial assistance were reviewed to ensure signed agreements are on file. Administration was instructed to verify documentation before initiating any financial management. Policy updated to require prior to managing any resident funds | 11/17/2025 | Annual audit of financial agreements has been implemented. | Administration |
| 455<br><br>Plan of Correction accepted by Jo A Evans RN 12/10/25 | Developed and implemented written policies for managing resident funds and representative payee services. Obtained signed consents from resident. Established a ledger system to document all financial transactions. Distributed quarterly statement to residents #3, #6, #7, and #8. | Monthly internal audits of resident fund records. Quarterly reviews to be performed by administration. | 12/2/2025 | Administrative training of Social Security Payee rules and Vermont licensing standards will be implemented and reviewed on an annual basis. | Administration |
| R461 | Developed and implemented written | Reviewed all residents receiving financial | 12/2/2025 | Administrative training on Social Security payee rules | Administration |

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| Plan of Correction accepted by Jo A Evans RN 12/10/25 | policies and procedures for representative payee services and resident fund management. Obtained written consent from resident #6. Established quarterly accounting and record keeping for resident #8. | services to ensure compliance. Obtained written consents where applicable. Implemented quarterly fund statements for all residents receiving personal fund management. | | and Vermont licensing standards. Monthly audits of resident fund records. Annual policy review and updates | |
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