

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

April 10, 2014

Ms. Holly Baker, Administrator
Manes House
127 Union Street
Bennington, VT 05201

Provider # 0193

Dear Ms. Baker:

Enclosed is a copy of your acceptable plans of correction for the unannounced onsite complaint investigation conducted on **March 10, 2014**. 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.

Sincerely,



Pamela M. Cota, RN
Licensing Chief

PC:ne

Enclosure

Division of Licensing and Protection

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0193 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED C 03/10/2014 |
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| NAME OF PROVIDER OR SUPPLIER MANES HOUSE | STREET ADDRESS, CITY, STATE, ZIP CODE 127 UNION STREET BENNINGTON, VT 05201 |
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| R100 | Initial Comments: An announced on-site complaint investigation was completed by the Division of Licensing and Protection on 3/10/2014. There were findings with this investigation. | R100 | THIS WAS AN UNANNOUNCED ON SITE COMPLAINT INVESTIGATION | |
| R169 SS=E | V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.e Staff responsible for assisting residents with medications must receive training in the following areas before assisting with any medications from the licensed nurse: (1) The basis for determining "assistance" versus "administration". (2) The resident's right to direct the resident's own care, including the right to refuse medications. (3) Proper techniques for assisting with medications, including hand washing and checking the medication for the right resident, medication, dose, time, route. (4) Signs, symptoms and likely side effects to be aware of for any medication a resident receives. (5) The home's policies and procedures for assistance with medications. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to insure that proper administration techniques during medication administration were adhered to. Findings include: 1.) During observation of medication administration at 8:15 AM, the caregiver failed to | R169 | | |

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

STATE FORM 327H11
Handwritten signatures and dates:
 Katherine Owen Manger 3/31/14
 Katherine Satterthwaite R.N. 3.31.14
 [Signature] 3.31.14

R169, R172, R176, R181, R233, R235, R246, R247, + R268 POC's accepted 4/3/14 BBA/ELRN/PML

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| R169 | <p>Continued From page 1</p> <p>wash or sanitize hands between 3 of 4 resident observations; Resident #1, Resident #2 and Resident #3. Spoke with caregiver after administration and s/he confirmed that s/he did not sanitize or wash hands between residents.</p> <p>2.) During observation of medication administration to Resident #1, the caregiver placed a Carvedilol 3.125 mg (milligram) tablet in her/his hand and handed it to the resident. The caregiver confirmed that the tablet was placed in their hand and stated that sometimes the pills are so small that it is hard to get them out of the package (pills were bubble packed) without touching them.</p> <p>3.) During observation, Resident #2 required a finger blood glucose be checked. The caregiver proceeded to obtain sample from finger and test without application of gloves or cleansing of hands before or after procedure. Confirmation made with caregiver immediately following incident.</p> | R169 | <p>1, 2 & 3 ALL STAFF RECEIVE MEDICATION TRAINING AND INSURE FOR DIABETES MANAGEMENT ANNUALLY & PER UNANNOUNCED MONTHLY spot checks ARE CONDUCTED BY THE R.N. AND IF PROPER PROTOCOL IS NOT FOLLOWED STAFF WILL NOT BE APO DELEGATED. STAFF MEMBER CITED WAS COUNSELED/TRAINED AND RE DELEGATED, FOR UNIVERSAL PRECAUTIONS ON 3/18/14 THIS WILL BE MONITORED BY HOUSE MANAGER AND NURSING STAFF</p> | |
| R172 SS=E | <p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.10 Medication Management.</p> <p>5.10.h All medicines and chemicals used in the home must be labeled in accordance with currently accepted professional standards of practice. Medication shall be used only for the resident identified on the pharmacy label.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to insure that all medications were</p> | R172 | | |

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| R172 | <p>Continued From page 2</p> <p>labeled and stored properly in accordance with acceptable standards of practice. Findings include:</p> <p>1.) During inspection of medication storage at 8:15 AM, a medicine bottle was in the medication cart and had a handwritten label taped over the original label. The label indicated, Ibuprofen 600 mg Exp 12/15. The original label indicated Ibuprofen 200 mg. Per interview with the manager/owner at 8:15 AM, s/he stated that the medication came from a resident that no longer wanted them and the pills were placed in the bottle and relabeled in an attempt to save money.</p> <p>2.) In the medication cart a bottle of pills with a handwritten label indicating that there were Tylenol 500 mg tablets in the bottle. Inquiry of the manager presented that the medication was left over from a deceased resident and in an attempt to save money the pills were kept.</p> | R172 | <p>ALL MEDICATIONS THAT WERE NOT LABELED IN ACCORDANCE WITH REGULATIONS HAVE BEEN REMOVED AND DESTROYED. STAFF HAS RECEIVED NOTIFICATION FROM R.A. AND MANAGEMENT THAT THIS IS NOT ALLOWED. STAFF COUNSELLED ON 3-18-14. WILL BE MONITORED BY HOME MANAGER AND NURSING STAFF.</p> | |
| R176 SS=E | <p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.10 Medication Management</p> <p>5.10.h (4)</p> <p>Medications left after the death or discharge of a resident, or outdated medications, shall be promptly disposed of in accordance with the home's policy and applicable standards of practice.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to insure that medications left after</p> | R176 | | |

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| R176 | <p>Continued From page 3</p> <p>the death or discharged resident, or outdated medications were promptly disposed of in accordance with the facility's policy and applicable standards of practice. Findings include:</p> <p>1.) In the medication cart a bottle of pills with a handwritten label indicating that there were Tylenol 500 mg tablets in the bottle. Inquiry of the manager presented that the medication was left over from a deceased resident and in an attempt to save money the pills were kept.</p> <p>2.) Confirmation was made by the manager regarding discontinued Warfarin 1mg tablets for Resident #4 that was retained on the medication cart. Per interview, the resident has frequent changes in dosing and in order to save money the medication was kept in the event that it was reordered at that dose.</p> <p>3.) In observation of medication storage for insulin, it was found that there were outdated vials of insulin for Resident #5. A box with that was labeled Lantus insulin, was dated as being opened 1/29/14. There were 2 open partially used vials of Lantus in the box and neither bottle was labeled. Per confirmation with the LPN at 12:30PM the vials were not labeled and s/he had placed both bottles in the one box because s/he was going to finish drawing up the vial soon. Confirmed that date opened was 1/29/14. Reviewed with LPN manufacturer's guidance (that was in box with the insulin bottles) that the insulin is to be discarded 28 days after opening.</p> <p>4.) In observation of medication storage for insulin, it was found that an opened bottle of Novolog insulin for Resident #5 was dated as being opened 1/27/14. Confirmed with LPN of</p> | R176 | <p>#1 REFER TO R 172 #'S 1 + 2</p> <p>#2 RESIDENT IN QUESTION HAS A CURRENT ORDER FOR WARFARIN WHICH CAN VARY WITH EACH PT/DUR DONE q 2-4 WEEKS. TO ENSURE RESIDENT RECEIVES PROPER DOSE & PRESCRIBED TIME DIFFERENT DOSING NEEDS TO BE ON HAND FOR RN/LPN TO DRAW IN EVENT THAT EXTENDED CARE PHARMACY CAN'T BE REACHED ON OFF HOURS. ALL DOSES WILL HAVE BE ORDER, LABED PROPERLY AND STORED IN LOCKED MED CART. WILL BE MONITORED BY RN/LPN</p> <p>#3/#4 ALL INSULIN IS MARKED WHEN OPENED AND INITIALS BY STAFF OPENING - IT WILL BE DESTROYED AFTER 28 DAYS. THE VIALS MENTIONED WERE ALSO OPENED ON 3-10-14. THIS WILL BE MONITORED BY HOUSE ON MANAGER AND NURSING. ALL MEDICATIONS HAVE BEEN MADE & EXTENDED CARE PHARMACY TO REFILL 208 VIALS. STAFF MONITORED THIS CHANGE ON 3-18-14</p> | |
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| R176 | Continued From page 4 date 1/27/14 being the date opened. Reviewed with LPN manufacturer's guidance (that was in box with the insulin bottles) that the insulin is to be discarded 28 days after opening. | R176 | | |
| R181 SS=E | <p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.11 Staff Services</p> <p>5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review and staff interview the facility failed to have evidence of completed Vermont required background checks for 6 of 7 employees as required. Findings include:</p> <p>1.) Per review of employee files, it was found that Child Abuse background checks (33 V.S.A.</p> | R181 | | |

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| R181 | <p>Continued From page 5</p> <p>Chapter 49) on 5 of 7 employees have not been completed. Per interview with the manager/owner, s/he stated that the employees have been with the facility for over 6 years. S/he further stated s/he was not aware of the need to obtain Child Abuse background checks.</p> <p>2.) Review of employee files presented that 2 of the 7 employees do not have Criminal background checks done. Confirmation was made with the manager/owner that these have not been completed.</p> | R181 | <p>① CHILD ABUSE BACKGROUND CHECKS WERE SUBMITTED ON 3-12-14 AND RESULTS OBTAINED ON 3-14-14. A COPY OF THESE RESULTS ARE ENCLOSED. THIS WILL BE DONE WITH EACH EMPLOYEE UPON HIRE. WILL BE MONITORED BY THE HOUSE MANAGER.</p> <p>② THE 2 EMPLOYEES LISTED INTO CRIMINAL BACKGROUND CHECKS/FINGER PRINTING DONE ON 3/26/14 THROUGH THE BENNINGTON SHERIFF'S DEPARTMENT. THIS WILL BE DONE WITH EACH EMPLOYEE UPON HIRE AND MONITORED BY THE HOUSE MANAGER - SEE COPIES OF RECEIPT FOR SUCH.</p> <p>ALSO PLEASE SEE COPIES ENCLOSED FOUND IN BOTH FILES OF THESE EMPLOYEES VERIFYING THAT CRIMINAL BACKGROUND (ABUSE REQUEST) CHECKS HAD BEEN COMPLETED PRIOR TO THIS INSPECTION.</p> <p>THIS IS BEING CARRIED OUT AS EVIDENCED IN THE RECENT NEW HIRE - PLEASE SEE COPIES OF BACKGROUND CHECK RESPONSES.</p> | |
| R233 SS=C | <p>VII. NUTRITION AND FOOD SERVICES</p> <p>7.1.a (2) The meals served each day must provide 100% of the Recommended Dietary Allowances (RDA) as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences and comply with the Dietary Guidelines for Americans.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to insure that meals served each day provided 100% of the recommended Dietary Allowances and comply with Dietary Guidelines. Findings include:</p> <p>1.) Review of menu with the manager, there were 4 out of 7 days without Meat/Equivalent of 4-5 oz. daily on Wednesday, Thursday and Friday of posted menu for week #3 dated 3/9-3/15/14. This was confirmed at 1:15 PM by the manager. An example of the meat servings that the facility utilized was Hearty Ham soup was an evening</p> | R233 | | |

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| R233 | Continued From page 6 meal and consisted of potato, carrots, celery and ham, but per manager confirmation it probably did not have the required servings per resident as required. 2.) Confirmation by the manager that there were 4 of 7 days without adequate portions of vegetables that were listed on the menu. March 12, 13, 14 and 15. 3.) Per confirmation with the manager at 1:15 PM, there were 7 out of 7 days for the posted menu, dated 3/9 - 3/15/14, that there was not adequate Bread/Rice/Cereal/Pasta/Equivalent servings. Bread or rolls are not offered at each meal per interview with the manager | R233 | 1) 2) 3) THE MENUS HAVE BEEN REVISED IN ACCORDANCE 2 REGULATORY REQUIREMENTS. COPIES ENCLOSED SUBSTITUTIONS FROM THE POSTED MENU OFFERED WILL BE DOCUMENTED ON OUR DAILY LOG AND MONITORED BY HOUSE MANAGER. ALTERNATES WILL BE LISTED ON THE DAILY MENU. | |
| R235 SS=B | VII. NUTRITION AND FOOD SERVICES 7.1.a.(4) The home must follow the written, posted menus. If a substitution must be made, the substitution shall be recorded on the written menu. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to insure that substitutions for the menu were written on the menu. Findings include: Per observation of the posted menu, there were no substitutions. At 9:00 AM, per interview with house manager, s/he stated that substitutions are provided if a resident does not want the prepared meal, but confirmed that these substitutions are not documented. | R235 | PLEASE SEE #R233 RE: SUBSTITUTIONS | |

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| R246 R246 SS=B | <p>Continued From page 7</p> <p>VII. NUTRITION AND FOOD SERVICES</p> <p>7.2 Food Safety and Sanitation</p> <p>7.2.a Each home must procure food from sources that comply with all laws relating to food and food labeling. Food must be 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 shall be rejected and kept separate until returned to the supplier.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to procure food from sources that comply with all laws relating to food and food handling. Findings include:</p> <p>At 12:50 PM during inspection of food storage, it was found that there were 4 jars of home canned goods. The LPN and caregiver were unsure who had made them and were unsure of what was in the jars. There was no labels or dates to indicate when made or what the contents were.</p> | R246 R246 | <p>All home canned goods were DISCARDED IN PRESENCE OF THE SURVEYOR. STAFF COUNSELED A STAFF MEETING ON 3-11-14 RE: REGULATIONS PERTAINING TO PROCUREMENT OF FOODS AND NOT TO ACCEPT HOME CANNED GOODS. THIS WILL BE MONITORED BY HOUSE MANAGER</p> | |
| R247 SS=E | <p>VII. NUTRITION AND FOOD SERVICES</p> <p>7.2 Food Safety and Sanitation</p> <p>7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service.</p> | R247 | | |

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| R247 | <p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to insure proper food storage monitoring as evidenced by the following:</p> <p>1.) No evidence provided by the facility regarding temperature monitoring of refrigerator/freezer. Per interview with staff and manager, the refrigerator has a built-in digital thermometer and it was confirmed at 12:50 PM that a log record is not kept.</p> <p>2.) At 12:50 PM upon opening the refrigerator door, there was a tube of blood on the shelf in a plastic bag, next to a bag of partially thawed hamburger. The caregiver confirmed that it had just been placed there by the nurse. Upon interview with the nurse, s/he confirmed that it was just drawn and the caregiver was to take it to the hospital lab at end of shift (which was not for a couple of hours).</p> <p>3.) Five containers of left overs found with only one container labeled with date and what the contents were. Caregiver unable to tell what other items were or when they were placed in the refrigerator.</p> <p>4.) Removed from the refrigerator by the LPN during inspection were rotten, moldy tomatoes and peppers from the crisper bin, along with a black slimy partial head of lettuce. The refrigerator shelves were dirty and s/he instructed the caregiver to clean them. There was also a piece of molded cheese with a resident's name on it that was removed secondary to being moldy.</p> <p>5.) It was confirmed with the caregiver that there were unlabeled and undated plastic bags of food</p> | R247 | <p># 1) TEMPERATURE MONITORING OF THE REFRIGERATOR / FREEZER WILL BE DONE DAILY AND RECORDED ON THE ENCLOSED FORM TO BE UTILIZED. WILL BE MONITORED BY THE HOUSE MANAGER.</p> <p># 2) BLOOD / URINE SPECIMENS WILL BE STORED ON A SEPARATE REFRIGERATOR LABELED FOR "MEDICAL USE ONLY" PRIOR TO TRANSPORT TO LABS. THIS DEFECT IS EFFECTIVE IMMEDIATELY. IT WILL BE MONITORED BY THE HOUSE MANAGER / LPN.</p> <p>3.) 4.) 5.) + 6.) ALL UNLABELED / UNDATED / EXPIRED / SPOILED FOODS WERE REMOVED IN THE PRESENCE OF THE SURVEYOR ON 3-10-14 - STAFF COUNSELED AND ADVISED OF REGULATORY REQUIREMENTS REGARDING STORAGE AND LABELING OF FOODS ON 3-18-14. THIS IS IN EFFECT IMMEDIATELY AND WILL BE MONITORED BY THE HOUSE MANAGER.</p> <p>THE REFRIGERATOR WAS CLEANED ON 3-10-14. THIS WAS ADDED TO THE STAFF DAILY CHORE LIST AND IS TO BE CHECKED BOTH AMT P.M. AND CLEANED REGULARLY. TO BE MONITORED BY THE HOUSE MANAGER.</p> | |
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R247 Continued From page 9
in the freezer and that the freezer was dirty. One of the plastic bags appeared to have gravy and another baked beans, neither the LPN nor the caregiver could confirm the gravy, but were sure of the beans. Two bags were unidentifiable.

6.) On the dry goods food storage shelf there were 2 cans of opened partially used frosting, the chocolate frosting being hardened with no date as to when opened. The vanilla frosting had a date of being opened on 2/4/14. Per caregiver cans of frosting are used immediately upon opening and s/he was unaware they were open. Also on the shelves were 2 pouches of seasoning mix with expiration dates of 12/12/13 and 7/7/13, a jar of peanut butter dated as expired April 2013 and a bag of dried bread. The caregiver was unsure if the bread was for pudding, stuffing or bird food.

R268 IX. PHYSICAL PLANT
SS=B

9.2 Residents' Rooms

9.2.a Each bedroom shall have at least 100 square feet of useable floor space in single rooms and at least 80 square feet per bed in double-bed rooms, exclusive of toilets, closets, lockers, wardrobes, alcoves or vestibules. These specifications may be waived for beds licensed prior to the adoption of the 1987 regulations.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to have at least 80 square feet of useable floor space per bed in a double-bed room and provide at least 36 inches between beds. Further, the facility failed to provide solid core

R247

R268

(emb)
6.) THE FROSTINGS WERE DISCARDED ON 3-10-14 IN THE PRESENCE OF THE SURVEYOR - PLEASE SEE PG. #9 - THE BAGS OF BREAD HAVE BEEN LABELED AND DATED FOR THE RESIDENT WHO FEEDS THE BIRDS. - ANY BREAD FOR STUFFING OR PUDDING'S WILL BE LABELED, DATED IN ACCORDANCE WITH REGULATIONS. THIS WILL BE MONITORED BY THE HOUSE MANAGER.

Division of Licensing and Protection

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0193 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 03/10/2014 |
|--|--|---|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER MANES HOUSE | STREET ADDRESS, CITY, STATE, ZIP CODE 127 UNION STREET BENNINGTON, VT 05201 |
|---|---|

| (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 |
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| R268 | <p>Continued From page 10</p> <p>doors to bedroom entrances. Findings include:</p> <p>1.) During tour of facility, Room#6 has double occupancy and the room size is 10.5 x 14.5 feet, making it 76.125 square feet per bed. The room had 2 beds, dressers and very little walking space. The space between the beds presents at 17 inches between beds and not the required 36 inches. Confirmation of measurements was made by the LPN at 3:30PM.</p> <p>2.) Room #8 is a room with double occupancy and presents with 28 inches between the beds. Confirmation was made of the measurements by the LPN at 3:30PM.</p> <p>3.) Three of the bedrooms that were viewed had entrance doors that presented with glass panes and not of the solid core construction required. This was confirmed by he LPN at 3:30PM.</p> | R268 | <p>1.) 2.) + 3.) THE ROOM WAS CLEARED OUT AND MEASURED WITH A CARPENTERS RULER - THE MEASUREMENTS ARE 13.6 X 14.5 WHICH DOES MEET THE REQUIREMENT IN THE REGULATIONS. THE ROOM WAS REARRANGED AND THERE IS MORE THAN 36 INCHES BETWEEN THE 2 BEDS. ITEMS HAVE BEEN REMOVED & FURNITURE REARRANGED TO ALLOW FOR ADEQUATE WALKING SPACE</p> <p>1 RM. HAS DOUBLE DOORS WITH GLASS PANELS - 1 RM. HAS A WOODEN DOOR WITH A GLASS PANEL - IN SPEAKING 2 YAM COST @ 802-871-3322 PER FRANCES KEELER RN, MSID, DBA, ASST. DIR. DIRECTOR - SHE SUGGESTS WE ARE COVERED AS PRIVATE CONCERNS ARE MET AS WE HAVE DARKENING BLINDS & CURTAINS ON THE DOUBLE DOORS AND PRACTIC DARKENING CURTAINS ON THE SINGLE DOOR</p> | |
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Also -
Rm #8 HAS BEEN REARRANGED ALLOWING MORE THAN THE 36" REQUIRED BETWEEN BEDS.