

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

September 12, 2018

Mr. Jay Grimes, Administrator Meadows At East Mountain 157 Heritage Hill Place Rutland, VT 05701-8811

Dear Mr. Grimes:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 7, 2018.** 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

amlaMCotaPN

AUG 27 2018 Division of Licensing and Protection STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C 1002 B. WING 08/07/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 157 HERITAGE HILL PLACE MEADOWS AT EAST MOUNTAIN RUTLAND, VT 05701 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) R100 Initial Comments: R100 An unannounced on-site re-licensure survey was conducted conjunction with an entity reported incident investigation on 8/6/18 and 8/7/18 by the Division of Licensing and Protection. There were regulatory findings. R104 V. RESIDENT CARE AND HOME SERVICES R104 SS=C 5.1 Admission **R104 Corrective Action** 5.2.a Prior to or at the time of admission, each resident, and the resident's legal representative if any, shall be provided with a written admission The admission agreement will be agreement which describes the daily, weekly, or updated to include the required monthly rate to be charged, a description of the language on the transfer and services that are covered in the rate, and all other applicable financial issues, including an discharge of residents. explanation of the home's policy regarding The admission agreement will discharge or transfer when a resident's financial also be updated to include status changes from privately paying to paying language on ACCS and the with SSI or ACCS benefits. This admission agreement shall specify at least how the following personal needs allowance. services will be provided, and what additional charges there will be, if any: all personal care The Executive Director will be services; nursing services; medication responsible for completing this management; laundry; transportation; toiletries; and any additional services provided under ACCS plan of correction. or a Medicaid Waiver program. If applicable, the agreement must specify the amount and purpose This will be completed before of any deposit. This agreement must also specify September 15, 2018. the resident's transfer and discharge rights. including provisions for refunds, and must include a description of the home's personal needs allowance policy.

participants Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(1) In addition to general resident agreement requirements, agreements for all ACCS

shall include: the

TITLE

(X6) DATE

STATE FORM



| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
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| | | 1002 | B. WING | | C 08/07/2018 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE . | |
| MEADO | WS AT EAST MOUNT | | TAGE HILL F D, VT 05701 | PLACE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY) | D BE COMPLETE |
| R104 | Continued From pa | age 1 | R104 | · · · · · · · · · · · · · · · · · · · | 13 |
| | the amount of pers | e specific room and board rate, onal needs allowance and the ent to accept room and board ble payment. | | | |
| | by: Based on staff interfacility failed to include agreement the resirights for seven (7) sample, Resident # not include a described allowance poinclude in agreeme two of two residents | rview and record review, the ude in the admission dent's transfer and discharge of the seven residents in the 1, 4, 5, 6, 8, 9 and 10, and did iption of the home's personal plicy. The facility also failed to nts for all ACCS participants, s, Resident #11 and 12, the he amount of personal needs s include: | | | |
| | 4, 5, 6, 8, 9 and 10, agreements did not transfer and discha review of the medic and 12 present that Community Care State signed admission evidence that the allowance is include confirmed, in an interpretation of that the admission arequired language for transfer and dischaigments. | cal records for Residents #1, the signed admission include information regarding rge rights information. Further all records for Residents #11 they are ACCS (Assistive ervices-Medicaid) eligible and on agreements do not provide mount of personal needs ed. The Executive Director erview on 8/6/18 at 12:45 PM agreements do not include the or ACCS residents and the rge rights are not included in dmission agreements. | | R134 Corrective Ac | tion |
| R134 SS=D | V. RESIDENT CAR | E AND HOME SERVICES | R134 | | |



| Division | of Licensing and Pro | otection | | | FORM APPROVED | | |
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| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: _ | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, ST | ATE, ZIP CODE | | | |
| MEADOV | MEADOWS AT EAST MOUNTAIN 157 HERITAGE HILL PLACE RUTLAND, VT 05701 | | | | | | |
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| R134 | Continued From pa | ige 2 | R134 | D-11-17 111 | | | |
| | 5.7 Assessment | | | Resident 7 will have a | | | |
| | each resident within consistent with the orders, using an as by the licensing age regarding medication | ent shall be completed for n 14 days of admission, physician's diagnosis and sessment instrument provided ency. The resident's abilities on management shall be | | assessment completed she is safely able to se administer medication, residents currently self medication. | elf . No other | | |
| | implemented, if nec | hours and nursing delegation cessary. | | A new assessment too developed for resident | | | |
| | by: Based on staff inter facility failed to assi | of medication for one resident. | | administer medication be completed as part of annual assessment or significant change. | . This will of the | | |
| | (RN) on 8/6/18, s/h the only resident the medications S/He had been assessed to do so. The annulinstrument dated 7/ | with the Registered Nurse e stated that Resident #7 was at self-administered further stated that the resident by the RN prior to being able all Resident Assessment 1/6/18 was reviewed on 8/6/18 | | Residents that self ac medications will be au quarterly for a year to compliance. Audit find shared with the QI tea | udited assure dings will be am. | | |
| | medications is done 5:15 PM that there assessments done ability to self-admin and further stated to did not provide evidence. | addresses managing by staff. The RN stated at are no independent to indicate the resident's ister their own medications that the assessment reviewed lence that the resident was ninistering their medications. | | The Director of Nursir responsible for this plan will be comp 9/15/18 | an. | | |
| R136 SS=D | V. RESIDENT CAR | E AND HOME SERVICES | R136 | | | | |
| | 5.7. Assessment | | | in the second | | | |



| AND BLAN OF CORRECTION I IDENTIFICATION NUMBER | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
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| R134 | Continued From pa | ge 2 | R134 | | |
| | 5.7.a An assessme each resident withir consistent with the orders, using an as by the licensing age regarding medication | ent shall be completed for a 14 days of admission, physician's diagnosis and sessment instrument provided ency. The resident's abilities on management shall be hours and nursing delegation sessary. | | | |
| | by: Based on staff inter facility failed to asse | of medication for one resident, | | | |
| | (RN) on 8/6/18, s/hi the only resident that medications S/He i had been assessed to do so. The annu Instrument dated 7/ and section G.6.7a medications is done 5:15 PM that there a assessments done ability to self-admini and further stated to did not provide evid | with the Registered Nurse e stated that Resident #7 was at self-administered further stated that the resident by the RN prior to being able al Resident Assessment 6/18 was reviewed on 8/6/18 addresses managing by staff. The RN stated at are no independent to indicate the resident's ister their own medications hat the assessment reviewed ence that the resident was inistering their medications. | | R136 Corrective Action | <u>on</u> |
| R136 SS=D | V. RESIDENT CAR 5.7. Assessment | E AND HOME SERVICES | R136 | | |
| | J. I. ASSESSITIETI | | | | |



| AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | (X2) MULTIPLE | (X3) DATE SURVEY COMPLETED | | |
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| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | TATE, ZIP CODE | |
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| R136 | Continued From pa | age 3 | R136 | | |
| | 5.7.c Each residen | nt shall also be reassessed y point in which there is a lent's physical or mental | IVI30 | Resident 1 will have a ne assessment completed. | }W |
| | by: Based on staff interfacility failed to community failed to community facility failed to community facility | NT is not met as evidenced rview and record review the inplete an assessment when it change for one of seven in ent # 1. Findings include: Indeed a fall on 4/9/18 resulting in an intracerebral bleed (an intracerebral bleed (an intracerebral bleed (an intracerebral bleed) and in which a ruptured blood eding inside the brain) and was expital. Resident #1 was acility on 4/11/18 and was CE (a type of care and uses on care for people facing sor injury) on 4/12/18. The confirmed, in an interview on that there had not been a assessment completed for or interview of the stated that the resident indition following the fall since | | All residents that have a significant change in conwill have an assessment completed. An audit will be conducted quarterly for one year to compliance with this. Finds be reviewed at the QI means the Director of Nursing was responsible for the complete plan. This plan will be complete September 15, 2018/ | ed insure idings will eeting. will be oletion of |
| R140 SS=D | | RE AND HOME SERVICE'S | R140 | | |
| | 5.8 Physician Servi | ces | 151.8 | | |
| | telephone shall be | s' orders obtained via countersigned by the practitioner within 15 days of | | | |



| | NT OF DEFICIENCIES NOF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A BUILDING. | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | |
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| R136 | Continued From page | ge 3 | R136 | | |
| | annually and at any | shall also be reassessed point in which there is a ent's physical or mental | | | |
| - | | | | | 1 - 4 |
| | | | 1 | | |
| | by: Based on staff interviolation facility failed to complete the sample, Resider | view and record review the plete an assessment when change for one of seven in at # 1. Findings include: | | | |
| | facial fractures and a emergency condition vessel causes bleed admitted to the hosp readmitted to the facial admitted to HOSPIC philosophy that focu a life-limiting illness Registered Nurse co 8/7/18 at 8:30 AM, the significant change a Resident #1 and furtil significant formula in the significant formula in the significant change a Resident #1 and furtil significant change a significant formula in the significant formula | ed a fall on 4/9/18 resulting in an intracerebral bleed (an in which a ruptured blood ling inside the brain) and was bital. Resident #1 was cility on 4/11/18 and was E (a type of care and ses on care for people facing or injury) on 4/12/18. The onfirmed, in an interview on that there had not been a seessment completed for ther stated that the resident dition following the fall since | | | |
| R140 SS=D | V. RESIDENT CARE | E AND HOME SERVICE'S | R140 | R140 Corrective Acti | on |
| | 5.8 Physician Service 5.8.d All physicians' telephone shall be or physician/licensed p | orders obtained via | | The order for resident resubmitted to the phy signature. | #4 was sician for |



| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | (X3) DATE SURVEY COMPLETED |
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| MEADOWS AT EAST MOUNTAIN 157 HERIT | DRESS, CITY, STATE, ZIP CODE TAGE HILL PLACE D, VT 05701 ID PROVIDER'S PLAN OF COMMENTED FROM CONTROL OF COMMENTAGE CROSS-REFERENCED TO THE | ON SHOULD BE COMPLETE |
| R140 Continued From page 4 | R140 All telephone or |) |
| the date the order was given. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to insure that physicians' orders obtained via telephone were countersigned by the physician/licensed practitioner within 15 days of the date the order was given for one of seven residents, Resident #4. Findings include: Review of the medical record for Resident #4, there was a telephone order given by the nurse practitioner on 5/11/18 for clarification of wound treatment orders. There is no evidence that the signed telephone order was returned to the facility. Confirmation was made, in an interview with the Registered Nurse on 8/7/18 at 8:10 AM. | reviewed every order found not have it sent to t signature. Telephone orde quarterly for a y these audits will the QI team. The Director of responsible for this order. | two weeks. Any to be signed will he physician for rs will be audited ear. Findings of I be shared with Nursing will be the completion of |
| SS=D SS=D SN=D SN=D | This plan will be 9/15/18 | completed by |
| the administration of insulin, including return | | |

| | 8) | F | PRINTED: 08/14/2018 FORM APPROVED | |
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| Division of Licensing and Protection | | | | |
| AND PLAN OF COPRECTION IDENTIFICATION NUMBER | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | D BE COMPLETE | |
| R140 Continued From page 4 the date the order was given. | R140 | | | |
| This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to insure that physicians' orders obtained via telephone were countersigned by the physician/licensed practitioner within 15 days of the date the order was given for one of seven residents, Resident #4. Findings include: Review of the medical record for Resident #4, there was a telephone order given by the nurse practitioner on 5/11/18 for clarification of wound treatment orders. There is no evidence that the signed telephone order was returned to the facility. Confirmation was made, in an interview with the Registered Nurse on 8/7/18 at 8:10 AM. | | | | |
| R168 V. RESIDENT CARE AND HOME SERVICES SS=D | R168 | | | |
| 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (6) Insulin. Staff other than a nurse may administer insulin injections only when: | | Residents 2 and 3 have reviewed by the register The RN feels they both criteria for having insul | e been ered nurse. n meet the | |

i. The diabetic resident's condition and medication regimen is considered stable by the registered nurse who is responsible for delegating the administration; and

ii. The designated staff to administer insulin to the resident have received additional training in the administration of insulin, including return

appropriate staff that are unlicensed.



| Division | of Licensing and Pro | otection | 9 | | PRINTED: 08/14/2018 FORM APPROVED |
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| | The second second second | 1002 | B. WING _ | | C 08/07/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | ST | REET ADDRESS, CIT | Y, STATE, ZIP CODE | |
| MEADOV | VS AT EAST MOUNT | AIN | 7 HERITAGE HIL JTLAND, VT 057 | | |
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| R168 | Continued From pa | ge 5 | R168 | | |
| | deemed them comassessment; and iii. The registered condition regularly in condition or medition or medition or medition or medition. This REQUIREME by: Based on staff interpresent facility failed to assist the need for any choof two residents in Resident #2 and 3, administration. First Resident #2 and 3 insulin and upon returned is no evidence the Registered Nurthe stability or condition the Registered Nurthe stability or conditions and a depending on what with the staff, the refluctuations in their concerned, but address ordered. The Fe/8/6/18 at 5:15 PM to | | that ent's anges ced the ion for r two e ords, hat essed abetes. ced nsulin rview evere eway eed on ely | The RN will review dependent resident monthly basis to insinsulin administration unlicensed staff is a This will be docume resident record. Insulin dependent resident records a quarterly to insure a Audits will be review team. The Director of Nurresponsible for the this plan. This plan will be considered. | s on a sure that on by appropriate. ented in the esidents will audited compliance. wed by the QI esing will be completion of |
| R187 SS=A | V. RESIDENT CAF | RE AND HOME SERVICE | ES R187 | n. | |

5.12.b. (1)

A resident register including all discharges,



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| S | STATEMEN | NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: _ | E CONSTRUCTION | COM | E SURVEY PLETED |
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| ٨ | NAME OF F | PROVIDER OR SUPPLIER | | DDRESS, CITY, ST | | | |
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| | R168 | Continued From pa | age 5 | R168 | | | ense |
| | | demonstration, and deemed them com assessment; and | d the registered nurse has appetent and documented that | | | | |
| Đ. | | iii. The registered nurse monitors the resident's condition regularly and is available when changes in condition or medication might occur. | | | | | |
| | | by: | NT is not met as evidenced | | | | |
| | | facility failed to ass the need for any ch | erview and record review, the sess the resident's condition for hanges in medications for two the applicable sample, regarding insulin adings include: | | | | |
| | | insulin and upon re there is no evidenc the Registered Nur | are diabetics and receive eview of their medical records, ce in the medical record that rse has monitored or assessed | | | | |
| | | the stability or cond Resident #2 has his before meals and a depending on what with the staff, the re | dition of the resident's diabetes. is/her blood sugar's checked at bedtime and receives insulint the level is and per interview esident has had some blood sugars and they were | | | | |
| | | concerned, but adn as ordered. The R 8/6/18 at 5:15 PM to | ministered the insulin anyway Registered Nurse confirmed on that s/he does not routinely nt the condition of the diabetic | 2 | | | |
| | | residents. | 1 1 1 2 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 | | R187 Corrective Act | ion | |
| | R187 | V. RESIDENT CAF | RE AND HOME SERVICES | R187 | Transfers to another I | 4 13 | The state of the s |

SS=A

5.12.b. (1)

A resident register including all discharges,

Transfers to another level of care and the return will be maintained in a ledger going forward.

(11)

| CTION (X3) DATE SURVEY |
|---|
| C 08/07/2018 |
| ODE |
| ROVIDER'S PLAN OF CORRECTION (X5) CH CORRECTIVE ACTION SHOULD BE COMPLETE S-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) |
| |
| ansfers will be reviewed arterly to insure compliance. Idings will be shared with the team. The Director of Nursing will. Be sponsible for the plan of crection. The will be completed before 5/15. |
| i i |

by:

This REQUIREMENT is not met as evidenced

Based on staff interview and record review, the facility failed to report an allegation of abuse for



| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED C |
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| | | 1002 | B. WING | | 08/07/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | |
| MEADOV | NS AT EAST MOUNTA | UN | TAGE HILL F), VT 05701 | | |
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| R187 | Continued From pa | ge 6 | R187 | | |
| | transfers out of the | home and admissions. | | | |
| | by: Based on record re facility failed to insu | NT is not met as evidenced view and staff interview, the re that the facility resident II transfers out of the home. | | | |
| | to an acute care ho re-admitted to the fano evidence of the resident register. T confirmed on 8/7/18 does not record the they go to the hospi | en transferred from the facility spital on 4/9/18 and was acility on 4/11/18. There was transfer being recorded in the he Executive director 3 at 12:45 PM that the facility transfer of residents when ital and return. S/he further hissions and discharges are | | | |
| R207 SS=D | V. RESIDENT CAR | E AND HOME SERVICES | R207 | R207 Corrective | Action |
| | 5.18.b The licenseer report suspected or neglect or exploitation staff's responsibility incident did occur of the licensing age conduct its own invent delay reporting incident to Adult Pro- | abuse, Neglect or Exploitation and staff are required to reported incidents of abuse, on. It is not the licensee's or to determine if the alleged r not; that is the responsibility ncy. A home may, and should, estigation. However, that must of the alleged or suspected otective Services. NT is not met as evidenced | | The incident wash two staff members incident. Resident struck, although th should have been Resident #6 has h plan updated so th members will prov resident. | s witnessed the #6 was not ne allegation reported. ad her care nat two staff |
| | Based on staff inter | view and record review, the | | | |

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| STATEMENT | OF | DEFICIENCIES |
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| AND PLAN OF | FC | ORRECTION |

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.

| (X2) MULTIPL | E CONSTRUCTION |
|--------------|----------------|
| A. BUILDING | |

(X3) DATE SURVEY COMPLETED

1002

B. WING

C 08/07/2018

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

157 HERITAGE HILL PLACE RUTLAND, VT 05701

MEADOWS AT EAST MOUNTAIN

(X4) ID PRÉFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

COMPLETE

R207 Continued From page 7

one of seven residents in the sample, Resident #6. Findings include:

Progress note dated 7/10/18 written by the Resident Assistant (RA) stated that the resident made accusation that an RA was hitting him/her and s/he wanted to go to bed. An interview with the RA that wrote the note was conducted on 8/7/18 at approximately 9:00 AM and s/he stated that the incident was reported to the Licensed Practical Nurse and the Registered Nurse (RN). The RN confirmed at 9:15 AM that the incident had not been reported to the appropriate state agencies, including Adult Protective Services.

R208 V. RESIDENT CARE AND HOME SERVICES SS=A

5.18 Reporting of Abuse, Neglect or Exploitation

5.18.c Incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse, or if an injury requiring physician intervention results, or if there is a pattern of abusive behavior. All resident-to-resident incidents, even minor ones, must be recorded in the resident's record. Families or legal representatives must be notified and a plan must be developed to deal with the behaviors

This REQUIREMENT is not met as evidenced by:

Based on staff interview and record review, the facility failed to insure that an allegation of abuse was recorded in the resident record for one of two residents in the applicable sample, Resident #5. Findings include:

R207

R208

The facility will conduct education to assure all allegations of abuse are reported to the administrator and therefore the appropriate agencies.

Education on abuse will be conducted annually. All staff will be mandated to attend this training.

The Director of Nursing will be responsible for the completion of this plan.

This plan will be completed by 9/15/18.



| Division | of Licensing and Pr | otection | | | |
|--------------------------|--|---|---|--|---|
| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED |
| | | 1002 | B. WING | | C 08/07/2018 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | |
| MEADO | WS AT EAST MOUNT | AIN | TAGE HILL F D, VT 05701 | PLACE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE COMPLETE |
| R207 | Continued From pa | age 7 | R207 | | |
| | #6. Findings include | | | | |
| | Resident Assistant made accusation to and s/he wanted to the RA that wrote to 8/7/18 at approximation that the incident was Practical Nurse and The RN confirmed had not been reportant made accusately accusatel | ed 7/10/18 written by the (RA) stated that the resident that an RA was hitting him/her of go to bed. An interview with the note was conducted on ately 9:00 AM and s/he stated as reported to the Licensed of the Registered Nurse (RN), at 9:15 AM that the incident ted to the appropriate state Adult Protective Services. | | | |
| R208 SS=A | V. RESIDENT CAR | RE AND HOME SERVICES | R208 | R208 Corrective Act | tion |
| | 5.18.c Incidents invabuse must be reparesident alleges a injury requiring phy there is a pattern or resident-to-resident must be recorded in Families or legal reand a plan must be behaviors This REQUIREMENT by: Based on staff inter | Abuse, Neglect or Exploitation volving resident-to-resident orted to the licensing agency if abuse, sexual abuse, or if an sician intervention results, or if abusive behavior. All tincidents, even minor ones, in the resident's record, presentatives must be notified developed to deal with the | | A late entry will be ma Resident 5's chart. The nurse that reports incident, in a timely maken educated on the record any allegation the resident record. Of will also be educated need to record an ental resident record on any of abuse. | ed the nanner, has e need to of abuse in other staff as to the ry in the y allegation |
| | facility failed to insu was recorded in the | re that an allegation of abuse resident record for one of two licable sample, Resident #5. | | The administrator, as investigation, will revieus resident records that he an allegation of abuse | ew all nave made |



| STATEME | NT OF DEFICIENCIES N OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING. | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--|---|---|---|--|-------------------------------|
| | | 1002 | B. WING | | C 08/07/2018 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AL | DDRESS, CITY, S | TATE, ZIP CODE | The State of |
| MEADO | WS AT EAST MOUNT | RUTLAN | ITAGE HILL P D, VT 05701 | LACE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE COMPLETE |
| R208 | Continued From pa | age 8 | R208 | The state of the s | |
| Resident # 5 made allegations of being slapped in the back of his/her head by a direct care giver 7/6/18 and there was no evidence of the | | | The administrator will share findings with the QI team. | | |
| allegation being documented in the resident record. This was confirmed by the Licensed Practical Nurse on 8/7/18 at 8:30 AM, after s/he reviewed the medical record. | | | The administrator will responsible for the cothis plan. | | |
| R259 SS=D | VII. NUTRITION A | ND FOOD SERVICES | R259 | The plan will be comp 9/15/18. | eleted by |
| | 7.3 Food Storage | and Equipment | | | |
| | products and insection a food storage area u | mpounds (such as cleaning ticides) shall be labeled for and shall not be stored in the unless they are stored in a ompartment within the food | | | |
| | by: Based on observation the facility failed to compounds (such a insecticides) are lat and are not stored in unless they are store | ion and confirmation by staff, insure that Poisonous as cleaning products and peled for easy identification in the food storage area red in a separate, locked the food storage area. | | | |
| | under the kitchen si the special care uni Registered Nurse (I have access to the residents wander in confirmed on 8/6/18 | int were found in a cupboard ink in the common kitchen on t. Per interview with the RN), there are residents that kitchen and some of the to look for snacks. The RN 3 at 10:40 AM, that the not in a locked compartment. | | | - |



| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|--|---|-------------------------------|
| | 1002 | B. WING | | C 08/07/2018 |
| MEADOWS AT EAST MOUNT (X4) ID SUMMARY ST | TAIN 157 HEF | DDRESS, CITY, S RITAGE HILL P ND, VT 05701 | LACE | |
| PREFIX (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE COMPLETE |
| R208 Continued From p | | R208 | | |
| 7/6/18 and there wallegation being do record. This was of Practical Nurse on reviewed the medi | | | R259 Corrective | <u>Action</u> |
| R259 VII. NUTRITION A SS=D 7.3 Food Storage | | R259 | The cleaning ager the sink has been | |
| 7.3.i Poisonous compounds (such as cleaning products and insecticides) shall be labeled for easy identification and shall not be stored in the food storage area unless they are stored in a separate, locked compartment within the food | | | Any dangerous ch be stored in an un will be removed. | safe manner |
| storage area. | NT is not met as evidenced | | Staff will be educa properly store che | |
| Based on observat the facility failed to compounds (such a insecticides) are lal and are not stored | ion and confirmation by staff, insure that Poisonous as cleaning products and peled for easy identification in the food storage area | | The administrator item to weekly rou found will be remoimmediately. | inds. Any item |
| unless they are sto compartment withir Findings include: | red in a separate, locked the food storage area. | | The administrator findings to the QI to | will report the team on a |
| under the kitchen s the special care uni Registered Nurse (I have access to the residents wander in confirmed on 8/6/18 | int were found in a cupboard ink in the common kitchen on t. Per interview with the RN), there are residents that kitchen and some of the to look for snacks. The RN at 10:40 AM, that the not in a locked compartment. | | quarterly basis. The administrator for the completion The plan will be constant of the plan will be | of this plan. |