

**AGENCY OF HUMAN SERVICES** 

# DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection HC 2 South, 280 State Drive Waterbury, VT 05671-2060 <u>http://www.dail.vermont.gov</u> 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

April 12, 2019

Mr. Jay Grimes, Manager 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 **February 26, 2019.** 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,

amlaMCotaRN

Pamela M. Cota, RN Licensing Chief

vision of Licensing and Pro	CIECTION (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
STATEMENT OF DEFICIENCIES         (X1)         PROVIDER/SUPPLIER/CLA           AND PLAN OF CORRECTION         IDENTIFICATION NUMBER:		A BUILDING:		ÇOMPLETED	
				С	
	1002	B WING		02/26/2019	
ME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
	157 HEF	RITAGE HILL P			
EADOWS AT EAST MOUNT.	AIN RUTLAN	ID, VT 05701			
	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE CUMPLETE	
R100 Initial Comments:	and a second	R100	<u>R144</u>		
complaint was cor	onsite investigation of a aducted by the Division of ction on 2/25 & 26/2019. The ry deficiencies were identified:		A Registered Nurse v involved at time of ar assessment to includ	лу	
R144 V. RESIDENT CA SS=D	RE AND HOME SERVICES	R144	Staff will be educated that they are aware the		
5.9.c.(1)			Registered Nurse cal resident. They will als	n assess a	
accordance with s			educated to insure th a Registered Nurse p assessment that nee	at they have berform any	
by: Based on record failed to assure th	ENT is not met as evidenced review and interviews the facil nat the Registered Nurse (RN) sessment of the resident.	ity	completed. Any situation that req assessment will be re morning clinical meet	eviewed at	
Findings include: Per record review Resident #1 fell on 4/9/2018 and on 11/22/2018 sustaining significant injury. There is no indication that an RN was involved in assessing the resident at the time of the fall. The note for the fall on 11/22/2018 the note, written b a Licensed Practical Nurse (LPN), states "Resident assessed for injury". Per regulation th RN must assess a resident though the LPN may contribute observations to the assessment process. The State of Vermont Board of Nursing docume titled Vermont State Board of Nursing Role of th Licensed Practical Nurse in Patient Assessment and Triage Position Statement states as follows: Position Statement which Reflects the Nurse ' s Roles and Responsibilities: LPNs may not independently assess the health		in he by the	compliance. The Director of Resident Care and The Administrator will be responsible for the completion of this plan of correction. The plan will implemented my May 15, 2019.	or will be ompletion of n.	
		s.	May 13, 2013. R-144 POC acc M. Higgins, P		
vision of Licensing and Protection ABORATORY DIRECTOR'S GB PR	OVIDEBISUPPLIER REPRESENTATIVE	S SIGNATURE	Ading totale	(X8) DAT 4/10/19 If dontinuation she	

Division of Licens	ing and Protecti	n			FORM APPROVED
STATEMENT OF DEFIC AND PLAN OF CORREL	IENCIES (X1)	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		1002	8 WING	nan sen av den for an ander an ander ander an an an an ander an ander an ander an ander an ander an an an an an	C 02/26/2019
NAME OF PROVIDER C		STREET A	DRESS, CITY, S	STATE, ZIP CODE	
MEADOWS AT EAS	ST MOUNTAIN		ITAGE HILL F D, VT 05701	PLACE	
PREFIX (EACI	UMMARY STATEMEN I DEFICIENCY MUST LATORY OR LSC IDE	IT OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
R144 Continue	d From page 1		R144	۵۰۹۹۹۵۱۹۹۹۹۹۹۹۹۹۹۹۹۹۹۹۹۹۹۹۹۹۹۹۹۹۹۹۹۹۹۹	
independ LPNs ma nursing c patient a: or revisio APRN, o practition	lently develop or a contribute to t are planning pro ssessment and o n remain the res r other authorize er.			R145 Resident #1 passed away preventative measures in	with
R145 V. RESID SS=E	ENT CARE ANI	HOME SERVICES	R145	but not well documented of plan.	on care
5.9.c (2)	•		Promoto		
each resi as identifi of care m necessar	dent that is base ed in the resider ust describe the	a written plan of care for d on abilities and needs it assessment. A plan care and services sident to maintain ling;		Resident #2 will have fall prevention measures adde her care plan upon her ret the facility. Resident #3 passed away end stage COPD.	urn to
by: Based on facility fail (RN) over care for ea services n maintain v Per record with high r prevention residents I falls howe	record reviews a ed to assure that sees developme ach resident that ecessary to ass vell-being. Findir I review of care isk for falls there interventions in had significant ir	plans for 3 residents is no evidence of fall the care plans. All 3 jury in relation to the evidence of revision of	· · · · · · · · · · · · · · · · · · ·	A Registered Nurse will ov the development of all writ care plans. Residents that are fall risks have falls prevention" ac their care plan.	ten s will
residents.	The third reside	nt remained in the			

Division of Licensing and Protection STATE FORM

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If continuation sheet 2 of 9

		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	1	ECONSTRUCTION	(X3) DATE SURVE COMPLETED
		1002			C 02/26/201
	PROVIDER OR SUPPLIER	STREET AF	NOFEE AITY C	TATE, ZIP CODE	·····
			TAGE HILL P		
MEADO	WS AT EAST MOUNT	AIN	D. VT 05701		
{X4} ID	SHIMMADY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORREC	TI/381
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE CON
R145	Continued From pa	age 2	R145		······································
	hospital for treatme	ent of the injury and there was			
		nity to revise the plan specific		2000	
	to the fall.		:	Each fall will be reviewe	
				clinical meeting to insur	e
		d fallen in April 2018 and had a		appropriate intervention	is are in
		a result of the fall. The		place on the care plan.	
		onal falls on 3/2, 3/5, 3/7, 6/3, D/22/2018 with no injury or		· · · · · · · · · · · · · · · · · · ·	
	minor injury (bruise			A daily clinical meeting	will bo
		11/22/18 which resulted in a		held to review falls and	
		brae. In a review of the plan of			upuale
		is no evidence of any fall	ĩ	care plans as needed.	
		itions or revision of the care		· · · · · · · ·	
	plan after the falls.			Care plans will be revie	wed
				monthly to insure comp	liance
		s found on the floor in the	1	with findings shared with	h the OI
		plaints of Left Hip pain. The		committee. This will cha	
		erred to RRMC ER and was	<b>W</b>	quarterly if findings are	
		racture of the Left Hip. The the hospital and there is no		after 3 months.	positive
		available. The resident has no	1	aner o monins.	
		ventions in the care plan.			
				The Resident Care Dire	
	3). Resident #3 had	d prior falls but the most recent		The Administrator will be	-
	fall happened on 1/	/29/2019 and resulted in a Left		responsible for this plan	le -
	3	or Pelvic Rami Fracture and an			
		e. It is reported that the	• 1	This plan will be implem	ented by
		o the bathroom. The fractures		5/15/19.	,
		re described in hospital reports typical of Osteoporosis. There	4		
		on interventions or care plan		R-145 POC accep m. Higgins EU  -	sted y hille
		e plan related to falls. There is	}	14-145 I US and	0 -
		ecial precautions in bed		m Hinging PU 1-	s, Keny, RU
		s related to the fractures.	-	1011 1. Adu 2	V
		on of any interventions			
		Falls post injury. The resident			
		lity on 2/4/19 and was placed			
	on Hospice 2/21/19	).			
	All thron realidents !	had Falls risk assessments			
	censing and Protection	10V 1 013 1135 03303511101113			

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It continuation sheet 3 of 9

Division o	of Licensing and Pro	tection			
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		1002	8 WING	nan mana kana kana mana kana kana kana k	C 02/26/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	ORESS, CITY, S	STATE, ZIP CODE	
*****	10 AT CAOT MOUNT	157 HER	TAGE HILL F		
MEADOW	S AT EAST MOUNT	RUTLAN	D, VT 05701		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
R145	Continued From pa	ge 3	R145		
	with scores above of for falls. Per intervie Residential Care Di initial Care Plans for by the admitting nu (Licensed Practical revised by LPNs. T that s/he does try to often doesn't get to when revisions are that the care plans contain the above if The State of Vermot titled Vermont State Licensed Practical and Triage Position LPNs may not inde status of an individi independently deve LPNs may contribu nursing care planni patient assessmen or revision remain t APRN, or other aut practitioner. V. RESIDENT CAR 5.9.c (7) Assure that sympto	IO which indicate a high risk aw on 2/26/19 at 2:45pm the rector (RCD) confirmed that is residents are usually done rese who is often an LPN Nurse) and are also often the RCD, who is an RN, stated o sign off on care plans but it and doesn't always know done. S/he also confirmed for these residents did not nformation. The Board of Nursing document a Board of Nursing Role of the Nurse in Patient Assessment of Statement states as follows: pendently assess the health ual or group and may not slop or modify the plan of care, te to the assessment and ing processes; however, t and care plan development the responsibility of the RN, horized health care RE AND HOME SERVICES		R150 Any resident that has a fa have a note added to the on or about the time of fa resident is not transferred the facility then notes will entered into the residents on at least the next three Fall interventions will be r at the daily clinical meetin	ir chart II. If the I from be chart shifts. eviewed —
	accident are record	led at the time of occurrence,			
	along with action ta	iken;		ter and the second s	
	This REQUIREME	NT is not met as evidenced			
Division of Lic STATE FORM	censing and Protection		6800	LVZC11	If continuation sheet 4 of

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Division of Licensing STATEMENT OF DEFICIEN	CIES I	X1) PROVIDER/SUPPLIER/CLIA	1 (27) 1119 700	LE CONSTRUCTION	l.s.a
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	1	LE CONSTRUCTION	(X3) DATE SURVEN COMPLETED
		1002	B WING		C 02/26/2019
NAME OF PROVIDER OR S	UPPLIER	STREET A	ODRESS CITY	STATE, ZIP CODE	
MEADOWS AT EAST I	1.5737387TA11		ITAGE HILL I		
A CONSAILASI	NOUNIAN	4	ID, VT 05701		
PREFIX (EACH DE	EFICIENCY N	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMP
R150 Continued F	rom page	• 4	R150		
Based on re	cord revie	ew and interviews the facility	1	any resident that has	a fall
or accident :	are recorr	ymptoms or signs of illness led at the time of		between daily meetir	igs. Any
occurrence,	along with	h action taken for Resident		necessary changes t	o the care
#1, who exp	erienced	a number of falls. Findings		plan will be made by	a
include:				Registered Nurse.	
Per record r	eview the	resident had falls on 3/2, 21, and 10/22/2018 with no		Any resident that has	s a change in
injury or min	or iniury (	bruise, skin tear) and two		condition will also be	reviewed for
falls on 4/9/1	8 and 11/	22/18 with major injuries.		proper charting and	interventions
There is no a		ed follow up to the falls on		at the daily clinical m	
involved a m	vi izu 18. Iaior iniun	The fall on 4/9/2018 and transfer to the		2	
Emergency	Room (EF	R) and did contain follow-up		Notes on residents t	hat fell as
notes. There	is no folle	ow-up note for the fail on		well as residents wit	
		ote on 7/17/18 for the fall	;	changes will also be	reviewed at
there are inc	ident repo	review of incident reports orts for falls on 10/21/18 e similar in nature but		the daily clinical mee	eting.
		, and vital signs. There are		Interventions and ch	larting on
no notes in t	ne record	regarding either fall.		these issues will als	o be
In a ration of	films man.			surveyed and report	ed at the
FALLS ASSE	SSMENT	ided tool titled FALLS AND DOCUMENTATION the	4 - MARINA - 4 - 44	monthly QI meeting	for three
		"All falls must have			
		esident chart. Each fall, no	ł	months and quarter	ly if found to
		st have at least three the first 24 hours Initially		be adequate.	
		ent - The next two shifts	i		• • • • • • • • • •
following the	incident	.4: Interventions a. The		The RCD and Admi	
		and report any r following a fall."		be responsible for the	nis pian ui
		/2019 the RCD confirmed		correction.	
that the docu	mentation	provided was the only		This plan will be im	niomented hv
documentatio	on availab	le in regards to the falls.		This plan will be im May 15, 2019.	
R188 V. RESIDEN SS=E	T CARE A	ND HOME SERVICES	R188	0 100 200 0000	kd 411119
				m. Higgins, eu	15. Cury, ni
on of Licensing and Prote	ction				1 V

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	STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           AND PLAN OF CORRECTION         IDENTIFICATION NUMBER.		* · · ·	(X2) MULTIPLE CONSTRUCTION A BUILDING		
		1002			C 02/26/2019	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DORESS CITY.	STATE, ZIP CODE	s	
4= 4000		157 HER	ITAGE HILL I			
MEADUY	VS AT EAST MOUNT	AIN RUTLAN	D, VT 05701			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLET	
R150	Continued From p	age 4	R150		and Processing and an an an and an and an	
	failed to assure tha or accident are rec occurrence, along #1, who experience include: Per record review 3/5, 3/7, 6/3, 7/16, injury or minor inju falls on 4/9/18 and There is no docum 3/2, 3/5, or 3/7/201 involved a major in Emergency Room notes. There is no 6/3/18 and one brie the previous day. If there are incident r and 10/22/18 which contain different tir	eview and interviews the facility at symptoms or signs of illness corded at the time of with action taken for Resident ed a number of falls. Findings the resident had falls on 3/2, 10/21, and 10/22/2018 with no ry (bruise, skin tear) and two 11/22/18 with major injuries, rented follow up to the falls on 8. The fall on 4/9/2018 ijury and transfer to the (ER) and did contain follow-up follow-up note for the fall on ef note on 7/17/18 for the fall n a review of incident reports reports for falls on 10/21/18 h are similar in nature but nes, and vital signs. There are ord regarding either fall.		<b>D100</b>		
	FALLS ASSESSMI policy statement sa documentation in t matter how minor. documentations wi at the time of the ir following the incide nurse shall document interventions that c In an interview on 2 that the document	provided tool titled FALLS AND ENT DOCUMENTATION the ays: "All falls must have he resident chart. Each fail, no must have at least three thin the first 24 hours Initially noident - The next two shifts ent4: Interventions a. The ent and report any occur following a fail." 2/26/2019 the RCD confirmed ation provided was the only allable in regards to the falls.		<b>R188</b> Any resident that has a have a note added to the on or about the time of resident is not transferr the facility then notes we entered into the resider on at least the next thre	neir chart fall. If the ed from rill be nts chart	
R188 SS=E	V. RESIDENT CAP	RE AND HOME SERVICES	R188	· · · · · · · · · · · · · · · · · · ·		

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	of Licensing and Pr	(X)) PROVIDER/SUPPLIER/CLIA	- was subjective	DI C CONCEDUCTION	NO. ONTE ONOMIN
	OF CORRECTION	IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
			A BOILDIN		-
		1002	B WING		C 02/26/2019
JAN482 /22	800V/052 00 0000 50				02/20/20/10
www.e.ue	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
MEADO	WS AT EAST MOUNT	AIN	ITAGE HILL D, VT 0570		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ND BE COMPLE
R188	Continued From pa	age 5	R188	Fall interventions will be	
	5.12.b.(2)			at the daily clinical meet any resident that has a f	all
	A roomed for onch a	esident which includes:		between daily meetings.	
		mergency notification		necessary changes to th	e care
		ddress and telephone number		plan will be made by a	
		entative or, if there is none, the		Registered Nurse.	
		an's name, address and		A.,	· ·
		instructions in case of resident's assessment(s);		Any resident that has a c	
		arding any accident or incident		condition will also be rev	
	and subsequent fo	llow-up; list of allergies; a		proper charting and inter	
		agreement; a recent		at the daily clinical meeti	ng.
		resident, unless the resident he resident'		Notos on residente that f	معالم
		ompleted; and a copy of the		Notes on residents that f	
		gal authority to another, if any,		well as residents with sta	
				changes will also be revi the daily clinical meeting	
		NT is not met as evidenced		Interventions and chartin	a on
	by: Based on record re	eview and staff interviews the		these issues will also be	5
		ure that the record for each		surveyed and reported a	t the
		notes regarding any accident or	-	monthly QI meeting for th	
	incident. Findings i	nclude:		months and quarterly if for	
	Dor rocord roulou	he resident had falls on 3/2,		be adequate.	-
		10/21, and 10/22/2018 with no		•	
		ry (bruise, skin tear) and two			
		11/22/18 with major injuries.			
		ented follow up to the fails on 8. The fail on 4/9/2018			
		jury and transfer to the			
	Emergency Room	(ER) and did contain follow-up		:	
		follow-up note for the fall on			
		ef note on 7/17/18 for the fall on a review of incident reports	•		
		eports for falls on 10/21/18			
		n are similar in nature but			
	censing and Protection	99449999, market and a second constraints and a second constraints on the constraint of the second second second			
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# Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1002	B WING		C 02/26/2019
NAME OF PROVIDER OR SUPPLIE		DDRESS, CITY, 1	STATE, ZIP CODE	02/20/2019
MEADOWS AT EAST MOUN	HAIN	ITAGE HILL I D, VT 05701	PLACE	
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETE
R188 Continued From contain different t no notes in the re	page 6 times, and vital signs. There are ecord regarding either fall.	R188	The RCD and Admin be responsible for the correction.	
FALLS ASSESSN policy statement :	provided tool titled FALLS AND /IENT DOCUMENTATION the says: "All falls must have the resident chart. Each fall, no		This plan will be imp May 15, 2019.	-
matter how minor	r, must have at least three within the first 24 hours Initially		R-158 POC 6	iccepted 4/11/19
at the time of the following the incid	incident - The next two shifts ient4: Interventions a. The nent and report any		M. Higgins,	Rujs, Reny, Ru
interventions that In an interview on that the documen	occur following a fall." 2/26/2019 the RCD confirmed tation provided was the only vailable in regards to the falls.			
	RE AND HOME SERVICES	R200		
5.15 Policies and	Procedures		· · · ·	
procedures that g	have written policies and overn all services provided by shall be available at the home equest.			
This REQUIREME	ENT is not met as evidenced			
Based on record r facility failed to as	review and staff interview the sure that there were written			
by the home and t	edures for all services provided that a copy is available for est. Findings include:	1 (8) (14)		
there are no polici Assessment, Falls	/26/2019 the RCD stated that les available regarding Fail Risk s Prevention, Fall Interventions ff, or Reporting of Falls to the	те		

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Division of Licensing and Pr	otection			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X:) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1002	B WING		C 02/26/2019
NAME OF PROVIDER OR SUPPLIER	STREET AD	ORESS, CITY, ST	ATE, ZIP CODE	
MEADOWS AT EAST MOUNT	ΔΙΝ	TAGE HILL PL D, VT 05701	ACE	
PREFIX (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 APPRO DEFICIENCY)	LD BE COMPLETE
R188 Continued From pa	age 6	R188		
contain different tir no notes in the rec In a review of the p FALLS ASSESSMI policy statement sa documentation in t matter how minor, documentations wi at the time of the ir following the incide nurse shall document interventions that of In an interview on 3 that the document documentation ava R200 V. RESIDENT CAP SS=E 5.15 Policies and Each home must h procedures that go the home. A copy s for review upon rec This REQUIREME by: Based on record re facility failed to ass policies and procee by the home and th review upon reque Per interview on 2/ there are no policie Assessment, Falls	nes, and vital signs. There are ord regarding either fall. Frovided tool titled FALLS AND ENT DOCUMENTATION the ays: "All falls must have he resident chart. Each fall, no must have at least three thin the first 24 hours Initially holdent - The next two shifts ent4: Interventions a. The ent and report any foccur following a fall." 2/26/2019 the RCD confirmed ation provided was the only allable in regards to the falls. RE AND HOME SERVICES Procedures have written policies and wern all services provided by shall be available at the home	R200	<b>R 200</b> New policies will be developmention, fall intervention fall intervention fall intervention preventions. The facility will review all and replace, create and the as necessary. Any necessary policy will reviewed at daily clinical Any policy found to be inadequate will be update	ent, falls ons, falls ord policies update I be meeting.

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If continuation sheet 7 of 9

Division	of Licensing and Pr	otection			FURMAPPROVED
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		1002	a WING		C 02/26/2019
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	
MEADO	WS AT EAST MOUNT.	AIN	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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
R200	Continued From pa	ige 7	R200		
	confirmed that ther Precautions and ot and procedures for	col). The RCD further e were not policies for Spinal her direct care interventions unlicensed direct care staff ing Assistants (LNAs).		created as needed to insu compliance. The RCD and Administrat	
R266 SS=E	IX. PHYSICAL PLA	NT	R266	be responsible for the implementation of this pla	n.
	9.1 Environment		**************************************	This plan will be impleme 5/15/19.	nted by
		ust provide and maintain a nitary, homelike and nment.		R-200 POC alle Milliggins, Ru/s. C	pted 4/11/19
	by: Based on record re facility failed to assi maintenance of a s include: Per record review of #1, #2 & #3) assess there are no fall pre the initial plan of ca interventions includ Resident #1 had a stated "Resident no chair in dining room not go off- faulty co information in notes checking alarms for	NT is not met as evidenced view and staff interview the ure the provision and afe environment. Findings of three residents (Residents sed as High Risk for Falls evention interventions found in re and limited additional ed as a response to falls. fall on 3/5/18 and the note sted to have slipped out of in p [after] supper. Alarm did nnector found." There is no s or the care Plan regarding r function prior to or after the at 11 am on 2/26/19 the RCD		Mi Higgins, Ru JS, D	uy, es
	stated that the main the alarms and ther unsure if that was s	ntenance man used to check re was a record but s/he is till the case. At 2 pm on onfirmed that there was no	1 		

Division of Licensing and Protection STATE FORM

LVZC11

Division	of Licensing and Pr	ratection			FURMAPPROVED	
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	3		(X3) DATE SURVEY COMPLETED	
		1002	B WING		C 02/26/2019	
NAME OF	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY,	STATE, ZIP CODE		
MEADO	WS AT EAST MOUNT	AIN	ITAGE HILL I D, VT 05701			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	O BE COMPLETE	
R200	Continued From pa	age 7	R200	Ser Sele "International and a selected and an an an and a selected and an an an an an an and a selected and and 		
	confirmed that ther Precautions and of and procedures for and Licensed Nurs	col). The RCD further re were not policies for Spinal her direct care interventions unlicensed direct care staff ing Assistants (LNAs).		R 266 Staff currently do shift to shift rounds for resident care items. The inspection of alarms and		
R266 SS=E	IX. PHYSICAL PLA	NT	R266	other fall prevention devic be added to this check list	es will	
	9.1 Environment					
	9.1.a The home m safe, functional, sa comfortable enviro	ust provide and maintain a nitary, homelike and nment.		If an item is found to be da or inoperable it will be repl corrected.		
	by: Based on record re facility failed to ass maintenance of a s include: Per record review of #1, #2 & #3) assess there are no fall pre the initial plan of ca interventions includ Resident #1 had a i stated "Resident no chair in dining room not go off- faulty co information in notes checking alarms for fall. In an interview stated that the main the alarms and ther unsure if that was s	NT is not met as evidenced view and staff interview the ure the provision and afe environment. Findings of three residents (Residents sed as High Risk for Falls evention interventions found in re and limited additional ed as a response to falls. fall on 3/5/18 and the note ited to have slipped out of a p [after] supper. Alarm did nnector found." There is no. or the care Plan regarding function prior to or after the at 11 am on 2/26/19 the RCD itenance man used to check e was a record but s/he is till the case. At 2 pm on onfirmed that there was no		These items will also be a environmental rounds that completed by the Administ weekly. Any discovered iss will be corrected. Findings these rounds will continue summarized for the QI con monthly.	are trator sues of to be	

Division of Licensing and Protection STATE FORM

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If continuation sheat, 8 of 9

Division of Licensing and Pro	otection			FURMAPPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED
	1002	B WING		C 02/26/2019
NAME OF PROVIDER OR SUPPLIER	STREETA	ODRESS CITY	STATE, ZIP CODE	
MEADOWS AT EAST MOUNTA	NN 157 HEF	RITAGE HILL I ID, VT 05701	PLACE	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
R266 Continued From page	ge 8	: R266	200-200	<b>*************************************</b>
is no evidence that,	arm checks available. There after identifying a problem action was taken to assure functional.		The RCD and Administrat be responsible for comple plan.	
			This plan will be implemen 5/15/19.	nted by
			R- 206 POC alleg	oted 4/11/19
			R-206 POC aller Mi Higgins, eu / s	. Riny &
		1990		
		отосновно та та с		
		мин на		
sion of Licensing and Protection TE FORM		5800 L.Y	VZC11	If continuation sheet 9 d