VERMONT

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
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

August 13, 2019

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 investigation survey conducted on **July 24, 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,

Pamela M. Cota, RN
Licensing Chief

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
	1002	A. BUILDING: _____ B. WING _____	C 07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS AT EAST MOUNTAIN	157 HERITAGE HILL PLACE RUTLAND, VT 05701

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R100	Initial Comments An unannounced investigation of one Complaint and four Facility Reported Incidents was conducted by the Division of Licensing and Protection on 7/24/2019. The following regulatory deficiencies were identified as a result of the investigation. Findings include:	R100		
R145 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that the plan of care described the necessary services to assist 3 applicable residents (Resident #1, #2 & #3) to maintain independence and well being. Findings include: 1). Per record review Resident # 1's plan of care did not reflect current skin condition. A monthly nursing summary dated 6/5/19 did not note any skin issues beyond a rash. . On 6/1/19, Resident #1 received a skin tear on the left elbow and bruising on both wrists during care. This was not noted on on the monthly summary or the plan of care. This was confirmed by the facility administrator on 7/24/19 at 2:40 PM.	R145	**R145** Resident #1, Resident #2 and Resident #3 will have their care plans reviewed and amended appropriately. A new care plan form has been developed. Every resident is receiving a new care plan. As the new care plans are being rolled out it will be reviewed for accuracy and corrected as necessary. After the initial change to our care plans is made, audits will be conducted monthly to insure compliance. Ten percent of the facility charts will be audited for accuracy. If there are more than two care plans found to be non-compliant then a facility wide review will be launched. The Director of Resident Care will be responsible for the completion of this plan. This plan of correction will be completed by September 14, 2019.	

R145-R224 POC's accepted 8/13/19 MHiggins RN/PMC

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R145	Continued From page 1 2). Per record review Resident #3 has significant cognitive decline and was party to a relationship with Resident #4. There were some encounters between the residents which were consensual and some encounters where Resident #3 was documented as upset and hollering for Resident #4 to stop or for staff to remove the other resident from the area. There was no documentation in the care plan regarding protecting Resident #3 and for assuring that any contact was welcome and consensual. The Director of Nursing Services (DNS) confirmed, in interview 7/24/19 at 1:25 PM, that the Care Plan did not reflect the resident's declining cognitive status or assuring that the relationship was consensual. 3). Per record review Resident #4 has Dementia. The Resident became involved in a personal relationship with Resident #3. There were some encounters between the residents which were consensual and some encounters where Resident #3 was documented as upset and hollering for Resident #4 to stop or for staff to remove the other resident from the area. Resident #4 became agitated and angry when attempts at redirection were made. The Director of Nursing Services confirmed, in interview 7/24/19 at 1:25 PM, that the care plan did not contain the information regarding interventions for behavior and monitoring for safety checks.	R145		
R206 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.a The licensee and staff shall report any	R206		

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R206	Continued From page 2 case of suspected abuse, neglect or exploitation to the Adult Protective Services (APS) as required by 33 V.S.A. §6903. APS may be contacted by calling toll-free 1-800-564-1612. Reports must be made to APS within 48 hours of learning of the suspected, reported or alleged incident. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to report suspected abuse as required by regulation for 1 applicable resident (Resident # 2). Findings include: Per a note by a Resident Assistant (RA) dated 5/21/19 states that Resident # 2 said that h/she said that they were "raped by the night nurse". The State agency was not notified of the incident until 7/3/19. This is confirmed by the facility Administrator on 7/24/19 at 2:40 PM.	R206	Staff training is already taking place to prevent this from happening again. Chart reviews are also being done to discover any other issues that may have not been reported. Any positive findings will be reported to the state. Ten percent of all charts will be audited monthly to insure no other issues have gone unreported. If a chart is found to have a reporting issue discovered then a facility wide audit will be conducted. The Director of Resident Care will be responsible for the completion of this plan of correction. It will be completed by September 14, 2019.	
R208 SS=E	V. RESIDENT CARE AND HOME SERVICES 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:	R208		

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R208	Continued From page 3 Based on record review and staff interview the facility failed to report suspected abuse or a pattern of abuse to the State Licensing Agency, in the required timeframes, for Resident #3. Findings include: Per record review an allegation that Resident #3 was inappropriately touched by resident #4 and the contact was not consensual was made to Facility Administrative staff. The facility considered that the relationship between the residents was consensual but failed to assure that on an ongoing basis it remained so or that this was true for all contact. As a result though there were times when the resident hollered out to get staff intervention or asked to have the other resident removed no reports were made to the Licensing Agency. The Facility Administrator confirmed that the facility didn't report the issues until a concern was expressed by Resident #3's family.	R208	(R208 continued) team immediately. Any resident to resident relationship that requires consent will be reviewed to insure that both parties can give consent. If a resident is deemed to be incompetent measures will be put in place to insure the safety and dignity of both residents. Residents that give consent will be educated on the use of their personal help button and be asked to use it if they need help in not giving consent at any moment. If a pattern develops it will be reported to the licensing agency. Ten percent of all charts will be reviewed monthly to insure	
R224 SS=G	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure 2 applicable residents (Resident # 1 & #3) were free from verbal and physical abuse. Findings include:	R224		

(R208 continued)
compliance. If an incident is discovered it will trigger a facility wide review. Any discovered incidents will be reported to the appropriate licensing agencies.

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

It will be completed by September 14, 2019.

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R224	Continued From page 4 1). Per record review and confirmed by staff interview, Resident # 1 was verbally and physically abused by a staff member during care. Two staff stated that they heard a Resident Assistant (RA) yell loudly at Resident #1. The RA said "you didn't need to grab my god damn hair" in a loud voice that could be heard outside the room. A nursing note dated 6/1/19 noted bruising to top of left wrist 2.5 cm (Centimeter) x 1.5 cm. Bruising to the right inner and outer wrist measuring 1.5 cm x 1.0 cm and 1.0 cm x 1.0 cm respectively. A skin tear to the left elbow measuring 0.5 x 0.5 cm was also noted. A facility RN (Registered Nurse) stated in an interview with the facility Administrator that the bruises " did look like they could be finger marks". The facility Administrator confirmed on 7/24/19 at 2:40 PM that the physical and verbal abuse did occur and that the facility had substantiated the abuse. 2). Per a Facility report there is an allegation that Resident #3 was inappropriately touched by resident #4 and the contact was not consensual. In an interview with the Facility Administrator s/he sated that the relationship between Residents #3 & #4 was consensual when it began and that Resident #3 actually sought out Resident #4 at times. The Residents were reportedly observed by staff kissing and hugging each other. In a review of the nursing notes it was found that, although there were times that Resident #3 was mutually engaged with Resident #4, there were also times when the attentions of Resident #4 were not welcomed. Resident #3 would holler out or ask staff to remove Resident #4 from the room. Eventually there were nurses notes on two occasions asserting that Resident #4 had been found in bed with Resident #3. There is no mention of clothing being removed or any form of intercourse. The nurse removed Resident #4	R224	(R224 continued) recognized that resident #3 could not give consent. There have been no further incidents since that plan started. Any resident to resident relationship that requires consent will be reviewed at morning clinical meeting. If either resident is deemed to be unable to give consent then measures will be put in place to insure the resident is protected. If a resident is assessed to be competent and wishes to participate in the relationship, they will be educated on the use of a personal help button, and asked to use it if they wish not to participate in the behavior that	

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R224	Continued From page 5 from the room. This information was not reported to the Facility Administrator or Director of Nursing according to interview. In an interview on 7/24/19 at 2:50 PM the Facility Administrator confirmed that the facility had failed to assure that Resident #3 did not receive nonconsensual sexual attention.	R224	(R224 Continued) requires consent at that moment. Staff will then respond to protect the residents rights. Staff will be educated on behavior that needs to involve consent, and if witnessed, that it must be reported to a supervisor immediately. Ten percent of charts will be reviewed monthly for any other similar issues. Any discovered issue will trigger a facility wide review. It will also be reported to appropriate agencies As required. The Director of Resident Care will be responsible for the completion of this plan. This plan will be completed by September 14, 2019.	