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

January 29, 2020

Mr. Steven Doe, Manager
Our Lady Of The Meadows
1 Pinnacle Meadows
Richford, VT 05476-7637

Dear Mr. Doe:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 31, 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

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

JAN 28 2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0197	A. BUILDING: _____ B. WING _____	C 12/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF THE MEADOWS	1 PINNACLE MEADOWS RICHFORD, VT 05476

(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
R100	Initial Comments: An unannounced on-site investigation of 2 self-reports was conducted by the Department of Licensing and Protection on 12/31/19. The following regulatory violations were identified:	R100		
R145 SS=D	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 record review and staff interview the facility failed to provide instructions to all direct care staff regarding the health care needs for 1 applicable resident after a suspected nonconsensual sexual encounter, (Resident #3). This citation was previously cited on 05/22/18. The findings include the following: Per medical record review, progress notes dated 12/26/19 as a late entry, identifies on 12/24/19 at 5:30 PM, Resident #3 was found sitting on his/her bed with no clothing on from the waist down. Resident #4, who was also sitting on the bed, was redirected out of the room. Resident #3 was evaluated by the Registered Nurse (RN) Unit Manager and was found without injury, was not in any distress and stated s/he was not not afraid.	R145	(PLEASE SEE ATTACHED)	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: STEVEN A. JOE — TITLE: ADMINISTRATOR — (X6) DATE: 1/24/20

R145 - R208 POC accepted 1/28/20 MBertrandRN/ PMC

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R145	Continued From page 1 Resident State mandated assessment completed on 11/05/19, identifies that the resident has both short and long term memory deficits, makes poor decisions related to daily life and needs cueing and supervision. The resident is able to express his/herself using speech but has difficulty finding words and finishing thoughts. S/He is hard of hearing and may miss some of the message. Progress notes identify specific initiatives that were put in place to ensure the safety of both residents. Per review of the care plan for resident #3, there is no documented evidence that specific initiatives were put in place to prevent a recurrence of the suspected incident of 12/24/19. Confirmation was made by the RN Unit Manager on 12/31/19 at 1:30 PM that the care plan does not identify any initiatives to keep Resident #3 safe from any future possible nonconsensual sexual encounters.	R145		
R150 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (7) Assure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to record in the medical record occurrences as well as actions taken, for 3 of 4 sampled residents, related to falls and/or	R150	(PLEASE SEE ATTACHED)	

SAD

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R150	Continued From page 2	R150		

physical/sexual abuse, (Resident #2, #3 & #4). the findings include the following:

1. Per medical record review, Resident #2 was admitted 03/07/18 with diagnosis to include but not limited to Alzheimer's Disease, Malignant Neoplasm of the Prostate, Urinary Retention, Atherosclerotic Heart Disease and Pacemaker implant. Per review of one incident report dated 12/22/19, identifies that Resident #2 had a witnessed fall at 11:30 AM. The resident was seen falling to his/her knees. Registered Nurse (RN) on-call was contacted and instructed direct care staff to call Emergency Medical Services after speaking to the Power of Attorney.

Per review of the nurses' notes, Resident #2 was sent again to the hospital on 12/24/19 for evaluation. The resident was admitted and treated with intravenous fluids, antibiotics and scheduled to return to the facility after treatment. Nurses notes evidence communication with hospital staff identifying that the resident was not eating, developed skin breakdown of the coccyx and required sedation. S/He returned to the facility on 12/27/19 on Hospice services.

Per review of the nurses notes for Resident #2, there is no documentation related to the falls, nurse contact or instructions to staff on how to manage the resident who kept falling. Nor do the nurses notes identify the transportation to the Emergency Room on 12/22/19 at 11:30 AM.

RN, Unit Manger confirms on 12/31/19 at approximately 2:30 PM, that s/he had been informed by the direct care staff on 12/24/19 (2 days post falls), that Resident #2 had a total of 4 falls on Sunday 12/22/19 at various times throughout the day. The resident was sent to the

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R150	Continued From page 3	R150		

Emergency room after the 11:30 AM fall, and returned to the facility on the same date. Confirmation was also made by the RN that the medical record for Resident #2 does not evidence the falls that occurred on 12/22/19 nor are there consistent incident reports that describe all the falls.

The RN also confirms that the nurse on call does not necessarily come into the facility to evaluate residents. However, the nurse does have remote access to the medical record for review and/or documentation. Per review of the Fall Assessment and Action Plan, directs the nurse to document the fall in the progress notes.

2. Per medical record review, progress notes dated 12/26/19 as a late entry, identifies on 12/24/19 at 5:30 PM, Resident #3 was found sitting on his/her bed with no clothing on from the waist down. Resident #4, who was also sitting on the bed, was redirected out of the room. Resident #3 was evaluated by the Registered Nurse (RN) Unit Manager and was found without injury, was not in any distress and stated s/he was not not afraid. Confirmation was made by the Registered Nurse (RN) Unit Manager, on 12/31/19 at 2 PM that the occurrence and actions taken were documented for Resident #3 on 12/26/19 as a late entry, 2 days post incident.

Per review of the progress notes of Resident #4, there is no documented evidence that the incident occurred. Confirmation was made by the RN on 12/31/19 during the interview that s/he neglected to document the occurrence. Per review of the policy titled Abuse Prohibition under identification: Document the incident on an incident report form and document all reports on the resident record.

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R191	Continued From page 4	R191		
R191 SS=D	V. RESIDENT CARE AND HOME SERVICES	R191	(PLEASE SEE ATTACHED)	

5.12 Records/Reports

5.12.c A home must file the following reports with the licensing agency:

5.12.c.(1) When a fire occurs in the home, regardless of size or damage, the licensing agency and the Department of Labor and Industry must be notified within twenty-four (24) hours. A written report must be submitted to both departments within seventy-two (72) hours. A copy of the report shall be kept on file.

5.12.c.(2) A written report of any accident or illness shall be placed in the resident's record. Any untimely deaths shall be reported and a record kept on file.

5.12.c. (3) A report of any unexplained absence of a resident from a home for more than 12 hours shall be reported to the police, legal representative and family, if any. The incident shall be reported to the licensing agency within twenty-four (24) hours of disappearance followed by a written report within seventy-two (72) hours, a copy of which shall be maintained.

5.12.c.(4) A written report of any breakdown or cessation to the home's physical plant's major services (plumbing, heat, water supply, etc.) or supplied service, which disrupts the normal course of operation. The licensee shall notify the licensing agency immediately whenever such an incident occurs. A copy of the report shall be sent to the licensing agency within seventy-two (72) hours.

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R191	Continued From page 5	R191		

5.12.c. (5) A written report of any reports or incidents of abuse, neglect or exploitation reported to the licensing agency.

5.12.c. (6) A written report of resident injury or death following the use of mechanical or chemical restraint.

This REQUIREMENT is not met as evidenced by:
Based interview and record review the facility failed to report to the licensing agency a resident to resident altercation that resulted in an untimely death for 1 applicable resident, (Resident #1). The death occurred 11 days after a fall and the Office of the Medical Examiner, preliminary report identifies the immediate cause of death as a femoral fracture due to blunt impact (fall) (pushed and fell 11/29/19). The findings include the following:

Per medical record review, Resident #1 had a witnessed fall on 11/29/19 during the evening shift, after being pushed from behind by Resident #2, and fell to the floor landing on his/her walker. The resident was unable to move his/her lower half of his/her body and was complaining of pain. Emergency Services were notified and was transported to the hospital for evaluation. The Emergency Room later confirmed that the fall resulted in a fracture right hip/femur and the resident was scheduled for surgery on 12/02/19 in the afternoon.

Progress notes dated 12/10/19 evidence the facility was notified that Resident #1 passed this morning while still in the hospital.

The Office of the Medical Examiner, preliminary

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R191	Continued From page 6 report identifies the immediate cause of death as a femoral fracture due to blunt impact (fall) (pushed and fell 11/29/19). Confirmation was made by the Registered Nurse (RN) Unit Manager on 12/31/19 at approximately 9:30 AM that the RN on call the evening of the incident was notified at approximately 9 PM but did not report the incident to Licensing or Adult Protective Agency timely. The Unit Manger made the report of the incident to Licensing on 12/02/19 at 10:30 AM, the time she was made aware of the incident. Per review of the facility Abuse Prohibition Policy identifies the following: a. Report any incident to the Administrator immediately; b. Report the incident to the State Regulatory Agency within 3 days of the occurrence. Per regulation any suspected reports of abuse are to be reported to Adult Protective Services within 48 hours of learning of the alleged incident. On 12/31/19 at 2 PM, by the Human Resource Manager, who is responsible for tracking educational offering for Direct Care Staff. However, it is the responsibility of the professional staff to report any education they attend. There have been no reported educational attendance to programs related to Abuse/Neglect/Exploitation.	R191		
R206 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation	R206	(PLEASE SEE ATTACHED)	

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R206	Continued From page 7 5.18.a The licensee and staff shall report any 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 interview and record review the facility failed to report a suspected case of abuse to the licensing agency and Adult Protective Services for 1 applicable resident who was the victim of a resident to resident physical assault (Resident #1). The findings include the following: Per medical record review, Resident #1 had a witnessed fall on 11/29/19 during the evening shift, after being pushed from behind by Resident #2, fell to the floor landing on his/her walker. The resident was unable to move his/her lower half of his/her body and was complaining of pain. Emergency Services were notified and was transported to the hospital for evaluation. The Emergency Room later confirmed that the fall resulted in a fracture right hip/femur and is the resident was scheduled for surgery on 12/02/19 in the afternoon. Confirmation was made by the Registered Nurse (RN) Unit Manager on 12/31/19 at approximately 9:30 AM that the RN on call the evening of the incident was notified at approximately 9 PM but did not report the incident to Licensing and Protection nor to Adult Protective Services timely. The Unit Manger made the report to Licensing on 12/02/19 at 10:30 AM, the time she was made aware of the incident.	R206		

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R208	Continued From page 8	R208		
R208 SS=D	V. RESIDENT CARE AND HOME SERVICES	R208	(PLEASE SEE ATTACHED)	

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 interview and record review the facility failed to report a resident to resident physical abuse for 1 applicable resident (Resident #1). The findings include the following:

Per medical record review, Resident #1 had a witnessed fall on 11/29/19 during the evening shift, after being pushed from behind by Resident #2. Resident #1 was unable to move his/her lower half of his/her body and was complaining of pain. Emergency Services were notified and Resident #1 was transported to the hospital for evaluation. The Emergency Room later confirmed that the fall resulted in a fracture right hip/femur and is scheduled for surgery on 12/02/19 in the afternoon.

Confirmation was made by the Registered Nurse (RN) Unit Manager on 12/31/19 at approximately 9:30 AM that the RN on call the evening of the incident was notified at approximately 9 PM, but

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R208	Continued From page 9 did not report the incident to Licensing or Adult Protective Agency timely. The Unit Manger made the report to Licensing on 12/02/19 at 10:30 AM, the time she was made aware of the incident.	R208		

Our Lady Of The Meadows
Plan of Correction
Residential Care Home State Survey
December 31, 2019

R145

5.9.c (2)

Action:

The Nurse Manager has reviewed the care plans for each resident to ensure that it is based on abilities, needs and includes services necessary to address behavioral changes as identified in the resident assessment (Please see Attachment A for an example care plan that addresses specific initiatives put in place).

The care plan for Resident #3 was updated on 1/13/20 to reflect the specific initiatives that were put in place to prevent a recurrence of the suspected incident of 12/24/19

Measures:

The Nurse Manager met with the nursing team to review the necessity of updating the written plan of care to describe the care services necessary to address specific initiatives put in place.

Monitors:

The Nurse Manager and entire Nursing Staff will monitor this practice to ensure that this deficiency does not reoccur.

Date Completed:

1/24/20

Licensing agency note: example care plan removed from accepted POC packet due to privacy. PMcotaRN

R150

5.9.c (7)

Actions:

1) A "soft note" was not provided for Resident #2 as he/she passed away on 1/3/20.

2) On 1/1/20, the Nurse Manager provided a "soft note" for Resident #4 related to the incidents that occurred on 12/24/19.

Measures:

The Nurse Manager and entire nursing team, including those nurses providing "On-Call" nursing coverage, reviewed the On Call Triage Nurse Policy (Please see Attachment B) and the revised Abuse Prohibition Policy (Please see Attachment C) and will ensure that each resident's medical record will contain nursing documentation reflecting that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken.

Monitors:

The Nurse Manger and entire nursing team will monitor this practice to ensure that this deficiency will not reoccur.

Date Completed:

1/24/2020

R191

5.12

Action:

The local hospital notified the State of Vermont Authorities and the Vermont Medical Examiner as Resident #1 passed away at the local hospital eleven days after the incident.

The Abuse Prohibition Policy used by Our Lady Of The Meadows was revised to comply with Vermont Residential Care Home Licensing Regulations. (Please see Attachment C).

The Nurse Manager and entire nursing team, including those nurses providing "On-Call" nursing coverage, reviewed the revised Abuse Prohibition Policy and signed a statement of verification (please see Attachment D, E, F, G, and H.)

Measures:

The Nurse Manager will provide an annual review of the Abuse Prohibition Policy to ensure that the entire nursing team stays in compliance.

Monitors:

The Nurse Manager and Administrator will monitor this practice to ensure that this deficiency will not reoccur.

Date Completed:

01/24/20

R206

5.18.a

Action:

The Nurse Manager notified Adult Protective Services on the morning of the next business day after the event. The event occurred on Friday (11/29/19) late in the evening and was reported on the following Monday morning (12/2/19).

The Abuse Prohibition Policy used by Our Lady Of The Meadows was revised to comply with Vermont Residential Care Home Licensing Regulations. (Please see Attachment C).

The Nurse Manager and entire nursing team, including those nurses providing "On-Call" nursing coverage, reviewed the revised Abuse Prohibition Policy and signed a statement of verification (please see Attachment D, E, F, G, and H.)

Measures:

The Nurse Manager will provide an annual review of the Abuse Prohibition Policy to ensure that the entire nursing team stays in compliance.

Monitors:

The Nurse Manager and Administrator will monitor this practice to ensure that this deficiency will not reoccur.

Date Completed:

01/24/20

R208

5.18.c

Action:

The Nurse Manager notified Adult Protective Services and the licensing agency on the morning of the next business day after the event. The event occurred on Friday (11/29/19) late in the evening and was reported on the following Monday morning (12/2/19).

The Abuse Prohibition Policy used by Our Lady Of The Meadows was revised to comply with Vermont Residential Care Home Licensing Regulations. (Please see Attachment C).

The Nurse Manager and entire nursing team, including those nurses providing "On-Call" nursing coverage, reviewed the revised Abuse Prohibition Policy and signed a statement of verification (please see Attachment D, E, F, G, and H.)

Measures:

The Nurse Manager will provide an annual review of the Abuse Prohibition Policy to ensure that the entire nursing team stays in compliance.

Monitors:

The Nurse Manager and Administrator will monitor this practice to ensure that this deficiency will not reoccur.

Date Completed:

01/24/20

ATTACHMENT B

Ave Maria Community Care Homes, Inc.

Personnel Policies for Ave Maria Community Care Homes, Inc.

520 On-Call Triage Nurse Policy

Effective Date: 5/8/2018

Ave Maria CCH, Inc. may require on-call skilled nursing duties as an additional responsibility for its nurses. At Ave Maria Community Care Homes, Inc., the definition of the "On-Call Triage Nurse" is the practice of working at home or at another place with cell phone coverage taking calls after normal business hours and/or over the weekend instead of physically being at Ave Maria Home or Our Lady of the Meadows. This is an outline of our policy related to On-Call Triage Nurse arrangements.

When we determine to assign a nurse to On-Call Triage Nurse duty, we look at factors such as position and job duties, performance history, related work skills, and the impact on the Organization.

Your compensation, benefits, work status, work responsibilities as a licensed nurse, and the amount of time you are expected to work each day or each pay period will remain "as is" while you assume the responsibility of being a On-Call Triage Nurse (unless changes are agreed upon in writing).

You and your supervisor must agree upon your schedule. If there is no written agreement about your schedule, you will work the same schedule as you did before you started assuming the responsibility of being a Nurse On-Call. You cannot change your schedule until your supervisor approves the change.

During your On-Call Triage Nurse hours, your at-home workspace will be considered an extension of our workspace. Therefore, workers' compensation benefits may be available for any job-related accident that happens in your at-home workspace during your On-Call Triage Nurse hours. We will investigate all job-related accidents immediately.

Ave Maria CCH, Inc. has no responsibility for an injury that happens at home outside of the agreed-upon On-Call Triage Nurse hours. You must also agree to maintain safe conditions at all times while you are working as the On-Call Triage Nurse. You are expected to follow the same safety habits as if you were working at one of the Ave Maria CCH, Inc. locations.

If an injury happens while working as the On-Call Triage Nurse, you must immediately report it to the Administrator or designee for instructions on getting medical treatment.

Being the On-Call Triage Nurse is an alternative method for meeting the business needs of Ave Maria CCH, Inc.. It is not a universal employee benefit. We have the right to refuse to make on-call triage nurse responsibilities available to an employee. We also may terminate an existing on-call triage nurse arrangement at any time.

Ave Maria Community Care Homes, Inc.

Personnel Policies for Ave Maria Community Care Homes, Inc.

Procedure

While the nurse is fulfilling the responsibility of being the On-Call Triage Nurse he/she will be required to:

- Carry a cell phone and/or a pager.
- Have the assigned laptop ready and available in order to access the Electronic Medical Record for Ave Maria Home and Our Lady of the Meadows.
- Be within an area with cell phone coverage .
- Return a call or a page within approximately 30 minutes.
- Refrain from drinking alcohol.
- The On Call Triage Nurse provides support to the Medication Administration Staff at Our Lady Of the Meadows and Ave Maria Home between the hours of 4:30pm and 6:00am Monday through Friday, and from 4:30pm on Friday to 6:00am on Monday (to cover the weekend) and for 24 hours on Thanksgiving, Christmas Day, New Years Day and Easter Sunday.
- The Nurse Manager will coordinate with the nurses with On Call Triage Nurse duties in establishing a monthly On Call Triage Nurse schedule and a method for reporting pertinent medical information to the On Call Triage Nurse as needed. The schedule is to be kept up to date and posted in each medication room(s) at Ave Maria Home and Our Lady of the Meadows.
- Upon receiving a call the On Call Triage Nurse should access the progress reports for the resident in concern in order to have the most recent electronic medical record information available.
- When called, the On Call Triage Nurse will:
    - Asses the situation (if there is an issue that has not been identified in the progress report/EMR, the Triage Nurse should err on the safe side).
    - Provide the needed information or support over the phone (coordinating with staff, other health care professionals, resident responsible parties etc. and documenting in the nurse progress notes as required).

Personnel Policies for Ave Maria Community Care Homes, Inc.

- **Make a personal visit to Ave Maria Home or Our Lady of the Meadows only if absolutely necessary**. While it would not be typical for the On-Call Triage Nurse to have to travel to Ave Maria Home or Our Lady of the Meadows, if this is does occur, the nurse would be expected to "clock in and out". The time the nurse spends physically at either location will be treated as compensable according to the agreed upon rate of pay for that nurse.

- As a back up system, if the scheduled On Call Triage Nurse does not respond to the call/page, the Medication Administration Staff are instructed to call any other member of the Ave Maria CCH, Inc. Nursing team.

ATTACHMENT C

abuse prohibition POLICY

What we want to happen...

We will not tolerate any form of abuse, neglect, or exploitation.

Why it's important...

Staff must be skilled in working with confused residents so that challenging behavior is avoided whenever possible and handled with dignity and compassion when it occurs.

How to make it happen...

1. Maintain a ZERO tolerance for ANY form of abuse, neglect, or exploitation.
2. Maintain a work and living environment that is professional and free from threat of and/or occurrence of harassment, abuse (verbal, physical, mental, psychological, or sexual), neglect, corporal punishment, involuntary seclusion, or misappropriation of property.
3. Protect residents from abuse, neglect, or exploitation by anyone, including but not limited to staff, other residents, consultants, volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.
4. Provide a safe, comfortable, and homelike environment.
5. Promote an atmosphere of communication and sharing with residents and staff without fear of intimidation, retribution, or retaliation.
6. Promote staff understanding and appreciation of their unique position of trust with all residents and particularly the most vulnerable of residents.
7. Ensure that staff use caring, ethical, and professional behavior in all relationships with residents.

Definitions

Abuse — Any willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, pain, or mental anguish.

Mental Abuse — The infliction of mental/emotional suffering. It includes, but is not limited to, humiliation, harassment, making demeaning statements, intimidation, threats of punishment or deprivation.

Physical Abuse — The infliction of physical pain or injury to a resident. It includes, but is not limited to, pushing, hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment, or the misuse of physical or chemical restraints.

Sexual Abuse — Includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault.

Verbal Abuse — The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm or saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.

Involuntary Separation or Seclusion — Separation of a resident from other residents or from his/her room or confinement to his/her room (with or without roommates) against the resident's will, or the will of the resident's legal representative. Emergency or short-term monitored separations from other residents are not considered involuntary seclusion. Monitored seclusion may be permitted, for a limited period of time, as a therapeutic intervention for agitation until professional staff can develop a plan of care to meet the resident's needs.

Exploitation or Misappropriation of Resident Property — The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. Examples include theft of a resident's private television, false teeth, clothing, jewelry, money, using a resident's telephone, etc.

Neglect — The failure to provide goods and services necessary to avoid physical harm or mental anguish. Neglect is the failure to provide the necessary treatment, rehabilitation, care, attention, food, clothing, shelter, supervision, or medical services by a caregiver. Neglect is also creating situations in which esteem is not fostered. This could include instances where competent resident's wishes are not honored, restricting contact with family, ignoring the resident's need for verbal and emotional contact.

Vulnerable Adult — Any person over 18 years of age suffering from physical or mental infirmity or dysfunction impairing the person's ability to care for or protect himself.

Misuse of Restraints — Chemical or physical control of a resident beyond the physician's orders or not in accordance with the resident's plan of care and acceptable medical practice. This includes a psychopharmacologic drug that is used for discipline or convenience and not required to treat medical symptoms. This also includes any physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the resident cannot remove easily that restricts freedom of movement or normal access to one's body and is used for discipline or convenience and not required to treat the resident's medical symptom. (A recliner could be considered a restraint if the resident is unable to operate the chair by themselves. If this is the case a nurse must be notified to get a doctor's order, for the resident to sit in a recliner.)

Actions:

1. Screening of Staff
    a. When selecting staff members or volunteers, give attention to prior work experience and references.
    b. Reference the State of Vermont Office of Professional Regulation for each Licensed Nursing Assistant prior to hiring. If not in good standing, do not hire.
    c. Reference the Board of Nursing for each licensed nurse prior to hiring. If the nurse is not in good standing with regard to abuse and neglect, do not hire.
    d. Do criminal background checks on all potential employees, volunteers, and students. Criminal records disqualify an individual from employment, volunteering, or training.

2. Training of Staff

a. Give each new staff member a clear description of his/her expected duties, responsibilities, and conditions of employment, including staff treatment of residents.

b. Give each new staff member an orientation and annual training which shall include a review of abuse, neglect, and exploitation policies and the Resident's Bill of Rights.

c. Provide education, through orientation and ongoing sessions, in the following areas: dealing with aggressive residents, recognizing and reporting abuse and neglect without fear of reprisal, recognition of signs of employee burnout and stress.

3. Prevention of Abuse

a. Provide a safe living environment for residents through good maintenance and housekeeping practices and adequate equipment and buildings.

b. Require assigned personnel to know the whereabouts of each resident at all times and establish a procedure in the event a resident is reported missing.

c. Assign sufficient staff on each shift to meet the needs of the residents; give staff access to information about specific resident care needs.

d. Supervise staff in such a manner as to identify inappropriate behaviors such as rough handling of residents.

e. Assess residents, create a service plan, and monitor to identify needs and behaviors that have the potential for leading to conflict or neglect: aggressive behaviors, wandering into other residents' rooms, communication disorders, and total dependency.

f. Ensure that each employee understands that he or she is obliged to report knowledge of apparent abuse or neglect of a resident or misappropriation of a resident's property to his or her immediate supervisor.

g. Ensure that each employee understands that individuals who fail to report a case of alleged abuse within 48 hours of learning of the abuse may be subject to a monetary penalty imposed by the state.

4. Identification

a. Evaluate the safety and well-being of the victim. Remove from immediate danger.

b. Arrange immediate medical evaluation if indicated.

c. Document the incident on an incident report form.

d. Secure any physical evidence related to the incident for examination by the proper authorities.

e. Investigate all incidents and injuries incurred by residents.

5. Investigation

a. Inform the Staff RN immediately of an incident of alleged or suspected abuse. If the incident occurs when the Staff RN is not available, the On-Call Nurse will be notified. The On-Call Nurse will take any immediate action necessary and notify the Staff RN as soon as possible.

b. The Staff RN will conduct a thorough investigation of reports of alleged resident abuse or neglect to determine if the conduct of the individual is in violation of any standard of care, interviewing any and all witnesses.

c. A written report will be completed and submitted to Adult Protective Services and the State Regulatory Agency by a Staff RN within 48 hours of the reportable incident (Please note that reporting on a weekend or holiday may be necessary). If a Staff RN is not available within the 48-hour window, the On-Call Nurse will file the report. A copy of the written report with be given to the Administrator.

It is important to update Adult Protective Services and the State Regulatory Agency if the condition of the victim changes (i.e. if the victim is hospitalized and his/her condition worsens as a result of injuries sustained in the incident).

d. Protect the resident or residents involved in a case of suspected abuse from potential additional harm during the investigation procedure. This includes, but is not limited to, suspension of an employee in question.

e. The Staff RN or On-Call Nurse will notify the resident's family and/or responsible party and physician as soon as possible of the incident, and when completed, the results of the investigation.

f. When a charge of resident abuse, neglect, or exploitation by an employee or volunteer is being investigated, the

employee or volunteer should be placed on un-paid leave until the charge is fully investigated by Adult Protective Services. If the charge is substantiated, the employee/volunteer shall be terminated promptly.

6. Reporting of Abuse

   a. Report any incident to the Staff RN and Administrator immediately. If incident occurred after hours the individual responsible for medication administration (The Med. Tech.) will notify the Nurse On-Call. The Med. Tech. will then request that any staff who were witnesses of the incident, relay the details of what they saw and heard. These details will be provided to a Staff RN upon the RN's arrival to work.

   b. The Staff RN will report the incident to the State Regulatory Agency and Adult Protective Services within 48 hours of the occurrence when:

      1) There is a specific written or verbal allegation of resident abuse, neglect, or misappropriation of resident property.
      2) There is a reasonable suspicion of resident abuse, neglect, or misappropriation of resident property.
      3) There is actual knowledge of resident abuse, neglect, or misappropriation of property.

   c. When appropriate, also notify the following persons and agencies:

      ✓ Law enforcement officials when there are allegations of criminal acts
      ✓ Ombudsman
      ✓ The organization's legal counsel
      ✓ The State Board of Nursing
      ✓ Nurse Aide Registry
      ✓ Others, as specified by state or local law

   d. Document all reports on the Resident Record.

7. Resident-to-Resident Abuse

   a. In the instance that a resident alleges abuse, sexual abuse, or if an injury requiring health care provider intervention results, or if there is a pattern of abusive behavior or if a resident is found to have been abused by another resident of

the facility, a thorough investigation will be conducted by the Staff RN. If the instance requires health care provider intervention or if there is a pattern of abusive behavior, the Staff RN will report the incident to Adult Protective Services and to the Division of Licensing and Protection within 48 hours. A copy of this report will be given to the Administrator. Before reporting resident-to-resident incidents, review the criteria for reporting. Isolated resident-to-resident abuse (hitting/slapping/name calling/ etc.) with no injury or injury that does not require health care provider intervention, or with no allegations of any abuse or if there is no pattern of abusive behavior do not require reporting. However, all resident-to-resident incidents must be recorded in the resident record and their families or legal representative must be notified.

b. Institute appropriate interventions such as counseling, psychiatric evaluation and treatment, behavior modification. When necessary, offer the resident to move to a different room. Any strategies developed to deal with the behaviors must be added to the care plan(s).

c. If the residents' behavior does not respond to the interventions and he or she continues to be a threat and a danger to others, discharge may be necessary.

8. Quality Assurance

a. Evaluate the following trends no less often than monthly, and more frequently when indicated:

- ✓ Increasing injuries on the same resident
- ✓ Multiple injuries in a specific location
- ✓ Injuries in residents who are dependent
- ✓ Increasing injuries of unknown origin
- ✓ Increasing incidents involving same staff

b. When trends are identified, investigate further in order to determine if a problem exists.

c. All incidents, injury, and abuse data and investigations are to be documented by the nurse in the respective resident's progress notes.

TIPS

- *Take immediate action – never delay action on a suspected incident.*
- *If a resident is hospitalized, stay in touch.*

ATTACHMENT 5

In signing this document, I am acknowledging that the Administrator has provided me with a copy of **The Abuse Prohibition Policy** and the **On-Call Triage Nurse Policy** at Our Lady Of The Meadows Residential Care Home for me to review. I, as a member of the Nursing Team at Our Lady Of The Meadows, fully understand my role and responsibilities as stated in these policies and further agree to adhere to these policies while conducting my duties at Our Lady Of The Meadows.

Jenny Powder RN
Name Printed

Signature

1/24/20
Date

Administrator

1/24/20
Date

ATTACHMENT E

In signing this document, I am acknowledging that the Nurse Manager has provided me with a copy of **The Abuse Prohibition Policy** and the **On-Call Triage Nurse Policy** at Our Lady Of The Meadows Residential Care Home for me to review. I, as a member of the Nursing Team at Our Lady Of The Meadows, fully understand my role and responsibilities as stated in these policies and further agree to adhere to these policies while conducting my duties at Our Lady Of The Meadows.

Claire L. Doe RN
Name Printed

Claire L. Doe RN
Signature

1-23-2020
Date

Nurse Manager

1/23/2020
Date

ATTACHMENT F

In signing this document, I am acknowledging that the Nurse Manager has provided me with a copy of **The Abuse Prohibition Policy** and the **On-Call Triage Nurse Policy** at Our Lady Of The Meadows Residential Care Home for me to review. I, as a member of the Nursing Team at Our Lady Of The Meadows, fully understand my role and responsibilities as stated in these policies and further agree to adhere to these policies while conducting my duties at Our Lady Of The Meadows.

Linda Foss, RN
Name Printed

Linda Foss RN
Signature

01/22/20
Date

Nurse Manager

1/23/2020
Date

ATTACHMENT G

In signing this document, I am acknowledging that the Nurse Manager has provided me with a copy of **The Abuse Prohibition Policy** and the **On-Call Triage Nurse Policy** at Our Lady Of The Meadows Residential Care Home for me to review. I, as a member of the Nursing Team at Our Lady Of The Meadows, fully understand my role and responsibilities as stated in these policies and further agree to adhere to these policies while conducting my duties at Our Lady Of The Meadows.

Chari Andersen
Name Printed

Chari Andersen
Signature

01/22/2020
Date

Terry Bodden PA
Nurse Manager

1/23/2020
Date

ATTACHMENT 4

In signing this document, I am acknowledging that the Nurse Manager has provided me with a copy of **The Abuse Prohibition Policy** and the **On-Call Triage Nurse Policy** at Our Lady Of The Meadows Residential Care Home for me to review. I, as a member of the Nursing Team at Our Lady Of The Meadows, fully understand my role and responsibilities as stated in these policies and further agree to adhere to these policies while conducting my duties at Our Lady Of The Meadows.

Pamela Jacobs
Name Printed

Signature

1-23-20
Date

Nurse Manager

1/24/20
Date