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

December 17, 2021

Ms. Lori Cannon, Manager
Barbara's 1840 House, Inc
Po Box 536
Wallingford, VT 05773

Dear Ms. Cannon:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 4, 2021.** 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

and Protection

'ES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0613	A. BUILDING: _____ B. WING _____	C 08/04/2021

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARBARA'S 1840 HOUSE, INC	PO BOX 536 WALLINGFORD, VT 05773

(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 investigation of a complaint was conducted on 8/4/2021 by the Division of Licensing and Protection. The following are the findings from the investigation.	R100		
R224 SS=E	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 observations, interviews, and record reviews the facility failed to assure that one resident was free from restraints. Findings include: 1. Per interview, Resident #1 was observed by the complainant, on 4/14/21 at 1 PM, to be in a wheel chair with a head rest support. The resident, who had long hair, was tethered to the head rest by having their hair wrapped around the support base attachment. The resident does not communicate verbally but does have a communication process with caregivers that includes facial expressions, hand actions, and verbalization of sounds. The staff on duty have all been employed at the facility for a number of years. The owner of the facility confirmed, in an interview on 8/4/21 at 9:35 am, that they became aware of the issue after Resident #1's return from a wheel chair evaluation appointment, on 4/14/21.	R224	IMMEDIATE CORRECTION PLEASE SEE ATTACHED	9/8/2021

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: LICENSOR — (X6) DATE: 9/8/2021

R224 - R266 POC's accepted 12/1/21 mHiggins RN/omw

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
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R224	Continued From page 1 The owner/Executive Director (ED) stated that though they are frequently in and about the facility they had never noted Resident #1's hair being tethered to the headrest. The ED further stated that the practice was immediately discontinued. Resident #1 is awaiting a new chair with new attachments. The ED states that they have not been able to discover how long the practice has been in place or how it first began. The staff member, who accompanied Resident #1 to the above appointment on 4/14/21, confirmed in an interview, on 8/4/21 at 10:39 am, that the process, as taught to them, had always been tethering the hair because the headrest side stabilizers were not working. The staff member, who was in charge, stated that the process was always used as far as they knew. The House Manager was on vacation during the investigation. Per record review, Resident #1 has issues maintaining head stability and has long used headrest support to maintain head stability. No documentation has been found regarding the actual tethering of her hair to the headrest. There are no apparent physician's orders for the headrest or for the vest support to maintain body alignment and for safety.	R224	Immediate correction of inadvertent practice — 4/14/21 RE training complete — 4/15/21 And ongoing — (4/23) ongoing See attached Signed orders approving use of pads and equipment received — 8/30/21	
R266 SS=D	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment.	R266		8/30/21

9/6/2021

Division of Licensing and Protection

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R266	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to assure a safe environment for Resident #3. Findings include: Per observations, on 8/4/21 during the midmorning hours, Residents #1, #2, and #3 all have 1/2 siderails attached to their beds. Per interview with the ED, the siderails are in place for resident safety and to assist in repositioning. The siderails were reviewed by the surveyor and they were tight fitting to the mattress, without large gaps at the head of the bed, and with gap size that would prevent entrapments with one exception. Per observation,on 8/4 at 10:40 am, of Resident #3's siderails, it is noted that, though the gaps are blocked by a hard backed padded device the topmost gap was missing small rods that assure a safe gap size. The owner/ED informed the maintenance man immediately and the maintenance man examined the siderail. The ED informed the surveyors of the plan for resolving the issue and notified this surveyor, via e-mail on 8/5/21 the siderails were repaired and replaced on the bed later that day.	R266	RAILS REPAIRED BY STAFF MAINTENANCE SEE ATTACHED ADDITIONAL SIGNED PHYSICIAN'S ORDERS ALLOWING USE OF RAILS AND WHEELCHAIR ADAPTERS	8/6/202 8/30/21

9/16/2021

R224, 6.12
Section 6.12

This inadvertent technique was ceased immediately 4/14/21.
Consultation with guardian, CAP Case Manager, and the RRMC physiatry department commenced immediately and is ongoing.

4/23/21

All staff completed a specialized training, recommended by CAP Case Manager, on support guidelines, so that this, or any other type of related issue could ever occur.

Collaboration with physician, professional guardian, CAP Case Manager, and other related medical staff, as well as trainings will be ongoing. Ongoing physician's orders will be requested and on file for review.

R266 IX
SS=D

We very much appreciate the consultation from the Surveyor who brought the broken rail to our attention. We had it repaired immediately, 8/5/21.

We strive to keep an ambient environment, continually making upgrades. (8/5/21 –ongoing)

Regular trainings and checks on bed rail safety have been in place, and will continue in a heightened manner, with all documentation available for review, preventing any issue from re-occuring.
Our in house maintenance person is well skilled and apprised of what is needed, and appreciated consult from surveyor. Should any repair be needed for specially fitted equipment, and we also have rapport with equipment vendors for any repair that is further specialized. Correction will be immediate in all instances.

9/6/2021