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

September 17, 2019

Ms. Mary Mougey, Manager
Ethan Allen Residence
1200 North Avenue
Burlington, VT 05408-2777

Dear Ms. Mougey:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 10, 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

PRINTED: 07/30/2019
FORM APPROVED

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
	0128	A. BUILDING: _____ B. WING _____	C 07/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ETHAN ALLEN RESIDENCE	1200 NORTH AVENUE BURLINGTON, VT 05408

(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 Facility Reported Incident was conducted by the Division of Licensing & Protection on 7/10/19. The following regulatory deficiencies were identified:	R100	Please see attached Plans of Correction	
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 record review and staff interview the facility failed to assure that a written plan of care is developed for each resident that is based on the care and services necessary meet the needs of the resident for Residents #1 and #2. Findings include: 1). Per record review the Facility Reported Incident (FRI) report states that Resident #1 has been noted to be inappropriately touching Resident #2. There have been additional incidents of Resident #1 being inappropriate with other residents. The Care Plan for Resident #1 was reviewed and the care plan does not address the specific behavior noted nor does it address any of the interventions stated to be in place such as medication review/changes, 1:1 monitoring, redirection, and Every 15 minute checks. The	R145		

R145 - R224 POCs accepted 9/17/19 M Higgins RN/mc

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R145	Continued From page 1 Director of Nursing Services (DNS) confirmed on the afternoon of 7/10/19 that the care plan generated in the Electronic Medical Record (EMR) system does not allow for individualization with specific information for the residents. 2). Per record review Resident #2 is the resident most recently targeted by another resident and inappropriately touched. The Care Plan for resident did not address the interventions in place to protect the resident and prevent any further incidents. The Director of Nursing Services (DNS) confirmed on the afternoon of 7/10/19 that the care plan generated in the Electronic Medical Record (EMR) system does not allow for individualization with specific information for the residents.	R145		
R178 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies. This REQUIREMENT is not met as evidenced by: Based on record review the facility failed to assure that there are a sufficient number of staff available at all times to provide necessary care, to maintain a safe environment, and to assure prompt action in cases of injury, or other incidents. Findings include: Per record review there are 2 RA's (Resident	R178		

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R178	Continued From page 2 Assistants) on staff for the overnight shift. There are residents in the facility who require the assistance of 2 staff for care. The residents are located on 2 floors. At the time 2 staff are caring for a resident, the other floor/unit is not covered by a staff person. Additionally the facility has stated that every 15 minute safety checks are being performed by staff for Resident #1. In a review of pages titled 15 Minutes Checks for [Resident Name] it is found that from 6/24/19 to 7/9/19 there are no 15 minute checks documented for 179 times plus there are no checks documented for the entire Evening (3-11PM) shift on 7/3/19.	R178		
R208 SS=D	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: Based on record review and Staff interview the facility failed to assure that all allegations of abuse or patterns of alleged abuse are reported to the State Licensing Agency within the required time frames. Findings include:	R208		

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R208	Continued From page 3 Per review of the intake for a facility self-reported incident, it is found that the earliest incident of potential abuse included in the report happened more than 48 hours before the incident was reported. Additionally the review of the medical record for Resident #1 revealed that there were at least 7 other incidents of inappropriate touching documented as far back as September of 2017. The notes in the record do not identify the resident who was the recipient of the inappropriate conduct by Resident #1. The Facility Administrator and the Director of Nursing Services stated, on the afternoon of 7/10/19, that they were not aware of all of the incidents found in the medical record.	R208		
R224 SS=D	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 record review and staff interview the facility failed to assure that one resident is free from abuse, for Resident #2. Findings include: Per review of the intake for a facility self-reported incident it is found that the report concerns Sexual Abuse (non-consensual inappropriate touching) between Resident #1 & Resident #2. In the report it states that Resident #1 was observed to be inappropriately touching Resident	R224		

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R224	Continued From page 4 #2. Resident #2 has End-Stage Dementia and is non-verbal. The resident is unable to consent to any contact by another Resident. Additionally the review of the medical record for Resident #1 revealed that there were at least 7 other incidents of inappropriate touching documented as far back as September of 2017. The additional notes in the record do not identify the resident who was the recipient of the inappropriate conduct by Resident #1. It is unknown how many, if any, previous incidents involved Resident #2. The Facility Administrator and the Director of Nursing Services stated, on the afternoon of 7/10/19 that they were not aware of all of the incidents other than the reported incident.	R224		

8/1/19

Response to Complaint investigation on July 10, 2019 as follows:

R145- Resident Care and home Services:

1) Care plan reviews scheduled on a Monthly basis. Effective starting 9/1/19
2) Resident care plans in resident rooms reflecting resident specific needs for ADLS, care and behaviors to assist in interdisciplinary team communication resulting in more integrated plan of care.
3) New electronic medical record system being explored that will carry information throughout to all disciplines as well as allow for individualized plans with real time interventions as changes in care arise.
4) Resident medication review, Res [redacted] started on estrogen therapy per MD rec.

R178- Resident Care and Home Services:

1) Adult family care home options explored for resident [redacted]
2) Resident [redacted] enjoys spending a majority of his time in his room. A door activity alarm will be placed on resident door to signal of room exit and entrance activity. EFFECTIVE IMMEDIATELY 15 min checks are overseen and enforced by nursing every shift. Monitored by nursing QS
3) Interviewing for 3rd caregiver on overnight shift.

R208- Resident care and home services:

1) House wide education refresher on abuse reporting, definition of abuse as well as mandated reporting. Started immediately to be completed by 9/15/19
2) New in house investigation documentation process implemented with DON and administrator.

R224- VI. Resident rights:

1) Staff education refresher on documenting and follow up on alleged victims of and res/res issue. Monitor for s/s of emotional distress and document accordingly for a sufficient time period following event. Started immediately to be completed by 9/15/19