



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

October 20, 2022

Ms. Maria Duggan, Manager
Heaton Woods
10 Heaton Street
Montpelier, VT 05602-2480

Dear Ms. Duggan:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 6, 2022**. 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,

A handwritten signature in cursive script that reads "Pamela M. Cota RN".

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0297	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/06/2022
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NAME OF PROVIDER OR SUPPLIER HEATON WOODS	STREET ADDRESS, CITY, STATE, ZIP CODE 10 HEATON STREET MONTPELIER, VT 05602
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(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
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R100	Initial Comments: On 9/6/22 the Division of Licensing and Protection conducted and unannounced on-site investigation of two complaints. The following regulatory deficiencies were identified:	R100	Updated Transportation SOP to incorporate alternative drivers and means to transport. Elaborating on the need for last minute appointments. Education was provided to all managers, nursing staff and transportation coordinator. New shared calendar in use which enables nursing staff, DNS and Adminstator to see upcoming appointments, add new ones as necessary and to be prepared to assist when needed. All clinical staff have been re-educated and are expected to read nursings 24 hour report daily and to know what clinical care needs to be followed up on.	9/21/2022
R126 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to provide necessary services to meet the medical needs of one applicable resident (Resident #2). Findings include: Per record review Resident #2 was admitted to the home in March of 2021 with diagnoses including Atrial Fibrillation (irregular/rapid heartbeat), Hypertension (High blood pressure), Chronic Obstructive Pulmonary Disease, Restrictive Lung disease (decreased lung function due to rigidity of the chest or lungs), Renal Insufficiency (Kidney failure), Dyspnea (difficulty breathing), Chronic Obstructive Pulmonary Disease, Alzheimer's Disease, and a Seizure Disorder. Resident #2 tested positive for Covid on 2/15/22. During the initial period of Covid infection	R126	DNS and Administrator will meet monthly to discuss the process and ensure consistency for 3 months.	

Division of Licensing and Protection LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 10/13/2022
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R126 - R202 POC's accepted 10/17/22 JEVans RN/PMU

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R126	<p>Continued From page 1</p> <p>Resident #2 was noted to have a mild cough and nasal congestions with stable vital signs; however periods of confusion, agitation, shortness of breath, weakness, and fatigue on exertion were observed beginning on 2/17/22. On 2/26/22 Resident #2 stated she felt tired and weak, and presented with a low blood pressure of 110/58. That evening Resident #2 was transported to the emergency room for evaluation when his/her blood pressure further decreased to 98/52 and s/he presented with a pale face, difficulty breathing, and a weak irregular pulse. Resident #2 was evaluated and discharged from the hospital that evening. Staff continued to note fatigue and began monitoring with checks three times daily in response to his/her "deconditioned status".</p> <p>On 3/1/22 Nursing staff noted significant changes in Resident #2's presentation including increased need for assistance with Activities of Daily Living (ADLs), use of a wheelchair which was not previously needed, pain and difficulty breathing. His/her left arm blood pressure was 90/50 and right arm blood pressure was 88/48. Resident #2's primary care provider's office was contacted regarding this significant change in presentation, and a previously scheduled appointment was "moved up" to 4/1/22. The same afternoon the Provider's office called back and scheduled an appointment on 3/3/22. A note on 3/2/22 stated Resident #2's appointment was canceled due to lack of transportation. This cancellation resulted in the delay of an in-person assessment by his/her Primary Care Provider until the previously scheduled appointment on 4/1/22 occurred four weeks later. After the appointment on 4/1/22 Resident #2's provider consulted with his/her Neurologist and Cardiologist, and medication changes were made to address low blood</p>	R126		
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R126	<p>Continued From page 2</p> <p>pressure, fatigue, weakness, and onset of diarrhea and lack of appetite resulting in weight loss.</p> <p>During an interview commencing at 2:09 PM on 9/6/22 the facility Administrator stated Resident #2's appointment on 3/3/22 was canceled because appointments are not typically scheduled on the day of the week his/her appointment was scheduled. On that day of the week the facility van is reserved for activities, however accommodations are made for medically necessary appointments. The Administrator explained the staff who transports and at times attends appointments is responsible for communicating the need for accommodation with the office staff and the Resident's family, and if necessary other means of transport would be utilized. The Administrator stated s/he could not recall if any activities were scheduled at the time of the appointment; and if any attempts were made to contact Resident #2's family regarding transport or to arrange another means of transportation. At 2:43 the Administrator stated 2 Licensed Practical Nurses, a Med Tech, the Director of Nursing, and additional administrative staff were on duty at the time of the appointment, and the facility was fully staffed with caregivers. She stated there are no facility policies that would have prevented any of the staff on duty from taking Resident #2 to his/her appointment on 3/3/22.</p>	R126		
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R191 SS=D	V, RESIDENT CARE AND HOME SERVICES	R191		
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5.12 Records/Reports

5.12.c A home must file the following reports with

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R191	<p>Continued From page 3</p> <p>the licensing agency:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>5.12.c. (5) A written report of any reports or incidents of abuse, neglect or exploitation reported to the licensing agency.</p> <p>5.12.c. (6) A written report of resident injury or</p>	R191	<p>Executive Director, DNS and Administrator re-educated themselves on all the reporting requirements in particular reporting unexpected deaths. DNS took action immediately and reported the death the same day. DNS and Administrator will communicate upon death of residents in the future to ensure all proper reporting has been done correctly.</p>	9/6/2022

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R191	<p>Continued From page 4</p> <p>death following the use of mechanical or chemical restraint.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to report the untimely death of one applicable resident (Resident #1) to the Division of Licensing and Protection. Findings includes:</p> <p>Resident #1 had a diagnosis of Depression, Traumatic Brain Injury, and Arthritis. On 8/5/22 s/he was diagnosed with Covid-19. Precautions were initiated and nursing monitored the resident's vital signs, oxygen levels and lung sounds. On 8/9/22 Resident #1's appetite declined and s/he developed nausea and vomiting. On 8/11/22 the resident was brought to the ED, administered intravenous fluids and medication for nausea and sent back to the RCH. The resident's behavior was difficult to manage at times, often refusing personal care and was verbally abusive with staff. Despite erratic behaviors, Resident #1 remained in quarantine until 8/16/22 when s/he was permitted to leave his/her room. Resident #1 resumed eating in the dining room without symptoms of nausea and/or vomiting. On 8/17/22 s/he was in and out of her room most of the day. During the early morning of 8/18/22 an LNA went to check on Resident #1 and found the resident to be "...purple in color and not breathing". The LNA immediately reported the observation to the nurse and because Resident #1 was a "full code" EMS was called, attempted to revive Resident #1, however was unsuccessful. Resident was pronounced dead at 7:45 AM. Although the Medical Examiner was contacted, there was a failure to report the "unexpected death" to the Division of Licensing & Protection, as required. Resident #1's death had</p>	R191		
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R191	Continued From page 5 not been expected, s/he resumed her daily activities and had demonstrated recovery from Covid symptoms, returning to his/her baseline.	R191	Updated Transportation SOP to incorporate alternative drivers and means to transport.	9/21/2022
R202 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.16 Transportation</p> <p>5.16.b Transportation for medical services and local community functions shall be provided up to twenty (20) miles, round-trip without charge, not to exceed four (4) round-trips per month. Residents may be charged, at a reasonable rate, for those miles in excess of twenty (20) miles round-trip and for any or all mileage for transportation not prescribed herein.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to provide transportation for medical services for one applicable resident (resident #2). Findings include:</p> <p>Per record review Resident #2 was admitted to the home in March of 2021 with diagnoses related to significant Cardiovascular, Pulmonary, and Neurological conditions. Resident #2 tested positive for Covid on 2/15/22. During the initial period of Covid infection Resident #2 was noted to have a mild cough and nasal congestions with stable vital signs; however periods of confusion, agitation, shortness of breath, weakness, and fatigue on exertion were observed beginning on 2/17/22. On 3/1/22 staff noted significant changes in Resident #2's presentation including increased need for assistance with Activities of Daily Living (ADLs), use of a wheelchair which</p>	R202	<p>Elaborating on the need for last minute appointments. Education was provided to all managers, nursing staff and transportation coordinator. New shared calendar in use which enables nursing staff, DNS and Adminstator to see upcoming appointments, add new ones as necessary and to be prepared to assist when needed.</p> <p>DNS and Administrator will meet monthly to discuss the process and ensure consistency for 3 months.</p>	

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R202	<p>Continued From page 6</p> <p>was not previously needed, pain and difficulty breathing, and low blood pressure. His/her left arm blood pressure was 90/50 and right arm blood pressure was 88/48. Resident #2's primary care provider's office was contacted regarding this significant change in presentation, and a previously scheduled appointment was "moved up" to 4/1/22. That same afternoon the Provider's office called back and scheduled an appointment on 3/3/22. A note on 3/2/22 stated Resident #2's appointment was canceled due to lack of transportation. This cancellation resulted in a delay of an in-person assessment by his/her Primary Care Provider until the previously scheduled appointment on 4/1/22 occurred four weeks later.</p> <p>During an interview commencing at 2:09 PM on 9/6/22 the facility Administrator stated Resident #2's appointment on 3/3/22 was canceled because appointments are not typically scheduled on the day of the week the appointment was scheduled. On that day of the week the facility van is reserved for activities, however accommodations are made for medically necessary appointments. The Administrator explained the staff who transports and at times attends appointments is responsible for communicating the need for accommodation with the office staff and the Resident's family, and if necessary other means of transport would be utilized. The Administrator stated s/he could not recall if any activities were scheduled at the time of the appointment; and if any attempts were made to contact Resident #2's family regarding transport or to arrange another means of transportation. At 2:43 the Administrator stated 2 Licensed Practical Nurses, a Med Tech, the Director of Nursing, and additional administrative staff were on duty at the time of the appointment,</p>	R202		

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R202	Continued From page 7 and the facility was fully staffed with caregivers. She stated there are no facility policies that would have prevented any of the staff on duty from taking Resident #2 to his/her appointment on 3/3/22. Please refer to Tag 126.	R202	Updated Transportation SOP to incorporate alternative drivers and means to transport. Elaborating on the need for last minute appointments. Education was provided to all managers, nursing staff and transportation coordinator. New shared calendar in use which enables nursing staff, DNS and Adminstator to see upcoming appointments, add new ones as necessary and to be prepared to assist when needed. DNS and Administrator will meet monthly to discuss the process and ensure consistency for 3 months.	
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