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 4, 2023

Mr. David Anderson, Manager
Heaton Woods
10 Heaton Street
Montpelier, VT 05602-2480

Dear Mr. Anderson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 7, 2023**. 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,

Carolyn Scott, LMHC, M.S.
State long Term Care Manager

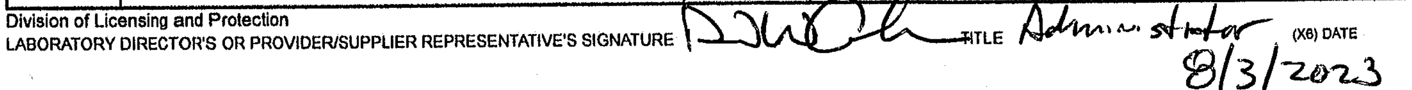
Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0297	A. BUILDING: ______ B. WING ______	C 07/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATON WOODS	10 HEATON STREET MONTPELIER, VT 05602

(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 re-licensure survey and complaint investigation was conducted on 7/5/23 and completed on 7/7/23 by the Division of Licensing and Protection. The following regulatory violations were identified as a result of the re-licensure survey. Findings include:	R100		
R179 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced	R179	After closer inspection of our training records, 4 out of 5 staff had completed their required training for the year. The 5th did have the majority of their training complete. We will continue to monitor staff training to ensure a timely completion of all trainings to include the 12 hour minimum requirement. * HR director and department managers will be responsible for trainings. Tag R179 accepted on 8/4/23 - M. McIntosh RN	

Division of Licensing and Protection



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE Administrator (X6) DATE 8/3/2023

Division of Licensing and Protection

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R179	Continued From page 1 by: Based on staff interview and record review, there was a failure to ensure 12 hours of required education was provided each year to staff who provide direct care to residents. Findings include: During the course of survey a request was made to review evidence of the required 12 hours of training for staff who provide direct care to staff. The newly appointed Administrator for the RCH (Residential Care Home) confirmed s/he lacked access to the information and after further review of an outdated staff trainings list/spread sheet it was confirmed the required 12 hours of training had not been provided to 5 of 5 applicable staff.	R179		
R200 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, there was a failure to develop policies and procedures to govern the process for investigating and preventive measures for resident falls; the routine monitoring of hot water temperatures throughout the building; and........ 1. As part of ensuring residents are provided a safe environment, hot water temperatures should be monitored and adjusted if the temperatures exceed 120 degrees Fahrenheit (F). During	R200	Hot Water We have produced a written policy in regards to monitoring hot water temperatures in resident occupied areas on a monthly basis. The failed mixing valve which was the cause of our hot water issue was repaired on 7/20/23, and subsequent monitoring has our water temperatures under the 120° maximum. Hot water monitoring will be documented and located in the maintenance office.	7/20/23

* To be done by the Maintenance Manager.

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R200	Continued From page 2 random surveillance on 7/5/23 beginning at 2:18 PM of hot water temperatures throughout the RCH found elevated hot water temperatures ranging from 127 degrees (F) to 135.6 degrees (F). When asked if a policy & procedure had been developed and followed to ensure consistent monitoring of hot water temperatures, the surveyor was informed by the Director on the afternoon of 7/5/23 a policy and process had not been developed. 2. As part of ensuring residents are provided a safe environment, reviewing and analyzing falls is necessary to identify causes of falls, addressing effective interventions to aid in prevention of reoccurrence; assessing and targeting residents who are at a higher risk; ongoing staff education and evaluating the environment to ensure all areas in resident rooms and living areas remain free of potential fall hazards. Per review of facility falls documentation, 71 falls (both witnessed and unwitnessed) occurred from January 2023 up to date of survey (7/5/23). On the afternoon of 7/5/23 when asked if a policy and procedure had been developed to address falls, the Director of Nursing confirmed a policy and procedure was not in place. Per anonymous interview on 7/5/23 at 1:38 PM a resident confirmed s/he had sustained a fall on 6/11/23, the resident indicated to have been on the floor for "an hour or so." The resident stated "I had no way of alerting any staff I had fallen, I yelled out a few times for help" Per anonymous interview on 7/5/23 at 5:30 PM a staff member confirmed the fall sustained by (the above mentioned resident) on 6/11/23. The staff member stated "Resident was found by the Medication Tech on shift during the evening	R200	Fall Prevention The fall prevention and response Policy/protocol has been updated to include the following: 1. A quick reference guide for Staff response to falls. Training of Staff will begin at our 1st Staff meeting on August 3rd, and will be completed with all staff by August 24th, 2023. This training will be included in the orientation of new Staff. 2. We have formed a fall prevention committee, which will meet monthly. 3. Bayada Healthcare will be Providing a quarterly fall risk assessment for all residents who have been deemed at risk for falls. 4. Call bell lanyards were ordered on July 31st 2023 with expected delivery within 3 weeks. Those residents deemed most significantly at risk for falls will be offered one of these lanyard call bells upon arrival.	

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R200	Continued From page 3 medication pass." The staff member recalled witnessing the resident in the dinning room at approximately 5:15 PM, and the next observation of the resident was when the resident was observed on the floor within the hallway of his/her apartment at approximately, 6:08 PM. The staff confirmed the resident ambulates independently however the resident was unable to alert staff that s/he had fallen. The staff confirmed the location of the fall prevented the resident to utilize the call bell button. The call bell system is mounted on a wall in the bedroom area of the apartment, a cord that extends from the system does not reach to the hallway location of apartment where the resident was found. Per interview on 7/5/23 at 4:52 PM the DON confirmed call lights are available to residents in the bed room and bathroom areas of the apartments, s/he confirmed the cord does not extend to all areas of the apartment. When asked how residents alert staff when a fall occurs where a call light is out of reach or unavailable, the DON stated "We can't put call lights everywhere. Staff round the building, answer call lights that are alerted to pagers, and staff utilize walkie talkies to communicate with each other." When asked how falls are managed, the DON indicated, the Med tech alerts a nurse for assessment, if a nurse is not available, a call to the DON with observation is provided and determination if resident should be further assessed at an acute setting is determined. No clear plan was presented for fall prevention, no specific individual interventions have been incorporated for fall prevention, and follow up nursing actions were not identified.	R200	5. After a resident has experienced a 3rd fall within 30 days, a physical therapy order and evaluation will be requested from MD. * DON will provide oversite with support from administrator Tag R200 accepted on 8/4/23 - M. McIntosh RN	
R266 SS=F	IX. PHYSICAL PLANT	R266		

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R266	Continued From page 4 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview there was a failure to ensure the RCH provided and maintained a safe, functional and homelike environment. Findings include: 1. Per observation at 2:18 PM the hot water temperature tested in resident's room #20 registered at 135.6 degrees (F); at 2:20 PM in resident's room # 24 the hot water temperature registered at 132 degrees (F); at 2:25 in resident's room # 46 the hot water temperature was 136 degrees (F); and resident's room #1 the temperature was 127 degrees (F). Upon finding the hot water temperatures were above the required 120 degrees (F) at 2:30 PM the Administrator was informed along with the maintenance manager. An urgent call was placed by the Administrator to a contracted plumbing company. Adjustments were made to the hot water tank mixing valve to decrease the hot water temperatures. Two rechecks were conducted by the surveyors as attempts were made to lower the water temperatures. By 4:20 PM, accompanied by the maintenance staff and 2 plumbers, hot water temperatures were rechecked and found the temperatures had been reduced from 106 degrees (F) to 116 degrees (F). The Administrator confirmed close monitoring of the hot water temperatures will continue as adjustments were being made and specific	R266	See R206 for Plan of Correction	

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R266	Continued From page 5	R266		

plumbing parts were required to be replaced.

2. Per observation at 10:00 AM on 7/5/23 of Resident apartments during the facility tour, rooms were observed to have a call light system. The Administrator confirmed during the tour that each resident room is equipped with a call bell system that is mounted to a wall in the bedroom area and a cord extends from the system. Through observation of multiple apartments, resident beds and chairs are positioned in close proximity to the call light system which allows residents to call for assistance, however the length of the cord does not extend to allow use throughout the room.

Per anonymous interview on 7/5/23 at 1:25 PM a staff indicated residents are unable to alert staff if assistance is needed if they are unable to reach the call light within there apartment. The staff continued to state "There are times residents are found on the floor, and they have no way of notifying us, we round the floors and that's how they are found."

Per anonymous interview on 7/5/23 at 1:38 PM a resident confirmed s/he had sustained a fall on 6/11/23, the resident indicated to have been on the floor for "an hour or so." The resident stated "I had no way of alerting any staff I had fallen, I yelled out a few times for help"

Per record review of the facility falls report, 71 falls (witnessed and unwitnessed) occurred from January 2023 until date of survey 7/5/23.

Per interview on 7/5/23 at 4:52 PM the DON confirmed 71 falls were recorded to have occurred since January 2023. The DON confirmed residents have a call bell system within

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R266	Continued From page 6 the bedroom area and bathroom area of the apartments. The DON further stated, "sometimes they [residents] won't wait for assistance and try do tasks themselves." The DON indicated staff round the facility and utilize walkie talkie to communicate with each other. The DON did not indicate nursing related services and oversight performed post-fall, to identify follow-up nursing interventions, for fall prevention and safety.	R266	Tag R266 accepted on 8/4/23 - M. McIntosh RN	
R291 SS=G	IX. PHYSICAL PLANT 9.6 Plumbing 9.6.d Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, there was a failure to ensure hot water temperatures did not exceed 120 degrees Fahrenheit. Findings include: Per observation at 2:18 PM the hot water temperature tested in resident's room #20 registered at 135.6 degrees (F); at 2:20 PM in resident's room # 24 the hot water temperature registered at 132 degrees (F); at 2:25 in resident's room # 46 the hot water temperature was 136 degrees (F); and resident's room #1 the temperature was 127 degrees (F). Upon finding the hot water temperatures were above the required 120 degrees (F) at 2:30 PM the Administrator was informed along with the Maintenance manager. An urgent call was placed by the Administrator to a contracted plumbing company. Adjustments were made to the hot	R291	See R200 for Plan of Correction	

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R291	Continued From page 7 water tank mixing valve to decrease the hot water temperatures. Two rechecks were conducted by the surveyors as attempts were made to lower the water temperatures. By 4:20 PM, accompanied by the maintenance staff and 2 plumbers, hot water temperatures were rechecked and found the temperatures had been reduced from 106 degrees (F) to 116 degrees (F). The Administrator confirmed close monitoring of the hot water temperatures will continue as adjustments were being made and specific plumbing parts were required to be replaced. It was further confirmed by the Administrator a formalized process for hot water testing had not been developed to ensure residents resided in a safe and functional environment.	R291	Tag R291 accepted on 8/4/23 - M. McIntosh RN	
R302 SS=F	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced by:	R302	Maintenance Manager has been assigned responsibility for conducting and documenting fire alarm tests. Fire alarm tests will be conducted at least 6 times a year, two times each shift. Documentation will be maintained in the maintenance office.	

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R302	Continued From page 8 Based on staff interview and record review, there was a failure to conduct Fire Drills on at least a quarterly basis with rotating times for the past 12 months. Findings include: During the course of survey a request was made to review fire drills conducted over the past 12 months. The newly appointed Director did not have access to this information, although s/he was informed fire drills had been conducted. However, what was provided to the surveyor were 3 documented fire drills performed on 2/1/22, 4/29/22 and 8/31/22. The times recorded did not differtiate whether the drills occurred in the AM or PM, confirming an incomplete document. No additional drills could be located.	R302	Tag R302 accepted on 8/4/23 - M. McIntosh RN	
R313 SS=F	XI. RESIDENT FUNDS AND PROPERTY 11.1 A resident's money and other valuables shall be in the control of the resident, except where there is a guardian, attorney in fact (power of attorney), or representative payee who requests otherwise. The home may manage the resident's finances only upon the written request of the resident. There shall be a written agreement stating the assistance requested, the terms of same, the funds or property and persons involved. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, there was a failure by the RCH to appropriately manage resident funds to include obtaining a written agreement stating assistance was requested to manage funds for 15 applicable residents. (Residents #1, 2, 3, 4, 5 ,6, 7, 8, 9, 10, 11, 12, 13,	R313	Resident funds will now be managed by the administrator on the premises of Heaton Woods. For those residents who choose, they will sign a request form giving Heaton Woods permission to hold their moneys in a safe locked secure setting. These resident accounts will be available to residents upon request. Accounting will be done by the administrator at least on a quarterly basis, and any given time a resident or family requests. The transition process will be completed by August 25th 2023.	

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R313	Continued From page 9 14, 15) Findings include: Upon request by the surveyor to obtain a list of residents who have money held in a resident fund and managed by the RCH, it was determined by the newly appointed Administrator, the process for handling resident funds was unclear and was not made aware of the full process. Initially, the Administrator was attempting to locate the actual cash held for the 15 identified residents. However, after further discussion it was disclosed no money was held at the RCH but in an account managed by the affiliated Living Well Group facility in Burlington. It was further disclosed by the Administrator on 7/7/23 evidence of an agreement stating assistance was requested by the residents and/or representative could not be made available.	R313	Tag R313 accepted on 8/4/23 - M. McIntosh RN	
R314 SS=F	XI. RESIDENT FUNDS AND PROPERTY 11.2 If the home manages the resident's finances, the home must keep a record of all transactions, provide the resident with a quarterly statement, and keep all resident funds separate from the home or licensee's funds This REQUIREMENT is not met as evidenced by: Based on staff interview, there was a failure of the RCH to keep consistent and updated records of all transactions and provide the resident and/or representative with quarterly statements for 15 applicable residents. (Residents #1, 2, 3, 4, 5 ,6, 7, 8, 9, 10, 11, 12, 13, 14, 15) Findings include: Although 15 residents had money held by the RCH at a separate location, an updated record	R314	See R313 for Plan of Correction	

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R314	Continued From page 10 for transactions to be submitted on a quarterly basis to each resident and/or representative could not be provided when requested at the time of survey.	R314	Tag R314 accepted on 8/4/23 - M. McIntosh RN	
R315 SS=F	XI. Resident Funds and Property 11.3 The personal property of the resident shall be available for the resident's use and securely maintained when not in use. This REQUIREMENT is not met as evidenced by: Based on staff interview, there was a failure to ensure resident funds were available for use and securely maintained. Findings include: Per interview on the afternoon of 7/5/23 the Administrator was initially unsure if resident funds were held at the RCH or off site. It was then confirmed resident funds were not held on-site at the facility but being managed remotely at the affiliated Living Well Group facility in Burlington. The actual cash funds were not readily available upon request to the residents. Presently, if money was requested by a resident, a process of debiting/crediting the account was performed by accounting staff at the Burlington facility. This present process was confirmed by the Administrator on the afternoon of 7/5/23.	R315	See R313 for Plan of Correction Tag R315 accepted on 8/4/23 - M. McIntosh RN	
R999 SS=F	MISCELLANEOUS 4.13.b Whenever the authority is vested in the governing board of a firm, partnership, corporation, company, association or joint stock association, there shall be appointed a duly authorized qualified manager, however named,	R999	As administrator on day 3 of my tenure, I felt well supported by the executive management team. (con't on next page)	

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HEATON WOODS	10 HEATON STREET MONTPELIER, VT 05602

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R999	Continued From page 11 who will be in charge of the daily management and business affairs of the home, who shall be fully authorized and empowered to carry out the provisions of these regulations, and who shall be charged with the responsibility of doing so. The manager of the home shall be present in the home an average of 32 hours per week. The 32 hours shall include time providing services, such as transporting, or attendance at educational seminars. Vacations and sick time shall be taken into account for the 32-hour requirement. In the event of extended absences, an interim manager must be appointed. This requirement is not met, as evidenced by: Based on interview and record review, there was a failure of the governing board and corporation of Living Well Group to ensure the newly designated Administrator/Manager was provided adequate orientation and necessary information for the daily management and business affairs of the RCH prior to assuming the position as Administrator. Although the Administrator has an extensive and qualified professional history in previous residential facilities, s/he assumed the position at Heaton Woods on 7/3/23 with limited on-site provisions to access required information during the re-licensure survey. Information regarding the daily management and business affairs of the RCH was unknown or unavailable to the Administrator. Access to personal employee records; resident funds; maintenance services and daily management of the RCH was limited and/or inaccessible to the Administrator. Although the previous Administrator had provided some orientation to the newly appointed Administrator/Manager, it was identified the process was limited.	R999	the executive director was due to return to Heaton Woods to provide me further support on July 5th. Due to circumstances beyond her control, she was unable to return to VT from out of state due to a canceled flight, but she was available by phone, as was the rest of the executive management team. Living Well Group executive management has an onboarding process for managers which includes both phone and onsite support from all executive management team members * On boarding of Dave Anderson completed on 8/3/2023 Tag R999 accepted on 8/4/23 - M. McIntosh RN	