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

April 23, 2024

Wendy Audette, Manager
Heaton Woods
10 Heaton Street
Montpelier, VT 05602-2480

Dear Ms. Audette:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 26, 2024.** 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.

If you have any questions, please feel free to contact me at (802) 585-0995.

Sincerely,

Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

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 03/26/2024

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

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R100	Initial Comments: On 3/26/24 the Division of Licensing and Protection conducted an unannounced on-site investigation of two complaints. The following regulatory deficiencies 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 staff interview and record review there was a failure to update one applicable resident's (Resident #1's) Plan of Care to address disruptive and intrusive behaviors. Findings include: The facility's Behavior Management policy effective 10/2020 states, " If a pattern of disruptive or unsafe behaviors emerges, it should be addressed in the resident's care plan." Per record review, between 10/23/23 and 2/28/24 there are 15 notes written in Resident #1's resident record documenting aggressive, disruptive, and intrusive behaviors towards other residents and staff. During this time frame Resident #1 was noted with behaviors including: a. hitting another resident with a pool noodle	R145	R145 Resident #1's careplan has been updated to reflect mentioned behaviors that need to be managed. Interventions have been modified and individualized and staff educated on how to follow care plan interventions and guidance as to prevent harm to other residents. A specific behavioral plan was created and is being followed. Behavioral careplan updated on 4/15/24 R145 Plan of Correction accepted by Jo A Evans RN on 4/22/2024	

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] RN

TITLE: Executive Director Administrator

(X6) DATE: 4/22/2024

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R145	Continued From page 1	R145		

repeatedly during an exercise class on 10/23/23

b. poking another resident in the ribs, then attempting to touch the nurse who tried to redirect him/her on 12/18/23

c. attempting to touch and tickle other residents, then charging towards and attempting to kiss and touch staff who tried to redirect him/her away from the other residents on 12/28/23

d. charging towards staff and slamming his/her walked down on the ground repeatedly in the vicinity of staff and other residents on 12/29/23

e. swinging his/her walker over another resident's head and hitting the other resident's wheelchair with the walker; followed by aggressively pushing and pulling other resident's wheelchairs in the hallway to move them out of the way, which resulted in a resident's finger being pinched in the wheels of their wheelchair as they were pushed towards a wall on 1/3/24

f. attempting to touch other residents in the dining room after the residents stated they did not want to be touched, then slamming his/her walker on the floor as staff attempted to redirect on 1/4/24

g. attempting to "get into another resident's face" then "leaning over" the other resident who reported Resident #1 was pushing his/her chair towards the table from behind; followed by slamming his/her own walker on the floor on 1/23/24

h. attempting to touch and kiss two other residents who had stated they did not want to be touched, then slamming his/her walker on the ground as other residents yelled out and staff

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R145	Continued From page 2 attempted to redirect on 1/25/24 i. repeatedly attempting to kiss another resident, then trying to kiss the staff who tried to redirect him/her on 2/28/24 Per record review Resident #1's Care Plan identified "Behaviors- reminders" as an area of focus initiated on 5/30/23 with the goal "Will not act out in a way that is harmful to self or others" and a single intervention which stated, "Care Staff will report any changes from baseline behaviors". Resident #1's Care Plan was not updated to include interventions to address the pattern of aggressive, disruptive, and invasive behaviors towards other residents and staff in response to the documented staff reports of this change in Resident #1's behaviors. During an interview commencing at 3:04 PM on 3/26/24 the Business Manager for the organization that manages the facility and the current Director of Nursing confirmed Resident #1's Care Plan was not updated to address Resident #1's pattern of aggressive, disruptive, and intrusive behaviors towards other residents and staff. In conclusion this deficient practice is a risk for more than minimal harm to all residents resulting from unidentified residents needs and interventions that results in inappropraite behaviors toward others.	R145		
R179 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services	R179		

MMAndette RN 4/22/2024
Executive Director/Interim Administrator

Division of Licensing and Protection

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R179	Continued From page 3 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 by: Based on staff interview and record review there was a failure to ensure 3 out of 5 sampled staff completed the required yearly trainings; and a failure to demonstrate competency in ensuring implementation of infection control measures per facility policy for 2 applicable staff. Findings include: Upon request for facility policies and procedures related to staff training on the afternoon of 3/26/24, the Executive Director provided a copy of the Living Well Group Employee Manual effective	R179	R179 All staff are to have finished their elearn competencies prior to starting their orientation. Additionally, all managers/directors will ensure that staff are signed off individually and in person on each competency before they work with residents. Current staff will renew their elearns yearly as well as demonstrate competence on both a yearly and as needed basis in all 12 elearn categories. They will be signed off as competent by their respective managers/directors. Sampled staff that had not completed their elearns will complete them by May 1st, provided they are still employed by LivingWellGroup/ Heaton Woods. Current staff's competency will be verified (they will be signed off by their respective managers) by 6/1/2024	

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R179	Continued From page 4 1/1/24 for review. Living Well Group is the organization that manages the facility. The introduction section of the manual states, "The purpose of this manual is to communicate the policies, procedures, and expectations for all Living Well Group (herein referred to as LWG and encompassing all LWG locations) employees. You must read, understand, and comply with all provisions of the manual." Per review of the employee manual Section 3.8 In-Service states, "Staff development is important for all employees. All LWG team members are expected (and some are required by the state of Vermont) to complete 12 in-service hours on record per year. 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." The In-Service policy includes a list of required trainings, which is consistent with the yearly trainings required by the licensing agency and includes infection control measures." 1. On the afternoon of 3/26/24 the Executive Director and the current Director of Nursing were requested to provide documentation of completion of the required yearly trainings for a sample of 5 staff. Per record review 3 out of 5 facility staff did not complete all required yearly trainings. This finding was confirmed at 4:21 PM on 3/26/24 by the Executive Director. This deficient practice is a risk for more than minimal harm for all facility residents due to inadequate staff education and training to safely and effectively provide resident care. 2. Per record review the facility experienced a Covid-19 outbreak during the months of	R179	COVID policies will be updated to reflect current VDH and CDC guidelines for congregate healthcare settings. Instructions on how to implement said policies will be communicated to all staff and nursing will be responsible for tracking and reporting cases (i.e. by completing line lists and contacting VDH immediately). To be completed by 6/1/24 R179 Plan of Correction accepted by Jo A Evans RN on 4/22/2024.	

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R179	Continued From page 5 December 2023 and January 2024. Per record review the first resident tested positive on 12/23/23; and 1/10/24 is the last day a resident was documented as testing positive. Per staff interviews and record review the Administrator and the Executive Director, who was the interim Director of Nursing during the Covid -19 outbreak, failed to demonstrate competency in implementation of the facility's policies and procedures for infection control measures to be taken facility when residents and staff test positive for Covid-19. a. Per interview commencing at 3:47 PM on 3/28/24, the VDH Registered Nurse (RN) who communicated with the facility during the Covid-19 outbreak confirmed there was a delay in reporting the Covid cases at the facility until 12/27/23, which in turn resulted in a delay in the facility receiving guidance and support from VDH. Per record review, on 12/27/23 the Administrator emailed an "update on Covid guidelines" to facility staff which stated the facility strongly encouraged/recommended Covid positive residents remain in their rooms, however because they did not want the residents to feel sad or lonely "if they do want to be out and socializing, [the staff] would just encourage them to mask". During the interview on the afternoon of 3/28/24 the VDH RN confirmed the information provided to staff on 12/27/23 was not consistent with the current VDH guidance for infection control measures at the time of the facility's Covid- 19 outbreak. The information provided in the Administrator's email was also inconsistent with the facility's policies and procedures which state "The resident should remain in their apartment and only leave in an emergency". Per record review the Administrator had not completed training in infection control measures	R179		

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R179	Continued From page 6	R179		

at the time of the outbreak, and this training had not been completed as of 3/26/24.

b. Per review of the facility policies and procedures provided by the Executive Director for review on the afternoon of 3/26/24, infection control measures to be taken in response to residents and /or staff testing positive for Covid -19 include notifying the state of Vermont and documenting each positive test result on a "line list". A "line list" is a document that tracks information about each case during an outbreak of an infectious disease. This document is utilized to determine the length and severity of an outbreak, assist the facility and the Vermont Department of Health (VDH) in rapid identification of new cases, and facilitate communication between the facility and VDH staff who provide supportive guidance for implementation of infection control measures during an outbreak.

During an interview commencing at 1:07 PM on 3/26/24, a facility nurse who performed Covid- 19 testing for residents and staff on 12/24/23 stated when s/he notified the Interim Director of Nursing regarding the first positive case, s/he did not receive instructions to initiate a line list and notify VDH as indicated in the facility's policies and procedures. Per review of staff training records, the Executive Director who was the interim Director of Nursing during the Covid-19 outbreak, had not completed any of the required trainings including training in infection control measures at the time of the outbreak, and as of 3/26/24 the required trainings had not been completed.

c. Facility policies and procedures indicate "the state" [VDH] should be notified when staff and residents test positive, and a line list should be initiated when the first staff or resident tests

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R179	Continued From page 7 positive for Covid-19 and updated following each additional staff or resident who tests positive. In an email to the Administrator on 12/24/23 the facility nurse indicated multiple staff tested positive prior to the documented outbreak stating, "We have had way too many employees testing positive lately." The facility nurse confirmed additional staff tested positive during the outbreak. On the morning of 3/26/24 the Executive Director confirmed the information reported to the VDH RN did not include information about staff cases. Per review of email communications, the VDH RN who provided support and guidance during the outbreak requested the Administrator send the facility's line list on 12/29/23 and again on 1/8/24. A list of resident names and the dates they tested positive for Covid -19 was not provided to the VDH RN until 1/9/24. Per record review an additional resident tested positive on 1/10/24. Facility policies and procedures state Families and Residents should be updated when there is a new Covid -19 case, and if there are multiple cases an update should be provided every couple of days. Per review of facility email communications related to the Covid outbreak provided for review on request, families and residents were not notified regarding the Covid positive cases until 12/28/23. On the afternoon of 3/26/24 the Executive Director confirmed s/he had not completed any of the required trainings, and the Administrator had not completed training in infection control measures. The Executive Director acknowledged the infection control measures implemented the Covid outbreak were not consistent with the	R179		

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R179	Continued From page 8 facility's policies and procedures. This deficient practice is a potential risk for more than minimal harm to all facility residents due to ineffective infection control measures.	R179		