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DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVINGDivision 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 3, 2020

Ms. Erin Barry-Fenton, Manager  
Loretto Home  
59 Meadow Street  
Rutland, VT 05701-3994

Dear Ms. Barry-Fenton:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 29, 2020**. 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  
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0138	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  C 10/29/2020
NAME OF PROVIDER OR SUPPLIER  LORETTO HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 59 MEADOW STREET RUTLAND, VT 05701		
(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 complaint investigation was conducted by the Division of Licensing and Protection on 10/28/2020, followed by an off-site record review on 10/29/2020. There were regulatory deficiencies identified as a result of this investigation.	R100	Please see attached Plan of Correction	
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 staff interview, and record review the facility failed to report incidents of alleged Resident to Resident abuse for three of twenty four residents (Residents #2, #4, and #5) to the Licensing agency. Findings include:  1. Per review of the facility's internal investigation, a physical altercation involving (Resident #1 and Resident #2) occurred on 9/17/2020. Resident #2 was found on the floor in her/his room. Resident #1 had pushed the door open and then pushed her/him on her/his chest and s/he fell backwards on her/his back and head. The internal investigation states that the incident was reported	R208		

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

40X311

If continuation sheet 1 of 4

R208 - R224 AOCs accepted Sfreeman/p/rmc

Division of Licensing and Protection

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R208	<p>Continued From page 1</p> <p>to Adult Protective Services (APS), however there is no mention that it was reported to the State licensing agency.</p> <p>Per review of the facility's policy titled "Resident Rights/Abuse &amp; Neglect" "The Administrator and D.O.N. (Director of Nursing) shall report any case of suspected abuse, neglect, or exploitation to the Adult Protective Services (APS) as required by 33 V.S.A.6903 and the Division of Licensing".</p> <p>During an interview on 10/28/2020 at 4:35 PM, the facility Manager confirmed that this incident had not been reported to the licensing agency.</p> <p>2. On 10/28/2020 at 10:20 AM when asked if there had been any other altercations involving residents, the facility Manager reported that on 10/25/2020, Resident #3 was observed slapping Resident #4 on her bottom.</p> <p>Per review of the facility's internal investigation Resident #3 and #4 were walking in the hall when "Out of the blue [Resident #3] slapped [Resident #4]'s behind. [Resident #4] was taken back by this action", "[s/he] didn't do anything wrong". Resident #3 stated "[S/he] started it".</p> <p>Per record review, a Nurse's Note dated 10/25/20, at 4:00 PM Resident #3 was walking the halls with Resident #4 and struck Resident #4 in the back.</p> <p>During an interview on 10/28/2020 at 4:35 PM, the facility Manager confirmed that this allegation had not been reported to the licensing agency.</p> <p>3. Per interview with a Medication Tech. on 10/28/2020 at 2:50 PM, (on 10/19/2020) s/he was contacted via radio by another staff member</p>	R208		

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R208	Continued From page 2  stating that Resident #5 had been slapped in the face by Resident #3.  Per record review, on 10/19/2020 Resident #3 "got into an argument with another Resident (Resident #5). This argument started when [Resident #5] tried to take [Resident #3]'s blanket from [him/her]. Staff at this time intervened & separated the Residents. [Resident #3] stated that [Resident #5] had slapped [him/her]".  During an interview on 10/29/2020 at 9:09 AM, the facility Manager confirmed that staff had not reported this allegation to her/him, and that it had not been reported to the licensing agency as required.	R208		
R224 SS=G	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 staff interviews and record review the facility failed to ensure that one of twenty four residents (Resident #1) was free from physical abuse. Findings include:  Per review of the facility's internal investigation, on 9/17/2020 Resident #2 was found on the floor in her/his room complaining of left hip pain and unable to move her leg without pain. The internal investigation concluded Resident #1 had been	R224		

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R224	<p>Continued From page 3</p> <p>attempting to get Resident #2 out of what s/he thought was her/his office. Resident #1 was demanding that Resident #2 leave. Resident #2 had attempted to explain that it was her/his own room when Resident #1 pushed the door open pushed Resident #2 on her/his chest. S/he fell backwards on her/his back and head. Due to the possible injuries sustained from the fall, Resident #2 was sent to the hospital for evaluation. S/he was admitted to the hospital with a fractured pelvis.</p> <p>During an interview on 10/28/2020 at 10:00 AM, the facility Manager confirmed that Resident #1 had pushed Resident #2 causing her to fall to the floor resulting in the fracture.</p>	R224		

Plan of Correction Loretto Home Residence for complaint investigation October 29,2020

R208 V. Resident Care and Home services

What action will you take to correct the deficiency?

DON will educate staff about notifying Administrator and DON in a timely manner after resident to resident incident occurs.

Administrator will create a flow chart instructing Administrator/DON of notification to DAIL and APS after a resident to resident incident.

What measure will be put into place or systemic changes you will make to ensure the deficient practice does not occur?

Administrator will oversee education to ensure completion by all staff. All education will be completed by 11/18/2020.

R224 Residents' Rights

The submission of this plan of correction does not imply agreement with existence of this deficiency. It is submitted in the spirit of cooperation, to demonstrate our commitment to continued improvement in the quality of our resident's lives. The Loretto Home does not agree with the characterization of this resident situation. As the care plan for this resident shows, Resident 1 had no history of aggressive behaviors. The resident had never had any verbal or physical interactions with any residents or staff, thus this incident was not foreseeable.

What action will you take to correct the deficiency?

Review resident rights with all staff.

What measure will be put into place or systemic changes you will make to ensure the deficient practice does not occur?

Review and educate all staff on resident rights. Education will be completed by 11/18/2020.

**Flow sheet for reporting Resident to Resident Altercation within 48 hours**

**Report incident to APS**

<https://dlp.vermont.gov/aps/make-aps-report>



**Report incident to DAIL**

[ahs.dailscintake@vermont.gov](mailto:ahs.dailscintake@vermont.gov)



**Notify Local Authorities**

773-1816



**Report Resident on Resident incidents  
immediately to Director of Nursing and  
Administrator**

Loretto Home Inservice

### Education on Notifying DoN and Administrator about Resident to Resident Incidents

12-Nov-20

[illegible]