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

January 27, 2020

Ms. Melissa Greenfield, Manager
Meadows At East Mountain
240 Gables Place
Rutland, VT 05701-8811

Dear Ms. Greenfield:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 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

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
	1002	A. BUILDING: _____ B. WING _____	C 12/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS AT EAST MOUNTAIN	240 GABLES PLACE 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 onsite investigation of two Facility Reported Incidents was conducted by the Division of Licensing & Protection. The following deficiency was identified:	R100		
R227 SS=D	VI. RESIDENTS' RIGHTS 6.15 Residents have the right to refuse care to the extent allowed by law. This includes the right to discharge himself or herself from the home. The home must fully inform the resident of the consequences of refusing care. If the resident makes a fully informed decision to refuse care, the home must respect that decision and is absolved of further responsibility. If the refusal of care will result in a resident's needs increasing beyond what the home is licensed to provide, or will result in the home being in violation of these regulations, the home may issue the resident a thirty (30) day notice of discharge in accordance with section 5.3.a of these regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure that the resident's right to refuse care was respected. Findings include: Per record review, on 11/18/2019 Resident #1 complained about treatment by an LNA regarding care the night before. At that time the resident was in the bathroom being assisted by a Licensed Nurses Aide (LNA). According to the investigation notes, the resident became agitated and was resisting the LNA's attempt to assist them in dressing. The LNA reportedly persisted in the attempts to assist the resident into the	R227	**R227 Corrective Action Plan** All current staff will be educated on our existing residents bill of rights. This training also occurs upon hire. An audit will be conducted to assure all employees have been educated and understand the residents bill of rights and the right to refuse care. Audit will occur x3 months and will be reviewed at QI x6 months. This plan will be implemented by January 17, 2018.	

R227 POC accepted 1/24/20 MHiggins RN/PMC

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R227	Continued From page 1	R227		

clothing though the resident did not want to wear that specific clothing. After the incident the resident did complain to other staff, that the LNA had grabbed their wrist. The facility assessment did reveal the resident had bruises on their wrist and upper arm.

In the investigation interview the LNA denied having grabbed the resident's wrist or arm but stated that they had prevented the resident's attempts to hit them. The LNA stated that the resident began hitting, kicking, and punching them. The LNA stated they called for help on the walkie talkie, briefly stepped out of the room, and then returned to the room but monitored from a distance, did not touch the resident again. The LNA was hired on 11/1/2019. Background checks completed 10/31/2019 showed no concerns regarding this staff person.

In an interview on 12/10/2019, at 1:15 PM, the resident stated that they are happy at the facility and feel safe. The resident stated that a staff member had made them put "dirty" pajamas (previously worn) and they had also grabbed his/her arm. The resident has requested no further male caregivers which is now on the care plan for this resident.

In an interview on 12/10/2019 the Facility Administrator stated that they had known the LNA prior to their employment at the facility. There was no problem with the background checks conducted upon employment. The investigation did reveal that the resident had bruises on their arm and wrist but the LNA denied grabbing the resident. The facility was unable to substantiate abuse but the LNA was terminated due to the failure to respect the resident's refusal.