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 4, 2023

Ms. Jamie Goodwin, Manager
North End Ranch
2 Westview Court
Rutland, VT 05701

Dear Ms. Goodwin:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 1, 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,

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
	0667	A. BUILDING: _____ B. WING _____	C 12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH END RANCH	2 WESTVIEW COURT 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 11/29/22 and completed on 12/1/22. The following regulatory violations were identified:	R100	Please see attached plans of correction.	
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 of the RCH RN to update the care plan for 1 applicable resident who demonstrated changes in physical mobility; mental status and required closer monitoring prior to the administration of a medication. (Resident #1) Findings include: Although the RN had completed written plan of care for Resident #1 for October/2022, there was a failure to update the care plan when the resident experienced dehydration and hypotension (requiring Emergency Department intervention) to direct staff to monitor blood pressure prior to administering Diazepam (for antianxiety & sedative use) and monitoring of fluid intake. Resident #1 also demonstrated a decline	R145		

R145 - R178 POCs accepted 12/22/22 FMcIntosh RN/PMC

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R145	Continued From page 1 in ambulation/mobility requiring a wheelchair and experiencing difficulty manipulating utensils when eating and holding a cup to drink. Resident's #1 physical and mental decline required staff to monitor the resident to assure the implementation of a safety and monitoring plan. On the afternoon of 11/29/22 the RN confirmed the failure to update the care plan as a result of the recent changes Resident #1 was demonstrating and the need to further educate/delegate staff with medication administration of the medication, Diazepam.	R145		
R150 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (7) Assure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, there was a failure of the RCH nurse to document when an onsite visit was made to assess a resident who was demonstrating changes and decline in their health status. Findings include: Over the course of approximately 1 week, Resident #1 was demonstrating a decline both cognitively and physically. The RN was notified on Monday 11/1/22 of Resident #1's visit to the ED on 10/31/22 for dehydration and somnolence and after treatment was discharge back to the RCH. The RN Contact Note dated 11/1/22 acknowledged the residents weekend visit to the ED and the discussion regarding decreasing	R150		

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R150	Continued From page 2 Resident #1's Diazepam, as per suggestion of the ED Physician, which may have been contributing to the resident's mental and physical decline. On 11/3/22 Resident #1 was experiencing shortness of breath and having difficulty eating, grasping food or holding a glass to drink. In addition the resident was coughing. A Covid test was negative and the RN came to visit the resident in the late afternoon of 11/3/22. The RN failed to write a note describing his/her assessment of the patient and update the physical management of the resident to assure safety was utilized with ambulation and also the monitoring of Resident #1's blood pressure prior to the administration of Diazepam. Per interview on 11/29/22 at 1:50 PM, the RCH RN confirmed s/he failed to document the visit made during the afternoon of 11/3/22 to assess Resident #1 recent health decline or any actions taken as a result of the visit.	R150		
R178 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RCH failed to assure prompt, appropriate action when a resident demonstrated changes in their physical and mental condition for 1 applicable	R178		

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R178	Continued From page 3 resident. (Resident #1) Findings include Resident #1, who was mentally disabled with cognition deficits along with a diagnosis of hypertension and hypothyroidism demonstrated on the evening of 10/30/22 both physical and mental changes. Resident's blood pressure was recorded as 96/67 (which was unusually low); slurred speech; in and out of consciousness; face discolored gray; and inability to converse with RCH staff. The "on-call" staff was notified to determine whether the resident required emergent intervention. Despite the presenting physical and cognition changes it was decided by RCH staff because Resident #1 had an upcoming medical appointment on 10/31/22 no emergent intervention would be initiated. Resident #1 remained confused and demonstrated agitation on 11:00 PM - 7:00 PM shift. On 10/31/22 the resident's guardian brought the resident to Urgent Care. However, due to vital signs and physical presentation Resident #1 was sent via ambulance to the Emergency Department (ED) with hypotension (low blood pressure). Later that day, Resident #1 was discharged from ED with a diagnosis of somnolence and dehydration and a suggestion to reduce Resident #1's Diazepam (Valium) used for agitation. This was discussed with the resident's primary and guardian. Eventually a modified decrease was initiated reducing the noon dose of Diazepam from 5 mg to 2.5 mg. On the early morning of 11/1/22 Resident #1 was found on the floor in his/her bedroom, bruising noted on right upper arm. Cause of fall was unknown however resident was noted to not be wearing socks with treads. Later on 11/1/22 Resident #1's remained unsteady and demonstrated some shortness of breath. On 3-11	R178		

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R178	Continued From page 4 PM on 11/2/22 a progress note describes Resident #1 as "...inattentive and unfocused with speech." And by 11/3/22 the resident's mobility was fluctuating showing increased deficits in ambulation, now requiring 2 assists, gait belt and walker and eventually requiring a wheelchair. Per interview on 11/29/22 at 1:30 PM, the RN confirmed although s/he was notified on 11/1/22 (Monday) regarding Resident #1's change in status and Emergency Department visit on 10/31/22 for dehydration and hypotension, it was not until 11/3/22 when the RN made a visit to assess the resident for continued physical and mental changes along with supervising RCH staff regarding monitoring of Resident #1's hypotension and decline in ambulation. On 11/4/22 at 1:45 AM Resident #1 was found on the floor in his/her bedroom. Staff reported no injuries noted, socks with treads not in use. Later Resident #1 attended 2 medical/dental appointments and returned to the RCH. On the early morning of 11/5/22 Resident #1 could not get out of bed, noting to be weak and lethargic and complained of rib pain when attempting to get up. Throughout 11/5/22 Resident #1 required increased assistance with ambulation and informed the night staff on 11/6/2022 about concerns s/he broke his/her ribs stating a door had hit him/her but could not say when/where. On 11/7/22 of the 7:00 AM - 3:00 PM Resident #1 was described via progress note as "groggy" and to have "shallow breathing". However, staff failed to contact the RCH RN until 11/7/2022 3 days after the resident's fall on 11/4/22; resulting in continued complaints of rib pain; or the residents decline in mobility and transfer status. On the afternoon of 11/7/22 the RN made an on-site visit and assessed the resident to require	R178		

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R178	Continued From page 5 emergent intervention. Resident #1 was transferred to the ED via EMS. Resident #1 was diagnosed with right sided fractured ribs, subarachnoid hemorrhage, a large pleural effusion (fluid build up between the lungs and chest), acute hyponatremia (low concentration of sodium in blood), and hypokalemia (low concentration of potassium in blood). Resident #1 was admitted to the hospital and expired on 11/9/22. Although the RCH has a schedule of individuals listed to be "on-call" to include both medical staff and supervisors, the process, criteria or policy and procedure for when and why staff should be contacting the "on-call" staff has not been developed per the Director of Risk Management & Compliance on 11/29/22 at 11:11 AM. When notified, the "On-Call" employee/supervisor would decide whether to notify medical staff. Per telephone interview on 12/1/22 the on-call supervisor stated medical questions would be "...deferred to MD...unless on a weekend, when medical staff would not make a visit to the RCH...and no RN is on call." As a result, a resident would be sent to the ED. In addition, it was confirmed by Agency management (who provide the oversight of this RCH) staff delayed contacting the RN, acknowledging difficulties with communication between staff and RN creating a delayed response or prompt and appropriate action. Also noted, Resident #1's care plan dated October/2022 stated " Falls will be evaluated for further interventions after each incident". Thus, although Resident #1 demonstrated significant health symptoms from 11/4/22 to 11/7/22 to include 2 falls, which should have warranted a nursing assessment, there was significant delay by staff in contacting the RN.	R178		

North End Ranch Plan of Correction for 12/1/22 Licensing visit

R145 – 5.9.c (2) Written plan of care update

Individual's plan of care was not updated after changes in health.

Action: Experienced Developmental Services / Residential nursing staff were brought in to audit systems and care plans for all residents, and assist in developing a system for responsive changes.

Measures / Systemic Changes: Standard policy and EMR set up will be changed to allow for updates to the Nursing Care Plan on an as-needed basis. The change will include a workflow for updating and training staff on any new or different process, method, equipment or monitoring needed. With a new plan of care, the EMR will be updated, and the plan will be printed out and added to the resident's binder. The staff will be instructed on the change in the binder by the nurse and at change of shift report.

Monitoring: Compliance team and NER manager will monitor nursing care plan changes.

Date of Completion: 1/3/23

R150 – 5.9.c (7) Illness symptoms acted on and recorded

RMHS Nurse did not record actions taken or symptoms at several points.

Action: Experienced RNs worked with NER manager and staff to set a regular schedule for nurse staffing on site and establish communication protocols for staff to check in with nursing / medical for any concerns or emergencies. NER Manager also reviewed expectations for nursing documentation to be incorporated into the hiring process for a new residential nurse.

Measures / Systemic Changes: Expectation for nursing documentation and health management of residents is reviewed and updated, with nursing contact notes written each day the nurse is on site a minimum standard. In addition, the minimum standard is that any assessment or consultation by phone is also required to be documented as per the agency-wide standards. Nursing staff will also regularly review the shift notes completed by staff.

Monitoring: NER Manager and Residential Program Director will monitor nursing notes completion and hold nursing staff accountable.

Date of Completion: 1/3/23

R178 – 5.11 – Staff services

Process for communicating health concerns with RN and with on call med was not clear.

Action: NER Manager and Compliance team reviewed the existing procedures and immediately clarified with staff their ability to call 9-1-1 and the medical staff on call when necessary.

Measures / Systemic Changes: The NER Manager and Compliance team are writing a clear and concise procedure for residential staff for how and when to contact medical personnel with emergent health concerns in residents. Staff will be trained in this procedure, it will be added to the resource binder at NER. The RNs auditing NER systems will also develop clear guidelines and expectations for the residential nurse position in terms of assessing and managing emergent health conditions in residents. The current fall / incident tracking system will be incorporated into the EMR and staff trained so that the nurse, the NER Manager and Quality manager can identify any patterns or acute incidents that need addressing.

Monitoring: NER Manager will incorporate this procedure into the staff training, as well as monitor adoption through staff supervision. Quality Improvement Manager will track event reports through the EMR and report to Residential Program Manager and NER Manager any findings.

Date of Completion: 1/3/23