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

February 8, 2023

Mr. Steven Doe, Manager
Our Lady Of The Meadows
1 Pinnacle Meadows
Richford, VT 05476-7637

Dear Mr. Doe:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 12, 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
	0197	A. BUILDING: ______ B. WING ______	C 12/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF THE MEADOWS	1 PINNACLE MEADOWS RICHFORD, VT 05476

(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: On 12/5/22 the Division of Licensing and Protection conducted an unannounced on-site investigation of a facility reported incident. Additional information was provided by the facility's nursing staff on 12/6/22, 12/7/22, and 12/12/22. The following regulatory deficiencies were identified:	R100		
R126 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to provide and arrange necessary services to meet one applicable resident's personal and psychosocial needs. (Resident #1). Findings include: Per record review Resident #1 was admitted to the facility in March of 2022 with diagnoses including Dementia, Post Traumatic Stress Disorder (PTSD), Auditory Hallucinations, Anxiety Disorder, and a history of Major Depressive Disorder. On 11/18/22 Resident #1 was emergently discharged from the facility to a hospital emergency department following an assault on another resident the previous day. The other resident (Resident #2) was slapped on the	R126	(Please See Attached)	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] Steven Wolf
TITLE: Administrator
(X6) DATE: 1/24/23

R126 - R162 POC's accepted 2/1/23 JEvans RN/PMM

Division of Licensing and Protection

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R126	Continued From page 1 face by Resident #1 and sustained facial fractures subsequent to a fall while trying to get away from Resident #1. A note written by the Director of Nursing on the morning 11/18/22 stated Resident #1 "has become unpredictable and exhibits intermittent bouts of increased agitation with potential for violence". During the time period between Resident #1's admission in March of 2022 and his/her emergency discharge on 11/18/22 s/he demonstrated behaviors posing significant risk of injury to other residents, staff, and self. In addition to the assault on 11/17/22, Departmental Notes reported Resident #1 threatened another resident on 4/28/22 requiring staff to " keep a close eye to prevent him/her from pushing the other resident"; "slammed chairs against the wall as though s/he was in active combat" on 6/20/22; and grabbed a staff member by the neck, choking him/her, requiring two additional staff to remove his/her hands from the staff's throat, and leaving visible wounds on staff's neck on 9/5/22. On 9/14/22 the Director of Nursing noted Resident #1's Resident Assessment was updated related to "behavior issues that could be a concern for his/her or other resident's safety". Despite diagnoses of several mental health conditions and significant indicators of psychological decompensation, Resident Assessments for Resident #1 completed on admission in March of 2022 and in September of 2022 due to change in behavioral status both indicate the date of the last medication review by a medical provider was 1/9/22 and stated Resident #1 had not been evaluated/assessed by a qualified mental health specialist. At 3:40 PM on 12/5/22 the Administrative	R126		

Division of Licensing and Protection

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R126	Continued From page 2 Manager in training and Finance Manager confirmed Resident #1's multiple mental health diagnoses and increasingly concerning behaviors, and acknowledged the Resident Assessments indicated s/he had not not been evaluated/assessed by a qualified mental health specialist.	R126		
R128 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Per record review and staff interview there was a failure to administer medications as ordered for 2 applicable residents. (Resident #1 and Resident #2). Findings include: 1. Per record review Resident #1 was ordered Tylenol Arthritis 650 mg caplets One tablet every 8 hours as needed for chronic pain. Per review of Resident #1's Medication Administration Record, Tylenol Arthritis Extended Release 650 mg tablets Two tablets scheduled once daily was administered. On the evening of 12/5/22 the Registered Nurse confirmed the administration of Tylenol Arthritis Extended Release 650 mg tablets to Resident #1 was not consistent with signed physician's orders provided on request. 2. Per record review Resident #2 was ordered	R128	Please SEE ATTACHED	

Division of Licensing and Protection

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R128	Continued From page 3 Tylenol 650 mg as needed for pain. Tylenol 650 mg scheduled three times daily was administered on 11/1/22 - 11/4/22 and 11/18/22 - 11/30/22. On the evening of 12/5/22 the Registered Nurse confirmed the administration of Tylenol to Resident #2 was not consistent with signed physician's orders provided on request.	R128		
R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to complete an accurate assessment for one applicable resident (Resident #1). Findings include: Per record review the Director of Nursing completed a Resident Assessment on the afternoon of 9/14/22 indicating Resident #1 did not have a urinary tract infection in the last 30 days. A note written by the Director of Nursing on the morning of 9/14/22 indicated Resident #1's urine specimen tested positive for a urinary tract infection that morning. The Resident Assessment on 9/14/22 also did not indicate Resident #2 is receiving Enhanced Residential Care (ERC) services in contrast to a Level of Care Variance	R136	(Please see attached)	

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R136	Continued From page 4 request on 8/10/22 indicating Resident #1 is receiving ERC services. At 3:40 PM on 12/5/22 the Administrative Manager in training and Finance Manager acknowledged inaccuracies in Resident #1's Resident Assessment.	R136		
R145 SS=G	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 record review and staff interview there was a failure to develop a plan of care to address the care and services necessary to maintain the independence and well being for two applicable residents (Resident #1 and Resident #2). Findings include: 1. Resident #1 was admitted to the facility in March of 2022 with diagnoses of Dementia, Post Traumatic Stress Disorder (PTSD), Auditory Hallucinations, Anxiety Disorder, history of Major Depressive Disorder, Hearing Loss, Dizziness, Diabetes Mellitus, cardiovascular conditions including history of a Cerebral Infarction (stroke), and frequent urinary tract infections. Resident #1	R145	(Please see attached)	

Division of Licensing and Protection

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R145	Continued From page 5 is allergic to bee venom and is prescribed an Epipen. Resident #1 demonstrated aggressive and assaultive behaviors at the facility including following and threatening another resident on 4/28/22; slamming chairs against a wall "as though s/he was in active combat" on 6/20/22; choking a staff member leaving visible wounds on the staff's neck and requiring two additional staff to remove his/her hands from the staff's throat" on 9/3/22; and engaging in verbal conflict with his/her roommate on 9/8/22 and 9/13/22. On 11/17/22 Resident #1 approached the doorway of Resident #2 and slapped his/her face as s/he attempted to back Resident #1 away from his/her doorway. Both residents require walkers for mobility. Resident #2 fell over his/her walker as s/he attempted to push past Resident #1 who was blocking the doorway with his/her walker. Resident #2 sustained facial fractures due to the fall. While Resident #1's Care Plan dated 9/5/22 addressed "history of behaviors relating back to his/her military service" and included instructions to "remove resident from potentially dangerous situations" and to ensure a second staff member is "in near area able to intervene in the event this resident goes after direct care staff"; the nurse failed to update Resident #1's care plan to include specific interventions to ensure the safety of other residents including 24/7 eyes on monitoring, redirecting Resident #1 away from other resident's rooms and close contact with other residents, and reporting any behavior or concerns to nursing or administrative staff until approximately one hour before documentation of a decision to emergently discharge Resident #1 on 11/18/22 due to the assault on another	R145		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0197	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ___ B. WING ___	(X3) DATE SURVEY COMPLETED C 12/12/2022

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R145	Continued From page 6 resident the previous day. Additionally, Resident #1's Care Plan failed to address his/her risk for falls; frequent urinary tract infections; Diabetes Mellitus; risk for cardiovascular events; and psychosocial needs related to anxiety, PTSD, auditory hallucinations, and history of Major Depressive Disorder. His/her Care Plan also failed to identify risk for an allergic reaction requiring the use of an Epipen, and to include indications and instructions for use of the Epipen. 2. Resident #2 was admitted to the facility in September of 2022 with diagnoses including Alzheimer's, Epilepsy, Hypokalemia (low potassium levels); Lack of Coordination; Cardiac Conduction Disorders (irregular heartbeat managed with a pacemaker), Syncope and Collapse (fainting associated with inadequate blood flow to the brain), Edema; Infectious Colitis, Urinary Tract Infections, Infective Ankle Synovitis (pain and inflammation inside the ankle joint), Dorsalgia (severe back pain), Sciatica (nerve pain from the lower back down the leg), and Dysuria (painful urination). Resident #2's medications include the anticoagulant medication Eliquis, which prevents formation of blood clots and increases risk of bleeding. Resident #2's care plan failed to address his/her risk for a cardiac event; risk for seizures associated with Epilepsy; risk for infections; and management pain related to acute and chronic infections, sciatica, joint inflammation, and dysuria. His/her care plan failed to address the risk for bleeding associated with the use of the anticoagulant medication Eliquis. A single entry in his/her care plan that briefly mentioned bleeding was entered on 11/18/22, the day after s/he fell as	R145		

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R145	Continued From page 7 a result of an assault by another resident and sustained facial fractures, and simply instructed staff to report any ecchymosis (bruising), bleeding, or edema at the sites of the facial fractures. Similarly, Resident #2's high risk for falls was not adequately addressed in his/her initial care plan dated 9/29/22 which stated only "Resident will not fall from bed or chair" and failed to identify specific interventions related to risk for falls. Resident #2's Progress Notes documented falls on 10/2/22, 10/8/22, and 11/4/22. Interventions related to fall prevention were not identified until an update to his/her care plan on 11/18/22, following the fall sustained during assault by another resident the previous day. The facility Administrative Manager in training and Finance Manager acknowledged deficiencies in Resident #1's and Resident #2's Care Plans on the afternoon of 12/5/22.	R145		
R162 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview there was a failure to ensure all medication orders were signed by a physician for 2 applicable residents. (Resident #1 and Resident #2). Findings include:	R162	(Please See Attached)	

Division of Licensing and Protection

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R162	Continued From page 8	R162		

1. On the afternoon of 12/5/22 the Registered Nurse was requested to provide signed orders for medications listed on Resident #1's November 2022 MAR. Per review of the documentation provided, the Registered Nurse was unable to provide signed orders for Ferrous Sulfate (Iron supplement) 325 mg daily, Olanzapine 5 mg tablet One tablet at bedtime, and Tylenol Arthritis Extended Release 650 mg tablets Two tablets every morning.

On 12/5/22 the Registered Nurse confirmed signed orders for Ferrous Sulfate 325 mg tablets, Olanzapine 5 mg tablets, and Tylenol Arthritis Extended Release tablets were not present.

2. On the afternoon of 12/5/22 the Registered Nurse was requested to provide signed orders for medications administered to Resident #2. The Registered Nurse was unable to locate the signed orders during the site visit, however the following day Resident #2's signed admission orders were located and provided. The documentation provided did not include signed orders for the following medications:

* Amoxicillin/Clavulanate (antibiotic) 875/125 mg One tablet twice daily for 7 days
* Cyanocobalamin (Vitamin B 12) 1,000 mcg/ml vial injected subcutaneously once monthly
* Tylenol 325 mg Two tablets scheduled three times daily
* PreserVision Areds 2 Softgels One softgel twice daily for eye health

While signed orders were provided for the use of Tylenol as needed for pain on 12/7/22, signed orders for scheduled Tylenol 325 mg Two tablets

Division of Licensing and Protection

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R162	Continued From page 9 administered three times daily 11/1/22 - 11/4/22 for pain following a dental extraction, and Tylenol 325 mg Two caplets three times daily for pain after fall and facial fractures administered 11/18/22 - 11/30/22 were not provided after multiple requests. On 12/5/22 the Registered Nurse confirmed signed medication orders were not available on request for Resident #2; and on 12/6/22, 12/7/22, and 12/12/2 email communications with Nursing staff confirmed the lack of signed orders for medications including Amoxicillin/Clavulanate, Cyanocobalamin, Tylenol, and Preservision Areds 2.	R162		

Our Lady of the Meadows
Plan of Correction
Residential Care Home State Survey
December 12, 2022

R126

5.5.a

Action:

Resident #1 previously was living at St. Joseph's Home, a Residential Care Home in Burlington, and seeing Amelia Gennari MD as a PCP. During Resident #1's 7/14/2021 appointment with Gennari MD, it was stated that Resident #1 had completely resolved his depressed mood after the initiation of Escitalopram. It was then recommended during an appointment on 1/19/22 by Amelia Gennari MD that Resident #1 be moved to a facility with a locked unit/memory care unit due to his worsening auditory hallucinations and elopement history. Additionally, during this appointment on 1/19/22, it was noted that Resident #1 had been recently prescribed Olanzapine for his progressive neurocognitive deficits and worsening auditory hallucinations and was tolerating it well per Gennari MD. **(Please see Attachments A-B).**

Resident #1 was assessed, and his medical record was reviewed by the Admission Coordinator prior to his admission to Our Lady of the Meadows. It was concluded, with nursing expertise, that he was appropriate for our level of care at the time of admission. Resident #1 was then admitted to Our Lady of the Meadows on 3/1/22. At this time, Resident #1 had diagnoses of Major neurocognitive disorder/dementia, major depression in remission, and auditory hallucinations, all managed with medication. **(Please see attachment C for Resident #1's Problem List prior to admission to Our Lady of the Meadows).**

On 4/28/22, it was reported Resident #1 was following another resident around the unit and threatening her to let him out of the building. Resident #1 was not physical with this resident and was able to be redirected by staff. On 6/20/22, it was reported Resident #1 was slamming chairs against the wall but did not harm himself, another resident, or staff and was quickly redirected by staff. On 9/3/22, it was reported Resident #1 grabbed a staff member by the neck requiring two other staff members to remove his hands. This was his first reported episode of being physically aggressive. Due to this event, staff were instructed to be aware of resident #1's whereabouts, always have another staff member outside the room

when caring for the resident, always have the call light within reach, and additional dementia training was offered to staff throughout the month of October. On 11/3/22, Resident #1 had an appointment to be evaluated as a new patient of Jonathan Speer, PA with the Richford Health Center. It was during this appointment that Resident #1 was diagnosed with PTSD and anxiety. At this time, it was not recommended by Speer, PA to make any changes to resident #1's plan of care. **(Please see attachment D).**

Resident #1's mental health conditions were managed initially during his stay at Our Lady of the Meadows and did not require mental health services. It had been previously communicated to the nursing staff at Our Lady of the Meadows that Northwestern Medical Center no longer provides consultation for geriatric psychiatric patients, therefore, Northwestern Medical Center was not consulted when Resident #1 began to have behavioral episodes. With all reported behaviors, Resident #1 was redirected or validated during the time behavior took place, urine was tested for a UTI if this was suspected, the PCP was notified, and any recommendations were followed. Additionally, Resident #1's Olanzapine was increased per PCP orders on two occasions during his stay at Our Lady of the Meadows to try and manage his behaviors.

On 11/17/22, Resident #1 approached the doorway of Resident #2 and slapped her as she attempted to back Resident #1 away from her doorway. Resident #2 fell over her walker as she attempted to push past Resident #1 who was blocking the doorway with his walker. Resident #2 sustained facial fractures due to the fall. It was decided by the administration and nursing team that Resident #1's behavior had become unpredictable with the potential for violence and therefore he could not live in a community setting. Speer, PA was also consulted and deemed Resident #1 was above the level of care Our Lady of the Meadows could provide. On 11/18/22 Resident #1 was emergently discharged from the facility due to being harmful to himself or others.

Measures:

The Nurse Manager and The Admission Coordinator will take extra precautions during the pre-admission process by carefully screening potential residents, especially those with a diagnosis of PTSD, before they are admitted to Our Lady of the Meadows to ensure all personal, psychosocial, nursing, and medical needs can be met.

Monitors:

The Nurse Manager and the entire Nursing Staff will monitor this practice to ensure that this deficiency does not reoccur.

Date Completed:

1/24/23

R128

5.5.c (2)

Actions:

Resident #1 was given scheduled Tylenol consistent with the order from the previous PCP, Tylenol Arthritis 650mg tablet, Take 2 Tabs by mouth daily. When Jonathan Speer, PA assumed care of resident #1 on 11/3/22, Speer wrote a Tylenol order as a PRN, Tylenol 650mg tablet, and Take 1 every 8 hours as needed for arthritis pain. This change was not communicated to nursing staff and was written under the medication list from the visit summary as "Continue", therefore, missed as a change by nursing staff.

For Resident #2, the Nurse Manager initially scheduled Tylenol per the standing orders on 11/1/22-11/4/22 for pain control after dental extraction. Standing orders give approval for medications listed to be scheduled for three days. The two additional doses of Tylenol given should have been ordered from the PCP. The Tylenol order was then discontinued on 11/4/22. From 11/18/22-11/30/22, Tylenol was initially scheduled per the standing orders for the first three days post-fall. Per nursing judgment, Resident #2's pain was controlled well with the Tylenol regimen and it was reported by the physician at NMC that her facial fractures would take 6-8 weeks to heal, therefore, Tylenol was continued despite obtaining a written order by PCP. The scheduled Tylenol order was then discontinued and could be given PRN if the pain persisted.

Measures:

The Nurse Manager and the entire nursing team will ensure paperwork received pertaining to residents is read carefully and with attention to detail.

The Nurse Manager and the entire nursing team will ensure that Residents taking scheduled medications per standing orders shall have a physician's order after 3 days.

Monitors:

The Nurse Manager and the entire nursing team will monitor this practice to ensure that this deficiency will not reoccur.

Date Completed:

01/24/23

R136

5.7.c

Actions:

Action for Resident #1 was not possible as he/she was emergently discharged on 11/18/2022. When the Nurse Manager was updating Resident #1's assessment due to behavioral changes, Resident #1 being positive for a UTI was overlooked.

Resident #2 is not receiving Enhanced Residential Care (ERC), this resident is Private Pay.

Measures:

The Nurse Manager and the entire nursing team will ensure that each resident shall be reassessed annually and at any point when there is a change in the resident's physical or mental condition with attention to detail.

Monitors:

The Nurse Manager and the entire nursing team will monitor this practice to ensure that this deficiency will not reoccur.

Date Completed:

01/24/23

R145

5.9.c

Action:

Action for Resident #1 was not possible as he was emergently discharged on 11/18/2022.

The Nurse Manager updated Resident #2's Care Plan on 1/23/23 to include a plan of care that addresses these diagnoses, Seizures, Falls Risk, Bleeding Potential, Pain, and UTI. **(Please see attachment E).**

Measures:

The Nurse Manager met with the entire nursing staff to review the requirement to oversee the development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. She also reviewed that the plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being.

Monitors:

The Nurse Manager will monitor this practice to ensure that this deficiency does not reoccur.

Date Completed:

01/24/22

R162

5.10.c

Actions:

Resident #1

The Nurse Manager has located the physician's order for Ferrous Sulfate 325mg tablet given PO every other day. **(Please see attachment F).**

The Nurse Manager has located the physician's order for Olanzapine 5mg tablet one tablet PO at bedtime. **(Please see attachment G).**

Resident #2

The Nurse Manager has located the physician's order for Amoxicillin/Clavulanate 875/125mg one tablet PO BID for 7 days. **(Please see attachment H).**

Nursing confirmed with Resident #2's PCP on 1/19/23 Cyanocobalamin 1000mcg/mL SC monthly injection is not ordered for resident #2 and was never entered on MAR.

Nursing scheduled Tylenol 325mg tabs, Two tabs PO TID, initially intended to be scheduled per the standing orders for the first three days post-fall. Per nursing judgment, Resident #2's pain was controlled well with the Tylenol regimen and it was reported by the physician at NMC that her facial fractures would take 6-8 weeks to heal, therefore, Tylenol was continued despite obtaining a written order by PCP. The scheduled Tylenol order was then discontinued and could be given PRN if the pain persisted.

Nursing confirmed frequency with PCP for PreserVision Areds 2 Soft gels, One soft gel PO BID, order obtained 01/24/23. **(Please see attachment I).**

Nursing reviewed the chart for Resident #2 to obtain signed medication orders for Tylenol and PreserVision Areds requested by the surveyor via email on 12/6/22. Standing orders for Resident #2 were emailed to the surveyor on 12/7/22. At the time, these were the only two medications nursing was asked to locate by the surveyor. The request for signed orders for Amoxicillin/Clavulanate and Cyanocobalamin was not made known until the survey statement was received.

Measures:

The Nurse Manager and entire nursing team will ensure that staff will not assist with or administer any medication, prescription, or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record.

Monitors:

The Nurse Manger and entire nursing team will monitor this practice to ensure that this deficiency will not reoccur.

Date Completed:

1/24/23