



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

June 5, 2023

Mr. Steven Doe, Administrator
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 **April 19, 2023**. 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,

A handwritten signature in cursive script that reads "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: 0197	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 04/19/2023
--	--	--	---

NAME OF PROVIDER OR SUPPLIER
OUR LADY OF THE MEADOWS

STREET ADDRESS, CITY, STATE, ZIP CODE
**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: An unannounced follow-up survey was conducted on 4/19/23 by the Division of Licensing and Protection to determine regulatory compliance from an investigation of a facility reported incident conducted on 12/5/22. The following regulatory violations were found not to be back in compliance with the Residential Care Home Licensing Regulations effective 10/3/2000:	(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 nursing care and services to meet the needs of 3 applicable residents (Residents #1, #2, #3). Findings include: 1. There was a failure to ensure signed medication orders and administration of medications as ordered as follows: a) For Resident #1: On 1/25/23 Resident #1's provider called in an order for "Sertraline 25 mg oral tablet 1 tab by mouth every day for 2 weeks, if well tolerated increase to 50 mg every day". The copy of the order received from the pharmacy did not contain an actual or electronic physician's	(R126)	(PLEASE SEE ATTACHED)	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

STEVEN A. DOE
ADMINISTRATOR
5/21/23

QU9712

Joseph Olio
Manager
5-24-23

If continuation sheet 1 of 15

Tags R126 to R162 accepted on 6/5/2023 - J. Evans/C. Scott

Division of Licensing and Protection

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 R-C 04/19/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER
OUR LADY OF THE MEADOWS

STREET ADDRESS, CITY, STATE, ZIP CODE
**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
{R126}	Continued From page 1 signature and a supporting diagnosis or problem the medication is prescribed to treat. A planned two week follow up with Resident #1's provider did not occur until 2/13/23; and a Nursing note dated 2/14/23 states "Resident's sertraline increased to 50 mg daily as she has tolerated the 25 mg dosing for the last 3 weeks. Order was to increase to 50 mg if resident tolerated the 25 mg after 2 weeks". On 3/24/23 a verbal order was received by Nursing staff to discontinue administration of Sertraline, and his/her Medication Administration Record (MAR) indicates the order for Sertraline 50 mg tablets was discontinued on 3/24/23. At 4:11 PM on 4/19/23 the Nurse Manager confirmed a delay in the scheduled increase for Sertraline to 50 mg daily following a two week administration of 25 mg daily as ordered; and confirmed s/he was unable to provide documentation of a written signed order to discontinue Sertraline for Resident #1. On 4/7/23 Resident #1's Nurse Practitioner ordered Risperidone 0.25 mg at bedtime with instructions to monitor for effectiveness and increase to BID (twice daily) after one week if no adverse effect. There was a 3 day delay in administration of this medication, and the first dose was given on 4/10/23. The April 2023 MAR indicated the medication was still being given once daily as of 4/19/23, nine days after the first dose was given, and the MAR had not been updated to include the prescribed increase to twice daily one week after the medication was started as ordered. There is no documentation of monitoring for the effects of the new medication between 4/11/23 and 4/17/23. At 4:08 PM on 4/19/23 the Nurse Manager confirmed there was a delay in initiating the administration of Risperidone, and the failure to increase to twice daily administration one week	{R126}		

SAD

Jo

Division of Licensing and Protection

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 R-C 04/19/2023
--	--	--	---

NAME OF PROVIDER OR SUPPLIER
OUR LADY OF THE MEADOWS

STREET ADDRESS, CITY, STATE, ZIP CODE
**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
(R126)	<p>Continued From page 2</p> <p>after the medication was initiated as ordered.</p> <p>Resident #1's Nurse Practitioner ordered Docusate Sodium 100 mg capsules 1-2 capsules by mouth daily as needed for constipation in 2/2/23, however Resident #1's MARs for March and April 2023 list only "Docusate 100 mg tablet" with no further instructions regarding the dose, route, schedule, and condition the medication is intended to treat as ordered.</p> <p>b) For Resident #2: An electronically signed Telehealth Summary written by Resident #2's Memory Care Provider dated 12/19/22 notes Resident #2 "is on Mirtazapine 7.5 mg HS (at bedtime). 15 mg was too sedating" and lists Mirtazapine 7.5 mg tablets as a current medication. Resident #2's March and April 2023 MARs include orders for Mirtazapine 15 mg by mouth at bedtime. A Continuity of Care Document created on 1/24/23 stated to be authored by Resident's Primary Care Provider (PCP), which does not include an actual or electronic physician's signature, indicates Mirtazapine 15 mg at bedtime has been ordered for Resident #2 since 10/20/22. There is no evidence of a signed order or request for an order clarification from Resident #2's PCP following receipt of the signed document from the Memory Care Provider dated 12/19/22 indicating Mirtazapine 7.5 mg at bedtime is ordered for Resident #2.</p> <p>Please refer to tags 128 and 162.</p> <p>2. There was a failure to oversee development of written plans of care that address the care and services necessary to maintain independence and well-being for 3 applicable residents (Residents #1,</p>	(R126)		

SAD

JO

Division of Licensing and Protection

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 R-C 04/19/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER OUR LADY OF THE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 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
{R126}	<p>Continued From page 3 #2, and #3) as follows:</p> <p>a) Resident #1 has Alzheimer's Disease and displays signs of confusion and a decline in ability to communicate verbally as noted on 3/9/23. S/he has a cardiac pacemaker due to a Conduction Disorder of the heart, which is a blockage of the electrical impulses that contract the muscles of the heart. On 2/6/23 the facility was notified regarding a pacemaker report of an episode of ventricular tachycardia with a heart rate of 215 beats per minute. Resident #1 was assaulted by another resident in November of 2022 and sustained facial fractures. A Nursing Note on 1/19/23 states Resident #1's PCP feels s/he is experiencing PTSD from the assault, and subsequent Nursing Notes document changes in eating pattern with weight loss, gagging and vomiting, anxiety around other residents and not wanting to socialize or participate in activities on 2/21/23; multiple attempts to leave his/her room then retreating back inside, and continued nausea and vomiting on 3/23/23; and increased anxiety with paranoia and agitation was noted on 4/6/23 following the discontinuation of Sertraline on 3/24/23 due to decline observed while s/he was taking this antidepressant medication.</p> <p>Resident #1's plan of care fails to address care and services required related to Alzheimer's Disease; risk for a cardiovascular event; and the physical and psychological impact of trauma including emotional distress, anxiety, agitation, nausea/vomiting, and risk for weight loss.</p> <p>b) Resident #2 is diagnosed with Frontotemporal Dementia (FTD) including the behavioral and semantic (affecting speech and ability to</p>	{R126}		

895

Jo

Division of Licensing and Protection

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 R-C 04/19/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER
OUR LADY OF THE MEADOWS

STREET ADDRESS, CITY, STATE, ZIP CODE
**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
{R126}	Continued From page 4 comprehend language) variants of this degenerative brain disease. Progressive atrophy of brain cells associated with FTD causes increasing changes in personality, behaviors, cognitive ability and communication deficits. Resident #2's care plan does not specifically address behavioral concerns related to verbal and physical aggressions towards other residents and intrusive behaviors documented on 1/12/23, 1/19/23, 2/6/23, 2/27/23, 3/6/23, 3/20/23, and 3/28/23. His/her plan of care identifies the goal "Resident will not fall from bed or chair", however the plan does not identify interventions to reduce and address falls including the use of a lowered bed which began on 3/16/23, and a plan to safely lift the resident after falls which was noted to result in staff injuries and risk for resident injuries on 3/31/23, 4/3/23, 4/4/23, 4/10/23, and 4/19/23. An bed rail issue is noted on 4/17/23 however there is no plan for the safe use of a bedrail included in Resident #2's plan of care. Resident #2's care plan does not address his/her frequent intentional transitions to the floor with refusal to get up or participate in lift assists; and episodes of "arm crawling" or "army crawling" when s/he transitions to the floor and uses his/her arms to crawl along the floor. These behaviors pose safety risks for Resident #2, create trip/fall risks for other residents, and impede access to hallways and resident rooms. Additionally, his/her plan of care does not include goals and interventions related to urinary and fecal incontinence documented in Nursing Notes on 3/31/23 and 4/17/23. c) Resident #3 is diagnosed with severe Vascular Dementia and cardiovascular conditions including high blood pressure, history of stroke and heart	{R126}		

(S-A)

(J6)

Division of Licensing and Protection

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 R-C 04/19/2023
--	--	--	---

NAME OF PROVIDER OR SUPPLIER
OUR LADY OF THE MEADOWS

STREET ADDRESS, CITY, STATE, ZIP CODE
**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
(R126)	<p>Continued From page 5</p> <p>attack, Heart Failure, and Angina. His/her plan of care does not address risk for cardiovascular event. S/he is prescribed Nitroglycerine as needed for chest pain. Use of Nitroglycerin requires monitoring due to risk of rapid drop in blood pressure and pulse. Falls and injury may occur due to dizziness, lightheadedness and fainting; and it is important to ensure the Resident is not standing when the medication is administered and gets up slowly following administration. Nitroglycerine requires storage without exposure to heat, moisture, and light; and is ineffective when the bottle is not stored properly, opened frequently or expired. Resident #3's plan of care does not include a plan for Nitroglycerine administration and storage.</p> <p>Please refer to tag 145</p> <p>3. There was a failure to ensure completion of a significant change of condition assessment for Resident #1 who began to display signs of PTSD following a physical assault by another resident in November of 2022 and demonstrated a significant change of condition following the assault including increasing anxiety and agitation; changes to eating pattern with weight loss, gagging and vomiting; anxiety around other residents and not wanting to socialize or participate in activities; and multiple attempts to leave his/her room then retreating back inside. A reassessment of Resident #1 was signed as completed by the Nurse Manager for Resident #1 on 1/24/23, however the first page of the Resident Assessment form does not indicate the reassessment was a significant change in status assessment. Section F5 Change in Behavioral Symptoms of the assessment form completed on 1/24/23 indicates</p>	(R126)		

SAD

Js

Division of Licensing and Protection

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 R-C 04/19/2023
--	--	--	---

NAME OF PROVIDER OR SUPPLIER
OUR LADY OF THE MEADOWS

STREET ADDRESS, CITY, STATE, ZIP CODE
**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
{R126}	Continued From page 6 Resident #1 had no change in behavioral status in the previous 90 days. On the afternoon of 4/19/23 the Nurse Manager confirmed a significant change of condition assessment was not completed in response to changes in Resident #1's physical and psychological condition. Please refer to tag 136	{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. Administration of Sertraline, Risperidone, and Docusate Sodium were not consistent with the physician's orders for Resident #1 as follows: a) A Nursing Note for Resident #1 dated 1/25/23 states "MD has called in an order for Sertraline 25 mg daily for two weeks, if tolerated MD would like to increase to 50 mg daily, we will administer this at hs (bedtime) and f/u (follow up) with MD in two weeks to determine if dose should increase". Per record review Nursing staff did not contact the prescriber regarding the Sertraline increase to 50	{R128}	<i>(PLEASE SEE ATTACHES)</i>	

995

Division of Licensing and Protection

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 R-C 04/19/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER
OUR LADY OF THE MEADOWS

STREET ADDRESS, CITY, STATE, ZIP CODE
**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
{R128}	<p>Continued From page 7</p> <p>mg until 2/13/23, and a Nursing note dated 2/14/23 states "Resident's sertraline increased to 50 mg daily as she has tolerated the 25 mg dosing for the last 3 weeks. Order was to increase to 50 mg if resident tolerated the 25 mg after 2 weeks". At 4:11 PM on 4/19/23 the Nurse Manager confirmed lack of communication with the prescriber resulted in a delay in the scheduled increase for Sertraline to 50 mg daily following a two week administration of 25 mg daily as ordered.</p> <p>b) On 4/7/23 Resident #1's Nurse Practitioner ordered Risperidone 0.25 mg at bedtime with instructions to monitor for effectiveness and increase to BID (twice daily) after one week if no adverse effect. There was a 3 day delay in administration of this medication, and the first dose was given on 4/10/23. The April 2023 Medication Administration Record (MAR) indicated the medication was still being given once daily as of 4/19/23, nine days after the first dose was given, and the MAR had not been updated to include the prescribed increase to twice daily one week after the medication was started as ordered. Per review of Nursing Notes, there is no documentation of monitoring for the effects of the new medication between 4/11/23 and 4/17/23. At 4:08 PM on 4/19/23 the Nurse Manager confirmed the delay in initiating the administration of Risperidone, and the failure to increase to twice daily administration one week after the medication was initiated as ordered.</p> <p>c) Resident #1's Nurse Practitioner ordered Docusate Sodium 100 mg capsules 1-2 capsules by mouth daily as needed for constipation in 2/2/23, however Resident #1's Medication Administration Records (MARs) for March and April 2023 list "Docusate 100 mg tablet" with no</p>	{R128}		

SAD

J6

Division of Licensing and Protection

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 R-C 04/19/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER
OUR LADY OF THE MEADOWS

STREET ADDRESS, CITY, STATE, ZIP CODE
**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
(R128)	Continued From page 8 further instructions regarding the specific dose, route, schedule, and condition the medication is intended to treat as ordered. 2. An electronically signed Telehealth Summary with Resident #2's Memory Care Provider dated 12/19/22 notes Resident #2 "is on Mirtazapine 7.5 mg HS (at bedtime). 15 mg was too sedating" and lists Mirtazapine 7.5 mg tablets as a current medication. Resident #2's March and April 2023 Medication Administration Records include orders for Mirtazapine 15 mg by mouth at bedtime. A Continuity of Care Document created on 1/24/23, stated to be authored by Resident's Primary Care Provider (PCP), which does not include an actual or electronic physician's signature, indicates Resident #2 has been taking Mirtazapine 15 mg at bedtime since 10/20/22. There is no evidence of a signed order or order clarification from Resident #2's PCP following receipt of the signed document from the Memory Care Provider dated 12/19/22 which prescribes Mirtazapine 7.5 mg at bedtime.	(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:	(R136)	(PLEASE SEE ATTACHE.)	

CAD

Ja

Division of Licensing and Protection

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 R-C 04/19/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER
OUR LADY OF THE MEADOWS

STREET ADDRESS, CITY, STATE, ZIP CODE
**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
{R136}	<p>Continued From page 9</p> <p>Based on record review and staff interview there was a failure to complete a change in condition assessment for one applicable resident (Resident #1). Findings include:</p> <p>Resident #1 was admitted to the facility on 9/29/22. Resident #1 began to display signs of PTSD following a physical assault by another resident in November of 2022. Nursing Notes indicate Resident #1 experienced a significant change following the assault including a Nursing Note dated 1/19/23 documenting anxiety and a change in sleep pattern which indicates his/her Primary Care Provider (PCP) feels Resident #1 is experiencing Post Traumatic Stress Disorder (PTSD) from the assault. Subsequent notes document changes to eating pattern with weight loss, gagging and vomiting; anxiety around other residents and not wanting to socialize or participate in activities on 2/21/23; multiple attempts to leave his/her room then retreating back inside, continued nausea and vomiting on 3/23/23; and increased anxiety with paranoia and agitation on 4/6/23.</p> <p>A reassessment of Resident #1 was signed as completed by the Nurse Manager for Resident #1 on 1/24/23, however the first page of the Resident Assessment form does not indicate the reassessment was a significant change in status assessment. Section F5 Change in Behavioral Symptoms of the assessment form completed on 1/24/23 indicates Resident #1 had no change in behavioral status in the previous 90 days.</p> <p>On the afternoon of 4/19/23 the Nurse Manager confirmed a significant change of condition assessment was not completed in response to</p>	{R136}		

SAD

Jo

Division of Licensing and Protection

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 R-C 04/19/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER
OUR LADY OF THE MEADOWS

STREET ADDRESS, CITY, STATE, ZIP CODE
**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
{R136}	Continued From page 10	{R136}		
{R145} SS=G	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.9.c (2)</p> <p>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;</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure the written plan of care that addresses care and services necessary to maintain independence and well-being for 3 applicable residents (Resident #1, #2, and #3). Findings include:</p> <p>1. Resident #1 is diagnosed with Alzheimer's Disease and displays signs of confusion including attempting to use a high rise toilet seat as a walker on 3/31/23; mood dysregulation; and decline in verbal communication noted as "word salad" speech on 3/9/23, which is a term used to describe confused and unintelligible speech characterized by random use of words and phrases.</p> <p>S/he has a cardiac pacemaker due to a Conduction Disorder of the heart, which is a</p>	{R145}	(PLEASE SEE ATTACHES)	

SAD

J6

Division of Licensing and Protection

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 R-C 04/19/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER
OUR LADY OF THE MEADOWS

STREET ADDRESS, CITY, STATE, ZIP CODE
**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
{R145}	Continued From page 11 blockage of electrical signals that stimulate the heart to contract. On 2/6/23 Resident #1's daughter notified the facility regarding receipt of a pacemaker report stating Resident #1 experienced an episode of ventricular tachycardia with a heart rate of 215 beats per minute. Resident #1 was assaulted by another resident in November of 2022 and sustained facial fractures. Nursing Notes document increasing anxiety following the assault including a Nursing Note dated 1/19/23 documenting anxiety with a change in sleep pattern and indicating his/her Primary Care Provider (PCP) feels Resident #1 is experiencing Post Traumatic Stress Disorder (PTSD) from the assault. Subsequent notes indicate changes to eating pattern with weight loss, gagging and vomiting, anxiety around other residents, and not wanting to socialize or participate in activities on 2/21/23; multiple attempts to leave his/her room then retreating back inside, continued nausea and vomiting on 3/23/23; and increased anxiety with paranoia and agitation on 4/6/23 following the discontinuation of Sertraline on 3/24/23. Resident #1's plan of care fails to address care and services required related to Alzheimer's Disease; risk for a cardiovascular event; and the physical and psychological impact of trauma including anxiety, agitation, nausea/vomiting, and risk for weight loss. 2. Resident #2 is diagnosed with Frontotemporal Dementia (FTD) including both behavioral and semantic (affecting speech and language comprehension) variants of this degenerative brain disease. Progressive atrophy of brain cells	{R145}		

SAD

Jo

Division of Licensing and Protection

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 R-C 04/19/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER
OUR LADY OF THE MEADOWS

STREET ADDRESS, CITY, STATE, ZIP CODE
**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
{R145}	<p>Continued From page 12</p> <p>associated with FTD causes increasing changes in personality, behaviors, cognitive ability and communication deficits.</p> <p>Resident #2's care plan lists "Dementia Resident at risk for safety issues"; however does not specifically address behavioral concerns related to verbal and physical aggressions towards other residents and intrusive behaviors documented in Nursing Notes on 1/12/23, 1/19/23, 2/6/23, 2/27/23, 3/6/23, 3/20/23, and 3/28/23.</p> <p>His/her plan of care identifies the goal "Resident will not fall from bed or chair", however the plan does not identify interventions to prevent falls and decrease risks for injury due to falls including the use of a lowered bed which began on 3/16/23, and a plan to safely lift the resident after falls. Fall lift assists for Resident #2 are noted to result in staff injuries and risk for resident injuries on 3/31/23, 4/3/23, 4/4/23, 4/10/23, and 4/19/23. A Nursing Note on 4/17/23 states "there is an issue with [Resident #2's] bed rail" however there is no plan for the use of a bedrail included in Resident #2's plan of care. Resident #2's care plan does not address frequent intentional transitions to the floor with refusal to get up or participate in lift assists; and episodes of "arm crawling", also referred to as "army crawling", when s/he transitions to the floor and uses his/her arms to crawl on the floor. These behaviors pose safety risks for Resident #2, create trip/fall risks for other residents, and impede access to hallways and resident rooms.</p> <p>Additionally, his/her plan of care does not include goals and interventions related to urinary and fecal incontinence documented in Nursing Notes on 3/31/23 and 4/17/23.</p>	{R145}		

CAD

Ja

Division of Licensing and Protection

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 R-C 04/19/2023
NAME OF PROVIDER OR SUPPLIER OUR LADY OF THE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 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
(R145)	Continued From page 13 3. Resident #3 is diagnosed with severe Vascular Dementia; and cardiovascular conditions including high blood pressure, history of stroke and heart attack, heart failure, and Angina (chest pain due to reduced blood flow to the heart). His/her plan of care does not address risk for a cardiovascular event. S/he is prescribed Nitroglycerine as needed for chest pain. Use of Nitroglycerin requires blood pressure monitoring due to risk of rapid drop in blood pressure and pulse. Administration of Nitroglycerine presents a risk for falls and injury due to dizziness, lightheadedness and fainting resulting from rapid dilation of the blood vessels. It is important to ensure the Resident is not standing when the medication is administered and gets up slowly following administration. Nitroglycerine requires storage without exposure to heat, moisture, and light; and this medication is ineffective when the bottle is not stored properly, is opened frequently or expired. Resident #3's plan of care does not a plan for Nitroglycerine administration and storage. On the afternoon of 4/19/23 the Nurse Manager acknowledged the plans of care for the sampled residents did not address all resident's conditions and needs.	(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	(R162)	(PLEASE SEE ATTACHED)	

SAD

56

Division of Licensing and Protection

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 R-C 04/19/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER
OUR LADY OF THE MEADOWS

STREET ADDRESS, CITY, STATE, ZIP CODE
**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
{R162}	<p>Continued From page 14</p> <p>written, signed order and supporting diagnosis or problem statement in the resident's record.</p> <p>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:</p> <p>Nursing Notes for Resident #1 dated 1/25/23 states "MD has called in an order for Sertraline 25 mg daily for two weeks, if tolerated MD would like to increase to 50 mg daily, we will administer this at hs (bedtime) and f/u (follow up) with MD in two weeks to determine if dose should increase". The written order in Resident #1's record for "Sertraline 25 mg oral tablet 1 tab by mouth every day for 2 weeks, if well tolerated increase to 50 mg every day" does not contain an actual or electronic physician's signature.</p> <p>A Nursing Note for Resident #1 dated 3/24/23 indicates a verbal order was received to discontinue administration of Sertraline, and his/her Medication Administration Record indicates the order for Sertraline 50 mg tablets was discontinued on 3/24/23.</p> <p>At 4:11 PM on 4/19/23 the Nurse Manager confirmed s/he was unable to provide documentation of a written signed order to discontinue Sertraline for Resident #1.</p>	{R162}		

59

50

Deficiency Statement Plan of Correction (POC) for Survey Date: 04/19/23

Facility Name: Our Lady of the Meadows

Deficiency Regulation	How the deficiency was corrected	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
<p>R126 5.5a</p>	<p>A signed order was received on 5/24/23 to support starting resident on Sertraline 25mg daily beginning on 1/24/23.</p> <p>A signed order was received on 5/17/23 to support d/c Sertraline 50mg on 3/24/23.</p> <p>Risperidone 0.25mg scheduled for HS was ordered on 4/7/23 but did not start until 4/10/23. This delay was due to the resident experiencing flu or cold-like symptoms, in addition to not wanting to start new medication over the weekend without nursing present in the building.</p> <p>Docusate Sodium order from PCP corrected on MAR to reflect the complete order.</p> <p>On 5/17/23 a signed order was obtained from PCP to continue Mirtazapine 15mg PO at HS.</p>	<p>05/24/23</p> <p>05/17/23</p> <p>05/19/23</p> <p>5/19/23</p> <p>05/17/23</p>	<p>The Nurse Manager met with the nursing team on 05/18/23 to instruct them on the expectation to begin utilizing the computer-generated automatic Stop Date function on the EMR effective 05/25/23.</p> <p>The Nurse Manager will reconcile all Resident's medication orders and the Medication Administrative Record (MAR) on a regular basis to ensure that the orders are signed by the physician and that the MAR is accurate.</p>	<p>Nurse Manager</p>

R126 5.5a 2.	All three resident's care plans were updated and are based on the abilities and needs as identified in the resident assessment.	06/02/23	<p>The Nurse Manager met with the nursing team on 05/18/23 to review the expectations regarding developing a resident care plan. Additionally, going forward two nurses will review and sign off on all resident care plans before they are implemented by the Direct Care Staff.</p> <p>Also, a per diem registered nurse is actively reviewing all current residents' care plans to ensure accuracy and provide findings to the Nurse Manager for review and implementation.</p>	Nurse Manager
R126 5.5a 3.	Resident #1's assessment was updated to reflect a significant change in status vs reassessment and note changes in behavior status in the previous 90 days.	05/19/23	<p>The Nurse Manager met with the nursing team on 05/18/23 to review the expectations that each resident will be reassessed annually and at any point when there is a significant change in the resident's physical or mental condition.</p> <p>Additionally, going forward two nurses will review and sign off on each resident assessment before it is part of the resident's clinical record.</p>	Nurse Manager
R128 5.5c	<p>Upon entering new medication orders that are time sensitive and require follow-up with the ordering provider, computer generated automatic stop dates will be implemented.</p> <p>Risperidone 0.25mg scheduled for HS was ordered on 4/7/23 but did not start until 4/10/23. This delay was due to the resident experiencing flu or cold-like symptoms, in addition to not wanting to start new medication over the weekend without nursing present in the building.</p> <p>Reviewed order for Docusate Sodium. Order from PCP corrected on MAR to reflect the complete order.</p>	<p>05/24/23</p> <p>05/19/23</p>	<p>The Nurse Manager has met with the nursing team on 05/18/23 to instruct them on the expectation to begin utilizing the computer-generated automatic Stop Date function on the EMR effective 05/25/23.</p> <p>The Nurse Manager will reconcile all Resident's medication orders and the Medication Administrative Record (MAR) on a regular basis to ensure that the orders are signed by the physician and that the MAR is accurate.</p> <p>Additionally, Resident's MARs will be evaluated by a nurse at the monthly medication cycle change to ensure medication orders are complete.</p>	Nurse Manager

	A signed order was then obtained from PCP to continue Mirtazapine 15mg PO at HS.	05/17/23		
R136 5.7c	Resident #1's assessment was updated to reflect a significant change in status and noted behavioral status had changed as compared to the status of the previous 90 days.	05/19/23	<p>The Nurse Manager met with the nursing team on 05/18/23 to review the expectations that each resident will be reassessed annually and at any point when there is a significant change in the resident's physical or mental condition.</p> <p>Additionally, going forward two nurses will review and sign off on each resident assessment before it is part of the resident's clinical record.</p>	Nurse Manager
R145 5.9c(2)	Residents 1, 2, and 3 care plans were updated and are based on the abilities and needs as identified in the resident assessment.	05/18/23	<p>The Nurse Manager met with the entire nursing staff on 05/18/23 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.</p> <p>Additionally, going forward two nurses will review and sign off on all resident care plans before they are implemented by the Direct Care Staff.</p> <p>Also, a per diem registered nurse is actively reviewing all current residents' care plans to ensure accuracy and provide findings to the Nurse Manager for review and implementation.</p>	Nurse Manager
R162 5.10c	<p>A signed order was received to support starting resident on Sertraline 25mg daily beginning on 1/24/23.</p> <p>A signed order was received to support d/c Sertraline 50mg on 3/24/23.</p>	<p>05/24/23</p> <p>05/17/23</p>	The Nurse Manager will reconcile all Resident's medication orders and the Medication Administrative Record (MAR) on a regular basis to ensure that the orders are signed by the physician and that the MAR is accurate.	Nurse Manager