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

August 11, 2023

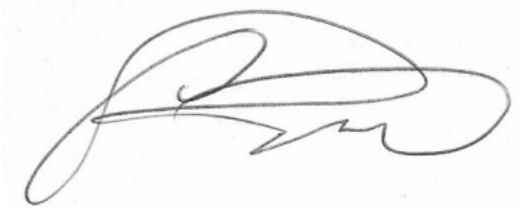
Mr. Joseph Olio, Manager
Our Lady Of The Meadows
1 Pinnacle Meadows
Richford, VT 05476-7637

Dear Mr. Olio:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 18, 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,



Carolyn Scott, LMHC, M.S.
State long Term Care Manager

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 07/18/2023

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 7/18/23 the Division of Licensing and Protection conducted on unannounced on-site investigation of one complaint. The following regulatory deficiencies were identified during the investigation:	R100	Please See Attachment	
R208 SS=G	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 there was a failure to report a pattern of aggressive and assaultive behaviors demonstrated by one applicable resident (Resident #1) to the Division of Licensing and Protection. Findings include: Per record review Resident #1 demonstrated a pattern of abusive behaviors including 6 incidents of assaultive behavior between 5/18/23 and 6/19/23. Nursing Notes document Resident #1 "ramming his/her walker into other resident's walkers and making threats towards staff and other residents" on 5/18/23; ramming a chair into staff then swinging fists, grabbing staff tightly, and attempting to bite staff on the morning of 5/19/23	R208		

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R208	Continued From page 1 followed by "punching and kicking at staff that were trying to direct her away from another resident" on the afternoon of 5/19/23; "hitting at, trying [to] bite and whip staff with his/her chair remote" and "going after residents" on 6/4/23; "combative behavior" including punching staff in the mouth during wound care on 6/16/23; and "swinging, biting, kicking, pushing his/her walker into staff, tossing chairs, and going after other residents in their rooms that were sleeping" followed by Resident #1 losing his/her balance and falling as s/he attempted to run away from staff, and combative behavior as staff attempted to assist on 6/19/23. On 7/7/23 Resident #1 punched one staff member in the abdomen and another in the face when they responded to another resident yelling and attempted to guide Resident #1 out of the other resident's room and into his/her own room. Resident #1 "came back out of his/her room" and "went limp" as staff attempted to guide him/her to a safe area. Resident #1 was lowered to the floor by staff, and assisted back up to a standing position following administration of Lorazepam. Per Nursing Notes "[Direct Care Staff] were gathering other Residents for AM meal on the other end of the hallway and then observed [Resident #1] strike another Resident (Resident #2) with his/her walker resulting in [Resident #2] falling to the floor." Resident #2 was transported to the hospital, diagnosed with a hip fracture, and determined to be a "non surgical candidate". A Nursing Note on 7/10/23 indicates "It is unclear if [Resident #2] can be rehabilitated or not, referrals have been sent out to SNF (Skilled Nursing Facilities) at present". On the morning of 7/18/23 the facility's Financial Manager confirmed Resident #2 was still receiving inpatient care in the hospital for the injury sustained during the	R208		

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R208	Continued From page 2 assault by Resident #1 on 7/7/23. While the facility reported the incident of resident-to-resident abuse on 7/7/23 resulting in an injury requiring physician's intervention to the licensing agency in a timely manner, the facility failed to notify the licensing agency regarding the pattern of abusive behavior demonstrated by Resident #1 including 6 incidents of assaultive behavior that occurred between 5/18/23 and 6/19/23. At 3:11 PM on 7/19/23 the Manager confirmed Resident #1's pattern of abusive behaviors was not reported to the licensing agency.	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 interview and record review there was a failure to protect the right to be free of physical abuse for one applicable resident (Resident #2). Findings include: Per record review Resident #1 has diagnoses including Severe Vascular Dementia with Agitation and Adjustment Disorder with Depressed Mood; and a history of disruptive and aggressive behaviors. Per record review Resident #1 demonstrated a pattern of abusive behaviors	R224		

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R224	Continued From page 3 including 6 incidents of assaultive behavior between 5/18/23 and 6/19/23. Resident #1's Care Plan indicates s/he is "At risk for injury to self and others due to aggressive behaviors" with identified goals including "Resident will be redirected, validated or removed from the area prior to escalations" initiated on 5/17/23, and "Will not harm self or others" initiated on 5/26/23. Interventions identified in the Care Plan include "Attempt validation, redirection or removal from area prior to or as aggression progresses to avoid injury to self and others", and "Remove Resident from public area when behavior is disruptive". On 7/7/23 Resident #1 punched one staff member in the abdomen and another in the face when they responded to another resident yelling and attempted to guide Resident #1 out of the other resident's room and into his/her own room. Resident #1 "came back out of his/her room" and "went limp" as staff attempted to guide him/her to a safe area. Resident #1 was lowered to the floor by staff, and assisted back up to a standing position following administration of Lorazepam. Per Nursing Notes "[Direct Care Staff] were gathering other Residents for AM meal on the other end of the hallway and then observed [Resident #1] strike another Resident (Resident #2) with his/her walker resulting in that Resident falling to the floor." Resident #2 was transported to the hospital, diagnosed with a hip fracture, and determined to be a "non surgical candidate". A Nursing Note on 7/10/23 indicates "It is unclear if [Resident #2] can be rehabilitated or not, referrals have been sent out to SNF (Skilled Nursing Facilities) at present". On the morning of 7/18/23 the facility's Financial Manager confirmed Resident #2 was still receiving inpatient care in the hospital for the	R224		

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R224	Continued From page 4 injury sustained during the assault by Resident #1 on 7/7/23. Please refer to tag 266.	R224		

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Deficiency Statement Plan of Correction (POC) for Survey Date:

Facility Name:

Deficiency Regulation	How the deficiency was corrected	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R208 5.18.c	The Facility Manager has met with the Nursing staff and instructed them that any pattern of abusive behavior must be reported to the Division of Licensing and Protection.	08/08/2023	On 08/08/2023, The nursing team received an official write-up for not following the Residential Care Home Licensing Regulations. A new copy of the Residential Care Home Licensing Regulations has been issued to the nursing team for review.	Facility Manager and Nurse Manager
	• Due to the patterned behavior exhibited by Resident #1, Administration met with Resident #1's POA on Friday 7/27/23 to discuss the ongoing behavioral patterns. Due to the care needs and being harmful to oneself or others, Resident #1 received a 30-day termination notice with a discharge date of August 26, 2023.	7/27/2023	• A copy of The Discharge letter was given to the POA, and a copy was placed in Resident #1's chart.	
	• In-person training will be conducted. Utilizing the Cares Dementia-Related Behavior, Module #4: Key Responses to Dementia-Related Behavior and a training session on Resident Rights.	8/11/2023	• Mandatory training for Nursing, Direct care, and activity Staff is being conducted and will be completed by 8/8/2023. The pieces of training cover Key Responses to Dementia-Related Behavior and Resident Rights. Tag R208 accepted on 8/9/23 - J. Evans	
R224 6.12	• Due to the patterned behavior exhibited by Resident #1, Administration met with Resident #1's POA on Friday 7/27/23 to discuss the ongoing behavioral patterns. Due to the care needs and being harmful to oneself or others, Resident #1 received a 30-day termination notice with a discharge date of August 26, 2023.	7/27/2023	• A copy of The Discharge letter was given to the POA, and a copy was placed in Resident #1's chart.	Facility Manager
	• In-person training will be conducted. Utilizing the Cares Dementia-Related Behavior, Module #4:	8/11/2023	• Mandatory training for Nursing, Direct care, and activity Staff is being	

R224 6.12 (Continued from page 1)	Key Responses to Dementia-Related Behavior and a training session on Resident Rights.		conducted and will be completed by 8/8/2023. The pieces of training cover Key Responses to Dementia-Related Behavior and Resident Rights. Tag R224 accepted on 8.9/23 - J. Evans	