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 28, 2024

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 **April 23, 2024.** 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.

If you have any questions, please feel free to contact me at (802) 585-0995.

Sincerely,

Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

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 04/23/2024

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 4/23/24 the Division of Licensing and Protection conducted an unannounced onsite relicensure survey, and investigation of one facility reported incident and one complaint. The following regulatory deficiencies were identified:	R100		
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 to ensure development of a written plan of care which described the care and services required to maintain the resident's well-being for one applicable resident (Resident #1). Findings include: Per record review Resident #1 was admitted to the facility's memory care center on 1/24/23 with a diagnosis of Alzheimer's Disease, and was admitted into hospice care on 2/22/24. S/he has a documented history of refusing personal care with episodes of aggressive and assaultive behaviors towards staff attempting to provide care as documented in Nursing Notes written on 12/5/23, 12/27/23, 1/9/24, and 1/16/24. Per interview with Direct Care Staff (DCS) on the morning of	R145	Please See Attachments	

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Manager	6-24-24

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R145	Continued From page 1 4/23/24, Resident #1 has periods of time when s/he is unable to verbally communicate, and has a history of resisting care with verbally and physically aggressive behaviors towards staff. Per review of the facility's internal investigation of an incident occurring on 3/28/24, Resident #1 sustained a skin tear to his/her right elbow and lacerations across his/her nose and left cheek when staff continued to provide incontinence care as Resident #1 swung his/her arms in resistance to care. A Progress Note in Resident #1's record dated 3/29/24 documents this incident and states Resident #1 was flailing his/her arms around and injured himself/herself while resisting care. See Tag 227 On review of the Plans of Care on file in Resident #1's record, the Plans of Care on file prior to the incident that occurred on 3/28/24 did not identify Resident #1's history of refusing care; history of aggressive/assaultive behaviors towards staff while resisting care as noted in Resident #1's record on 12/5/23, 12/27/23, 1/9/24, and 1/16/24; and risk for injury to self or others while resisting care. The plans of care on file prior to the incident on 3/28/24 also did not include instructions for staff regarding appropriate interventions to maintain a safe environment in response to Resident's resistance to care and aggressive/ assaultive behaviors. At 2.:33 PM on 4/23/24 the facility's Finance Manager acknowledged Resident #1's plan of care did not describe care and services related to aggressive/assaultive behaviors and resistance to care prior to the incident that occurred on 3/28/24, which resulted in Resident #1 sustaining injuries. In conclusion this deficient practice is a risk for	R145	Please see Attachments	

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R145	Continued From page 2 more than minimal harm to this resident resulting from unidentified residents needs and interventions. Deficient care planning was a factor in actual harm to Resident #1 who sustained a skin tear and lacerations during a physical altercation with staff who did not have access to a plan of care which described goals and interventions related to resistance to care and aggressive /assaultive behaviors.	R145	Please see Attachments	
R176 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (4) Medications left after the death or discharge of a resident, or outdated medications, shall be promptly disposed of in accordance with the home's policy and applicable standards of practice. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure the Residential Care Home (RCH) disposed of outdated or unused medication in accordance with Section 5.10.h of the Vermont Residential Care Home Licensing Regulations effective 10/3/2000. Findings include: On the afternoon of 4/23/24, the Nurse Manager confirmed the RCH did not have a current policy and procedure in place for the disposal of expired medications. Per observation of the facility medication rooms, it was noted that expired medication, and creams,	R176		

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R176	Continued From page 3 were observed to be in use. Findings include a 2.5 ml container of Lumigan ophthalmic solution expired on 12/23, a 500 count bottle of 325 mg Aspirin tablets expired on 2/24, a 80 count bottle of hair and nail Vitamins expired on 2/24, a 1.76 oz container of Voltaren topical gel expired on 10/23, a 1.76 oz container of Diclofenac sodium gel expired on 11/22, a 100 tablet bottle of One a day Vitamins expired on 3/31/24, two boxes of One touch ultra test strips expired on 3/31/24, three boxes of 0.5 oz Ear wax removal drops expired on 1/24, a 90 mcg Ventolin HFA inhaler expired on 4/24, a 350 count container of soft gel Vitamin D3 expired on 11/23, 100 count bottle of Senna-Plus tablets expired on 2/23, a 125 count bottle of Complete Multivitamins expired on 3/23, a 250 count bottle of Super Vitamin B-complex expired on 1/24, and a 500 count bottle of low dose Aspirin expired on 2/24. This was confirmed by the unit Registered Nurse at the time of finding. In conclusion this deficient practice is a potential risk for more than minimal harm to all facility residents due to the possible use of medications which are expired and ineffective.	R176	Please see Attachments	
R179 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not	R179		

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R179	Continued From page 4 limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure 4 out of 5 sampled staff completed the required yearly trainings. Findings include: The home's Personnel Policy 314 entitled Educational Assistance effective 5/1/2011 states, "Vermont State Regulations mandate that all Direct Care Staff receive at least 12 hours of education yearly". This policy indicates all Direct Care Staff are required to complete all mandatory training. At 11:55 AM on 4/23/24 the Human Resources Manager was requested to provide documentation of the trainings completed during the previous year for a sample of 5 staff. Per review of the staff training records provided for review, 4 out of the 5 sampled staff had not	R179	Please see Attachments	

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R179	Continued From page 5 completed the required yearly trainings. This finding was confirmed by the Financial Director at 2:42 PM on 4/23/24. This deficient practice is a potential risk for more than minimal harm for all facility residents due to inadequate staff education and training to safely and effectively provide resident care.	R179		
R181 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the Executive Director failed to provide written	R181	Please See Attachments	

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R181	Continued From page 6 documentation stating the decision to hire a direct service employee with a substanciated criminal background. Findings include: Policies and procedures related to Staff Criminal Background Checks were not on file and available for review on request on the afternoon of 4/23/24, and had not been developed by the facility. At 11:55 AM on 4/23/24 the Human Resources Manager was requested to provide criminal background checks for a sample of 5 staff for review. The results of criminal background checks revealed 1 of 5 employees had a substanciated conviction. On the afternoon of 4/23/24 the HR Manager confirmed the employee's personnel file did not contain a written statement indicating the decision to hire the employee did not pose a threat to residents of the Residential Care Home. In conclusion this deficient practice is a potential risk for harm to all facility residents due to the failure to conduct a review of criminal background checks and document an administrative decision was made that the substantiated findings did not pose a threat to the safety and well-being of facility residents.	R181	Please see Attachments	
R190 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced	R190		

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R190	Continued From page 7 by: Based on staff interview and record review there was a failure to ensure all required criminal background and abuse registry checks were completed for 5 out of 5 sampled staff. Findings include: On the afternoon of 4/23/24 the Human Resources Manager was requested to provide the facility's policies and procedures related to the completion of criminal background and abuse registry checks for staff. The HR Manger provided a copy of document entitled DAIL Background Check Policy Updated: February 10, 2024, which is a document created by the Vermont Department of Aging and Independent Living. The document includes a definition of the term "Long Term Care Facility " which states this type of facility includes Residential Care Homes. Section III. Background Check Requirements of the document provided states, " Long-term care facilities are required to conduct background checks as set forth in the regulations that govern each facility... and are not subject to the DAIL Background check policy. At 11:55 AM on 4/23/24 the Human Resources Manager was requested to provide documentation of the criminal background and abuse registry checks completed for a sample of 5 staff for review. Per review of the documentation provided, all required criminal background and abuse registry checks had not been completed for 5 out of 5 sampled staff. This finding was confirmed by the Finance Manager at 2:44 PM on 4/23/24. In conclusion this deficient practice is a potential risk for more than minimal harm for all residents, as the requirement for criminal background and	R190	Please see Attachments	

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R190	Continued From page 8 abuse checks is intended to ensure all residents are free from the risk of harm.	R190		
R200 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure written policies and procedures that govern services provided by the home are in use and effective by failing to ensure staff are educated on their location and are able to find and use policies to drive resident care and facilitiy practices. Findings include: On 4/23/24 members of the facility's managerial team were requested to provide the facility's policies and procedures for review pertaining to deficient practices identified during the course of the relicensure survey and investigation process. Policies and procedures related to completion of staff criminal record and abuse registry checks; resident rights, specifically around refusals of care; and nursing services including disposal of outdated medications, development of resident plans of care and written plans for the administration of PRN psychoactive medications by staff other than a nurse; and completion of resident assessments were requested. The requested policies and procedures were not able to be located by staff for review on request. This	R200	Please see Attachments	

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R200	Continued From page 9 finding was acknowledged by the Finance Manager at 2:36 PM on 4/23/24. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents due to failure to provide accessible information and clear instructions related to tasks staff are required to perform.	R200		
R227 SS=G	VI. RESIDENTS' RIGHTS 6.15 Residents have the right to refuse care to the extent allowed by law. This includes the right to discharge himself or herself from the home. The home must fully inform the resident of the consequences of refusing care. If the resident makes a fully informed decision to refuse care, the home must respect that decision and is absolved of further responsibility. If the refusal of care will result in a resident's needs increasing beyond what the home is licensed to provide, or will result in the home being in violation of these regulations, the home may issue the resident a thirty (30) day notice of discharge in accordance with section 5.3.a of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure the right to refuse care for one applicable resident (Resident #1). Findings include: Policies and procedures related to the facility resident's right to refuse care were not on file and available for review on 4/23/24 as confirmed by the facility's Finance Manager at 2:36 PM on	R227	Please see Attachments	

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R227	Continued From page 10 4/23/24. Per record review Resident #1 was admitted to the facility on 1/24/23 to the memory care unit with Alzheimer's Disease, and was admitted into hospice care on 2/22/24. S/he has a history of refusing personal care with incidents of aggressive and assaultive behaviors towards staff attempting to provide care as documented in Nursing Notes written on 12/5/23, 12/27/23, 1/9/24, and 1/16/24. See tag 145. Per review of the facility's internal investigation of an incident occurring on 3/28/24, Resident #1 sustained a skin tear to his/her right elbow and lacerations across his/her nose and left cheek when staff continued to provide incontinence care as Resident #1 swung his/her arms in resistance to care. A Progress Note in Resident #1's record dated 3/29/24 documented this incident and states Resident #1 was flailing his/her arms around and injured himself/herself while resisting care. The facility's internal investigation report and the Progress Note dated 3/29/24 both report staff held Resident #1's hands to prevent movement due to potential exposure of the injuries to fecal matter as Resident #1 flailed his/her arms in resistance to care. Per interview with Direct Care Staff #1 commencing at 10:25 AM on 4/23/24, Staff #1 stated Resident #1 immediately became resistant to care when s/he noticed Resident #1 was soiled and initiated an attempt to bring the Resident to the bathroom for incontinence care. Staff #1 stated Resident #1 was swinging his/her arms in resistance to care while s/he attempted to pull down the resident's soiled pants as the resident sat down on the toilet seat; which resulted in Resident #1 striking himself/herself in the face	R227	Please See Attachments	

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R227	Continued From page 11 and banging his/her elbow on the sink. During the interview Staff #1 stated it was obvious the resident was refusing care. After the Resident sustained injury, Staff #1 radioed for assistance and Staff #2 responded. During an interview commencing at 9:49 AM on 4/23/24, Staff #2 stated when s/he entered Resident #1's room Staff #1 was holding the resident by the arms as Resident #1 was resisting care. Per record review, Staff #1 had not completed any of the trainings required by regulations including but not limited to trainings in Resident Rights; Mandatory Reporting of Abuse, Neglect, and Exploitation; Respectful and Effective Interactions with Residents; General Care and Supervision of Residents; and Dementia Training staff as required for direct care staff who provide care in a Memory Care Special Care Unit. Additionally, prior to the incident resulting in injury on 3/28/24 Resident #1's Plan of Care did not include instructions for staff regarding appropriate interventions in response to resistance to care including aggressive and assaultive behaviors towards staff as noted in Resident #1's record on 12/5/23, 12/27/23, 1/9/24, and 1/16/24. At 2:36 PM on 4/23/24 the facility's Finance Manager acknowledged the failure to ensure Resident #1's right to refuse care during the incident that occurred on 3/28/24. In conclusion this deficient practice caused actual harm to Resident #1, sustained a skin tear and lacerations as a result of a physical altercation with staff who continued to provide care as the resident refused by physically resisting care. Please refer to tags 145 and 179.	R227	Please see Attachments	

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Deficiency Statement Plan of Correction (POC) for Survey Date: 4/23/2024

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
R145 R145 Plan of Correctioin accepted by Jo A Evans RN on 6/28/24	The policy was on file and ready to review at the time of the survey. Care plan was updated on 3/29/24 to reflect resisting care and, history of aggressive/assaultive behaviors towards staff. Included in the care plan are instructions for staff for appropriate interventions to maintain a safe environment.	6/28/2024 6/11/2024	Adding to our monthly staff meeting agendas, the location of policies and procedures will be reviewed for all shifts. This will ensure current and future employees will be familiar with the location of the policies and procedures. Nursing will review monthly on resident patterns and care needs to ensure proper care plans are updated.	HR Manager/Nurse Manager Nurse Manager
R176 R175 Plan of Correction accepted by Jo A Evans RN on 6/28.24	The policy was on file and ready to review at the time of the survey. Expired medications and treatments were immediately destroyed and discarded.	6/28/2024 4/24/2024	Adding to our monthly staff meeting agendas, the location of policies and procedures will be reviewed for all shifts. This will ensure current and future employees will be familiar with the location of the policies and procedures. Med-Techs will be performing monthly reconciliation on all resident medications and treatments to ensure all items are not expired while in use.	HR Manager/Nurse Manager Nurse Manager
R179 R179 Plan of Correction accepted by Jo A Evans RN on 6/28/24	4 out of the 5 sampled staff that were out of compliant have completed their mandatory training.	6/11/2024	The Relias Training program has been changed so that staff are required to do a certain number of trainings every month. Prior settings allowed staff to complete numerous training courses at one time which can result in long periods of time with no training/education. This change will also help staff stay current on their training/education as it will be reviewed monthly.	HR Manager/Finance Manager
R181	The policy was on file and ready to review at the time of the survey.	6/28/2024	Adding to our monthly staff meeting agendas, the location of policies and procedures will be reviewed for all shifts. This will ensure current and future employees will be familiar with the location of the policies and procedures.	HR Manager/Nurse Manager

(continued) R181 R181 Plan of Correction accepted by Jo A Evans RN on 6/28/24	The employee that had a substantiated conviction has written a statement indicating how the decision to hire the employee will not pose a threat to residents here at this facility.	6/11/2024	All current and future employees that have any substantiated convictions will have a written statement indicating how their employment will not pose a threat to the residents at this facility including DUI's. Also, our current policy, 203 Employment Reference Checks, As been revised to include language that any substantiated conviction will have a written notice including DUI's	HR Manager
R190 R190 Plan of Correction accepted by Jo A Evans RN on 6/28/24	The policy was on file and ready to review at the time of the survey.	6/28/2024	Adding to our monthly staff meeting agendas, the location of policies and procedures will be reviewed for all shifts. This will ensure current and future employees will be familiar with the location of the policies and procedures.	HR Manager/Nurse Manager
	All employees working for this facility have had all required criminal background and abuse registry checks completed.	6/11/2024	Following the regulations, we are currently providing all required criminal background and abuse registry checks to prior employees as well as current employees. To follow an annual schedule going forward, all required annual checks will be conducted in the month of December.	HR Manager
R200 R200 Plan of Correction accepted by Jo A Evans RN on 6/28/24	All policies were on file and ready to review at the time of the survey.	6/28/2024	Adding to our monthly staff meeting agendas, the location of policies and procedures will be reviewed for all shifts. This will ensure current and future employees will be familiar with the location of the policies and procedures. In addition to our monthly staff meetings, we have edited our personal policies to include information on how to access policies and procedures. All current staff will receive an updated copy of the personal policies as well as any future employees.	HR Manager/Nurse Manager
	A new policy called "702 Resident Rights Awareness has been created and placed in our policy binder.	5/2/2024	All policy storage locations have been reviewed with the nursing and administration team. A new Personnel Policy has been created and placed in our Personnel Policy Handbook. All staff have received and reviewed the new policy along with our continued annual training for resident rights.	Nurse Manager/Administrator
R227	The Policy, managing challenging behaviors under the Dementia Care Section was on	6/28/21024	Adding to our monthly staff meeting agendas, the location of policies and procedures will be reviewed	HR Manager/Nurse Manager

(continued) R227 R227 Plan of Correction accepted by Jo A Evans RN on 6/28/24	file and ready to review at the time of the survey. We have reviewed the residents rights with Staff #1 to ensure they are current on the policy. A new Personnel Policy has been created called "702 Resident Rights Awareness" which has been received and reviewed by all staff members. Staff #1 has completed all trainings required by regulations as well as additional trainings related to this incident. Resident #1's care plan was updated on 3/29/24 to reflect resisting care and, history of aggressive/assaultive behaviors towards staff. Included in the care plan are instructions for staff for appropriate interventions to maintain a safe environment.	6/11/2024	for all shifts. This will ensure current and future employees will be familiar with the location of the policies and procedures. A new Personnel Policy has been created and placed in our Personnel Policy Handbook. All staff have received and reviewed the new policy along with our continued annual training for resident rights. The Relias Training program has been changed so that staff are required to do a certain number of trainings every month. Prior settings allowed staff to complete numerous training courses at one time which can result in long periods of time with no training/education. This change will also help staff stay current on their training/education as it will be reviewed monthly. Nursing will review monthly on resident patterns and care needs to ensure proper care plans are implemented.	Administrator HR Manager/Finance Manager Nurse Manager