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 **June 5, 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 06/05/2023

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 6/5/23 the Division of Licensing and protection conducted an unannounced on-site investigation of one complaint. The following regulatory deficiencies were identified during the investigation:	R100		
R207 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.b The licensee and staff are required to report suspected or reported incidents of abuse, neglect or exploitation. It is not the licensee's or staff's responsibility to determine if the alleged incident did occur or not; that is the responsibility of the licensing agency. A home may, and should, conduct its own investigation. However, that must not delay reporting of the alleged or suspected incident to Adult Protective Services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to report an incident of suspected abuse to the licensing agency. Findings include: Per record review Resident #1 was admitted to the facility's dementia unit on 8/18/21 with diagnoses including unspecified dementia and anxiety disorder. Per review of the facility's video recording of an incident occurring on the morning of 9/15/22, a direct care staff responded to Resident #1 spilling a beverage and striking the staff member by aggressively turning the chair the resident was seated in away from the table and striking back at the resident. After the staff member cleaned up the spill and walked to a work station Resident #1 was observed walking	R207	Please See Attachments	

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R207	Continued From page 1 towards the work station then pushing and striking the same staff. The staff responded by defensively striking and pushing back at Resident #1 including a second push/strike as Resident #1's was turning to walk away. Moments after the staff member walked away from the work station following this interaction Resident #1 was observed returning the area and aggressing towards another staff member. Per staff interview this incident was observed by an outside provider who reported the incident to the facility on the same day. At 7:03 PM on 6/5/23 the Director of Nursing confirmed the incident of suspected abuse of Resident #1 by staff was not reported to the licensing agency.	R207		
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 observation, record review, and staff interview there was a failure to ensure one applicable resident (Resident #1) was free from physical abuse. Findings include: Per record review Resident #1 was admitted to the facility's dementia unit on 8/18/21 with diagnoses including unspecified dementia and anxiety disorder. Per review of the facility's video	R224		

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R224	Continued From page 2 recording of an incident occurring on the morning of 9/15/22, a direct care staff responded to Resident #1 spilling a beverage and striking the staff member by aggressively turning the chair the resident was seated in away from the table and striking back at the resident. After the staff member cleaned up the spill and walked to a work station Resident #1 was observed walking towards the work station then pushing and striking the same staff. The staff responded by defensively striking and pushing back at Resident #1 including a second push/strike as Resident #1 turned to walk away. Moments after the staff member walked away from the work station following this interaction Resident #1 was observed returning the area and aggressing towards another staff member. On the afternoon of 6/5/23 the Manager confirmed staff struck and pushed Resident #1 in response to Resident #1's physical aggressions towards the staff member.	R224		

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Deficiency Statement Plan of Correction (POC) for Survey Date: 6/5/23

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
R207 5.18.b	On 9/15/22, The Nurse Manager met with Resident #1 moments after the interaction between Resident #1 and a direct care staff member. The Nurse Manager found Resident #1 to be uninjured and not in any apparent distress. Per review of the facility's video recording of the incident on the morning of 9/15/22, a direct care staff calmly walked to the dining room table where resident #1 was seated. The direct care staff member started to pick up a dirty cup from the table when the cup was knocked over spilling liquid. Resident #1 proceeded to strike the direct care staff multiple times as the staff member rotated Resident #1 away from the table to prevent liquid from spilling on the resident's lap. The staff member can be seen blocking and deflecting the hits from Resident #1 multiple times as s/he cleans up the table. Moments later, Resident #1 can be seen leaving the table and walking by the kitchen area where the direct care staff was exiting. Upon the two walking by each other, in one quick motion, Resident #1 strikes the direct care staff member, the direct care staff deflects the strike and pushes Resident #1 away. After reviewing the video footage, on 9/15/22, the direct care staff member was immediately placed on a leave of absence pending an	9/15/22	The Facility Manager met with the Nurse Manager and the nursing team on 6/6/23 to inform them that in addition to notifying Adult Protective Services about suspected or reported incidents of abuse, neglect or exploitation, the staff are also required to notify the licensing agency without delay.	Facility Manager

R207 5.18.b (Continued from page 1)	investigation. An APS report was filed, the Office of Professional Regulations received a report, and Resident #1 POA was notified of the incident. On 9/21/22, upon completing their investigation of the incident, the Manager and Nurse Manager met privately with the direct care staff member to inform her/him of their findings. Upon the conclusion of the meeting, the direct care staff member resigned his/her position, effective immediately, and was escorted out of the building. On 4/4/23, Adult Protective Services completed their investigation and based on their findings, the allegations were not substantiated.		Tag R207 accepted on 8/9/23 - J. Evans	
R224 6.12	On 9/15/22, The Nurse Manager met with Resident #1 moments after the interaction between Resident #1 and a direct care staff member. The Nurse Manager found Resident #1 to be uninjured and not in any apparent distress. Per review of the facility's video recording of the incident on the morning of 9/15/22, a direct care staff calmly walked to the dining room table where resident #1 was seated. The direct care staff member started to pick up a dirty cup from the table when the cup was knocked over spilling liquid. Resident #1 proceeded to strike the direct care staff multiple times as the staff member rotated Resident #1 away from the table to prevent liquid from spilling on the resident's lap. The staff member can be seen blocking and deflecting the hits from Resident #1 multiple times as s/he cleans up the table. Moments later, Resident #1 can be seen leaving the table and walking by the kitchen area where the direct care staff was exiting. Upon the two	9/15/22	Mandatory Dementia Care Training which included how to address challenging behaviors was provided to direct care and activity staff who are assigned to work on our special care unit on 2/2/23, 2/9/23, 2/10/23, 2/17/23, 3/27/23, and 4/20/23 through the CARES Healthcare Interactive. (CARES is an evidence based 6-hour award-winning dementia care training program developed with the Alzheimer's Association.) This training is offered regularly each year. On 9/1 – 9/15/22 and again 10/10 – 10/17/22, further mandatory Dementia Training was offered through the 6-hour MEMIC Dementia Training program entitled Understanding Dementia for Positive Outcomes for direct care and activity staff assigned to work in our special care unit. Additional mandatory training is provided on an ongoing basis to the direct care and activity staff who work in the special care unit through the online Relias Education Program. Training modules are 1 hour each and topics include: • Communicating Effectively	Facility Manager and Nurse Manager

	walking by each other, in one quick motion, Resident #1 strikes the direct care staff member, the direct care staff deflects the strike and pushes Resident #1 away. After reviewing the video footage, on 9/15/22, the direct care staff member was immediately placed on a leave of absence pending an investigation. An APS report was filed, the Office of Professional Regulations received a report, and Resident #1 POA was notified of the incident. On 9/21/22, upon completing their investigation of the incident, the Manager and Nurse Manager met privately with the direct care staff member to inform her/him of their findings. Upon the conclusion of the meeting, the direct care staff member resigned his/her position, effective immediately, and was escorted out of the building. On 4/4/23, Adult Protective Services completed their investigation and based on their findings, the allegations were not substantiated.		• Conflict Resolution • Dementia Care: Preventing Catastrophic Reactions • Essentials of Resident's Rights • Preventing Adverse Reactions to Dementia Care • Dementia Care: The Meaning Behind Behaviors Tag R224 accepted on 8/9/23 - J. Evans	