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

July 20, 2022

Mr. Dale Atwood, Manager
Our Lady Of Providence
47 West Spring Street
Winooski, VT 05404-1397

Dear Mr. Atwood:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 23, 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
	0198	A. BUILDING: _____ B. WING _____	C 06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PROVIDENCE	47 WEST SPRING STREET WINOOSKI, VT 05404

(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 on-site complaint investigation was conducted on 6/14/2022 and 6/21/2022 and completed on 6/23/2022 by the Division of Licensing and Protection. The following regulatory violations were identifed:	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 staff interview and record review, RCH nurses failed to provide the necessary services to meet the nursing and medical care needs of a resident who sustained a physical injury after experiencing a fall. (Resident #1) Findings include: 1. Resident #1 was admitted to the RCH on 8/2021. At the time of admission, the resident had a past history of falls and was demonstrating symptoms of late onset Alzheimer's disease with behavioral disturbance. A Physical Therapy note dated 8/18/21 stated Resident #1 "...demonstrated impairments in strength, balance, gait and endurance....is a high risk for falls." Both memory impairments and lack of compliance by Resident #1 decreased the opportunity for improvement in the resident's	R126	See attached document (62)	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 7-15-2022

R126 - R266 POC's accepted 7/18/22 FMcIntoshRN/PMC

Division of Licensing and Protection

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R126	Continued From page 1 mobility and success with physical therapy. On 5/3/22 at approximately 4:00 AM staff heard a noise coming from Resident #1's room and found the resident laying on his/her left side with a small amount of blood noted near the resident's forehead. Per Nursing note for 5/3/2022 at 6:00 AM "Resident laying beside recliner chair and wheelchair. Noted with egg size bump on left side of forehead. Evaluated for injury..." It required 3 staff with a gait belt to assist Resident #1 from the floor and placed in a wheelchair. The initial post fall assessment included vital signs reportedly conducted x 2 and per Incident Report dated 5/3/22 the neuro checks and vital signs were recorded as "stable". However, per telephone interview on 6/14/22 at 2:05 PM Nurse #2 who conducted the first assessment on 5/3/22 stated "...the resident's right eye was not opening...and had weakness in left hand....". Upon arrival for the day shift on 5/3/22, Nurse #1 received report regarding Resident's #1's fall and injury, and was informed by Nurse #2 "S/he was doing OK". Per interview on 6/21/22 at 10:30 AM, Nurse #1 stated s/he observed the resident and found him/her sleeping in recliner and observed a large hematoma on the left side of the resident's head. "S/He opened his/her eyes briefly....could not make a good assessment...questioned if the pupils were equal". No further vital signs were taken. The charge nurse further stated otherwise "I thought s/he was stable...doing fine" and had Resident #1 transported to the dining room for breakfast. Per interview on 6/14/22 at 1:08 PM Staff #1 stated after the fall Resident #1 was "sleepy"....and acknowledged while in the dinning room "..s/he was not himself/herself". Prior to the fall on 5/3/22 staff who provided care to Resident #1 had noted over approximately the	R126		

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R126	Continued From page 2 previous 7 days a change in the resident's mobility and increased weakness on his/her left arm and leg. Staff #2 also confirmed on 6/14/22 this concern was reported to the staff nurses working on the day shift. Staff #3 further also confirmed Resident #1 had complained of weakness and demonstrated a greater need for assistance with mobility and transfers, all was reported to nursing staff. Although during interview, Nurse #1 could not confirm being informed of Resident #1's changes in presentation and mobility. However, Nurse #2 later documented per Nursing Notes on 5/3/22 "Evening shift has reported resident having difficulty standing up for toileting and could not move his/her left hand, two assisted...." An assessment of the resident's change in mobility and left sided weakness was not conducted. Per RCH Policy Monitoring/Observations By Staff states " 3. Staff should report any changes to the RN and document changes in the resident's Service Notes. When staff report changes in a resident's condition to the RN, he/she must determine what action should be taken. Interventions that might be appropriate include: Additional evaluation by the RN and/or other health care professional." The nursing assessment and documentation conducted by Nurse #1 & 2 was inconsistent and failed to adequately meet standards of nursing practice which would include adequate assessment of eye opening and arousal to include pupil size and equal reaction to light; verbal response; motor response; orientation; speech; voluntary movements; and ability to swallow safely. (Per Lippincott, Manual of Nursing Practice, 8th addition, Neurological Disorders, page 475- 476). As a result, the resident remained in the facility post head injury, offered	R126		

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R126	Continued From page 3 food and brought to the dinning room without conclusive evidence Resident #1 was stable and not provided emergency medical intervention from 4:00 AM to 9:00 AM. Per interview on 6/14/22 at 2:40 PM the Director of Nurses (DNS) stated "...s/he should have been transferred right then and there after the fall". It was not until the DNS's arrival at the facility after 8:30 AM it was determined Resident #1 required emergency medical treatment and was transferred to the hospital. Resident #1 was subsequently diagnosed with a subdural hematoma after sustaining a "Coup-contrecoup injury" (a blow to the skull which leads to brain damage). Resident #1 failed to recover from the brain injury and was placed on Palliative Care. Resident #1 expired on 5/21/22.	R126		
R145 SS=E	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 of the RCH nursing staff to update individual Care Plans for 3 applicable residents. (Resident #1, 2 & 3) Findings include:	R145	See attached document (bc)	

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R145	Continued From page 4 1. Resident #1 was admitted to the RCH on 8/2021. At the time of admission, the resident had a past history of falls and was demonstrating symptoms of late onset Alzheimer's disease with behavioral disturbance. A Physical Therapy note dated 8/18/21 stated Resident #1 "....demonstrated impairments in strength, balance, gait and endurance....is a high risk for falls." A Fall Risk Evaluation was completed at the time of admission and Resident was determined to be at "High Risk" for falls. The Care Plan which was initiated at time of admission (8/21) denotes "At risk for falls" and interventions included "Res. to be walked using walker and WC (wheelchair) behind; Obtain order for Physical therapy; Optimum lighting, remove all fall hazards". However, since admission, Resident #1 had failed Physical therapy; had sustained falls and no longer was ambulating, relying on a wheelchair for mobility and 1-2 assists when toileting. Updates to the Care Plan were not completed. 2. Resident #2 was admitted to the RCH on 9/2021 and discharged to the hospital after sustaining a fall and readmitted to the RCH on 3/8/22 after receiving rehabilitation and long term care at a nursing home. The Care Plan had not been updated since 9/28/21 nor did it address the multiple falls (23) the resident had experienced with the last fall resulting in a fractured femur. In addition, upon the resident's readmission a Care Plan was never initiated despite the resident being placed on Hospice. The DNS confirmed on 6/23/22 the Care Plan for Resident #2 was a "skeleton and not complete". 3. Per record review Resident #3 was admitted to the facility on 2/19. A Morse Fall Scale Assessment for Resident #3 dated 2/13/19	R145		

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R145	Continued From page 5 documented a history of falls, and documentation of a Level of Care Variance on 3/1/19 indicated a high fall and safety risk. An incident report on 1/18/22 stated Resident #3 fell and sustained an injury to the back of his/her head, and on 2/8/22 coordination and balance issues with difficulty using a walker due to memory loss were noted after a visit with his/her primary care provider. On 2/22/22 Resident #3 was accepted into hospice care due to worsening heart failure, further decline of cognitive function and ability to perform ADLs, and further compromise of balance and ability to walk. A Care Plan dated 2/25/2019 failed to address Resident #3's risk for falls. There was a lack of Care Plan updates on record until 5/3/22 when Resident #3's Care Plan was updated to include a high risk for falls due to ongoing cognitive decline.	R145		
R266 SS=H	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RCH failed to ensure a safe environment was provided to all residents who reside at the facility. (Residents #1, 2, 3, 4, 5, 6, 7, 8) Findings include: On 6/14/22 the Surveyors requested the facility Incident Reports for the past 6 months (December 2021 thru May 2022). In response the	R266	See attached document (bcl)	

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R266	Continued From page 6 DNS provided Incident Reports for falls from December 2021 thru February 2022 and part of June 2022. Information from the incident reports identified 34 falls residents had experienced during this time period which included the following: 1. Resident #1 experienced falls to include: on 8/14/21 without injury; 9/2/21 developed a small hematoma on his/her head; 10/24/21 large left arm skin tear; 1/6/22 complained of knee pain; and 4/4/22 fall with no injury and on 5/3/22 sustained a head injury resulting in eventual hospitalization with a subdural hematoma and death 2 weeks after the last fall. 2. Resident #2 sustained a total of 23 falls from 11/16/21 thru 12/21/21. Injuries included head injuries x 2 and a fractured left femur requiring hospitalization. 3. In January 2022 7 reported falls were identified: Resident #5, sustained an injury to the back of their head on 1/31/22; Resident #6 sustained an injury to left temporal/parietal area of the head and multiple bruising on 1/29/22; and Resident #3 sustained injury to back of his/her head on 1/18/22. 4. In February 2022 8 reported falls included Resident #4 who sustained a softball sized egg on right side of forehead on 2/24/22; Resident # 8 fell hit head and complained of headache. Per review of the facility policy Accidents/Incidents - Facility Review states: The DNS and Administrator shall review accident and incident reports. The Administrator and Director of Nursing regarding accidents and incidents, and make recommendations about preventative	R266		

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R266	Continued From page 7 approaches and corrective actions". Per interview on 6/14/22 at 2:50 PM, the DNS confirmed there has not been any formal review or plan for fall prevention despite the multiple falls experienced by residents residing at the RCH. At the time of the onsite, and in an effort to ensure the safety of the residents, Surveyors requested an initial Fall Prevention Plan which was created and provided by the DNS on the afternoon of 6/21/22 and would eventually be shared with nursing staff and all caregivers.	R266		

Plan of Correction, Response to the State

R126; 5.5- the following POC will be implemented

Action:

1. Review and update admissions policy to ensure appropriate and comprehensive fall risk assessments are incorporated consistently and regardless of resident perceived condition.
2. Education to staff nurses about need for comprehensive fall risk assessment for every resident as they are admitted.
3. Review and revise current fall policy and protocol. Fall protocol will be updated to reflect appropriate and timely measurement of vital signs, neuro vital signs, and other follow up as needed based on incident.
4. Annual (or more frequent) review of fall protocol for nurses and ancillary staff.

Measure

1. Upon admission a MORSE FALL RISK assessment will be completed to determine resident fall risk
2. Appropriate fall interventions will be incorporated into resident care plan and clearly documented in resident clinical file.
3. All falls will be fully investigated and attended to immediately by nurse on duty (or on call).
4. All falls will be clearly documented on fall report and in resident medical record immediately after resident's safety has been secured.
5. With any fall, regardless of injury, the resident care plan will be reviewed and updated as appropriate.
6. The updates will be communicated to other nursing staff through the 24-hour report document.

Monitoring

1. All falls will be reported by telephone call to the resident's physician, identified contact person, and the Director of Health Services
2. Fall reports and aligned documentation will be reviewed by the nursing team, the Director of Health Services and when appropriate, the Administrator within 48 hours of a fall.
3. Fall reports will be audited for completeness on a weekly basis to start and then move to monthly once weekly is determined to be 100% accurate.

Completion:

Implementation of changes will occur within 60 days of this POC submission. Anticipated POC to be fully implemented by 9/15/2022

Plan of Correction, Response to the State

R145; 5.9.c- the following POC will be implemented

Action:

1. Review and update policy and template to be used to create individualized care plans for each resident.
2. The care plan will be used as a tool to update nurses and staff about resident changes in physical, mental, and emotional status.
3. All resident care plans will be reviewed, updated, and signed off as complete by the Director of Health Services (or other designated registered nurse) before being placed in resident medical record.

Measure:

1. Re-educate staff nurses about the importance and necessity of care plans that are up to date and currently reflect the resident needs and abilities.
2. All nurses will be required to view this quick and concise care plan writing tutorial: https://youtu.be/0ebTrlOJOsY
3. All nurses will be required to read this blog to understand their specific role in the care plan writing process: https://www.usa.edu/blog/how-to-write-a-care-plan/
4. Reinforce care plans must be comprehensive and complete within 14 days of resident admission to facility whether initial admit or return from other facility (hospital, SAR), at time of significant change, admission to HOSPICE care, and any other time the resident requires a change in level of support in any domain. Care plans must also be updated anytime the resident experiences a significant change in status.

Monitor:

1. Immediate review of all admission documents against the checklist to ensure all appropriate documents have been completed to ensure adequate documentation has been collected to effectively write an individualized care plan.
2. Create a list of residents that will include the date they are due for their annual care plan update
3. All care plans will be co-signed by the Director of Health Services to ensure all care plans are comprehensive and complete
4. Quarterly review of care plans using an audit tool. The audit tool will be designed to identify necessary updates such as medication changes, alterations in needs for ADL assistance, verbalizations by resident, and other necessary components that should be incorporated into the care plan.

Completion date:

Implementation of changes will occur within 60 days of this POC submission. Anticipated POC to be fully implemented by 9/15/2022

Plan of Correction, Response to the State

R266; 9.1.a- the following POC will be implemented

Actions:

1. Update fall reporting documents and processes.
2. Organize and manage storage of fall reports so that they are easily accessible and available for review.
3. Create and implement a PDSA system that includes a monthly review of all fall reports, brainstorming for interventions to minimize falls, and implementation of new policies and procedures intended to combat falls and consequential injuries.

Measurement:

1. Fall incident report has been updated so that all necessary information can be noted in one document for ease of review and assessment. (This document was put into effect on 6/21/2022)
2. All fall reports (and other incident reports) will be completed and placed in a notebook labeled Fall Reports.
3. Care plans and resident assessments will be updated to reflect changes in resident related to fall such as-increased oversight, use of walker, adjusting of medications, etc

Monitoring:

1. Once weekly the overnight nurse will review the fall reports against the audit tool to ensure all follow up has been implemented. Follow up will likely include resident assessment and care plan updates, as well as specific interventions that were noted such as-increase surveillance at night, remove fall hazards like throw rugs from resident room, etc.
2. Results of the audit will be reviewed with the Director of Health Services and other members of the nursing team for review and discussion.
3. The DHS and Administrator will review all fall reports and make recommendations for interventions or programming changes as appropriate.

Completion date

Implementation of changes will occur within 60 days of this POC submission. Anticipated POC to be fully implemented by 9/15/2022