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

May 11, 2018

Ms. Katy Lemery, Manager
Spring Village At Essex
6 Freeman Woods
Essex Junction, VT 05452

Dear Ms. Lemery:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 11, 2018.** 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
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
	0653	A. BUILDING _____ B. WING _____	C 04/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX JUNCTION, VT 05452

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R100	Initial Comments: An unannounced on site investigation for 2 self reports and 1 anonymous complaint was conducted by the Division of Licensing and Protection on 4/10 and 4/11/18. The findings include the following:	R100	Please see attached plan of correction.	
R136 SS=E	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: Based on observation, record review and confirmed by staff interview the facility failed to ensure that State mandated assessment is completed annually and/or at at the time of a change in condition, and that the assessment accurately identifies the health and emotional condition, for 4 of 9 sampled residents, (Residents #1, #2, #3, and #4). The findings include the following: 1. Resident #1, who had a reassessment dated 12/5/17 signed by the Registered Nurse, identifies that over the past 7 days the resident required a mechanical lift (Hoyer) to get out of bed with extensive assistance. The assessment indicated the resident requires limited assistance for dressing, extensive assistance for toilet use and personal hygiene. The resident is incontinent of	R136		

Katy Lemery - Executive Director 5/8/18

R136 - R208 POC accepted 5/9/18 MBertrandRN/Pme

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R136	Continued From page 1 urine multiple times a day and requires limited assistance to move from one location to another in the facility while sitting in the wheelchair. Assessment Definitions are as follows: Limited Assistance: receives physical help/assistance (touch to guide) three (3) or more occasions during the last seven (7) days. Extensive Assistance: while the resident performed part of the activity over the last seven (7) days, care givers were required to lift or pick up a limb or fully support the resident three (3) or more times a week. Total Dependence: Full staff support performance of the activity during the seven (7) day period. Per record review, Physical Therapist has directed staff to use a sit-to-stand transfer aid (lift) for all transfers. Per observation on 4/10/18 at approximately 4 PM the resident was transferred by two (2) care givers to and from the bathroom using the sit-to-stand lift. The resident requires toileting numerous times through out the day and evening and must be transferred via the lift. The resident is incontinent of urine during the night, is transferred to the toilet or requires incontinent care by a care giver. The resident requires assistance daily for dressing/undressing and bathing. The resident is unable to propel him or herself, for any distance in the wheelchair, and staff assistance is observed on 4/10/18, transporting the resident to attend activity programs and to the dining room for lunch. Per discussion with the Executive Director on 4/10/18 and the Director of Nurses on 4/11/18, the resident is totally dependent and requires the assistance of two (2) staff for all transfers, requires assistance with bathing/dressing and	R136		

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R136	Continued From page 2 personal hygiene daily and after toilet use. The resident requires the assistance of (1) staff member to be transported to various activities in the facility daily. Therefore, confirmation was made during the discussion at approximately 9 AM on 4/11/18 that the assessment is inaccurate and does not identify the current needs of the resident. 2. Resident #2, who had a reassessment/significant change dated 3/9/18 signed by the Registered Nurse, identifies that over the past 7 days the resident requires limited assistance with transfer from the bed/chair/standing position. Requires limited assistance for dressing, toilet use, bathing and personal hygiene. The resident is usually incontinent of urine, and requires supervision to move from one location to another in the facility. Assessment Definitions are as follows (and as above): Supervision: Oversight, cueing and encouragement (eyes only no touching) three (3) or more occasions during the last seven (7) days. Per interview with a family member on 4/10/18 at approximately 10 AM, identifies that Resident #2 needs assistance with bathing, dressing and toileting. Although the resident uses a rolling walker, h/she freezes in place and often times is stiff and unable to move limbs freely. Toileting is difficult due to shuffling gait and instability, inability to manipulate clothing and body parts, that frequently results in incontinence. Per review of the medical record, Resident #2 has had six (6) falls since January 2018. The resident has a diagnosis of Parkinson's Disease in which s/he freezes in place at any given time,	R136		

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R136	Continued From page 3	R136		

has noted Parkinson's tremors and needs help with toileting, bathing and dressing. The Medication Administration Record (MAR) for the month of April 2018, identifies that nursing staff apply a barrier cream each shift after incontinent episodes.

Per discussion with the Executive Director on 4/10/18 and the Director of Nurses on 4/11/18 the resident has had multiple falls, confirmation is made that the resident does freeze in place. Family is present daily and does assist with care needs. However, the assessment does not accurately reflect the resident's current status.

3. Per medical record review, Resident #3 fell on 1/14/18. The fall resulted in hospitalization with a diagnosis of a fractured pelvis. The resident returned to the facility on 1/17/18 with dependency on staff for multiple care needs to include positioning, pain management, toileting and bathing. The resident began Hospice services on 1/25/18 and deceased on 1/29/18.

Per medical record review a Resident Assessment was conducted on 1/14/18 prior to the fall, but was not signed by the Registered Nurse (RN). Nor is there evidence that a reassessment was completed at the time of readmission on 1/17/18 or thereafter. The Director of Nurses confirms on 4/11/18 that a reassessment was not conducted at the time of readmission after the fall that resulted in a fractured pelvis.

4. Resident #4, who had a reassessment dated 1/13/2018 signed by the Registered Nurse, identifies that over the past 7 days, the resident required supervision with transferring, was independent with mobility, required limited assistance with dressing, supervision with eating,

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R136	Continued From page 4 and limited assistance with toileting and personal hygiene. During observations on 4/10/2018, Resident #4 required full caregiver assistance during mealtime. S/he needed assistance with eating from a caregiver including verbal cues to open his/her mouth to eat and drink. Resident #4 required a wheelchair for mobility and was dependent on a caregiver to move from their room to the dining room. During interview on 4/11/2018, a caregiver transferring Resident #4 from the wheelchair to bed required the use of a gait belt and stated that Resident #4 required weight-bearing assistance from the caregiver in order to return to bed. A scoop mattress (safety mattress for accident prevention) was observed in Resident #4's apartment, which was included in an update to Resident #4's Care Plan on 4/1/2018. However, there was no evidence in the medical record that Resident #4's individual needs for the scoop mattress had been assessed and documented. Per record review, Resident #4 began "having difficulty with Activities of Daily Living (ADLs)" on 3/27/2018 and documentation indicates a decline in mobility and physical functioning. Hospice orders were dated in the chart for 3/29/2018 and Visiting Nurses Association services were initiated. During interview, the Director of Nurses stated that the scoop mattress was placed on the resident's bed following the initiation of hospice services, however this was not documented in the resident record. Confirmation was made with the Director of Nurses at 1:30 PM on 4/11/2018 that the Resident Assessment does not reflect the current needs of Resident #4.	R136		

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R145	Continued From page 5	R145		
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, the Registered Nurse failed to develop and implement written care plans to address each resident's identified needs to maintain independence and well being for 4 of 9 residents in the sample. (Residents #1, #2, #4, and #6). Findings include: 1. Per record review, Resident #1 was admitted to the facility in July 2017. Since admission the resident has been evaluated by a Physical Therapist who directed staff on 3/12/18, to use a sit-stand transfer aid (lift) for all transfers to and from bed/chair/toilet. The resident care care plan identifies a mobility problem and directs staff to use a Hoyer lift at all times dated 2/2/18 signed by the Registered Nurse (RN). A fall/safety awareness problem identifies on 3/12/18, to uses a sit to stand for all transfers signed by the RN. However, the direction to use the Hoyer lift at all times with 2 assist is still identified as the transfer aid. Per discussion with the Director of Nurses on 4/11/18 at approximately 9 AM, confirms that the care plan is confusing and needs to be clear	R145		

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R145	Continued From page 6 to the care staff what device is to be used and what the resident's current needs are. 2. Per record review, Resident #2 was admitted to the facility on June 2017, and has experienced six (6) falls in 2018. Facility incident reports identify all incidents were unwitnessed and the resident was found on the floor in his/her apartment. Five (5) of the (6) falls occurred before 8 AM. All incident reports are incomplete, for there are no comments and/or steps identified to prevent reoccurrence. Fall risk assessment completed on 7/12/17 identifies a score of 45 placing resident at high risk for falls. Per care plan dated 2/22/18, Fall/ Safety Awareness problem identifies resident is placed on the falling leaves program, fall risk evaluation/assessment, redirect as needed, low bed, transfer aid bed enabler, walker, no skid socks, motion sensor and to remove any environmental risks. Resident has a new treatment for a topical ointment to be applied daily to bilateral shoulders for possible eczema. Medication Administration Record (MAR) identifies the use of barrier cream after episodes of urinary incontinence every shift. There is no evidence that Resident #2's care plan was updated to address the pattern of falls to include interventions to monitor the resident and prevent or reduce injuries related to the falls. Nor is there evidence in the care plan to direct care providers on the management of either skin conditions. The Director of Nurses confirmed during interview on 4/11/18 at approximately 9 AM that the care plan does not address Resident #2's current care needs. 3. Resident #4 was admitted to the facility in January 2017, and experienced multiple falls and changes in his/her medical condition. Per record	R145		

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R145	Continued From page 7 review and review of facility incident reports, Resident #4 experienced episodes of unobserved falls in his/her bedroom and in the common areas of the facility on 12 days between January 1, 2018 and April 4, 2018. Resident #4's plan of care dated 1/17/2017 includes "Fall/ Safety Awareness" as a goal including "fall risk evaluation and assessment, redirect as needed, no skid stockings/shoes and Falling Leaves Program. On April 1, 2018 the, "Fall/ Safety Awareness" goal was updated to include "HiLo bed and scoop mattress". There is no evidence that Resident #4's care plan was updated to address the pattern of falls to include interventions to monitor the resident and prevent or reduce injuries related to the falls. The lack of a care plan to address Resident #4's identified needs was confirmed during interview with the Director of Nursing at 1:30 PM on 4/11/2018. 4. Resident #6 was admitted to the facility in November 2016. Per record review, Resident #6's Resident Assessment dated 11/27/2017 identifies the need for "Extensive Assistance" (defined as weight bearing help or full caregiver assistance) three or more times in the last 7 days in the Activities of Daily Living (ADLs) including Mobility in Bed, Transferring, Mobility, Dressing, Toileting, Personal Hygiene and Bathing. These ADLs required one person physical assistance. During observation on 4/10/18, Resident #6 required full caregiver assistance in order to complete personal hygiene. Per review of Resident #6's last Care Plan, written on 9/30/2017 and updated on 1/1/2018, includes the goal to, "Maintain current level of function" with minimum to moderate assistance for ADLs. Interventions include, "toilet use- provide assistance....personal hygiene/oral care- provide assistance". The care plan failed to include	R145		

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R145	Continued From page 8 specific interventions and frequency of care required in order to meet Resident #6's assessed needs related to personal hygiene, ambulation and bathing. The findings were reviewed with the Director of Nursing on 4/11/2018 at 1:30 PM.	R145		
R208 SS=D	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 record review and staff interview, the facility failed to report to the Division of Licensing and Protection a pattern of resident to resident altercations in a timely manner for 1 out of 9 applicable records reviewed, nor did the facility develop a specific plan to address the pattern of behavior for 1 out of 9 residents in the sample (Resident # 5). Findings include: Per record review, Resident # 5 exhibited a pattern of physically aggressive behaviors toward Resident # 4. Resident #5, with diagnoses including dementia, anxiety, and depression, had a behavior management plan addressing behavior concerns including, "increased agitation/	R208		

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R208	Continued From page 9 aggression related to confusion and Lewy Body" developed on 9/30/2017. On 11/11/2017, Resident #5, "became agitated" and shook Resident #4 by both arms. On 1/2/2018, Resident #5 exited his/ her room, entered the hallway and grabbed Resident #4 and shook his/ her arm above the elbow. The Behavior Plan had been reviewed on 12/29/2017, but there were no changes to address the repeated incidents between the residents, who lived in the same unit of the residence. Per review of the policy, Reporting on Allegations Abuse, Neglect or Exploitation of a Vulnerable Adult, "incidents involving resident to resident abuse must be reported to the Licensing Agency...if there is a pattern of abusive behavior." The Director of Nursing confirmed that the incident on 1/2/2018 had not been reported to the Division of Licensing and Protection, and that Resident #5's care plan had not been updated to address the pattern of physically aggressive behavior on 4/11/2018 at 1:30 PM.	R208		

5/1/2018

Ms. Pamela M. Cota, RN
Licensing Chief
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

Dear Ms. Cota,

In response to the letter received dated April 25th, 2018 regarding a complaint investigation at our facility on April 11th, 2018, here is our written plan of correction.

R136 SS=E

1. The corrective action taken to resolve this deficiency is new assessments will be completed on the three residents (Resident identified as #3 passed away on 1/29/2018) identified in the report as needed significant change assessments. Assessments will be completed by May 10th. Director of Nursing will sign off on and give a copy of each to the Executive Director.
2. The measure put in place to ensure this deficiency does not reoccur is The Director of Nursing and the Executive Director will receive a written report daily from nursing staff regarding resident statuses and changes. Based on this report the Director of Nursing will determine which residents she will do assessments for. At that time, she will gather all information needed in 7 days (i.e. charting per shift, MD notes, family input, staff input) she will update all assessments as necessary with significant change within 10 days of notice of change. As new assessments are completed the Executive Director will see the assessment to ensure completion.
3. This corrective action will be completed by the Director of Nursing or a RN delegated by the Director of Nursing. Director of Nursing will sign off on and give a copy of each to the Executive Director. The Executive Director will be checking assessments monthly to ensure accuracy.

R145 SS=E

1. The corrective action taken to resolve this deficiency is written care plans will be updated on the four residents identified in the report. Director of Nursing will complete and give a copy to the Executive Director by May 10th.
2. The measure put in place to ensure this deficiency does not reoccur is The Director of Nursing will receive a written report daily from nursing staff regarding resident statuses and changes. Based on this report, the Director of Nursing will determine which residents she will need to update care plans. At that time, she will gather all information needed in 7 days (i.e. charting, updated assessment) and she will then update the care plan as needed. Weekly the Director of

Nursing will inform the Executive Director of all care plan updates. Director of Nursing will provide the Executive Director with a copy to ensure completion.

3. This corrective action will be completed by the Director of Nursing or a RN delegated by the Director of Nursing and the Executive Director will ensure it is done. The Executive Director will be spot checking care plans monthly to ensure accuracy.

R208 SS=D

1. The corrective action taken to resolve this deficiency is Resident #5 will have an updated behavior plan that the Director of Nursing will complete and implement by May 10th. The residents listed in the deficiency currently live on different units in the facility.
2. The measure put in place to ensure this deficiency does not reoccur is that all Incident Reports and resident to resident incidents will go directly to the Executive Director daily to be signed off before going to the Director of Nursing. All incidents that are resident to resident specifically those that show a pattern of abusive behavior will be immediately reported to the state by the Executive Director.
3. This corrective action will be completed by the Executive Director.

Katy Lemery - Executive Director 5/8/18

Executive Director Signature Date