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

October 31, 2018

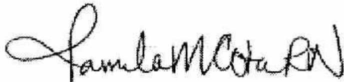
Ms. Susan Spadaro, Manager
Village At Cedar Hill, Inc
92 Cedar Hill Drive
Windsor, VT 05089-4436

Dear Ms. Spadaro:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 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
	1003	A. BUILDING: ______ B. WING ______	C 09/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE AT CEDAR HILL, INC	92 CEDAR HILL DRIVE WINDSOR, VT 05089

(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: The Division of Licensing and Protection conducted an unannounced onsite re-licensure survey and investigation of two entity self-reported incidents from 9/10/2018 through 9/11/2018 to determine compliance with the Vermont Assisted Living Residence licensing regulations. There were no regulatory violations identified related to the re-licensure survey. The following regulatory violations were identified related to one self-reported incident.	R100		
R213 SS=D	VI. RESIDENTS' RIGHTS 6.1 Every resident shall be treated with consideration, respect and full recognition of the resident's dignity, individuality, and privacy. A home may not ask a resident to waive the resident's rights. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the residence failed to ensure that Resident #1 was treated with consideration and respect, with full recognition of their individual dignity. Findings include: Resident #1, with diagnoses including dementia and impaired hearing, had a Resident Service Plan updated on 3/1/2018 stating, "resident becomes verbally aggressive when s/he does not wish to accept assistance, especially in the bathroom. Staff to take a step back, observe resident until resident calms. If resident says, 'get out' please get out." Per Progress Note dated 3/11/2018, Resident #1 became combative during AM (morning) care, caregivers switched	R213	The action we will take to correct this defiency will be to provide more specific dementia focused training to direct care staff. This will include dignity individual choice for care and respect.	

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan Spadaro

TITLE: Executive Dir 10/22/18

(X6) DATE 10/01/18

R213 POC accepted 10/23/18 SSherbrook RN/PME

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R213	Continued From page 1 out, caregivers will "follow his cues" and provide distant supervision. Per review of residence investigation documentation, Resident #1, "was having a difficult time accepting care". Resident #1 told staff to "get out" when s/he entered the room and attempted to provide assistance with getting dressed on the morning of 3/11/2018. Staff "A" followed Resident #1 into the bathroom. Resident #1 said, "Get out". Staff "A" requested s/he sit down in the bathroom so they could assist with getting dressed. Staff "B" entered the bathroom to assist with Resident #1's care. Resident #1 told Staff "B" to "Get Out". Staff "B" stated, "No, we need to help you." Per staff witness statement, Resident #1, "Finally sat down" and Staff "A" assisted Resident #1 with getting dressed. Staff "B" exited the bathroom to obtain tools to communicate in writing with Resident #1. When Staff "B" returned to the bathroom, Resident #1 stated, "Get out" and Staff "B" screamed, "No, we are not leaving". Resident #1 attempted to strike Staff "A" and Staff "B". Staff "B" exited the room to gather Resident #1's shoes and socks, and when s/he returned to the bathroom, Resident #1 said, "You out now. You out now". Staff "B" left the bathroom again to obtain bandage supplies for a skin abrasion on Resident #1's hand, and upon their return, Resident #1 attempted to strike staff and told them to, "Get out". Resident #1 then ambulated to the bed and staff applied a skin bandage. Resident #1 again stated, "Get out" and staff exited the resident's room. The episode lasted for 20 minutes and per staff witness statements, "yelling could be heard" outside the room which was, "upsetting to residents". During an interview on the afternoon of	R213	The measure and systemic change we have put into place to ensure that this deficient practice does not recur is to require all direct caregivers on the memory care unit to read and sign the educational tool titled Resident Rights. This states you agree to respect their dignity and their choices. This will be in addition to the expectation of following established policies and their service plan.	

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R213	Continued From page 2 9/10/2018, the Nurse Manager stated that, "staff were concerned about safety" and did not want Resident #1 to fall. However, there was no evidence of interventions consistent with the care plan to provide Resident #1 with choices regarding care. Per Resident #1's Resident Service Plan, staff were instructed to, "take a step back" and observe the resident until s/he calms. There was no evidence that staff respected Resident #1's choices regarding care despite multiple verbalizations to "get out". The Residential Services Director stated, "staff can be task oriented at times" and "we can do better" with communicating about care plans. The failure to treat Resident #1 with dignity, respect, and consideration of choices regarding care was reviewed with the Residential Services Director on the morning of 9/11/2018. Doreen Stoodley, RN Resident service director	R213	These corrective actions will be monitored by nursing staff daily, as they observe interactions between resident attendants and residents. Nurse's will utilize an audit tool to document these witnessed interactions.	11/10/18