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 1, 2024

Kelly Baptie, Manager
Village At Cedar Hill, Inc
92 Cedar Hill Drive
Windsor, VT 05089-4436

Dear Ms. Baptie:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 20, 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
	1003	A. BUILDING: _____ B. WING _____	C 06/20/2024

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: An unannounced on-site re-licensure survey in conjunction with investigation of one facility reported incident was conducted by the Division of Licensing and Protection on 06/18/24. The following regulatory violations were identified:	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 there was a failure to provide care and services to meet the nursing and medical care needs of one applicable resident (Resident #1). Findings include: Per review of the home's policies and procedures: a. The Facility's On Call Nurse Policy effective 6/7/23 states: " It is the policy of this campus to always have a nurse on call to assist with emergencies /incidents and answer clinical questions." The responsibilities of the on-call nurse identified in this policy include: "Guiding staff through clinical processes and answering clinical questions"	R126	**R126** All nurse managers and on call nurses will complete re-education on care pathways from the assisted living interact program. They will also read, review and sign the updated facility nurse on call policy. The on-call policy has been updated to state: "The responsibilities of the on-call nurse that are specific to the Village, include: a. a. Transcribing telephone orders after hours if a provider is not in the building. b. Calling the on call ARNP/MD if new orders are needed. c. Addressing incidents such as falls, skin tears, medication errors, resident to resident and changes in condition with the interact pathways and physician notification triage guides. d. Delegation of tasks to LPN's for follow up of vital information will be documented in the resident's record, and the RN or ARNP/MD will be notified of abnormal findings. e. Directing the need for EMS or acute care services." The Resident Services Director or designee will complete a monthly audit for the next 3 months on the documentation in Resident records, where residents haveutilized the facility on call services. The audits will be reviewed in the quarterly QAPI Meeting for the next 3 months.	9/1/24

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R126	Continued From page 1 "Communicating with the administrator /executive director with any emergencies or reportable events" "Assisting staff with problem solving, as needed" "Provides emergency staffing support based on resident needs to operate safely [sic]." "Calling the on-call ARNP/MD if new orders are needed." "Addressing incidents such as falls, skin tears, medication errors, resident to resident [sic], and changes in condition." "Triage changes in conditions and the need for EMS or acute care services." b. The home's Transfer Policies for Transfer to Acute Hospital states: "Should a resident show signs of illness, the resident assistant on duty will obtain basic health care data and notify the LPN/RN in charge/on call regarding the signs and symptoms which the resident is exhibiting. The licensed nurse will provide follow up directions to the resident assistant. He/she will contact the Resident's attending MP (medical provider) and LRP (legally responsible person) if deemed necessary." "A resident may be transferred to the Acute Care Hospital on order of his/her attending physician of the RN in Charge." "If the Resident Aid on duty considers the resident's health situation warrants immediate care, he/she will call nurse on duty or on call first to report residents status and if directed by the nurse will call 911 emergency services and he/she will notify the on-call nurse when resident has been transferred [sic]." Per record review Resident #1 was admitted to the home on 2/7/24 with diagnoses including Diverticulosis of both the small and large intestine, Gastro-Esophageal Reflux Disease,	R126	R126 Plan of Correction accepted by Jo A Evans RN on 7/31/24.	

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R126	Continued From page 2 Dementia and Mild Cognitive Impairment. Per review of Resident #1's Progress Notes: 1. On 2/26/24 Resident #1 presented with episodes of crying and complained of abdominal pain and low back pain. S/he was given warm prune juice, which did not result in a bowel movement or pain relief. S/he was then given a PRN (as needed) dose of Tums antacid tablets for abdominal pain; however this medication is prescribed for stomach upset, nausea, and heartburn. The following morning Staff noted during the night Resident #1 was "very anxious/restless, unable to relax or sit more than 2 minutes". 2. On 3/6/24: Resident #1 was given Tums antacid at 12:39 AM. At 7:19 PM it was noted s/he was "complaining of intense stomach pain. Toileted with no improvement" and a second dose of Tums was administered and documented as "Effective", however the Administration Note states, "Resident still having abdominal pain but complaining less of pain". At 8:18 PM the On-Call Registered Nurse (RN) noted a Resident Assistant (RA) reported Resident #1 was frequently stating s/he did not feel well, "spitting up reddish colored phlegm", "complaining of pain in upper abdomen", his/her "abdomen appeared to be distended", and his/her vital signs were "slightly abnormal". The On-Call RN instructed the RA to give Resident #1 PRN Miralax (Polyethylene Glycol 3350), which was given at 8:50 PM without documented positive effect. 3. On 3/7/24: At 7:23 AM Resident #1 was given another dose of PRN Miralax which was documented as	R126		

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R126	Continued From page 3 "Ineffective", followed by a scheduled dose of Miralax given by the same Staff during the 9:00 AM med pass. At 10:10 PM the On-Call Nurse noted an RA reported Resident #1 had "abnormal vital signs and discomfort [related to] constipation and what sounds like some anxiety [related to] not feeling well." The On-Call Nurse stated Resident #1's blood pressure was "slightly elevated", oxygen saturation rate was low, and his/her heart rate was high at 125 beats per minute. S/he instructed the RA to administer the laxative medication Senokot and recheck Resident #1's vital signs. A Progress Note entered by the RA at 10:27 stated Resident #1 "began crying out for help ...appeared pale and their abdomen was distended ... a RA took vitals and this RA called Nurse On-Call." The RA stated s/he "administered Senna 8.6 mg 2x with warm prune juice and vitals were taken a second time". Per record review Resident #1's MAR does not include documentation of Senna administration and only one set of vitals was documented on 3/7/24. 4. On 3/8/24: At 4:09 AM the Unit Aide noted Resident #1 was found on the floor and after s/he "slid down" while trying to put on shoes. The Aide reported Resident #1 was not in any pain, "was walking fine", and was "unwell before the fall". At 4:51 the same Unit Aide noted Resident #1 "was very sick ...yelling help me all night, saying they had to go to the bathroom even while sitting on the toilet ...was very uncomfortable and anxious ... having difficulty walking". At 7:46 AM the Nurse Manager noted Resident #1 had diminished bowel sounds and his/her abdomen was "distended and tender", and stated	R126		

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R126	Continued From page 4 "Will notify the provider today". At 8:58 AM the Nurse Manager noted the provider's office recommended transport to the emergency room for evaluation. A family member transported Resident #1 to the emergency room, where s/he was diagnosed with a perforated bowel and admitted for comfort measures and end of life care. At 12:40 PM the following day Resident #1 passed away. Resident #1's cause of death was documented as Sepsis (inflammatory process resulting from a systemic infection which damages vital organs) secondary to bowel perforation. Per review of email communications, at 8:40 PM on 3/6/24 the On-Call Nurse notified the Nurse Manager about calls received the previous night regarding Resident #1's abdominal pain; stated s/he wondered if Resident #1 "spitting up reddish colored phlegm" was "possibly blood"; noted Resident #1's frequent doses of Tums and history of 'diverticulitis."; and asked " ...can you see [him/her] tomorrow?" The Nurse Manager is a Licensed Practical Nurse (LPN) and it is not within his/her scope of practice to perform a physical assessment. At 5:02 AM on 3/7/24 the Nurse Manager responded "Yes, thank you"; however Resident #1's record does not include documentation of the LPN's observations or data collected and reported to a Registered Nurse in response to this request. Additionally, Resident #1's record does not contain documentation indicating Resident #1's Physician and family members including his/her Durable Power of Attorney were notified regarding his/her presentation on 3/6/24. Per record review, Resident #1's signed order for PRN Tums states "If symptoms persist after 24 hours, notify medical provider"; and the home's policies and	R126		

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R126	Continued From page 5 procedures indicate the licensed nurse will "contact the Resident's attending MP (medical provider) and LRP (legally responsible person) if deemed necessary." Per review of email communications, at 10:17 AM on 3/8/24 the On-Call Nurse notified the Nurse Manager regarding calls the previous night and reported Resident #1's vitals were not within normal limits, s/he was having stomach pain, and had a bowel movement yet. The On-Call Nurse stated, "I was worried about [his/her heart rate] being at 125, but I think it might have been from anxiety and pain. And then s/he fell later." The On-Call Nurse did not request information regarding Resident #1's current presentation, provide instructions or delegate nursing tasks to the Nurse Manager. Per record review there is no documentation of a physical assessment of Resident in response to staff reports of Resident #1's abdominal pain and distention, abnormal vital signs, spitting out reddish phlegm, and documentation of ineffective use of PRN medications in Resident #1's record. At 1:47 PM on 6/18/24 the Resident Services Director confirmed the On-Call Registered Nurse (RN) did not perform a physical assessment or seek medical attention in response to notification of Resident #1's signs and symptoms, which were indicative of pain and need for medical care. During an interview commencing at approximately 2:00 PM on 6/18/23, the Nurse Manager confirmed s/he did not notify Resident #1's physician regarding his /her change of condition until the morning of 3/8/24 or receive instructions from the On- Call Registered Nurse to notify Resident #1's physician.	R126		

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R126	Continued From page 6 In conclusion these deficient practices are cited as actual harm to Resident #1 which is evidenced by Resident #1 crying and yelling "help me"; and reports of Resident #1's discomfort, abdominal pain and distention, spitting up blood, and abnormal vital signs followed by diagnosis of a perforated bowel and sepsis resulting in Resident #1's death.	R126		
R128 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure medications were administered as ordered for one applicable resident (Resident #1). Findings include: 1. Per record review Resident #1 was admitted to the home on 2/7/24 with a Physician's order for Polyethylene Glycol 3350, which is a medication used to treat constipation and regulate bowel movements. Resident #1's admission orders signed by his/her Physician on 2/2/24 include this order which reads, "Polyethylene Glycol 3350 (Miralax oral powder for reconstitution) 17 gm = 1 packet (s), Oral, Daily, a capful twice daily until resultsin 8 oz of water [sic]" indicating this medication is ordered to be scheduled twice daily. Per record review, Resident #1's Medication Administration Records (MARs) for February and	R128	**R 128-** All new admission orders will be double checked by a second nurse. All admission orders will have a two-step process. One nurse will transcribe the order and one nurse will check the order once transcribed. The Resident Services Director will sign off on all admission orders to ensure compliance. The Resident Services Director or designee will perform random audits of physician orders monthly for the next 6 months. The audits will be reviewed in the quarterly QAPI Meeting for the next 6 months. All medication certified staff will complete retraining on PRN use of medications. The updated PRN medication policy will be reviewed and signed by all medication certified staff. The Resident Services Director or designee will conduct a monthly random audit of PRN medications to ensure corrective practices. The audits will be reviewed in the quarterly QAPI Meeting for the next 6 months. R128 Plan of Correction accepted by Jo A Evans RN on 7/31/24	9/1/24

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R128	Continued From page 7 March of 2024 include orders for "Miralax Oral Powder 17 GM/SCOOP (Polyethylene Glycol 3350) Give 1 scoop by mouth in the morning for Abdominal discomfort" with a start date of 2/8/2024. At approximately 2:00 PM on 6/18/24 the Nurse Manager confirmed Resident #1's Polyethylene Glycol 3350 order was entered as once daily in error instead of twice daily; and confirmed the prescribing physician had not been contacted by the facility to request clarification or changes to this order. During an interview commencing at 5:09 PM on 5/20/24 the Resident Services Director confirmed the prescribing physician had not been notified regarding this error, as it had not been discovered prior to the investigation on 6/18/24. 2. Per record review Resident #1's February and March 2024 MARs included an order for "Tums Oral Tablet Chewable 500 mg (Calcium Carbonate (Antacid)) [sic] Give 2 tablet by mouth every 3 hours as needed for Upset stomach, nausea, heartburn not to exceed 10 tablets in 24 hour period"; however the Standing Orders signed by Resident #1's Physician on 2/2/24 include an order for "Tums or generic brand 2 tablets every 2-3 hours as symptoms occur. Not to exceed 10 tablets in 24 hours. If symptoms persist after 24 hours, notify medical provider." Per review of Medication Administration Notes, on 2/26/24 Resident #1 was given Tums Antacid Tablets for abdominal pain, and on 3/6/24 Tums was given for Resident #1's "complaints of intense stomach pain"; however abdominal/stomach pain are not indications for the administration of Tums Antacid Tablets to Resident #1. Per review of Resident #1's MARs	R128		

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R128	Continued From page 8 and Progress Notes, there is no documentation indicating his/her medical provider was notified when symptoms were not resolved after 24 hours of Tums administration. On the afternoon of 6/20/24 the Executive Director and Resident Services Director acknowledged administration of the medications Miralax (Polyethylene Glycol 3350) and Tums to Resident #1 was not consistent with the Physician's orders. In conclusion this deficient practice is a risk for more than minimal harm resulting from the failure to administer medications as ordered.	R128		
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 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;	R179	**R 179-** All new hires will complete the required educations before providing direct care. All direct care staff will complete first aid training to be completed by 9/1/24. The Executive Director or designee will audit employee educations quarterly. The audits will be reviewed in the quarterly QAPI Meeting for the next 6 months. R179 Plan of Correction accepted by Jo A Evans RN on 7/31/24.	9/1/24

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R179	Continued From page 9 (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 5 out of 5 sampled staff completed all required yearly training. Findings include: On the morning of 6/18/24 the Executive Director was requested to provide training records for a sample of 5 Staff. At 11:47 AM on 6/18/24 the Executive Director and Resident Services Director confirmed 5 out of 5 sampled staff did not complete the required Resident Emergency Response Procedures and First Aid training. 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		
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 by: Based on staff interview and record review there	R190		

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R190	Continued From page 10 was a failure to ensure all required criminal record and abuse registry checks were completed by 4 out of 5 sampled staff. Findings include: On the morning of 6/18/24 the Executive Director was requested to provide documentation of criminal record and abuse registry checks completed for a sample of 5 staff. Per review of the background checks provided for review, all required criminal record and abuse registry checks were not completed for 4 out of 5 sampled staff. This finding was confirmed by the Executive Director and Resident Services Director at 11:47 AM on 6/18/24. In conclusion this deficient practice is a potential risk for more than minimal harm for all residents, as the requirement for criminal background and abuse checks is intended to ensure all residents are free from the risk of harm.	R190	**R 190-** The Human Resources Director or designee will complete a manual file audit of all current staff background checks. Any checks out of compliance will be redone and updated by 9/1/24. Annual Background checks for all staff will be conducted each October. All new hires will be signed off by the Human Resources Director to ensure all checks are completed and on file prior to the employee beginning training. Monthly, for 6 months, the Human Resources Director will do a random audit of background checks to ensure compliance. The audits will be reviewed in the quarterly QAPI Meeting for the next 6 months. R190 Plan of Correction accpeted by Jo A Evans RN on 7/31/24.	9/1/24