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

February 15, 2023

Ms. Laurie Griswold, Manager
Willows Of Windsor
121 State Street
Windsor, VT 05089-1213

Dear Ms. Griswold:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 10, 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,

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
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WILLOWS OF WINDSOR	121 STATE STREET WINDSOR, VT 05089

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R100	Initial Comments: An announced on-site re-licensure survey and complaint investigation was conducted by the Division of Licensing and Protection on 1/10/23. The following citations are associated with both the complaints and re-licensure survey. Findings include:	R100		
R136 SS=D	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 record review and staff interview, the RCH nurse failed to reassess annually 1 applicable resident. (Resident #3) Findings include: Per record review, the last annual assessment for Resident #3 was completed on 7/31/21. The RCH nurse failed to complete the annual reassessment as required. The omission was confirmed on the afternoon on 1/10/23 by the nurse responsible for completing the assessments.	R136		
R170 SS=D	V. RESIDENT CARE AND HOME SERVICES	R170		

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE
Doreen Stoodley RN 2/9/2023

R136 - R302 POC's accepted 2/13/23 Fmcintosh RN/PMe

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R170	Continued From page 1 5.10 Medication Management 5.10.f Residents who are capable of self-administration have the right to purchase and self administer over-the-counter medications. However, the home must make every reasonable effort to be aware of such medications in order to monitor for and educate the residents about possible adverse reactions or interactions with other medications without violating the resident's rights to direct the resident's own care. If a resident's over-the-counter medications use poses a significant threat to the resident's health, staff must notify the physician This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview and record review, the RCH nurse failed to conduct a Self-Administration of Medications assessment of 1 applicable resident . (Resident #4) Findings include: Resident #2 was identified to be capable of self-administration of his/her prescribed medications. Per interview with the RCH nurse confirmed a Self-Administration of Medications assessment could not be located which would determine if Resident #2 remained capable and competent to continue with the managment and administration of their medications since being admitted on 12/8/21.	R170		
R175 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (3)	R175		

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R175	Continued From page 2 Residents who are capable of self-administration may choose to store their own medications provided that the home is able to provide the resident with a secure storage space to prevent unauthorized access to the resident's medications. Whether or not the home is able to provide such a secured space must be explained to the resident on or before admission. This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interview, there was a failure of the RCH to ensure residents who are capable of self-administration of their medications are provided with a secure storage space to prevent unauthorized access to the resident's medications. Findings include: Resident #2 self-administer's his/her medications. Per interview at 2:30 PM, Resident #2 confirmed medications are stored in their room in a unlocked armoire/wardrobe. Observation noted medications are in bubble packs stored in a container behind the doors of the armoire. Included in the stored medications is Tramadol (a controlled substance used for pain management). The Tramadol was not locked and was accessible along with the other medications stored in Resident #2's room. The RCH nurse acknowledged at the time of observation, Resident #2's medications were not secured, especially the controlled medication, Tramadol.	R175		
R177 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management	R177		

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R177	Continued From page 3 5.10.h (5) Narcotics and other controlled drugs must be kept in a locked cabinet. Narcotics must be accounted for on a daily basis. Other controlled drugs shall be accounted for on at least a weekly basis. This REQUIREMENT is not met as evidenced by: Based on observations and staff and resident interview, there was a failure to keep controlled drugs in a locked cabinet. Findings include: Resident #2 is self administering medications. The medications are stored in the resident's unlocked armoire. Included with the other prescribed medication was Tramadol (a opioid controlled pain medication) 50 mg. which the resident can take every 6 hours for a total of 3 Tramadol in 24 hours. The observation of the storage of the Tramadol was confirmed by the RN and Resident #4 on the afternoon of 1/10/23. In addition, there is presently no accounting of the Tramadol either daily or weekly which is stored in the resident's unlocked armoire.	R177		
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	R179		

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R179	Continued From page 4	R179		

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;
(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 record review and staff interview there was a failure to ensure 5 out of 5 applicable staff completed all required yearly training to include Resident Rights; Fire Safety and Emergency Evacuation; Resident Emergency Response Procedures and First Aid; Mandatory Reporting of Abuse, Neglect and Exploitation; Respectful and Effective Interaction with Residents; Infection Control Measures; and General Supervision and Care of Residents. Findings include:

Per review on 1/10/23 of education training for 5 of 5 employees found minimal trainings of mandated State required hours to include Resident Rights, Fire Safety, Emergency Response & First Aid, Abuse/Neglect, Respectful Effective Communication, Infection Control and

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R179	Continued From page 5 General Care & Supervision. This was confirmed by the RCH nurse on the afternoon of 1/10/23.	R179		
R181 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the RCH owner/manager failed to ensure that an applicant who was hired by the facility did not have a conviction of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to public welfare. Findings include:	R181		

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R181	Continued From page 6 Per review of an employees personal file a criminal record check was obtained by the RCH. The results of the background check revealed that the employee had a criminal conviction on 12/19/19. The RCH owner/manager had not completed written evidence that the decision to employ this individual with a relevant criminal conviction did not pose a threat to residents.	R181		
R232 SS=E	VII. NUTRITION AND FOOD SERVICES 7.1.a.(1) Menus for regular and therapeutic diets shall be planned and written at least one (1) week in advance. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, there was a failure to develop a menu for a resident who requires a therapeutic diet for 1 applicable resident. (Resident #1) Findings include: Although the RCH RN had alerted staff regarding specific residents with special diets, there was a failure to ensure Resident #1, who receives dialysis 3 x per week for End Stage Renal Disease (ESRD), received the requiree Renal diet low in sodium, phosphorous, small amounts of potassium and consuming high quality proteins. Canned foods with high amounts of sodium along with Brown rice, bananas, orange juice & oranges, processed meats, potatoes, tomatoes and packaged, instant and highly processed items should be avoided. The diet restrictions are important to prevent further kidney damage. Per record review, Resident #1 requires a 3 gram sodium & 2 gram potassium diet. In November	R232		

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R232	Continued From page 7 2022 the "report card" from the dialysis unit noted Resident #1 continues to not reach his/her required Albumin goal of 4.0 (indicating insufficient intake of the right types of protein) and also had maintained an elevated potassium level. The recommendation from the staff at dialysis was to eat: "...fresh, unprocessed foods, such as fruit, lean meats needing 8-10 oz. of protein each day..." However, the effort and direction by RCH staff to ensure Resident #1 is provided a specific Renal diet is limited. Menus often consist of processed food to include sliced ham, hot dogs, pea soup, kielbasa, sausage, mashed and scalloped potatoes, canned soups (all contraindicated for a renal diet/3 gram sodium/2 gram potassium).	R232		
R233 SS=F	VII. NUTRITION AND FOOD SERVICES 7.1.a (2) The meals served each day must provide 100% of the Recommended Dietary Allowances (RDA) as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences and comply with the Dietary Guidelines for Americans. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, there is a failure of the RCH to provide on a daily basis meals 100% of the recommended Dietary Allowances as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences and comply with the Dietary Guidelines for Americans. Findings include:	R233		

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R233	Continued From page 8 Per review of the RCH menus provided from 12/19/22 through 1/8/23 and observation of food storage noted there was a failure to provide and serve to the residents sufficient daily servings of vegetables (3-5 servings daily servings: 1/2 cup cooked or chopped raw vegetables, 1 cup leafy vegetables or 3/4 cup of vegetable juice); two servings (total 4-5 oz/day) of meat, poultry, legumes, eggs & nuts; and for fruit servings (2-4 daily) to include: 3/4 cup fruit juice, apple/banana/ or other fruit, 1/2 cup of fresh, cooked or canned fruit or dried fruit. 1. Per review of menus from 12/19/22 - 12/25/22 noted eggs never offered for breakfast and served only twice during this week. Fresh fruit was not offered/served with the exception of juice for breakfast. The vegetable for the week consisted of 1 toss salad on 12/19/22 and string beans on 12/25/22. 2. For the week of 12/26/22 - 1/1/23 fruit offered x 1 in a yogurt parfait. Eggs were not offered and on 12/3/22 nothing was listed for lunch on the menu. 3. For the week of 1/2/23- 1/8/23 no fresh fruit listed on the menu; 1 serving of an egg for entire week. Also noted although on 1/6/23 the breakfast menu includes cereal or waffles/pancakes the lunch menu also was pancakes. Also on 1/7/23 nothing is recorded on the menu for lunch. During the environmental tour conducted on 1/10/23 at 9:45 AM accompanied by the RCH nurse observations of food storage noted no fresh fruit, but 1 jar of apple sauce. Can goods included 3 cans of corn, 5 cans of stewed tomatoes, 3 cans of kidney beans. The only fresh vegetable was noted to be a salad served during noon meal, frozen vegetables where noted in the	R233		

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R233	Continued From page 9 facility freezer. No other fresh vegetables were presently available for the week.	R233		
R245 SS=E	VII. NUTRITION AND FOOD SERVICES 7.1.c (4) Residents shall be provided with alternatives to the planned meal upon request. This REQUIREMENT is not met as evidenced by: Based on staff interview and resident interview, the provision of alternatives to the planned meal/menu was limited. Findings include: Per observation of the noon meal on 1/10/23, staff and residents were asked what alternatives are offered to residents if they do not like or want what was served. The response back from residents during the noon meal was "peanut butter & jelly" sandwich is the general alternative. There is no planned nutritious alternatives listed on the menus provided. Staff indicated "left overs", if any, could possibly be offered or a peanut butter & jelly.	R245		
R266 SS=F	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 observation and staff interview, the	R266		

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R266	Continued From page 10 RCH failed to provide and maintain a safe, functional, sanitary, homelike environment. Findings include: During a tour of the RCH accompanied by the RCH nurse on 1/10/23 at 9:40 AM the following observations were made: 1. On the lower level of the facility where 3 residents reside, a room used by the residents to watch TV was noted to be cluttered with a disassembled cabinet partially stored in a torn cardboard box was laying on the floor near the TV creating a tripping hazard. Behind one of the resident recliners was also disassembled parts for a stair glider. A large oval mirror was also noted to be stored behind a resident's chair. 2. On the lower level is a bathroom used by the 3 residents. The toilet seat was noted to be soiled with feces and there was black staining around the toilet bowl and floor. 3. Cigarette butts were observed to be in the trash container in the bathroom, creating a fire hazard. 4. A large hole was observed in the lower level hallway ceiling exposing building materials and wires along with a missing wall vent located close to the hallway floor. 5. In the RCH front porch vestibule, a location residents/visitors enter and pass through to exit the facility, multiple oxygen cylinder tanks were being stored. 3 of the tanks were free standing without holder/racks, creating a potential hazard if oxygen tanks were knocked over by residents/visitors passing through this unrestricted and unsafe location for oxygen tanks. Safety precautions and risk assessment for this storage of oxygen tanks was not established. 6. Observation of an unlocked storage cabinet located in the food storage/medication cart space	R266		

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R266	Continued From page 11 was noted to have bottles of milk of magnesia, fleet enemas, prescribed Chlorhexidine (a disinfectant & antiseptic), Docusate Sodium (stool softener). Although there is a wooden partition near the unsecured cabinet, the entrance partition is not secured and remains accessible to unauthorized individuals.	R266		
R302 SS=E	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RCH failed to conduct fire drills on at least a quarterly basis and rotate times of day among morning, afternoon, evening and night. Findings include: Per review of the fire drills conducted at the RCH noted a drill recorded to occur on "12/2021 at 10 AM" but had no exact day the drill was conducted.	R302		

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R302	Continued From page 12 A second reported drill is recorded at "4/2022" at 1:00 PM", again no specific day. Two other drills were recorded to have been conducted during the morning and early afternoon. The RCH administrative staff failed to conduct drills in the evening and also nights. This was confirmed by the RCH nurse on the afternoon of 1/10/23.	R302		

Willows of Windsor Survey 1/10/2023

Plan of correction

R136 Assessment

Action: All resident annual assessments will be completed within a 12 month period.

Measure: All current residents have had a chart audit to verify this requirement.

Corrective actions: Audit was completed on 1/31/23. All current residents do have a annual assessment.

Date to be completed: done on January 17, 2023.

R170 Medication management

Action:the" missing" Self Medication assessment was located upstairs in the MAR book.

Measures: This required annual assessment has been added to resident # 2's other annual assessments, to be in her chart, under Assessments.

Corrective measures: New Self assessment done on 1/30/23.

Date to be completed: done on Jamuary 30,2023

R175 Medication management

Action: To correct this deficiency, the pharmacy was contacted and they have provided a lock box for resident #2, to keep her controlled medication in her room, safely.

Measures: Locking medication box given to this resident with some education on keeping it out of sight and the key in a place that only she knows about.

Corrective actions: our pharmacy has agreed to include a statement for staff to sign (on the MAR) to have a way of tracking that a count is done and that the resident continues to use the lock box appropriately.

Date to be completed: done on January 31,2023

Doreen Stoodley RN 2/9/2023

R177 Medication management

Action: On this residents MAR there has been added a place to do a controlled drug count weekly. This will be done WITH Resident # 2.

Measures: The pharmacy is going to start sending smaller count "bingo" cards to fit better in the locked box and to have fewer number of this controlled drug in her room.

Corrective action: this monitoring will occur at a minimum of weekly.

Date to be completed : March 1, 2023

R179 Staff Services

Action: To correct this deficiecy, the mandatory education components listed have been included on the individual employee tracking tool.

Measures: All direct care staff now have a clear concise expectation for annual mandatory education.

Corrective action: Each topic will be done monthly (minimally).

Date to be completed: within one year; January 2024

R181 Staff services

Action: A letter explaining why we felt it was safe to hire sombody with a DUI conviction was created, and placed in one employee file.

Measures: to assure that all new hires have a background check and an abuse registry check, we will continue to ask perspective new hires to sign forms giving The Willows of Windsor permission to perfom these checks. Job offer will be contigent upon results.

Corrective action: the "hiring team" will meet to discuss whether or not we move forward with a job offer if any findings are discovered. Our ultimate goal is resident safety.

Date to be complated: done. A letter was placed in this employee's file on January 12, 2023.

R232 Menu's for regular and therapeutic diets

Action: To correct this deficiency the Registered Dietician at Fresenius Kidney Care was contacted. Although she stated she IS willing to assist with any education we may need regarding dietary information,she did review Resident # 1's history. She and the nephrologist are pleased with this dialysis resident's labs. (See included reports)

Measures: Some dietary print outs were sent to us. All caregiving staff will review this information from the dietician specific to phosphorus, sodium, potassium and fluid intake for Resident #1.

Corrective action: Careful attention will be given to the "report cards " that are sent back with this resident after each dialysis encounter. These show lab results, and give important information.

Date to be completed: this education will be completed by March 31, 2023.

R233 Meals served must provide 100% of the RDA to comply with Dietary Guidelines for Americans.

Action: 100% of the recommended daily allowance are being offered.

Measure's: to ensure that this deficient practice is corrected , new menu's have been designed to allow a way to be sure to include from the 6 food groups and to calculate this offering, daily.

Eggs are now offered at a minimum of two times weekly.

Corrective action: the menu's will be created weekly and monitored weekly by the home owner Laurie Griswold.

Date to be completed: done by Feb 6, 2023

R245 Residents shall be provided with alternatives to the planned meal upon request

Action: Other alternatives to the planned meal have always been offered.

Measures: Although many residents enjoyed the peanut butter and jelly sandwich alternative, we have added in a meat and cheese sandwich also. As always, left overs are also still offered.

Corrective action: These food offerings will be monitored by the owner.

Date to be completed: done by Feb 6, 2023

R266 Enviroment

Action: The downstairs living room clutter was removed, including the box of shelving, oval mirror and the stair glide.

Measures: Diligence to "putting items away" more timely.

Corrective action: Large ceiling tile was replaced. Two wall vent openings now have grates in place. Oxygen tanks are in a metal rack and have been moved downstairs to storage area. Downstairs toilet has been bleached at the base and recalked. This bathroom IS on a cleaning schedule. Bathroom cleaning audit tool created. This will be monitored by clinical staff.

Extra OTC's have been moved from the cupboard to the bottom drawer of the medication cart, where they are kept locked up.

Date to be completed: Feb 10, 2023

R302 Disaster and emergency preparedness

Action: a new fire drill schedule will be created to include day, evening and night shift. Evacuation will be performed.

Measures: 2 new books will be updated, these will include a fire drill plan and evacuation of the building. One will be for in the office and one for residents.

Corrective action:These fire drill schedules will be monitored by Laurie Griswold (owner) to be sure this deficient practice does not get missed again.

Date to be completed: New books and review of our Emergency preparedness process will be completed by March 31, 2023