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

March 23, 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 investigation survey conducted on **March 1, 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
	0044	A. BUILDING: _____ B. WING _____	C 03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF WINDSOR	121 STATE STREET 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 complaint investigation was conducted on 3/1/23 by the Division of Licensing and Protection to determine compliance with the Residential Care Home (RCH) Licensing Regulations effective 10/3/2000. The following regulatory violation was identified:	R100		
R114 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.3 Discharge and Transfer Requirements 5.3.a Involuntary Discharge or Transfer of Residents (2) In the case of an involuntary discharge or transfer, the manager shall: i. Notify the resident, and if known, a family member and/or legal representative of the resident, of the discharge or transfer and the specific reasons for the move in writing and in a language and manner the resident understands at least 72 hours before a transfer within the home and thirty (30) days before discharge from the home. If the resident does not have a family member or legal representative and requests assistance, the notice shall be sent to the Long Term Care Ombudsman, Vermont Protection and Advocacy or Vermont Senior Citizens Law Project. ii. Use the form prescribed by the licensing agency for giving written notice of discharge or transfer and include a statement in large print that the resident has the right to appeal the home's decision to transfer or discharge with the appropriate information regarding how to do so.	R114	**See attached**	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R114	Continued From page 1 iii. Include a statement in the written notice that the resident may remain in the room or home during the appeal. iv. Place a copy of the notice in the resident's clinical record. This REQUIREMENT is not met as evidenced by: Based on interview, and record review the RCH failed to ensure the resident, and or a family member/legal representative was notified of the Involuntary Discharge thirty (30) days prior to discharge form the home per regulatory guidelines for 1 applicable resident. (Resident #1) Findings include: Per record review, Resident #1 had a diagnosis of Dementia, Diabetes Mellitus, and a Non-healing lower extremity ulcer. On 11/15/22 a prescription for Seroquel 25 mg daily PRN (as needed) for increase agitation, and Trazadone 25 mg at bedtime for difficulty sleeping were obtained. On 11/25/22 a referral for a geriatric psych evaluation was placed by Resident #1's primary care provider for evaluation and treatment. On 11/29/22 an order for Seroquel 50 mg daily PRN for increased agitation was obtained. Due to Resident #1's increased combative behaviors and threats of elopement on 11/29/22 fifteen-minute safety checks were initiated for resident safety. Per interview in the afternoon on 3/1/23 a caregiver confirmed Resident #1 had shown increased aggressive behavior in the weeks prior to discharge stating that Resident #1 was only sleeping about two (2) hours per night and becoming increasingly physical with staff and hoarding multiple objects s/he shoved down his/her pants consistently.	R114		

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R114	Continued From page 2 Between 12/15/22 - 12/17/22 Progress Notes state Resident #1 pushed a female staff member up against a wall, informing the staff member " I will slit your throat". Resident #1 also swung a chair almost striking residents. As a result, on 12/17/22 after the accumulation of dangerous behavior that was unresponsive to medication and staff attempts at redirection failed, Resident #1 was transported to the hospital via EMS for evaluation. Per interview on 3/1/23 at 11:30 AM, the Manager and RN both confirmed Resident #1 demonstrated increased symptoms of dementia to include agitation and combativeness over the course of a few months. Manager and RN stated they were in communication with Resident #1's provider after admission to the hospital and it was agreed by both parties that Resident #1's needs exceeded the facilities capabilities. However, per interview with Manager and RN on the afternoon of 3/1/23 they both acknowledged that they failed to provide the resident, family, and/or legal representative with the required thirty (30) day Involuntary discharge notice.	R114		

R114 Plan of Correction

Failure to initiate involuntary discharge process.

The action taken to correct this deficiency is - we will from this time forward utilize our discharge/transfer notice form.

The measure's we have put into place to ensure this deficient practice does not recur are: education to office staff on the requirement to always use our discharge policies.

The corrective actions will be monitored by making it known that this is mandatory.

These corrective actions will be completed by 3/28/2023

Doreen Stoodley RN
Willows of Windsor
3/22/2023

Tag R114 POC accepted on 3/22/23 by M. McIntosh/P. Cota