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 19, 2021

Ms. Tonia Trask, Manager
Wintergreen Residential Care - North
360 New Road
Brandon, VT 05733

Dear Ms. Trask:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 21, 2021.** 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

PRINTED: 07/26/2021
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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
	0619	A. BUILDING: _____ B. WING _____	C 07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINTERGREEN RESIDENTIAL CARE - NORTH	360 NEW ROAD BRANDON, VT 05733

(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 investigation of 1 complaint and 1 entity self-report was conducted by the Division of Licensing and Protection on 7/20/2021 and completed on 7/21/2021. As a result of the investigation the following regulatory deficiencies were identified:	R100		
R115 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.3 Discharge and Transfer Requirements 5.3.a Involuntary Discharge or Transfer of Residents (3) A resident has the right to appeal the decision by the home to discharge or transfer. The process for appeal is as follows: I. To appeal the decision to transfer or discharge, the resident must notify the administrator of the home or the director of the licensing agency. Upon receipt of an appeal, the administrator must immediately notify the director of the licensing agency. II. The request to appeal the decision may be oral or written and must be made within 10 business days of the receipt of the notice by the resident. III. Both the home and the resident shall provide all the materials deemed relevant to the decision to transfer or discharge to the director of the licensing agency as soon as the notice of appeal is filed. The resident may submit orally if unable to submit in writing. Copies of all materials submitted to the licensing agency will be available to the resident upon request.	R115		

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donna Crook — TITLE: Manager — (X6) DATE: 8/6/21

R115-R266 POC's accepted 8/13/21 FMcIntoshRW/PMC

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R115	Continued From page 1 iv. The director of the licensing agency will render a decision within eight business days of receipt of the notice of appeal. v. The notice of decision from the director will be sent to the resident and to the home, will state that the decision may be appealed to the Human Services Board, and will include information on how to do so. vi. The resident or the home will have 10 business days to file a request for an appeal with the Human Services Board by writing to the Board. The Human Services Board will conduct a de novo evidentiary hearing in accordance with 3 V.S.A. §3091. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the RCH manager failed to follow the Involuntary Discharge process for 1 applicable resident (Resident #1). Findings include: Resident #1 was admitted to the RCH on 7/6/2021. Over the course of 2 weeks, Resident #1 demonstrated behaviors including resisting care; refusing medications and combative with staff. On 7/16/2021 at approximately 3:55 PM Resident #1 exited the RCH by kicking the window screen in his/her room and climbing out of the window experiencing an approximate 4 foot drop to the outside ground. Resident #1 was brought to the hospital to assess if any injuries occurred. As a result of the incident and behavioral issues, the owner determined Resident #1 was unsafe to return to the facility and informed family by phone Resident #1 could not be readmitted. Per interview on 7/20/20201 at 9:50 AM, the manager stated Resident #1's	R115	* The action we will take to correct the deficiency will be in the case an involuntary discharge we will follow all guidelines and do the proper process before removing the resident. * The measures we will put into place to ensure the deficient practice does not recur, will be - assess the resident better - check with other family or aides or the facility about the behavioral issues if any. not take any residents that have been or can be violent to themselves or others. * The corrective actions will be monitored by the manager and nurse and reported to the owner of any negative behaviors. * The date corrective action will be completed is 8/8/2021	

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R115	Continued From page 2 behavioral issues were not disclosed prior to admission and the resident was upset s/he was placed in the RCH. However, the owner/manager failed to provide to the resident and family the required Involuntary Discharge notification/documentation which would allow family and/or resident an appeal process if they were in disagreement with the discharge. This was confirmed with the owner/manager on 7/20/2021 at 12:40 PM.	R115		
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 and staff interview, the RCH nurse failed to conduct an assessment for the use of side rails for 2 applicable residents. (Residents #2; Resident #3) Findings include: During a self tour of the RCH on 7/20/2021 at 8:45 AM side rail use was observed on 2 resident beds. Per record review, there was a failure of the nurse to assess each resident for appropriate and safe use of the siderails whether for mobility or to assist with transfers. The nurse also failed to note Resident #3's bed and siderails were unsafe due to the improper fitting of the mattress and	R136	The action we have taken to correct the deficiency is to remove all bedrails from residents beds, and have the RN write a note in the residents chart next time we get an order to add bedrails. The measures we will take so the deficient doesn't recur is use a safer device for the residents beds such as pool noodles to ensure their safety. corrective actions will be monitored by the manager so the deficient practice doesn't recur.	

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R136	Continued From page 3 siderails creating a potential entrapment when an individual can become stuck, caught, wedged or trapped between the mattress/bed and the siderail. Refer to Tag: 266	R136	Corrective action will be completed by 8/8/21	
R179 SS=E	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; (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	R179	* Action we will take to correct the deficiency is upon hiring and during orientation, the new employee will read through all the 12 hrs of traing and the continue to complete monthly staff meetings/ trainings. * measures that will be put into place is if the employee doesn't show to the training they don't come into work until they read and complete a test on what the training was about. * corrective actions will be monitored by the RN as she is in charge of trainings. *	

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R179	Continued From page 4 by: Based on record reviw and staff interview, the RCH failed to ensure staff received 12 hours of required training each year. Findings include: Per review on 7/20/2021 of training records for staff employed at the RCH noted the yearly 12 hours of training were not all completed. Of the 5 employees reviewed, completed training hours ranged from 0 hours to 8 hours of training over the past 12 months. The lapse of training was confirmed with the owner and manager on afternoon of 7/20/21.	R179	Corrective action will be completed by 8/8/21	
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 observation and staff interview, there was a failure to protect a resident's dignity for 1 applicable resident. (Resident #2) Findings included: Upon arrival at the RCH on 7/20/2021 at 8:25 AM Resident #2 was observed sitting at a dinning room table wearing a top and only a disposable brief. At the time of the observation staff were attending to a resident while other residents were sitting in the same location as Resident #2. Per interview with caregiver at 11:55 AM on 7/20/2021 confirmed Resident #2 is resistant to wearing	R213	* The action we will take is to education staff more about "Residents Rights" and reasure residents are always covered and resident shall have privacy. * measures we will put into Place so the deficient doesn't recur will be residents are to wear a bathrobe over their night clothes if unable to change at that time— * corrective actions will be monitored by the manager to resure the deficient doesn't recur. * corrective action will be completed by 8/8/21	

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R213	Continued From page 5 clothing and was aware the resident did not have a lap covering and/or pants at the time of the observation.	R213		
R266 SS=E	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 RCH failed to maintain a safe environment as it relates to infection control during the Covid-19 outbreak situation by the failure of staff to wear masks. There was also a failure to protect the safety of a resident (Resident #3) who was observed in a bed with attached siderails creating the potential for entrapment. The RCH also failed to ensure all cleaning products were consistently stored in a secure location. Findings include: 1. Upon arrival at the RCH on 7/20/2021 at 8:30 AM steff was observed not wearing masks. When questioned why masks are not worn, the surveyor was informed by a staff member that masks were no longer required if the individual has been vaccinated. Shortly after, the owner and manager arrived at the RCH who also failed to wear a face mask. The owner stated the what s/he understood from a recent public directive from the CDC regarding no face mask if individuals were vaccinated was transitioned to the RCH and staff were informed face masks were not required if	R266	The action we have taken to correct the deficiency is to immediately make it mandatory to wear face masks again while in our facility wether it's employees or visitors- The measures put into place to ensure this practice doesn't recur is employee can't stay at work unless they're being compliant with wearing a mask and visitors will be asked to leave without a mask. corrective actions will be monitored by the manager so the practice doesn't recur. corrective dates will be completed by: 8/8/21	

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R266	Continued From page 6 vaccinated. However, per the State of Vermont Department of Health PPE (Personal Protective Equipment) Guidance effective 7/2/2021 states: "Face covering or mask (covering mouth and nose, including for fully vaccinated staff) and physical distancing at least six feet between persons, in accordance with CDC guidance; Fully vaccinated HCP can gather with other fully vaccinated staff without physical distancing or source control for dining, meetings, or in break areas as outlined in CDC guidance above. Fully vaccinated residents may gather without source control or physical distancing as long as there are no unvaccinated residents present." https://dail.vermont.gov/sites/dail/files//documents/LTCF_Operational_Guidance_Updated_06_29.pdf. 2. Per observations on 7/20/2021 at 8:45 AM, Resident #3 was laying in bed with siderails up. The siderails were noted to not fit properly resulting in an approximate 6-8 inch gap between the mattress and the side rail especially on Resident #3's right side. When brought to the attention of the owner and the manager, they were unaware of the potential for entrapment and possible harm if the resident's upper body became stuck, wedged or trapped between the mattress and siderail. Per interview at 2:15 PM the Hospice nurse assigned to Resident #3 stated the bed; mattress; and siderails were not provided by the Hospice DME company and agreed the present bed required replacement with appropriate fitting mattress and if needed siderails to assist the resident with mobility. 3. Per observation on 7/20/2021 at 8:40 AM, a closet which stored floor and window cleaning solutions; laundry detergent; and sanitizing sprays	R266	← addressed corrective actions on page 3 R 136	

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R266	Continued From page 7 was found to be unlocked. During the time of the observation one resident was noted to wander throughout the facility and had access to the closet. Per interview with the owner and manager confirmed the closet should have been locked.	R266	The action taken to correct the deficiency is educated employees on why the door must be locked at all times. A big reminder note has also been placed on the door as a reminder All cleaners have been put into closet and it has stayed locked. The measures taken will be all employees must work together and always keep door locked. If door is found unlocked the employee working will be written up then possibly terminated. corrective actions will be monitored by the manager and RN so this doesn't recur. corrective action will be completed on 8/8/21	