VERMONT

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AGENCY OF HUMAN SERVICES

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Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

May 23, 2025

Melissa Greenfield, Manager
Meadows At East Mountain
240 Gables Place
Rutland, VT 05701-8811

Dear Ms. Greenfield:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 6, 2025**. 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
	1002	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS AT EAST MOUNTAIN	240 GABLES PLACE RUTLAND, VT 05701

(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 On 5/6/25 the Division of Licensing and Protection conducted on unannounced on-site investigation of one facility reported incident and one complaint. The following deficiency was identified:	R100	Plan of Correction accepted by Jo A Evans RN on 5/23/25. Please review the attached document to review the accepted corrective actions.	
R142 SS=G	5.5.d General Care A home must provide each resident with adequate supervision and must facilitate obtaining assistive devices sufficient to prevent accidents, and/or to mitigate risk of injury due to accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, there is a failure to ensure care in a safe environment including adequate supervision to prevent accidents, and/or to mitigate risk of injury due to accidents which resulted in one applicable resident (Resident #1) sustaining injuries requiring hospitalization. Findings include: The home's Facility Security Policy effective August 2023 states the purpose of this policy is "to maintain safety of the facility and to ensure the building is as secure as possible; to provide a safe and secure environment for staff and residents, free from threat of theft, burglary, assault or injury." This policy was provided by the Executive Director on request for the home's policies and procedures governing resident care in a safe environment. Per record review, Resident # 1's diagnoses include Dementia with Behavioral Disturbance, Restlessness, and Agitation. Resident #1's	R142		

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R142	Continued From page 1 Service Plan includes "Falls" as an area of focus with an identified goal of the Resident remaining free of injury. Per Progress Notes, Resident #1 frequently expresses desire and intent to return to the home they lived in prior to admission, wanders throughout the memory care unit, and engages in exit seeking behaviors. On 4/24/25, Resident #1 tested positive for SARS-CoV-2 (COVID -19). Per Progress Notes, on 4/28/25 Resident #1 began to present with increased fatigue and required increased assistance with activities of daily living. On the early morning of 4/29/25, Resident #1 was noted to have been found on the floor at their bedside. Multiple Progress Notes for Resident #1 posted by Nursing Staff throughout 4/29/25 indicate this Resident presented with increased confusion and physical changes including weakness; and inability to stand, walk, and reposition themselves in bed without staff assistance. On 4/29/25 Resident #1 was evaluated in the Emergency Department and returned to the home with diagnoses of Dehydration and Weakness. Progress Notes on 4/30/25 indicated Resident #1 was able to ambulate independently with their walker and required supervision due to weakness and fatigue. A Note written by Nursing Staff at 8:09 PM on 4/30/25 instructed Staff to continue to monitor Resident #1 very frequently due to confusion, inability to remember, and poor safety awareness. Per record review and staff interview, on the early morning of 5/1/25 Resident #1 exited the memory care unit via a dining room door left unlocked by staff. Resident #1 entered a fenced courtyard adjacent to the dining room, and exited through the gate securing the courtyard fence by damaging the lock while pushing the gate open.	R142		

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R142	Continued From page 2 Per the Executive Director's written report of this incident, Resident #1 was found on the ground outside of the facility courtyard area at approximately 5:50 AM; and was outside and unattended for approximately an hour and twenty minutes after eloping from the facility. Per the National Weather Service, the temperature recorded at the airport in the town where this facility is located was documented as 35 degrees Fahrenheit at 5:00 AM on 5/1/25. Per Staff interview, Resident #1 was found by an individual walking near the facility who banged on a memory care door to alert staff that the Resident was on the ground outside. Per written statement provided by the Nurse who responded to this incident, Resident #1 was found lying on the ground shivering and wet; was wearing a short sleeve shirt and long pants; and was barefooted with their shoes several feet away. Resident #1 was transported to the hospital and admitted into inpatient care for hypothermia, a pelvic fracture, and a possible sacral fracture. During the investigation conducted on 5/6/25, safety concerns identified as contributing factors to this incident included: 1. There was a failure to ensure the secured memory care unit's exterior doors were locked to prevent Resident #1 from exiting the home. The home's Facility Security Policy includes procedures which state, "Nursing will ensure that the front door is securely closed and locked nightly at 8:00pm [sic]." and further states, " The special care unit courtyard door should be checked when not in use." During an interview and tour of the applicable memory care unit dining room and courtyard	R142		

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R142	Continued From page 3	R142		

commencing at 12:15 PM on 5/6/25, the Director of Maintenance confirmed Resident #1 was able to exit the memory care unit via the dining room because the door was left unlocked. On the afternoon of 5/6/25 the Executive Director and Director of Nursing confirmed the Nurse on duty on the night of 5/6/25 was responsible for ensuring the memory care unit doors were locked and secured .

2. There was a failure to ensure the gate and fencing surrounding the enclosed memory care courtyard was adequately constructed to withstand force; and a failure to maintain a safe and secure outdoor environment for use by memory care residents.

Per observation and staff interview, Resident #1 was able to exit the facility courtyard by applying force to the gate which damaged the lock. Resident #1 was then able to squeeze through the gate and elope from the secured areas of the memory care unit. On the afternoon of 5/6/25 the Director of Maintenance showed the Surveyor changes made the to courtyard gate's locking system in an effort to prevent this from occurring again. Per review of a statement written by the Executive Director, a "new sturdy lock" was installed on the courtyard gate as an intervention to ensure safety and security following the incident on the early morning of 5/1/25.

3. Memory Care Staff failed to perform safety checks of Resident #1 per the facility's policies and procedures on the early morning of 5/1/25.

Per a statement written by the Executive Director, Resident #1 was outside for approximately 1 hour and 20 minutes on the morning of 5/1/25. Per a written description of an In-Service training for

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R142	Continued From page 4 memory care staff conducted on 5/1/25, in July of 2023 the home implemented hourly safety checks for all memory care residents. One month prior to the incident on 5/1/25 all memory care Nurses and Aides completed an in-service training which included a detailed review of rounding policies including the expectation for no greater than 30 minutes to go by without completing a visual check of all residents in the memory care unit to verify their safety. The In-Service training document states, "This is a repetitive duty that must be completed all shifts."; and further states, "Wandering residents must be supervised so that staff have awareness of their whereabouts at all times. This will allow you to intervene during unsafe situations. Nursing must partake in rounding and ensure that aides are rounding at designated times ... a lot can happen in 30 minutes." On the afternoon of 5/6/25, the Executive Director and Director of Nursing confirmed the Registered Nurse and an Aide did not perform assigned job duties including performing all required checks of Resident #1 and ensuring the applicable dining room door was locked to prevent Resident #1 from exiting the home without supervision on the early morning of 5/1/25. This deficiency is cited at harm level due to the injuries Resident #1 sustained during the incident on the early morning of 5/1/25.	R142		

Deficiency Statement Plan of Correction (POC)

Survey Date: May 6, 2025

Facility Name: The Meadows at East Mountain

Deficiency Regulation:

R142 SSG

How the deficiency was corrected:

The following was put in place to ensure resident supervision and safety.

A new heavy duty combination lock was placed on the special care unit courtyard gate and the structure of the fence was verified to be secured. Facility had fire Marshall visit to approve lock on gate and new secure care keypad entry/exit door.

Thirty-minute checks were put in place to verify the special care unit courtyard door was locked securely while facility awaited installation of new keypad entry/exit door which was completed on 5/22/2025.

Motion sensors were placed on all 4 special care unit exit doors to alert staff when the door is in use.

An audit was created implementing daily checks to verify the lock on the courtyard gate is secure. This audit will remain in place.

An audit was created to verify the functioning of the motion sensors that were put in place on all 4 special care unit exit doors. This audit will remain in place.

An audit was created to review video footage to verify rounding is being completed per protocol. Review of footage will be completed four times weekly to include random shifts for observation that rounding has occurred. This audit will remain in place.

A rounding in-service was created and reviewed with all nurses and aides to enforce rounding expectations.

In person education was completed with nurses and aides to further clarify rounding expectations. The education will be added to our Relias educational platform immediately and annually.

An additional in-person security in-service was completed to review the security policy and locking of doors.

The security policy was updated to include the protocol for checking that doors are locked securely.

The overnight shift checklist was updated to include that the nurse will acknowledge that staff have rounded on all residents per protocol.

Residents service plan was updated to include exit seeking tendencies in [redacted] behavior focus and verification of elopement risk focus was present. Interventions have been put in place to address these topics. Resident supervision will be provided during routine 30-minute rounding.

Continue to follow through with the behavioral health referral to address mental health status.

IDT review of elopement and exit seeking tendencies completed to verify residents at risk including review of service plans, elopement risk and exit seeking behaviors.

Review of all 3 elopement logs to verify accuracy.

1:1 initiated upon return to facility on 5/8/2025 per family request for transition back.

Fifteen-minute checks initiated on resident upon return on 5/8/2025 and will continue until 5/23/2025.

Installation of keypad on special care unit courtyard door completed 5/22/2025.

Permit for installation of courtyard door keypad obtained.

Date corrected System changes to ensure compliance of the regulation:

Immediately on 5/1/2025

Who will monitor to ensure compliance:

Executive Director, Assistant Director, Director of Nursing, Maintenance Director

POC will be reviewed and discussed in QAPI x 6 months.

During monthly IDT and daily as needed, the team will review residents at risk of elopement, including exit seeking tendencies. Service plans will be updated to include a risk for elopement focus and exit seeking tendencies listed under behavior focus and verifying all 3 elopement logs are updated as needed.

Pronoun redacted by DLP 5-23-25

All items are maintained in POC binder.

Audits will be collected and reviewed weekly to verify completion.

As of 5/22/2025 all of the above interventions have been implemented. We will continue to monitor for compliance of this corrective action plan. If you have any questions, please do not hesitate to contact me.

Thank you,

Melissa Greenfield, LNHA

mgreenfield@themeadowsvt.com

802-775-3300

R142 Plan of Correction accepted by Jo A Evans RN on 5/23/25.