VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
www.dlp.vermont.gov

[phone] 802-241-0344
[fax] 802-241-0343

AGENCY OF HUMAN SERVICES

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

December 17, 2025

Joseph Olio, Manager
Our Lady Of The Meadows
1 Pinnacle Meadows
Richford, VT 05476-7637

Dear Mr. Olio:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 3, 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
	0197	A. BUILDING: _____ B. WING _____	C 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF THE MEADOWS	1 PINNACLE MEADOWS RICHFORD, VT 05476

(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 11/3/25 the Division of Licensing and Protection conducted an unannounced on-site annual survey and an investigation of 3 facility reported incidents. Findings include:	R100	Plan of Correction for all tags accepted by Jo A Evans RN 12/16/25. Please see the attached document to review the accepted corrective actions.	
R210 SS=F	5.11.c Staff Services The home must provide, or arrange for the provision of, at least twelve (12) hours of training upon hire and each year to each staff person providing direct care to residents. The manager may give credit towards the required 12 hours of training upon hire, for any formal training received in the twelve months preceding the date of hire, provided the home maintains documentation of the training and ensures competency in the subject matter. 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, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; (7) General supervision and care of residents; (8)Communication strategies, person-centered care, challenging behaviors and understanding dementia; (9) Recognition of and sensitivity to different cultures, belief systems, abilities, gender identities, sexual orientation; and	R210		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0197	A. BUILDING: _____ B. WING _____	C 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF THE MEADOWS	1 PINNACLE MEADOWS RICHFORD, VT 05476

(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
R210	Continued From page 1 (10) Trauma-informed care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review 5 out of 5 sampled staff did not complete the required trainings. Findings include: The home's Educational Assistance policy indicates all Direct Care Staff are required to complete all mandatory training. At 12:20 AM on 11/3/25 the Director of Finance was requested to provide documentation of trainings completed by 5 sampled staff. Per the training documements provided for review, 5 out of 5 staff had not completed all required trainings. This finding was confirmed by the Director of Finance at 3:23 PM on 11/3/25.	R210	See attachment	
R225 SS=F	5.12. b (4) Records/Reports The home must keep and maintain the following records: 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 is a failure to ensure all required criminal record and abuse registry checks were completed for 3 out of 5 applicable staff. Findings include: At 12:20 AM on 11/3/25 the Director of Finance was requested to provide documentation of	R225		

JO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0197	A. BUILDING: _____ B. WING _____	C 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF THE MEADOWS	1 PINNACLE MEADOWS RICHFORD, VT 05476

(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
R225	Continued From page 2 criminal records and abuse registry checks for a sample of 5 staff. Per the documentation provided for review, all required criminal record and abuse registry checks were not completed for 3 out of 3 sampled staff. This finding was confirmed by the Director of Finance at 3:35 PM on 11/3/25.	R225		
R232 SS=F	5.12.c (5) Records/Reports Any reports, allegations, or incidents of abuse, neglect, exploitation of residents or misappropriation of resident property must be reported to the licensing agency. i. The licensee and staff must report any case of suspected abuse, neglect or exploitation of a resident to Adult Protective Services (APS). A separate report must also be made to the licensing agency. APS may be contacted by calling toll-free 1-800-564-1612. The licensing agency may be contacted by calling toll-free 1-888-700-5330. The home must make the reports to APS and to the licensing agency immediately but not later than within 48 hours of learning of the suspected, reported or alleged incident. ii. In addition to filing the reports as described above, a home must conduct its own investigation and must take immediate steps to prevent further abuse, neglect or exploitation from occurring. The results of the home ' s investigation must be reported to the licensing agency within 5 business days from the date of the initial report of the allegation. The home's investigation and determination must not delay reporting of the alleged or suspected incident to Adult Protective Services	R232	See Attachment	

JO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0197	A. BUILDING: _____ B. WING _____	C 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF THE MEADOWS	1 PINNACLE MEADOWS RICHFORD, VT 05476

(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
R232	Continued From page 3 and to the licensing agency. iii. Incidents involving resident-to-resident abuse must be reported to the licensing agency any time a resident alleges, or the licensee or staff observe or suspect, verbal, physical or mental abuse; sexual abuse, if an injury has resulted; or if there is a pattern of abusive behavior. (A) All resident-to-resident incidents, even minor ones, must be recorded in the resident ' s record. (B) The home must notify legal representatives and families (if permitted) about the incident(s) and must document the report and the plan the home developed to address the behaviors. the following reports with the licensing agency: This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to ensure the home's reporting of abuse is consistent with the licensing requirements. Findings include: The home's Abuse Prevention policy includes a definition which states physical abuse includes, but is not limited to, "pushing, hitting, slapping, pinching, and kicking." and states verbal abuse includes, but is not limited to, threats of harm or saying things to frighten a resident. The Reporting of Abuse section of the home's Abuse Prohibition policy is states, "The Staff RN will report the incident to the State Regulatory Agency and Adult Protective Services within 48 hours of the occurrence" when there is reasonable suspicion or actual knowledge of resident abuse. The home's Abuse Prohibition policy also indicates if there is a pattern of abuse a thorough investigation will be conducted and the Staff RN	R232	See Attachment	

JO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0197	A. BUILDING: _____ B. WING _____	C 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF THE MEADOWS	1 PINNACLE MEADOWS RICHFORD, VT 05476

(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
R232	Continued From page 4 will report the incident to the Adult Protective Services and the licensing agency within 24 hours. Per review of facility reported incidents submitted to the licensing agency by the home, progress notes, and incident reports provided by the facility for review upon request during the investigation conducted on 11/3/25, known or suspected incidents of resident abuse, and patterns of abuse, were not reported to the Division of Licensing and Protection as required. 1. An incident of Resident #4 physically striking Resident #5 twice on 10/10/25 was not reported to the Adult Protective Services and the licensing agency within 48 hours as required. This incident was reported to the Adult Protective Services on 10/13/25 and to the licensing agency on 10/16/25. 2. Per review of Progress Notes, Staff Incident Reports and the written and verbal reports submitted to the licensing agency by the home, the following incidents of resident-to-resident abuse were not reported to the Division of Licensing and Protection: a. Documented incidents of Resident #2 engaging in physical abuse of other residents included holding Resident #1 down on 8/12/25 during an incident after which Resident #1 was observed with a red mark on their left eye; and an incident on 8/16/26 during which Resident #2 pushed another resident and tried to strike the other resident with their footwear. b. Documented incidents of Resident #4 engaging in physically abusive behaviors towards other residents included striking another Resident	R232	See Attachment	

JO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0197	A. BUILDING: _____ B. WING _____	C 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF THE MEADOWS	1 PINNACLE MEADOWS RICHFORD, VT 05476

(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
R232	Continued From page 5 on 3/18/25; hitting another Resident in the chest on 4/8/25; striking another Resident in the chest as they were walking by on 4/28/25 and throwing markers at another resident's face on 4/29/25. c. Documented incidents of physical abuse during which Resident #6 slapped an unidentified Resident on 5/15/25; and pushed another unidentified Resident causing this Resident to fall to the floor on 6/3/25; and documented incidents of verbal abuse during which Resident #6 yelled and cursed at an unidentified Resident then "proceeded to go towards the other resident angrily" on 10/17/25. 3. Per review of written and verbal reports of resident-to-resident abuse provided to the licensing agency by the home Residents #2's, Resident #4's and Resident #6's patterns of abuse evidenced by the documented incidents listed above were not reported to the licensing agency. The Director of Finance acknowledged the unreported incidents of resident-to-resident abuse and resident patterns of abuse at approximately 4:00 PM on 11/3/25 and acknowledged these findings during an exit conference call on the evening of 11/3/25. Please refer to tag 360	R232	See Attachment	
R360 SS=G	6.12 Resident's Rights Residents must be free from mental, verbal or physical abuse, neglect, and exploitation. Residents must also be free from restraints and	R360		

JD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0197	A. BUILDING: _____ B. WING _____	C 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF THE MEADOWS	1 PINNACLE MEADOWS RICHFORD, VT 05476

(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
R360	Continued From page 6 seclusion as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to ensure 3 identified applicable residents (Resident #1, Resident #3, and Resident #5), and multiple Residents who were not identified by name or room number in facility documentation, remained free of abuse by other residents of the home. Findings include: The home's Abuse Prohibition policy states, "We will not tolerate any form of abuse, neglect, or exploitation." 1. Per record review, Resident #1 is a Memory Care Center resident with diagnoses including Vascular Dementia Without Behavioral and Mood Disturbances, chronic Pain, and multiple medical conditions which impact cardiac and respiratory function. Per Resident #1's most recent Resident Assessment signed as accurate and complete by the Director of Nursing on 3/19/25, Resident #1 is never verbally abusive, physically abusive, or socially inappropriate. Per record review, Resident #2 is a Memory Care Center resident with diagnoses including Alzheimer's Dementia; Severe Dementia with Agitation; Behavioral Syndromes associated with physiological disturbances and physical factors; and multiple medical and psychological conditions. Per review of Progress Notes and Incident Reports, Resident #2 began to demonstrate a pattern of verbally and physically aggressive behaviors towards other residents and staff one month after admission to the home in April of 2025. Progress Notes on file in Resident	R360	See Attachment	

JO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0197	A. BUILDING: _____ B. WING _____	C 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF THE MEADOWS	1 PINNACLE MEADOWS RICHFORD, VT 05476

(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
R360	Continued From page 7 #2's record document communications with Resident #2's Primary Care Provider and the family conveying concerns related incidents of aggressive and assaultive behaviors during which other residents have been threatened, targeted, and physically assaulted by Resident #2. Per Progress Notes and Incident Reports, on 10/15/25 Resident #2 grabbed Resident #1 around the neck an caused Resident #1 to fall to the ground. Immediately following this incident Resident #1 experienced severe right hip pain which was described in a Progress Note dated 10/15/25 as Resident #1 "being unable to move without being in excruciating pain". Resident #1 was transported via ambulance to the closest Emergency Department, then transferred to another hospital for surgical repair of a hip fracture with a plan for discharge to a skilled nursing facility for rehabilitation before returning to the facility. As of 11/3/25 Resident #1 had not returned to the home. This incident is cited as harm level abuse due to the injury Resident #1 sustained and the pain Resident #1 experienced as a result of this injury. On the afternoon of 11/3/25 the Registered Nurse on duty confirmed Resident #2 was in pain on the floor when describing Resident #1's reaction to the outcome of this incident; and the Director of Finance acknowledged the finding of this incident as harm level abuse. Progress Notes and an Incident Report indicate the incident on 10/15/25 was preceded by Resident #2 holding Resident #1 down on 8/12/25, after which Resident #1 was observed with a red mark on their left eye. A Progress Note dated 8/18/25 indicates Resident #2 pushed an unidentified Resident and attempted to strike the other Resident with their footwear on 8/16/25.	R360	See Attachment	

JD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0197	A. BUILDING: _____ B. WING _____	C 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF THE MEADOWS	1 PINNACLE MEADOWS RICHFORD, VT 05476

(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
R360	Continued From page 8 2. Per record review, Resident #4 is a resident of the Memory Care Center who is living with the signs and symptoms of cognitive decline and has demonstrated a pattern of aggressive behaviors directed towards other residents of the home. Per record review diagnoses on file for Resident #4 include "Unspecified Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety." Per review of Resident #4's Care Plan, on 3/18/25 Behaviors were identified as an area of focus with a description of a history of harming others including "Lashing out verbally and physically at other residents, swearing, insulting, name-calling, slapping, punching/hitting." An annual Resident Assessment signed as complete and accurate by the Director of Nursing on 5/1/25 indicates Resident #4 is verbally abusive, physically abusive, and socially inappropriate daily. Per review of Progress Notes and Incident Reports, incidents during which Resident #4 had physically abused other residents of the home include: a. Per Progress Note dated 3/18/25, Resident #4 struck an unidentified resident. b. A Progress Note dated 4/8/25 states Resident #4 hit an unidentified resident in the chest and indicates Resident #4 has a history of aggressive behaviors towards this resident. c. Per Progress Note, Resident #4 struck another Resident in the chest as they were walking by on 4/28/25.	R360	See Attachment	

30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0197	A. BUILDING: _____ B. WING _____	C 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF THE MEADOWS	1 PINNACLE MEADOWS RICHFORD, VT 05476

(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
R360	Continued From page 9 d. A Progress Note dated 4/30/25 states Resident #4 "threw a marker at a different resident". An Incident Report regarding this incident states that on 4/29/25 Resident #4 grabbed markers from Resident #5 who was coloring in a common area of the home and threw the markers at Resident #5's face. While this incident was not documented in the Resident #4's Progress Notes until the following day, a Progress Note dated 4/29/25 states Resident #4's "behaviors persist and other residents are intimidated and upset by the behavior". e. A Progress Note dated 10/13/25 indicates Resident #4 struck another resident on the arm twice on 10/10/25 and states "this has happened several times previously". A Incident Report regarding this incident identifies Resident #5 as the person Resident #4 struck on 10/10/25. 3. Per record review, Resident #6 is a Memory Care Center resident with diagnoses including "Unspecified Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety", Mild Cognitive Impairment of unknown etiology, Irritability and Anger, and multiple medical and psychological condition. Per review of the Resident Assessment signed as accurate and complete by the Director of Nursing on 5/13/25, Resident #6 is verbally and physically abusive "less than daily" and socially inappropriate daily. Resident #6's Care Plan includes an area of focus entered on 6/19/25 which states this Resident has become intermittently verbally and physically aggressive toward staff and other residents with an identified goal of monitoring and managing undesired behaviors and an identified intervention of ensuring the safety of Residents	R360	See Attachment	

30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0197	A. BUILDING: _____ B. WING _____	C 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF THE MEADOWS	1 PINNACLE MEADOWS RICHFORD, VT 05476

(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
R360	Continued From page 10 and others. On 6/25/25 an update to Resident #6's Care Plan identified a new behavior potentially causing harm to self or others which states Resident #6 recently had several agitated episodes of becoming physical with staff and residents. Per Progress Notes, Resident #6 has demonstrated a pattern of aggressive and abusive behaviors directed towards other residents including the following incidents of verbal and physical abuse: a."Becoming angry" and slapping an unidentified Resident on 5/15/25 b. "Becoming agitated" and pushing another Resident, and causing this unidentified Resident to fall to the floor on 6/3/25 c. Resident #6 slapped Resident #1 across the face in reaction to their misunderstanding of an non-confrontational interaction between Resident #1 and another Resident. d. Resident #6 engaging in verbal abuse of an unidentified Resident evidenced by yelling and swearing at the other resident on 10/17/25, as documented in a Progress Note dated 10/20/25 which also states Resident #6 then "proceeded to go towards the other resident angrily". Staff intervened and redirected Resident #6 away from the other Resident. Additionally, Resident #6's pattern of abuse included multiple documented incidents of verbal and physical abuse of staff including but not limited to the following incidents that occurred while Staff were actively engaged in redirecting Resident #6 away from aggressions directed	R360	See Attachment	

50

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0197	A. BUILDING: _____ B. WING _____	C 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF THE MEADOWS	1 PINNACLE MEADOWS RICHFORD, VT 05476

(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
R360	Continued From page 11 towards other residents: a. A Progress Note dated 4/29/25 states that on the evening of Resident #6 was "agitated and arguing with other residents and lashing out verbally and physical with care staff trying to redirect [Resident #6]" . b. A Progress Note dated 6/16/25 states Staff were struck multiple times while trying to redirect away from other residents. This note states Resident was "shouting, slapping, hair pulling and kicking" during this incident; however, this Progress Note does not specify if the verbal and physical abuse documented on this date was directed towards Staff and/or Residents of the home. c, A Progress Note dated 8/25/25 states Staff reported Resident #6 was verbally and physically abusive to Staff and targeted Residents "each evening shift over the past weekend". This note further states Staff were "kicked, punched pushed, insulted and screamed at" as they intervened to keep Resident #6 away from other Residents. d. A Progress Note dated 10/16/25 states a Staff member was "slapped hard across the face" as they intervened when Resident #6 was being hostile towards other Residents. It is important to recognize potential for more than minimal harm to Residents witnessing Staff they are dependant on to meet their basic needs being verbally and physically abused, particularly when this abuse occurs while Staff are engaged in responding to another Resident whose actions pose a potential threat to their well-being.	R360	See attachment	

JO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0197	A. BUILDING: _____ B. WING _____	C 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF THE MEADOWS	1 PINNACLE MEADOWS RICHFORD, VT 05476

(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
R360	Continued From page 12 The Director of Finance acknowledged the finding of resident patterns of abusive behaviors impacting multiple residents of the home at approximately 4:00 PM on 11/3/25, and acknowledged the identification of Resident #2's, Resident #4's and Resident #6's patterns of abuse towards residents and staff during a review of findings conducted during an exit conference call on the evening of 11/3/25.	R360		
R430 SS=F	9.6.d Plumbing Hot water temperatures must not exceed 120 degrees Fahrenheit in resident areas. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure water temperatures in areas of the home accessible to residents are maintained at or below 120 degrees Fahrenheit. Findings include: During a tour of the home commencing at 10:30 AM on 11/3/25 water temperatures were observed to be above 120 degrees Fahrenheit in the following areas accessible to residents: 1 In the Memory Care area of the home: a. Room 185 125.2 degrees b. Room 179 123.1 degrees 2. In the Residential Care area of the home: a. Kitchenette sink in the dining room 131.7 degrees b. Bathroom near Dining Room 130.3 degrees c. Spa 124.7 degrees	R430	See attachment	

JO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0197	A. BUILDING: _____ B. WING _____	C 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF THE MEADOWS	1 PINNACLE MEADOWS RICHFORD, VT 05476

(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
R430	Continued From page 13 These findings were confirmed by the Director of Finance during the tour of the home on the morning of 11/3/25. Following adjustments to the home's hot water heating system on the afternoon of 11/3/25, water temperatures in the areas previously observed to be above 120 degrees Fahrenheit were confirmed by the Director of Finance to be maintained at or below 120 degrees Fahrenheit.	R430	See Attachment	

JO

Deficiency Statement Plan of Correction (POC)

Survey Date: 11/3/2025

Facility Name: Our Lady Of The Meadows

Deficiency Tag	How the deficiency was corrected	How other potential residents identified, and corrective action taken	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R210 Plan of Correction accepted by Jo A Evans RN on 12/16/25	The staff examples that were selected have achieved all 12 hours of training that were missing to be compliant with state regulations.	Internally ran an audit to see if other staff members, besides the selected examples, were out of compliance with their required 12 hours of training. Any staff member out of compliance will have extra time added in their shift to complete missed education	1/2/26	Adding to all staff meeting agendas to remind all staff it is their responsibility to maintain 12 hours of training per year.	Human Resources
R225 Plan of Correction accepted by Jo A Evans RN on 12/16/25	The background checks that were missing from the selected examples were ran and completed on the same day.	Internally ran an audit to see if other staff members, besides the selected examples, had missing material in their background checks. Any staff members with missing material were ran same day.	12/19/25	When running annual background checks on currently employed staff, A second person will review the list and sign off to ensure all current employees have had their background check completed.	Human Resources
R232 Plan of Correction accepted by Jo A Evans RN on 12/16/25.	1) Nursing was not on site at that hour. Nursing reported the incident when made aware on Monday 10/13 to APS an	Nursing completed an internal audit of incident reports to determine if other incidents have not been reported to which none were found. 11/20/25	1) 10/16/25	1) Educate all Care staff to inform on call RN of any incident between residents even if there is no injury. On Call RN can then file the report in a timely manner.	Nursing Staff

	oversight was made, as it was not reported to DAIL as well. This was corrected on 10/16/25. 2) Noted patterns of abuse will be submitted to APS and the Licesning agency with in 48 hours. 3) Noted patterns of abuse will be submitted to APS and the Licesning agency within 48 hours.		2) 12/2/25 3) 12/2/25	2) Care staff and nursing have been educated to report all incidents of resident-to-resident negative physical interactions immediately. All incidents will be reported to APS and DAIL within 48 hours to avoid subjective interpretation of abuse and patterns. 3) Care staff and nursing have been educated to report all incidents of resident-to-resident negative physical interactions immediately. All incidents will be reported to APS and DAIL within 48 hours.	Nursing Staff Nursing Staff
R360 Plan of Correction accepted by Jo A Evans RN on 12/16/25	Care plans were updated to reflect behavioral changes for respective residents. For residents #2, #4 and #6 their primary care providers were contacted regularly for possible medication regiment changes and diagnostic testing.	Reviewed and updated care plans on the memory care unit to add interventions to include de-escalation strategies. Restructuring certain group activities to new locations to help reduce noise/distractions which	12/19/25	- Nursing to review assessments and revise immediately after any behavioral changes are exhibited/documented and quarterly to see if updates need to be made. - Care staff and nursing have been educated to	- Nursing Staff

		can lead to increased agitated behaviors.	(Date for De-escalation training is TBD as we are waiting on a scheduling date with the company)	report all incidents of resident-to-resident negative physical interactions immediately. All incidents will be reported to APS and DAIL within 48 hours. - Adding additional mandatory training to all staff specifically in De-escalation. This specific training will be conducted annually, which will help new and current staff with identifying early signs of agitation and applying their skillset to redirect residents. - Restructuring certain group activities to new locations to help reduce noise/distractions which can lead to increased agitated behaviors.	- Nursing Staff - Human Resources - Activity Team Lead
R430 Plan of Correction accepted by Jo A Evans RN on 12/16/25.	Adjustments were made immediately to the facilities mixing valve to lower the water temperature below 120 degrees F.	Additional resident areas were checked for hot water. After the facilities mixing valve was adjusted, the additional areas were below 120 degrees Fahrenheit.	12/26/2025	Water temperatures will be tested weekly in resident areas with the findings recorded. This monitoring will provide information needed to adjust the mixing valve before the temperatures surpass 120 degrees Fahrenheit.	Kitchen Staff