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

September 1, 2022

Mr. Todd Hill, Manager
Assist Program
300 Flynn Ave
Burlington, VT 05401

Dear Mr. Hill:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 11, 2022.** 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
	0511	A. BUILDING: _____ B. WING _____	C 05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSIST PROGRAM	300 FLYNN AVE BURLINGTON, VT 05401

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T 001	Initial Comments An unannounced onsite complaint investigation was conducted on 4/26/22 and completed on 5/11/22 by the Division of Licensing and Protection. The following regulatory violations were identified:	T 001		
T 002 SS=G	V.5.1.a Resident Care and Services 5.1 Eligibility 5.1.a The licensee shall not accept or retain as a resident any individual who meets level of care eligibility for nursing home admission, or who otherwise has care needs which exceed what the residence is able to safely and appropriately provide, unless prior approval has been obtained from the licensing agency. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the TCR failed to meet the needs of a resident whose level of care needs exceeded what the TCR was able to safely and appropriately provide for 1 applicable resident. (Resident #1) Findings include: On 1/14/2022 Resident #1 was admitted to the TCR. The resident was an individual who previously received outpatient services from an agency who specialized in assistance with mental	T 002	Please see attached Plan of Correction.	

T002-T146 POC accepted FindlayRN/PMC

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T 002	Continued From page 1	T 002		

health and developmental disabilities, which discontinued operations in late 2021. Resident #1 was then transitioned to another designated agency for continuation of services in December 2021. After experiencing a mental health crisis and hospitalization Resident #1 was referred and accepted for admission to the new designated agency's TCR. Prior to admission a ISA (Individual Support Agreement) was completed on 12/30/2021 during this individual's transition to the newly assigned designated mental health agency. The ISA includes a "Needs Assessment" for general supervision, behavioral supports, health needs, future living arrangements and also provides essential strategies for supporting this resident's needs.

Shortly after admission, Resident #1 became inappropriately involved with Resident #2, who was also receiving mental health services and treatment while at the TCR. Despite the information provided by the ISA, which directed treatment management for Resident #1 to include being aware that Resident #1 was on ACT 248 (a public safety program which requires all providers must have 24/7 awareness of the resident's whereabouts due to safety concerns in the communities as a result of Resident #1's previous unsafe behaviors). In addition, per the ISA, staff providing services would be performing "....eyes on supervision...." allowing for being "...out of eyesight for 10 minutes followed by a check-in". When stable and regulated Resident #1 could walk 3 x per day "...for a total of 15 minutes and must check in with providers."

Although the specific management and supervision for Resident #1 was directed via the ISA, the more frequent "eyes on supervision" and 10-15 minute monitoring and frequent check-ins

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T 002	Continued From page 2 did not occur. Per interview with the Clinical Director on 5/10/22 at 10:22 AM stated if an individual required "15 minute checks, they would not be appropriate to be here". The TCR presently conducts only hourly checks. The Clinical Director further acknowledged the lack of awareness of Resident #1's specific needs as per the ISA, stating "...not aware it existed". S/he further confirmed when the referral was submitted requesting admission for Resident #1 to the TCR, the Clinical Director accepted the admission without a discussion with the designated agency's Developmental Services. The routine process for accepting an individual for admission is generally conducted by the Clinical Supervisor who stated on 5/10/2022 at 3:05 PM, prior to accepting an individual for treatment, a review of hospitalization records; Case Management Notes; and other entity documentation associated with the individual awaiting pending admission would occur. In the case of Resident #1, the Clinical Supervisor was not involved with the admission. In addition, s/he was also not aware of the ISA developed by the designated agency in collaboration with previous individuals involved with Resident #1s care needs. Although the document was available for review by staff who access the resident's electronic medical record the clinical team failed to identify the document. The provision of services at the TCR and what was required to keep Resident #1 safe did not occur. As a result of lack of supervision to include only conducting hourly checks by TCR staff, left this vulnerable individual in a compromised and emotionally inappropriate relationship as noted on surveillance camera recordings. Refer to Tag: 0023 & 0146	T 002		

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T 023 SS=G	V. 5.5.a Resident Care and Services 5.5 General Care 5.5.a Upon a resident's admission to a therapeutic community residence, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. The home's manager shall provide every resident with the personal care and supervision appropriate to his or her individual needs. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the TCR failed to provide and/or arrange the necessary services to meet a resident's psychosocial needs and appropriate supervision. (Resident #1) Findings include: Resident #1, identified with intellectual disability, depression and anxiety was admitted to the TCR on 1/14/22. Resident #1's ISA (Individual Support Agreement) was completed on 12/30/2021 during this individuals transition to a new designated mental health agency. The ISA includes a "Needs Assessment" for general supervision, behavioral supports, health needs, future living arrangements and also provides essential strategies for supporting this resident's needs. The ISA identified Resident #1 to be on ACT 248 (a public safety program which requires all providers must have 24/7 awareness of the resident's whereabouts due to safety concerns in the communities as a result of Resident #1's previous unsafe behaviors). In addition, per the	T 023		

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T 023	Continued From page 4 ISA, staff providing services would be performing "....eyes on supervision...." allowing for being "...out of eyesight for 10 minutes followed by a check-in". When stable and regulated Resident #1 could walk 3 x per day "...for a total of 15 minutes and must check in with providers." Consequently, during Resident #1's admission to the TCR, the directed supervision and monitoring as per the ISA was not acknowledged or followed in the management of Resident #1's significant challenges related to his/her intellectual developmental disability and psychiatric diagnosis. As a result, Resident #1 was monitored by staff only on an hourly basis and frequent check-ins by the resident were not established by TCR staff. At the time of Resident #1's admission, s/he quickly established a friendship with another resident of the facility (Resident #2). Per observation of video surveillance recorded on 1/15/22 - 1/17/22, Resident #1 and Resident #2 were viewed sitting in the facilities gazebo located in the back of the residence. Over the 3 day period, via the video recording of Resident #1 and Resident #2, inappropriate physical contact was observed multiple times to include fondling, kissing and uncovering clothing to expose themselves. Although the ISA documented the specific needs required to keep Resident #1 safe to include necessary monitoring, the TCR Manager stated during interview on 5/10/22 at 10:18 AM, a review of the ISA was not conducted although it was accessible and available since the end of December 2021 via the designated agency and TCR electronic medical record identified as Credible. "I was not aware it existed." Due to the lack of supervision and ineffective monitoring of Resident #1's whereabouts, the TCR and the	T 023		

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T 023	Continued From page 5 designated agency who serves this resident, failed to meet this resident's needs and protect this vulnerable and disabled individual from inappropriate sexual encounters over a 3 day period.	T 023		
T 079 SS=G	V.5.16.b Resident Care and Services 5.16 Reporting of Abuse, Neglect or Exploitation 5.16.b The licensee and staff are required to report suspected or reported incidents of abuse, neglect or exploitation. It is not the licensee ' s or staff's responsibility to determine if the alleged incident did occur or not; that is the responsibility of the licensing agency. A residence may, and should, conduct its own investigation. However, that must not delay reporting of the alleged or suspected incident to APS. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the TCR failed to conduct their own investigation after reporting an incident to Adult Protective Services (APS) involving the exploitation and inappropriate sexual encounter between to individuals who had resided at the TCR. (Resident #1 & Resident #2) Findings include: On 1/18/22 when another peer reported to the TCR nurse his/her concerns regarding Resident #1 noting "....an ongoing relationship with a client whom was previously staying at Assist...." and further reported residents had been seen "kissing". An incident report was completed by the TCR nurse on 1/18/2022 and a verbal report	T 079		

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T 079	Continued From page 6 provided to the Clinical Director regarding expressed concerns. No further review or investigation was initiated to discuss concerns with Resident #1 who was dependent on the designated agency and TCR to provide safe and structured support due to his/her mental capacity and developmental disabilities. The Clinical Director confirmed counseling, guidance and a review of the allegations made by another resident were not investigated. Further discussion with Resident #1 may have uncovered the inappropriate intimacy of the relationship which Resident #1 later informed community caregivers had transpired with Resident #2 between 1/15/2022 -1/17/2022. A review of surveillance video recordings at the time of the reported incident were not conducted, which would have validated the series of encounters between Resident #1 & Resident #2, however the Clinical Director confirmed on the morning of 5/10/2022, s/he was unaware how to access the video recordings.	T 079		
T 146 SS=G	IX.9.1.a Physical Plant 9.1 Environment 9.1.a The residence must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced	T 146		

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T 146	Continued From page 7 by: Based on observation, interview and record review, the TCR staff failed to provide and maintain a safe and functional environment for 1 applicable resident. (Resident #1) Findings include: Per review of the designated agency and TCR policy Camera Surveillance Policy last reviewed 7/27/2021 states "(the designated agency)..is committed to ensuring the safety of our clients and staff members in our facilities.....surveillance may be used to deter crimes on agency property and assist in protecting clients....". The policy further states: "The camera surveillance system should be used to ensure safety of individuals in the facility and to allow after incident reviews and after-the-fact investigations...". Per observation on the morning of 4/26/2022 a camera was visualized in the back of the TCR building providing a visualization of the facility's gazebo and any residents who chose to utilize this location. A monitor, used to visualize live camera surveillance from multiple cameras situated throughout the TCR was observed to be present in the staff office. However, it was confirmed by 2 Resident Counselors on the afternoon of 5/10/2022 the monitor is not operating presently and has been non-functioning for an unknown extended period of time. Although surveillance recordings are retained for a 6 month period, as per designated agency policy, at the time of the investigation, a request was made to view the recordings however, TCR staff were unaware if recordings existed and how to access if necessary. The Clinical Director stated on 5/10/2022 at 10:22 AM s/he "...had no knowledge how to review the video..." Access to the video surveillance recordings was	T 146		

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T 146	Continued From page 8	T 146		

granted after a legal request had been made by a Vermont agency associated with this investigation. Per observation off-site on 5/6/2022 of video surveillance recorded on 1/15/22 - 1/17/22, Resident #1 and Resident #2 were viewed sitting in the facility's gazebo. Over the 3 day period, via the video recording of Resident #1 and Resident #2, inappropriate physical contact was observed multiple times to include fondling, kissing and uncovering clothing to expose oneself.

In order to ensure resident safety, TCR staff conduct hourly checks, performing "eyes on" of each resident receiving services within the TCR. Per interview on 5/10/2022 at 3:00 PM a Resident counselor confirmed safety checks involved staff entering resident rooms; check smoking areas at the front or back of the building; and/or do a "check in" to obtain a status of how a resident was feeling often chatting in the Common area where residents regularly congregate.

Despite the fact staff had noted Resident #1 was becoming noticeably attached to a peer (Resident #2) and per Shift Note dated 1/17/2022 stated "Ct was reminded by staff to follow rules regarding boundaries and personal space with other clients..." No additional monitoring was considered by the Clinical Director and TCR clinical team to ensure and maintain a safe environment for Resident #1. On 1/18/22 when another peer reported to the TCR nurse his/her concerns regarding Resident #1 noting "....an ongoing relationship with a client whom was previously staying at Assist..." and further reported residents had been seen kissing. An incident report was completed by the TCR nurse on 1/18/2022 and a verbal report provided to the Clinical Director regarding expressed concerns.

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T 146	Continued From page 9 No further review or investigation was initiated to discuss concerns with the TCR team and especially Resident #1 who was dependent on the designated agency to provide safe and structured support due to his/her mental capacity and developmental disabilities.	T 146		

July 15, 2022

Agency of Human Services
Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
HC2 South, 280 State Drive, Waterbury, VT 05671-2060

Todd Hill, LICSW
Howard Center, Inc.
ASSIST Program

RE: **Plan of Correction for revised Statement of Deficiencies dated July 1, 2022**

Requirement
T 002
V.5.1.a Resident Care and Services

5.1 Eligibility
5.1.a The licensee shall not accept or retain as a resident any individual who meets level of care eligibility for nursing home admission, or who otherwise has care needs which exceed what the residence is able to safely and appropriately provide, unless prior approval has been obtained from the licensing agency .

Deficiency:

Based on staff interview and record review the TCR failed to meet the needs of a resident whose level of care needs exceeded what the TCR was able to safely and appropriately provide for 1 applicable resident. The provision of services at the TCR and what was required to keep Resident #1 safe did not occur. As a result of lack of supervision to include only conducting hourly checks by TCR staff, left this vulnerable individual in a compromised and emotionally inappropriate relationship as noted on surveillance camera recordings.

Corrective Action Steps:

To address this deficiency the Howard Center Program Manager will work with ASSIST Program staff taking referrals to ensure that all clinically significant information is obtained before deciding about acceptance of a referral.

In addition to ASSIST's regular process of talking to the referring entity and receiving recent clinical documentation about the referred clients, the Program will take the following additional steps:

1. For clients who are opened to the Howard Center, ASSIST will conduct a chart review. Specifically Program personnel will review any ISAs or other treatment plans on file that are active plans for the referred client.

2. For all clients, ASSIST staff who are taking referral information will ask additional questions around the supervisory needs related to their safety - specifically if they are able to be safely maintained on hourly eyes-on checks. Clients who need more intensive supervision than hourly checks to help maintain safety will not be considered for admission as ASSIST staff cannot provide that level of care.

3. For clients who receive services from any other Howard Center program, the ASSIST Program Manager or his/her/their designee will make reasonable attempts to reach the case manager of the client prior to admission.

TIMELINE FOR COMPLETION: July 15, 2022

Requirement:

T023
V.5.5.a Resident Care and Services

5.5 General Care
5.5.a Upon a resident's admission to a therapeutic community residence, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. The home's manager shall provide every resident with the personal care and supervision appropriate to his or her individual needs.

Deficiency:

Based on observations, staff interviews and record review the TCR failed to provide and/or arrange the necessary services to meet a resident's psychosocial needs and appropriate supervision. (Resident #1)

Due to the lack of supervision and ineffective monitoring of Resident #1's whereabouts, the TCR and the designated agency who serves this resident, failed to meet this resident's needs and protect this vulnerable and disabled individual from inappropriate sexual encounters over a 3 day period.

Corrective Action Steps:

To address this deficiency the ASSIST Program Manager will work with all staff in the Program to ensure that clients admitted to the Program are having their personal, psychosocial, nursing, and medical care needs met.

The ASSIST plan of correction includes the following steps:

1. For clients who are opened to the Howard Center, ASSIST personnel will conduct a chart review. Specifically they will review any ISAs or other treatment plans on file and are active plans for the referred client to help determine what the person's psychosocial, nursing and medical care needs are.

2. For all clients, staff who are taking referral information will ask additional questions as to the client's supervisory needs related to their safety, specifically if they are able to be safely maintained on hourly checks. Clients who need more intensive supervision than hourly checks to help maintain safety will not be consider for admission as staff cannot provide that level of care.

TIMELINE FOR COMPLETION: July 15, 2022

Requirement:

T 079
V.5.16.b Resident Care and Services

5.16 Reporting of Abuse, Neglect or Exploitation
5.16.b The licensee and staff are required to report suspected or reported incidents of abuse, neglect or exploitation. It is not the licensee's or staff's responsibility to determine if the alleged incident did occur or not; that is the responsibility of the licensing agency. A residence may, and should, conduct its own investigation. However, that must not delay reporting of the alleged or suspected incident to APS.

Deficiency:

Based on staff interview and record review, the TCR failed to conduct their own investigation after reporting an incident to Adult Protective Services (APS) involving the exploitation and inappropriate sexual encounter between to individuals who had resided at the TCR. (Resident #1 & Resident #2). No further review or investigation was initiated to discuss concerns with Resident #1 who was dependent on the designated agency and TCR to provide safe and structured support due to his/her mental capacity and developmental disabilities

Corrective Action Steps:

To address this deficiency, the ASSIST Program Manager or his/her/their designee will implement an additional internal review whenever a mandated report is made to Adult Protective Services or the Department of Aging and Independent Living.

ASSIST's plan of correction will include the following step:

1. The Howard Center shall ensure that the ASSIST Program conducts an internal, independent review of each instance of suspected abuse, neglect or exploitation of a vulnerable adult required to be reported pursuant to 33 V.S.A. §6903 et seq. However, the ASSIST Program may postpone or delay any such internal review if so requested by a governmental entity seeking to conduct its own inquiry first.

TIMELINE FOR COMPLETION: July 15, 2022, except for the camera surveillance equipment.

Requirement:

T146
IX.9.1.a Physical Plant
9.1 Environment
9.1.a The residence must provide and maintain a safe, functional, sanitary, homelike and comfortable environment.

Deficiency:

Based on observation, interview and record review, the TCR staff failed to provide and maintain a safe and functional environment for 1 applicable resident. (Resident #1) Although surveillance recordings are retained for a 6 month period, as per designated agency policy, at the time of the investigation, a request was made to view the recordings however, TCR staff were unaware if recordings existed and how to access if necessary. No further review or investigation was initiated to discuss concerns with the TCR team and especially Resident #1 who was dependent on the designated agency to provide safe and structured support due to his/her mental capacity and developmental disabilities.

Corrective Action Steps:

To address this deficiency the ASSIST Program Manager or his/her/their designee will change our process specific to when a report of a concern is made to Adult Protective Services or the Department of Aging and Independent Living. Additionally, the Program Manger will work with Facilities and Information Technology staff to improve the use of cameras on site to better review incidents with clients who are admitted.

Our plan of correction to achieve this will include the following steps:

1. The Howard Center shall ensure that the ASSIST Program conducts an internal, independent review of each instance of suspected abuse, neglect or exploitation of a vulnerable adult required to be reported pursuant to 33 V.S.A. §6903 et seq. However, the ASSIST Program may postpone or delay any such internal review if so requested by a governmental entity seeking to conduct its own inquiry first.

2. The camera surveillance system at the ASSIST Program is due to be replaced. The Program Manager will work with technical personnel at the Howard Center to ensure that video playback is functioning properly and can be viewed in a timely manner.

3. Whenever completing an independent review the Program Manger or his/her/their designee will assess whether video recordings may provide information relevant to the incident or be of assistance in the investigation.

TIMELINE FOR COMPLETION: July 15, 2022[1]

[1] At this time, the Howard Center cannot commit to a firm date for the completion of all necessary repairs of the ASSIST camera surveillance system. It is essential to note, however, that the Program's eyes-on hourly checks of clients does not rely upon this system. All such checks are done by ASSIST staff through their direct observations of clients.