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

October 20, 2022

Mr. Alexander Leveille, Manager
Copley House Community Care Home
379 Washington Highway
Morrisville, VT 05661-8968

Dear Mr. Leveille:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 8, 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
	0139	A. BUILDING: _____ B. WING _____	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPLEY HOUSE COMMUNITY CARE HOME	379 WASHINGTON HIGHWAY MORRISVILLE, VT 05661

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R100	Initial Comments: On 8/30/22 the Division of Licensing and Protection conducted an unannounced on-site re-licensure survey and one complaint investigation. Further information was requested and received on 9/8/22, which concluded the survey. The following regulatory deficiencies were identified:	R100	Please see Attached plan of Correction	
R126 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the Residential Care Home (RCH) failed to provide necessary services including increased supervision and monitoring to ensure the personal, medical, psychosocial and safety needs were met for one applicable resident who was experiencing a mental health crisis (Resident #1). Findings include: Per record review Resident #1 was admitted to the RCH in 2016 with a diagnosis of Schizophrenia. While residing at the home s/he has experienced frequent periods of psychiatric decompensation requiring inpatient hospitalization and/or care in a crisis stabilization program. On 3/1/22 the Case Manager noted	R126		

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Manager (X6) DATE 10/13/22

R126 - R303 POC accepted 10/17/22 JEVansickle/RME

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R126	Continued From page 1 Resident #1 presented with irritability and delusions. S/He had refused medications for two days and a medication change was made in response to his/her concerns the medication would cause a fall. On 3/8/22 Resident #1 was noted to be agitated and to have difficulty understanding and communicating during a meeting about his/her Order of Non-Hospitalization, which is a legal document outlining requirements for care and support in an outpatient residential setting instead of inpatient care. On 3/13/22 an Emergency Services Note reported Resident #1 fell while walking in the community and sought medical treatment at the Emergency Department for a swollen elbow and bruising due to the fall. The following day a Crisis Clinician requested police assistance when Resident #1 was observed in the middle of the road "flipping off" passing vehicles. Psychiatry notes stated Resident #1 presented as 'hostile, angry, and irritated" and with "poor insight, bizarre and illogical thought processes" during a Mental Status Exam conducted on 3/29/22. On 4/3/22 the Case Manager noted increased rapid and unintelligible speech and stated Resident #1 "agrees to maintain safety" in the home and community. Over the following 6 weeks numerous incidents of disruptive and dangerous behaviors in the community were noted. On 4/18/22 Crisis Support Staff transported Resident #1 back to the facility in response to a request for assistance from a local business owner due to prolonged periods of lingering and disturbing customers. On 4/21/22 staff noted Resident #1 was returned to the facility by police at 1 AM; at 11:12 AM the police notified staff Resident #1 "walked into the downstairs entry of an apartment, shouting/yelling, terrifying the woman who was asleep"; and at 4:30 PM Resident #1	R126		

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R126	Continued From page 2 was at the police department crying for 20 minutes then left the station "heading south". On 5/8/22 Resident #1 left sexually explicit letters at a bank and a church resulting in no trespass orders; and staff notes indicated police received reports from several community members that Resident #1 was walking "with pants around his/her ankles, not wearing underwear, private parts exposed, seemingly unaware of this" presumably due to poorly fitting clothing resulting from weight loss over the previous 2 months. On 5/12/22 Resident #1 took a box of rapid antigen Covid tests containing a bottle of toxic chemicals used in the testing process from an unlocked unattended office in the RCH, opened the testing supplies, and threw them in the trash. On 5/13/22 Resident #1's declining mental and physical health was evidenced by worsening of unintelligible communication to "almost constant guttural sounds verbalized". On 5/15/ 22 the facility Manager observed Resident #1 crossing through oncoming traffic and both lanes of travel on a busy highway in the rain. The same day Resident #1 violated a No Trespass Order when s/he interrupted morning mass at the local church; and again the following day when s/he rummaged through cupboards in the church kitchen. While the RCH made attempts to coordinate care with the Designated Agency's Case Management and Crisis supports there was a failure to implement a plan for increased monitoring and support to address disruptive and dangerous behaviors, weight loss of 20 pounds, and loss of ability to communicate that occurred between 3/1/22 and 5/18/22 when Resident #1 was hospitalized for psychiatric stabilization. At 3:20 PM on 8/30/22 the Manager acknowledged Resident #1's dangerous and disruptive	R126		

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R126	Continued From page 3 behaviors, and need for increased monitoring and support. The Manager stated Resident #1 had already significantly decompensated when s/he became the Manager in the end of April 2022, and confirmed a care plan to address Resident #1's mental health crisis was not created or implemented.	R126		
R128 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure medications were administered according to physician's orders for one applicable resident (Resident #1). Findings include: During a chart review for Resident #1 on 8/30/22 a signed physician's prescription form for Ativan (controlled substance medication for anxiety) 2 mg tablet twice daily was observed in Resident #1's chart attached to discharge instructions from an inpatient hospital stay in April of 2020. On the afternoon of 8/30/22 the Director of Nursing and Med Delegated staff confirmed the signed prescription form was likely overlooked when Resident #1 was discharged from the hospital, the signed prescription form for this controlled substance had been in Resident #1's chart since 2020, and Resident #1's order for Ativan was not	R128		

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R128	Continued From page 4 changed from 2 mg three times daily to 2 mg twice daily as ordered by the physician on discharge from the hospital. At 4:36 PM on 8/30/22 the facility Manager confirmed the signed prescriber's orders for Ativan was not given to the pharmacy and had remained in Resident #1's chart since April of 2020.	R128		
R145 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, there was a failure of the RCH nurse to develop a written plan of care for 2 applicable residents. (Residents #1 and # 2) Findings include: 1. Resident #2 has a history of urinary retention and requires the use of a urinary catheter. A care plan had not been developed by the nurse for the management of the urinary catheter to ensure staff responsible for the care of the catheter were maintaining sterile technique, monitoring fluid intake and output and changing the leg bag to a constant drainage bag each evening along with	R145		

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R145	Continued From page 5 the proper cleaning of both the constant drainage and leg bag. The acting Director of Nurses confirmed the lack of a care plan on the afternoon of 8/30/22. 2. Resident #1 is diagnosed with Schizophrenia. Per review of Case Management notes Resident #1 presents with "delusions, paranoid delusions, poor ADLs (activities of daily living), as well as impulsive, loud, aggressive, and intrusive behaviors"; and has a history or dangerous and disruptive behaviors in the community. A care plan has not been developed by the nurse for the management of safe outings and interactions in the community. On the afternoon of 8/30/22 the facility Manager confirmed there was a failure to develop a written plan of care for Resident #1. Please refer to Tag 126.	R145		
R147 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (4) Maintain a current list for review by staff and physician of all residents' medications. The list shall include: resident's name; medications; date medication ordered; dosage and frequency of administration; and likely side effects to monitor; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure medication orders included instructions for frequency of administration of two PRN (as needed) medications for one applicable resident (Resident	R147		

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R147	Continued From page 6 #1). Findings include: 1. Resident #1's Medication Administration Record (MAR) included an order for PRN Diphenhydramine (anti-histamine medication for allergies) 25 mg by mouth for sign/symptoms of allergic reaction. At 5:20 PM on 8/30/22 the Director of Nursing confirmed Resident #1's order for PRN Diphenhydramine did not include instructions for the frequency of administration including the amount of time between administration of doses and the maximum number of doses that could be administered in 24 hours. 2. Resident #1's MAR included a PRN order for "Loperamide 2 mg cap: take by mouth after each loose stool, not to exceed 4 tabs (8 mg) in 24 hours". At 5:38 PM on 8/30/22 the Director of Nursing confirmed Resident #1's order for Loperamide 2 mg capsules did not include instructions for the number of tablets to be administered, instructions for administration of additional doses, and the maximum number of doses that could be administered in 24 hours.	R147		
R167 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific	R167		

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R167	Continued From page 7 behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure a written plan of care was developed for the administration of psychoactive PRN (as needed) medications for two applicable residents (Residents #1 and # 3). Findings include: 1. Resident #3 has a physician order for Lorazepam 1 mg (benzodiazepine/sedative) orally twice daily PRN. The order lacks the reason and purpose for administering the medication. In addition, there was also a failure to develop a written plan for the administration of the PRN medication describing specific targeted behaviors associated with Resident #3. The deficient practice was confirmed on the afternoon of 8/30/22 by the mental health agency acting DON. 2. Resident #1 has a physician order for Olanzapine (antipsychotic) 5 mg twice daily PRN (as needed) for agitation. At 5:11 PM on 8/30/22 the Director of Nursing confirmed there was a failure to develop a written care plan for the administration of Olanzapine describing the specific behaviors associated with Resident #1 the medication is intended to address and the specific desired effects of this medication.	R167		

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R179	Continued From page 8	R179		
R179 SS=F	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 by: Based on record review and staff interview there was a failure to ensure 5 out of 5 applicable staff completed all required yearly trainings to include Resident Rights; Fire Safety and Emergency Evacuation; Resident Emergency Response Procedures and First Aid; Mandatory Reporting of Abuse, Neglect and Exploitation; Respectful and	R179		

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R179	Continued From page 9 Effective Interaction with Residents; Infection Control Measures; and General Supervision and Care of Residents. Findings include: Per review of staff in-service training records 5 out of 5 did not complete all required yearly trainings. Per documentation provided on request 1 staff (Staff #5) did not complete Fire Safety and Emergency Evacuation training; 4 out of 5 staff (Staff #1, #2, #3, and #4) did not complete Emergency Response and First Aid training; and 5 out of 5 staff (Staff #1,#2 #3, #4, and #5) failed to complete trainings in Resident Rights, Mandatory Reporting of Abuse, Neglect and Exploitation, and Respectful Effective Communication. On the afternoon of 8/30/22 the Manager confirmed there was a failure to ensure the required yearly trainings were completed.	R179		
R189 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b. (3) For residents requiring nursing care, including nursing overview or medication management, the record shall also contain: initial assessment; annual reassessment; significant change assessment; physician's admission statement and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of physician visits, signed telephone orders and treatment documentation; and resident plan of care. This REQUIREMENT is not met as evidenced by:	R189		

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R189	Continued From page 10 Based on record review and staff interview there was a failure to ensure the resident records for one applicable resident (Resident #1) contained an initial assessment; annual reassessments; reassessments when changes of mental health status occurred; and a resident plan of care. Findings include: Per record review and staff interview Resident#1 was admitted to the Residential Care Home (RCH) in May of 2016 with a diagnosis of Schizophrenia. During the course of the survey facility staff was asked to provide documentation of Resident #1's Resident Assessments for review. On review of the documentation provided an initial assessment completed within 14 days of admission; yearly assessments for 2017, 2020, and 2022; and significant change assessments in response to periods of mental health decline resulting in hospitalization in 2020 and 2022 were not maintained in Resident#1's records. Additionally, a plan of care addressing Resident #1's specific care needs was not maintained in Resident #1's record. On the afternoon of 8/30/22 the facility Manager confirmed Resident #1's records did not include a plan of care; initial assessment in 2016; annual reassessments for 2017, 2020, and 2022; and significant change assessments in 2020 and 2022.	R189		
R190 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff.	R190		

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R190	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to complete criminal background checks for one applicable staff (Staff #1). Findings include: During the course of the survey on 8/30/22 the facillty Manager was asked to provide documentation of criminal record and abuse registry checks for a sample of five staff employed at the home. Documentation provided did not include a Vermont criminal background check for one applicable staff (Staff #1) . On the afternoon of 8/30/22 the Manager confirmed a Vermont criminal background check was not completed for Staff #1.	R190		
R200 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview there was a failure to maintain written policies and procedures that govern all services in the home that are available for review upon request. Findings include: During the course of the survey on 8/30/22 the facility Manager, Director of Nursing, and staff	R200		

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R200	Continued From page 12 were observed to have difficulty providing information regarding facility policies and procedures. Copies of policies and procedures were not available for review as requested during the survey entrance interview with the facility Manager commencing at 11:37 AM on 8/30/22. On the afternoon of 8/30/22 the facility Manager confirmed copies of facility policies and procedures were not maintained and available for review at the Residential Care Home.	R200		
R247 SS=E	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview staff interview there was a failure to ensure all perishable food items are labeled, dated, and held at proper temperatures. Findings include: During a tour of the facility kitchen on the morning of 8/30/22 a cabinet with food items belonging to individual residents contained opened cereal boxes and other dry goods that were not labeled with the dates they were opened. One refrigerator in the basement contained cartons of eggs without food labels identifying what was contained inside the cartons and expiration dates,.and unlabelled opened containers of jam. Another refrigerator had containers of cottage cheese,	R247		

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R247	Continued From page 13 ketchup, cheese, and clarified butter that were not labeled with the date they were opened. The freezer in another basement storage room contained an open bag of frozen sausage and a zip lock bag of frozen fish without dated labels. A record of the refrigerator and freezer temperatures observed in the basement lacked documentation of monitoring after 8/1/22. The facility Manager confirmed the unlabelled food items in the cabinets, refrigerators, and freezer, and the lapse in monitoring to ensure food storage at safe temperatures during the course of the tour.	R247		
R266 SS=F	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, record review, and staff interview there was a failure to ensure care in a safe, sanitary, and comfortable homelike environment. Findings include: 1. Based on observation there was a failure to conduct Covid screenings, and to ensure all staff wear masks as required in health care facilities. Staff failed to provide a method for Covid symptom assessment and documentation upon arrival at the facility, and two staff were observed not wearing surgical masks as required in health care facilities. Additionally, throughout the course	R266		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0139	A. BUILDING: _____ B. WING _____	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPLEY HOUSE COMMUNITY CARE HOME	379 WASHINGTON HIGHWAY MORRISVILLE, VT 05661

(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
R266	Continued From page 14 of the survey staff were observed wearing masks below their nose or chin in the common areas, kitchen, and offices of the Residential Care Home. On the afternoon of 8/30/22 the Manager acknowledged the failure to ensure COVID symptom screening of visitors and proper masking of staff at the facility. 2. During the facility tour, the stairway landing outside the kitchen door was cluttered with 5 gallon buckets, and trash bags that were partially blocking the stairs down to the parking lot and trash receptacles. In the kitchen a corner cabinet with food items belonging to individual residents contained opened cereal boxes and other dry goods that were not labeled with the dates they were opened. One refrigerator in the basement contained cartons of eggs without food labels identifying what was contained inside the cartons and expiration dates,.and unlabelled opened containers of jam. Another refrigerator had containers of cottage cheese, ketchup, cheese, and clarified butter that were not labeled with the date they were opened. The freezer in another basement storage room contained an open bag of frozen sausage and a zip lock bag of frozen fish without dated labels. A record of the refrigerator and freezer temperatures observed in the basement lacked documentation of monitoring after 8/1/22, and the basement storage area was cluttered with boxes stacked close to the ceiling. The facility Manager confirmed the unlabelled food items in the cabinets, refrigerators, and freezer; the trash partially blocking the exterior stairway outside the kitchen door, and the lapse in monitoring to ensure food storage at safe temperatures during the course of the tour. Please see Tag 247. 3. During the facility tour the living room was	R266		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0139	A. BUILDING: _____ B. WING _____	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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R266	Continued From page 15 observed to be malodorous. Soiled waterproof pads were observed on the couch. A container of sanitizing wipes and a spray bottle containing an unknown liquid were observed on a table near the couch. The cleaning supplies were accessible to an unsupervised resident who was sitting on the couch beside the soiled waterproof pads. At 10:58 on 8/30/22 the facility Manager acknowledged the presence of soiled waterproof pads on the couch, unattended cleaning supplies accessible to residents, and the presence of a malodorous smell in the living room.	R266		
R302 SS=D	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to conduct a morning fire drill during the previous calendar year. Findings include:	R302		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0139	A. BUILDING: _____ B. WING _____	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPLEY HOUSE COMMUNITY CARE HOME	379 WASHINGTON HIGHWAY MORRISVILLE, VT 05661

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R302	Continued From page 16 On review of fire drill documentation for the previous 12 month period of time there was no documentation of a fire drill conducted during the morning hours of the day shift. On the afternoon of 8/30/22 the facility staff (Staff #1) requested by the Manager to produce documentation of fire drills occurring for the previous year confirmed a fire drill had not been conducted during the morning hours of the day shift over the previous 12 months.	R302		
R303 SS=E	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.d There shall be an operable telephone on each floor of the home, at all times. A list of emergency telephone numbers shall be posted by each telephone. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure there is an operable telephone on each floor of the home with a list of emergency telephone numbers posted beside the phone. Findings include: During the course of the facility tour on the morning of 8/30/22 there was no operable telephone accessible to residents and visitors on the second floor of the home, and the telephone on the third floor of the home did not have a list of emergency telephone numbers posted beside it. The facility Manager confirmed there was no list of emergency phone numbers posted beside the third floor phone at 10:50 AM on 8/30/22 and	R303		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0139	A. BUILDING: _____ B. WING _____	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
R303	Continued From page 17 confirmed there was not an accessible phone with emergency phone numbers posted beside it on the second floor of the home at 10:55 AM on 8/30/22.	R303		

R126

Copley House, a Level 3 RCH will:

- Upon admission and on an ongoing basis, make every effort to provide each resident with the necessary services to meet their psychological and physical needs and provide the support to live as independently as possible, according to their abilities
- The Treatment team has acquired a GPS tracking unit for patient #1 to be worn when the resident is out independently in the community to help locate them, when needed to ensure their safety.
    - Note: GPS unit implementation is in process. The treatment team is negotiating implementation at this point with patient #1. The GPS plan may only be implemented with informed consent by patient #1.
- Provide resident #1 with one-on-one support using available LCMHS resources, with the resident's informed consent. The treatment team is negotiating implementation at this point with patient #1

- Coordinate care between nursing, case management, Copley House staff and MCT (crisis staff) to ensure that resident #1 continues to live as safely and independently as possible, based on their current needs and abilities.
    - In the event a resident's needs exceed the standard scope of care for a Level 3 RCH, the resident's care plan will be reevaluated and the appropriateness of this level of care reviewed. Note that Copley House has had from time to time, been presented with residents who have initially been appropriate for our facility. Nevertheless, as their needs increase and due to lack of appropriate alternative housing availability. These residents have been left with limited alternatives therefore have remained at our facility when need was assessed as higher. Primarily this is a resident meeting the Level 2 needs by PASRR assessment but remains at RCH for months to a year waiting for a bed. Thus, it is only at admission that Copley House RCH can evaluate level of need and decline admissions that are beyond the scope of our facility. Once residents are housed, Copley House would need emergency eviction by DAIL to move resident who exceed the required care standards.

Implementation Date: October 15, 2022 Copley house manager is responsible for the implementation

R128

Copley House will:

- Ensure that each resident's medication, treatment, and dietary services shall be consistent with the physician's orders.
    - Current Physician(s) orders will be maintained on premises and in electronic record.

    - All Medication changes will be reviewed by nurse to ensure completeness and consistency, in compliance with doctors' orders and medication protocols

Implementation Date: December 15, 2022 the Copley house RN will be responsible for implementation

R145

Copley House will:

- Create a residential plan of care for each resident based on their identified abilities and needs.
- Provide residential care plans that:
    - Cover the care and services necessary to assist the residents to promote and maintain their independence, physical, and psychological wellbeing.
        - Review and update residential care plans quarterly and as needed By RN and House manager. As part of our EMR we are able to set review dates that require reapproval of care plans at kind intervals in this case it would be set to three months. this information will be readily available on EMR go back.

  implementation date October 31st 2022 Copley house manager is responsible for implementation
- Ensure that staff will be appropriately trained/delegated by the RN in the use of:
    - Basic medical devices such as:
        - Blood pressure cuff, stethoscope, pulse oximeter, scale
    - Personal healthcare equipment such as:
        - CPAP, catheter, glucometer, insulin delivery devices, other medical devices and DME
            - As ordered by the resident's provider (according to the RN's scope of practice and facility policy)
- Implementation Date: October 31, 2023 wo implementation will be responsibility of the house RN

R147

Copley house will:

- Ensure that all residents are provided with transportation/support to medical appointments (as needed/requested by resident)

- Provide a current med list for review by nurse/provider/medical staff, for any medical appointment or incident outside of the facility.
    - The list will include:
        - Resident's name/DOB
        - Medications
        - Date medication ordered
        - Dosage and frequency of administration
        - Potential side effects to monitor

- A current list of physicians' orders (POs) will be maintained on facility premises in resident chart.

- All medication changes will be reviewed regularly/as needed by the RN to ensure compliance with doctors' orders and medication protocols

- Any changes will be documented promptly by the RN/under RN supervision, in the "Med Change" book
    - Staff will review the med change book at the start of every shift.
    - Staff will review med change book prior to assisting residents with medications.
    - Staff will initial each change indicating they have read and understand the medication change prior to assisting residents.

  Implementation Date: October 31, 2023 Copley house RN will be responsible for implementation

R167

Copley House will ensure that:

- All medication distribution is overseen and regularly reviewed by the facility RN
    - The RN trains and delegates support staff to provide medication assistance and treatments per MD orders/under RN supervision.
    - Staff may only assist residents with their medications after being delegated by the RN to do so

Psychoactive medications:

- House staff will assist residents with psychoactive medications (PRN and scheduled) only after being trained/delegated by the RN

- Each resident who is prescribed psychoactive medications will have a med distribution plan consisting of:
  - Current MD/APRN orders for PRN psychoactive medications including:
    - The specific behaviors/symptoms which the medication is intended to address
    - The specific circumstances under which the medication may be provided, including:
      - How frequently a medication may be provided
      - The maximum dose that may be taken in 24 hours
      - A list of potential side effects for which the staff are to monitor
      - A list of non-pharmacological interventions that may help reduce the need for psychoactive PRN medication such as:
        - going for a walk, drinking a glass of water, lying down, etc.
  - After providing the psychoactive PRN medication, staff will monitor and document in the MAR (within 60 minutes) the resident's response to a specific medication, by asking the resident to describe their experience and by direct observation.

Implementation Date: October 31, 2022 Copley house RN we'll be responsible for implementation

R179

Copley House will:

- Ensure that all staff demonstrate competency in all required skills and techniques before providing care to residents.
  - There are 12 hours of required annual training for each staff person providing direct care to residents. The training includes:
    1. Residents' rights
    2. Fire safety and emergency evacuation procedures
    3. Resident emergency response procedures, such as CPR, accidents, police or ambulance contact and first aid
    4. Policies and procedures regarding mandatory reports of abuse, neglect, 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
    7. General supervision and care of residents

Implementation Date: November 5, 2022 Copley house assistant manager will be responsible for implementation

R189

Copley House will:

- Maintain a record for each resident to include:
  - Physician's admission statement, including:
    - Signed orders for all current medications/treatments, including telephone orders
    - A list of all current medications, updated as needed by physicians and monitored by RN
    - A list of approved standing orders for PRN/OTC medications
    - Notes from all scheduled physician visits, ED visits and lab/diagnostic test results

  - A detailed description of any and all nursing care provided including:
    - A nursing overview of the resident's physical and psychological needs, based on direct assessment upon admission and updated annually/as needed

    - An evaluation of each resident will be completed by the RN within 30 days after admission, reflecting the resident's biopsychosocial needs
      - Assessments will be updated monthly/as needed by RN to reflect resident's response/progress/changes
        - Includes daily staff notes/observation.
  - The RN will inform the resident's providers of any changes/concerns as needed

Implementation Date: November 24, 2022 Copley house RN is responsible for implementation

R190

Copley House will:

- Maintain the results of all:
  - Background checks/criminal records/adult abuse registry checks for all staff, required prior to hiring

  - The LCMHS Human Resources department will provide these records to the house manager

Implementation Date: September 28, 2022 Copley house manager is responsible for this implementation.

R200

Copley House will:

- Maintain and update a Policies and Procedure Manual that describes the services provided by this Level 3 RCH facility, including but not limited to:
    - Expectations of all residents/staff
    - Responsibilities of facility management/staff, in accordance with SOV/DAIL level III RCH regulations
    - Residents' Rights
    - A copy shall be available at the home for review upon request

- This manual will be stored in the med room

Implementation Date: November 15, 2022 Copley house manager is responsible for implementation

R247

Copley House will:

- Ensure that all perishable food and drink is labeled, dated and held at proper temperatures, according to current VT DPH/Food Safe practices

Effective Date: September 12th, 2022 Copley house Manager is responsible for implementation

R266

Copley House will:

- Provide and maintain a safe, functional, sanitary, homelike and comfortable environment.
- Ensure that all visitors are screened for COVID 19 according to current SOV DPH/DAIL guidelines
    - Copley house will post signage on the front door of entry restrictions, based on visitor COVID status, symptoms, or exposure
    - Masking requirements in the RCH will be enforced
    - All access and egress as from the building will be kept free of any obstruction
    - Copley House will ensure that all perishable food and drink is labeled, dated and held at proper temperatures, according to current VT DPH/Food Safe practices
    - Housing supplies will be maintained in areas that clients have no access to.

Implementation Date 9/15/2022: Copley house manager is responsible for oversight and implementation

- Copley house will acquire furniture that is stain resistant and waterproof

Copley house will order the furniture no later than November 15th the actual implementation date will depend on supply chain and availability but will not be delayed by any action of Copley house

Implementation Date: on date of arrival from vendor Copley house manager will oversee and implement this correction

R302

Copley House will:

- Maintain and make available to all staff and residents, written copies of a plan for the protection of all persons in the event of a fire/other emergency and for the evacuation of the building when necessary.
- Require that all staff participate in emergency response trainings upon hiring/annually and will be kept informed of their duties under the plan.
  - Fire drills will be conducted on at least a quarterly basis and will occur on morning, afternoon, evening, and night shifts.
  - The date and time of each drill, the effectiveness of response and the names of participating staff members will be documented.
  - Following a drill, supervisor/team lead will debrief staff on the response and identify any areas in need of improvement
- Safety procedures are in place for every shift

Implementation Date: October 19, 2022 Copley house Manager is responsible for oversight and implementation

R303

Copley House will:

- Install/maintain one operable telephone on each floor of the home, specifically for resident use
  - Post a list of emergency telephone numbers by each telephone. Training for residents will be provided if needed.

Implementation Date: Copley house manager will be responsible for the implementation of this correction will be dependent on external vendors availability.