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

December 21, 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 **November 15, 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 _____	R-C 11/15/2022

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
{R100}	Initial Comments: An unannounced follow-up survey was conducted on 11/7/22 by the Division of Licensing and Protection to determine regulatory compliance from a re-licensure survey and investigation of one complaint completed on 9/8/22. Additional information was received from the facility on 11/8/22 and 11/15/22. The following regulatory violations were found not to be back in compliance with the Residential Care Home Licensing Regulations effective 10/3/2000:	{R100}	please see attached plan	
{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 to ensure the personal, medical, psychosocial and safety needs were met for one applicable resident who requires supervision and monitoring for safe outings in the community (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	{R126}		

R126 - R266 POC's accepted 12/20/22 JEVans RN/PHN

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 _____	R-C 11/15/2022

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
{R126}	Continued From page 1 hospitalization and/or care in a crisis stabilization program. Between 3/1/22 and 5/18/22 Resident #1 experienced a period of psychiatric decompensation during which s/he displayed disruptive and dangerous behaviors in the community. Disruptive behaviors included prolonged periods of lingering in local businesses and disturbing customers; leaving letters with sexual content at a local church and bank; making messes at the local church; and walking with pants around his/her ankles while not wearing underwear and exposing private parts presumably due to poorly fitting clothing resulting from weight loss. Dangerous behaviors in the community included walking into the entryway of an apartment, yelling, and terrifying the woman who lives in the apartment; entering the road and "flipping off" passing vehicles; and crossing through oncoming traffic and both lanes of travel on a busy highway in the rain. Two local businesses initiated No Trespass Orders, one of which Resident #1 violated twice when s/he interrupted morning mass at the local church, then rummaged through cupboards in the church kitchen the following day. During this period of psychiatric decompensation Resident #1 experienced a weight loss of 20 pounds, and his/her ability to communicate verbally declined to verbal expressions limited to guttural sounds. After facility staff made several attempts at seeking a higher level of care for Resident #1, s/he was hospitalized for psychiatric stabilization between 5/18/22 and 9/6/22 when s/he was discharged from the hospital and returned to the home. The RCH has made attempts to coordinate care with the Designated Agency's Case Management and Crisis supports, implement the use of a GPS	{R126}		

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 _____	R-C 11/15/2022

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
{R126}	Continued From page 2 tracking device with Resident #1's consent, and engage in frequent check-ins with Resident #1; however due to the facility's voluntary and community integration based care, the lack of an Order of Non-Hospitalization (court order outlining conditions which must be met to remain in a residential care setting), Resident #1's unpredictable impulses to wander throughout and beyond the local community, and facility staffing limitations, there was a failure to implement a plan for the level of monitoring and support required to ensure Resident #1's personal and psychosocial needs are met for safe outings in the community. Between 9/8/22 and 11/4/22 staff documented 8 incidents of Resident #1 wandering in the community resulting in law enforcement, crisis clinicians, staff, or unknown individuals returning Resident #1 to the facility. On 9/8/22 s/he was found at a high school 4.6 miles from the facility and returned to the facility by the Sheriff's Department at 5:30 PM, followed by a Crisis clinician returning him/her to the facility from the community at 11:25 PM. On 9/10/22 s/he was returned to the house by "someone from the agency". On 9/11/22 s/he was returned from an undocumented location at 9:15 AM by staff followed by another staff returning him/her from Stowe which is approximately 9 miles from the residence at 2:50 PM. On 9/12/22 Resident #1 was returned to the residence from the Stowe Airport approximately 3 miles from the residence. On 10/23/22 staff notes indicate s/he was observed walking towards Stowe and returned to the house by "someone" at 11:10 PM and again at 2:00 PM when s/he was returned to the residence by a police officer. At approximately 12:00 PM on 11/5/22 Resident	{R126}		

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 _____	R-C 11/15/2022

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
{R126}	Continued From page 3 #1 left the facility and his/her whereabouts were unknown until the following day. Resident #1 traveled by unknown means to Interstate 89 in Waterbury Vermont and was reportedly picked up by a truck driver while hitchhiking on the southbound lane of the interstate. The truck driver transported Resident #1 to a truck stop in Enfield New Hampshire. The Enfield Police Department was dispatched to the location and assisted in transporting Resident #1 back into the care of facility staff on 11/6/22. Resident #1 refused to reveal where s/he spent the night of 11/5/22, and during the incident s/he disabled the GPS tracking device in use with Resident #1's consent subsequent to discharge from the hospital on 9/6/22. While facility and Designated Agency staff worked with the appropriate law enforcement agencies and conducted several searches to locate Resident #1 during this incident, Resident #1 continues to engage in dangerous and disruptive behaviors in the community and requires intensive monitoring and supports to ensure his/her personal and psychosocial needs are met for safe outings in the community. On the afternoon of 11/7/22 the RCH Manager confirmed Resident #1 left the facility on 11/5/22 and engaged in dangerous behaviors including hitchhiking on the interstate, entering the vehicle of an unknown driver, and traveling to New Hampshire without staff knowledge of his/her whereabouts.	{R126}		
{R145} SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2)	{R145}		

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 _____	R-C 11/15/2022

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
{R145}	Continued From page 4 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 1 applicable resident (Resident# 2). Findings include: 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 the proper cleaning of both the constant drainage and leg bag. On the afternoon of 11/7/22 the Registered Nurse and Manager confirmed a written plan of care had not been developed by the Nurse based on Resident #2's individual needs including the interventions required for the management of a urinary catheter.	{R145}		
{R147} SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (4)	{R147}		

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 _____	R-C 11/15/2022

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
{R147}	Continued From page 5 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 PRN (as needed) medication orders include instructions for the specific dose, frequency of administration, and maximum number of doses that can be safely administered in 24 hours for one PRN (as needed) medication for one applicable resident (Resident #1). Findings include: Resident #1's PRN Standing Medication Orders signed by his/her provider on 10/25/22 include an incomplete order for PRN Diphenhydramine (anti-histamine) for rashes, itchy skin, and insect bites, and allergic reactions. The order reads: "Benadryl (Diphenhydramine) 25-50 mg by mouth". Resident #1's order for PRN Diphenhydramine does not include instructions for the frequency of administration of Diphenhydramine including the amount of time between administration of doses and the maximum number of doses that can be safely administered in 24 hours. Additionally, Resident #1's Diphenhydramine order lists a dose range instead of a set dose which requires med delegated staff to perform an assessment to determine the appropriate dose to be given, and assessments are not within med delegated staff's scope of practice. On the afternoon of 11/7/22 the Registered Nurse	{R147}		

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 _____	R-C 11/15/2022

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
{R147}	Continued From page 6 confirmed Resident #1's order for PRN Diphenhydramine does not include instructions for the specific dose, frequency of administration including the amount of time between administration of doses, and the maximum number of doses that can be safely 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 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:	{R167}		

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 _____	R-C 11/15/2022

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
{R167}	Continued From page 7 1. Resident #3 has a physician's order for Lorazepam 1 mg (benzodiazepine/sedative) orally twice daily PRN for agitation and anxiety. On the afternoon of 11/7/22 the Registered Nurse confirmed there was a failure to develop a written plan for the administration of PRN Lorazepam that describes the specific behaviors associated with Resident #3 the medication is intended to address and educates the staff regarding the desired effects or undesired side effects staff must monitor for. 2. Resident #1 has a physician's order for Olanzapine (antipsychotic) 5 mg twice daily PRN (as needed) for agitation. On the afternoon of 11/7/22 the Registered Nurse confirmed there was a failure to develop a written care plan for the administration of Olanzapine that describes the specific behaviors associated with Resident #1 the medication is intended to address and educates the staff regarding the desired effects or undesired side effects staff must monitor for.	{R167}		
{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;	{R179}		

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 _____	R-C 11/15/2022

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
{R179}	Continued From page 8 (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 Effective Interaction with Residents; Infection Control Measures; and General Supervision and Care of Residents. Findings include: Per review of staff in-service training records the facility was unable to provide documentation of completion of all required yearly trainings for 5 out of 5 sampled staff. Staff #1 did not complete trainings in Resident's Rights; Emergency Response and First Aid; and Respectful and Effective Interactions with Residents. Staff #2 did not complete trainings in Resident's Rights; Emergency Response and First Aid; Mandatory Reporting of Abuse, Neglect and Exploitation; and Respectful and Effective Interactions with Residents. Staff #3 and Staff #4 did not complete	{R179}		

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 _____	R-C 11/15/2022

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
{R179}	Continued From page 9 trainings in Emergency Response and First Aid; Mandatory Reporting of Abuse, Neglect and Exploitation; and Respectful and Effective Interactions with Residents. Staff #5 did not complete trainings in Resident's Rights; Fire Safety and Emergency Evacuation; Mandatory Reporting of Abuse; Neglect and Exploitation; and Respectful and Effective Interactions with Residents. On the afternoon of 11/7/22 the Manager confirmed the failure to ensure 5 out of 5 sampled staff completed the required yearly trainings.	{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: 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 completed within 14 days of admission; annual reassessments; reassessments when changes of mental health status occurred; and a resident plan of care.	{R189}		

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 _____	R-C 11/15/2022

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
{R189}	Continued From page 10 Findings include: Per record review 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. Per review of the documentation provided, the 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 hospitalizations in were not maintained in Resident #1's records. Additionally, a reassessment subsequent to Resident #1's inpatient psychiatric hospitalization from 5/18/22 - 9/6/22 with completion date of 9/30/22 was completed by a Residential Support Staff and did not include the signature of a Registered Nurse. On the afternoon of 11/7/22 the facility Registered Nurse acknowledged the lack of Resident Assessments for Resident #1 to include an initial assessment in 2016; annual reassessments for 2017, 2020, and 2022; and significant change assessments following hospitalizations due to mental health decline; and the Manager and Registered Nurse confirmed the reassessment of Resident #1 with a completion date of 9/30/22 was not signed by a Registered Nurse.	{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}		

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 _____	R-C 11/15/2022

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
{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 #6). Findings include: On 11/7/22 the Manager was asked to provide documentation of criminal record and abuse registry checks for one applicable employee (Staff #6) hired on 10/17/22. Documentation provided indicated the background check was requested on 11/7/22 during the on-site survey. At 2:29 PM on 11/7/22 the Director of Human Resources, Safety, and Compliance for the Designated Agency that manages the Residential Care Home confirmed the Agency was unable to provide documentation of background checks completed for Staff #6 before the follow up survey on 11/7/22.	{R190}		
{R247} SS=F	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 there was a failure to ensure all perishable food items are labeled, dated, and held at proper temperatures. Findings include:	{R247}		

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 _____	R-C 11/15/2022

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
{R247}	Continued From page 12 During a tour of the facility commencing at 10:55 AM on 11/7/22 items without dates indicating when they were opened were observed in the kitchen refrigerator including a bottle of orange juice, a gallon of milk and half gallon of chocolate milk, lemon juice, soda, parmesan cheese, ketchup, barbeque sauce, pickles, and American cheese repackaged in plastic wrap; and there were two packages of hamburger without labels indicating the date they were transferred from the freezer to thaw. In the freezer there was an opened unlabeled bag of green beans. The unlabeled food items in the kitchen refrigerator were confirmed by the Assistant Manager during the kitchen tour on 11/7/22, and acknowledged by the Manager on the afternoon of 11/7/22.	{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. During a tour of the facility commencing at 10:55 AM on 11/7/22 items without dates	{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 _____	R-C 11/15/2022

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 13 indicating when they were opened observed in the main kitchen's refrigerator included a bottle of orange juice, a gallon of milk and half gallon of chocolate milk, lemon juice, soda, parmesan cheese, ketchup, barbeque sauce, pickles, and American cheese repackaged in saran wrap; and there were two packages of hamburger without dates indicating when they were transferred from the freezer to thaw. In the freezer there was an opened unlabeled bag of green beans. Please refer to tag 247. 2. During the facility tour commencing at 10:55 AM on the morning of 11/7/22 a reusable pad soaked with urine was observed on the couch in the TV room. There were no residents or staff observed in the area when this observation was made. The opened unlabeled food items, unlabeled meat thawing in the fridge, and urine soaked reusable pad were confirmed by the Assistant Manager during the course of the facility tour commencing at 10:55 AM on 11/7/22 and acknowledged by the Manager at 12:15 PM on 11/7/22.	{R266}		

Plan of correction Copley House RCH Monday, December 19, 2022

R126

Copley house upon consultation with licensing and protection as well as the medical director at Lamoille County mental health services. The plan of correction will be to discontinuing services at this level three RCH, due to the client's needs exceeding the scope of practice effective immediately

Lamoille county mental health continues working with inpatient facility to develop a treatment plan that will address client 1 housing and care needs

Implemented and completed by house manager 12/14/22

R145: In addition to editing the client's Residential Assessment and the Nurse Manager's physical assessment and RN Care Plan, a specific care plan for the client's foley care was implemented by the nurse manager and completed on_12/14/22_____. The specific care plan includes the medical reason for the chronic foley catheter. The care plan includes sections on hygiene practices before, during, and after emptying the client's bag, instructions for cleaning the bag itself, and instructions for emptying the foley bag with as much sterility as possible in a home care setting. Reasons to call the Nurse Manager are described. Staff are also instructed to document the client's urine output and its color, odor, and amount. Staff also document the client's intake of fluids so the RN may assess for adequate hydration as well as medical conditions such as fluid volume overload, oliguria, and hematuria. The charting for intake, output, color, odor, and consistency of urine is in kept in the client's room for privacy. Nurse Manager reviews input and output and signs off on all documentation after reading and verifying that there are no concerns. An in-person demonstration was provided to all staff who work with the client verified understanding and signed off on the in-person demonstration on 12/14/22.

R147 Procedure for medication changes is as follows: All medication changes must have a written or electronically signed order from the prescribing physician. The medication order is attached to a medication change form developed by the Nurse Manager that includes the Patient's name, DOB, Provider, Medication name, dose route time and reason for medication. All prn orders are now required to have a "reason" attached. The medication change form includes side effects for staff to observe for as well as the Nurse Manager's signature and date of medication change. All medication delegated staff are required to sign and date this medication change form verifying that they have seen the medication change form, order attached, and the change in the client's medication administration record (MAR). All prn medication that is classed as an anxiolytic and written by a prescriber will have a reason written in the prescription. The behavior care plan for that particular prn will have reasons to administer the medication, signs that the client is in need of that prn, the time the medication was given, the dose, the reason, the staff member's initials as well as any behavioral techniques such as distraction or therapeutic communication that can be used prior to administration of the behavioral prn medication. The staff must also document the result of the prn on the client's behavior in the time allotted (45 minutes to one hour). Completion dates for prn cited: 12/14/22____. All incomplete orders are followed up by the Nurse Manager by communicating with Genoa Pharmacy, the Director of Nursing, and providers' offices.

Completed by 12/21/22 by residential nurse manager

R179

The Copley house will ensure that staff demonstrates competency in skills and techniques that are expected to perform before providing direct contact with residents. There are twelve hours of training each year for each staff person providing direct care for residents. The training includes

1) Resident rights

2) Fire safety and emergency evacuation

3) Resident emergency response procedures, accidents, police or ambulance contact and basic 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

All new hires must finish training before starting shift as well as current employees

Implemented and completed by assistant manager 11/9/22

R189 : Resident #1's Resident Assessment completed on 11/29/22. All residents who are admitted to the facility will have a Resident Assessment completed by the Nurse Manager within 15 days of admission and annually. All clients who are discharged from a hospital or acute care setting will have a reassessment completed by the Nurse Manager within 72 hours. In addition to the Resident Assessment, a physical assessment will be performed by the Nurse Manager and documented in the client's chart. All clients also have individual Nursing Care Plans. Adjustments to individual RN Care Plans will be implemented within one week of readmission. Completion date of all Resident Assessments and Care Plans at facility: _12/14/22___.

Implemented and completed by residential nurse manager

190

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
- All employee background check are readily available and will be maintained with every new hire

Implemented and completed by assistant manager 12/12/22

247

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
- Kitchen will be checked once a week by assistant manager to ensure we are in compliance

Implemented and completed assistant manager 11/8/22

266

- Copley house will provide and maintain a safe, functional, sanitary, homelike, and comfortable environment.
- Common areas are inspected hourly and documented
- Check sheet set up and being checked once a week by assistant manager
- Records are being maintained for review
  Implemented and completed by assistant manager 12/13/22