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

January 10, 2025

Shannon Ayotte, Manager
Copley House Community Care Home
379 Washington Highway
Morrisville, VT 05661-8968

Dear Ms. Ayotte:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 16, 2024**. Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

If you have any questions, please feel free to contact me at (802) 585-0995.

Sincerely,

Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0139	A. BUILDING: _____ B. WING _____	C 12/16/2024

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: On 12/16/24 the Divison of Licensing and Protection conducted an unannouced on-site annual relicensure survey. The following regulatory deficiencies were identified:	R100	Corrective Actions for all tags cited accepted by Jo A Evans RN on 1/9/25. Please see the attached document to review corrective actions accepted for each individual tag.	
R176 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (4) Medications left after the death or discharge of a resident, or outdated medications, shall be promptly disposed of in accordance with the home's policy and applicable standards of practice. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure prompt disposal of expired house stock medications stored in the medication cart. Findings include: Policies and Procedures governing expired medications developed by the home are consistent with this regulatory requirement. During a review of the medication storage area of the home on the afternoon of 12/16/24, outdated House Stock medications were observed to be stored on the medication cart including: 1. Bacitracin Ointment expired 4/2024 2. Hydrocortisone Cream 1% expired 10/2024 3. Ibuprofen 200 mg tablets expired 7/2024 This finding was confirmed by the Med Tech at	R176		

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R176	Continued From page 1 2:30 PM on 12/16/24.	R176		
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 staff interview and record review there was a failure to ensure 4 out of 5 sampled staff completed all required yearly trainings. Findings include:	R179		

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R179	Continued From page 2 The home's policies and procedures governing staff trainings required by the licensing agency are consistent with this regulation. At 12:02 PM on 12/16/24 the Assistant Manager was requested to provide documentation of yearly trainings completed by a sample of 5 staff. Per review of the documentation provided by the Assistant Manager, all yearly trainings were not completed as required for 4 out of 5 sampled staff. This finding was confirmed by the Assistant Manager at 3:16 PM on 12/16/24. This is a repeat citation.	R179		
R190 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to complete all required criminal record and abuse registry checks for 5 out of 5 sampled staff. Findings include: The home's policies and procedures governing completion of staff criminal record and abuse registry checks have not been updated to include changes in the regulatory requirements effective 5/1/2023.	R190		

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R190	Continued From page 3 At 12:02 the Assistant Manager was requested to provide documentation of criminal record and abuse registry checks completed for a sample of 5 staff. Per review of the documents provided by the Assistant Manager, all required background checks were not completed for 5 out of 5 sampled staff. This finding was confirmed by the Assistant Manager at 3:16 PM on 12/16/24. This is a repeat citation.	R190		
R200 SS=F	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 staff interview and record review there was a failure to ensure development of policies and procedures governing all services provided by the home. During the survey conducted on 12/16/24 the Assistant Manager of the home was requested to provide copies of the home's policies and procedures governing Labeling and Storage of Perishable Foods and Beverages; Expired Foods, Maintenance of the home's Living Environment, Secure Storage of Hazardous chemicals including cleaning products, and Installation and Monitoring of Bed Rails and Side Rails.	R200		

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R200	Continued From page 4 On the afternoon of 12/16/24 the Assistant Manager confirmed the policies and procedures listed above were not on file and available for review on request.	R200		
R246 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.a Each home must procure food from sources that comply with all laws relating to food and food labeling. Food must be safe for human consumption, free of spoilage, filth or other contamination. All milk products served and used in food preparation must be pasteurized. Cans with dents, swelling or leaks shall be rejected and kept separate until returned to the supplier. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure food being stored in the food storage area in the basement of the home were discarded upon expiration. Findings include: Policies and procedures governing expired food were not on file and available for review on request. During a tour of the home commencing at 9:25 AM on 12/16/24, an unopened full case and an opened partial case of single serving peaches which expired in 2022 were observed to be stored a food storage room on the first floor of the home. This finding was confirmed by the Team Leader during the facility tour commencing at 9:25 AM	R246		

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R246	Continued From page 5 on 12/16/24.	R246		
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 foods and beverages are labeled and dated. Findings include: Policies and Procedures governing labeling and storage of perishables were not on file and available for review on request. During a tour of the home commencing at 9:25 AM on 12/16/24 the following perishable items were observed to be without the dates the items were opened or prepared: 1. Refrigerated items in the kitchen observed without the dates opened or prepared included 5 containers of leftovers without identifying labels; unwrapped butter; packages of shredded and sliced cheese; bottles of condiments, dressings, and sauces; and an open icing bag placed in a ceramic cup. A package of meat stored on a tray in the refrigerator was not labeled with the date the item was moved from the freezer to the refrigerator to thaw.	R247		

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R247	Continued From page 6 2. Unrefrigerated items observed in kitchen food storage areas observed without the dates the items were opened included containers of cereals, various snack foods, coffees, and non-dairy creamers. These findings were confirmed by the Team Leader during the tour of the home commencing at 9:25 AM on 12/16/24.	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 and staff interview there was a failure to ensure care in a safe, functional, sanitary, homelike and comfortable environment. Findings include: Policies and procedures governing maintenance of the home's living environment and secure storage of hazardous chemicals including cleaning products were not on file and available for review on request. During the tour of the home commencing at 9:25 AM on 12/16/24 the following environmental concerns were observed: 1. Couches in the main floor common areas	R266		

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R266	Continued From page 7 adjacent to the dining room were observed with worn and damaged upholstery. 2. The staff bathroom on main floor was observed to be unlocked and accessible to residents. An unlocked cabinet containing cleaning chemicals including disinfectants and sanitizers was observed in this bathroom. An unlabeled spray bottle containing a colored liquid was also observed in this unlocked bathroom cabinet. 3. Access to the tub and shower in Resident room 1-21 was observed to blocked by a case of Ready Bath Conditioning Shampoo Shower Caps stored across the top of the tub. Disposable briefs and bottles of Ensure nutritional supplement were stored on the seat of a walker in this bathroom. These findings were confirmed by the Assistant Manager during the tour of the home commencing at 9:25 AM on 12/16/24.	R266		
R291 SS=F	IX. PHYSICAL PLANT 9.6 Plumbing 9.6.d Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure water temperatures in resident accessible areas of the home are maintained at or below 120 degrees Fahrenheit. Findings include: Policies and procedures governing maintenance	R291		

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R291	Continued From page 8 of water temperatures in resident accessible areas of the home are consistent with this regulatory requirement. During a tour of the home commencing at 9:25 AM on 12/16/24 water temperatures in the following resident accessible areas of the home were observed to be above 120 degrees Fahrenheit: Resident room 1-21 121.1 F Resident room 1-29 122.7 F Resident room 2-14 121.3 F These findings were confirmed by the Assistant Manager during the tour commencing at 9:25 AM on 12/16/24. At 1:30 PM the water temperatures in these resident accessible areas were observed to be maintained at or below 120 degrees F following adjustments to the boiler made by the home's Maintenance Staff. This is a repeat citation.	R291		

Deficiency Statement Plan of Correction (POC)

Survey Date: 12/16/2024

Facility Name: Copley House Inc.

Deficiency Regulation	How the deficiency was corrected	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R176 Plan of Correction accepted by Jo A Evans RN on 1/9/25	Deficiency is corrected by updating the expired medication policy to include checking house stock medication and RX labels on medication.	1/7/2025	System changes will be done by the RN by creating a schedule with med specialist to implement a reoccurring day at the end of each month. Med specialist will use the schedule with reoccurring date to go through the medication cart, house stock, and back up medications to ensure expired medications are being removed and disposed of properly. If med specialist can not complete this task on the reoccurring date, RN will complete and remove expired medication.	The RN will monitor for compliance
R179 Plan of Correction accepted by Jo A Evans RN on 1/9/25	Staff have been notified during staff meeting on 12/17/2024, that all required trainings are due by Feb 1st of every year.	12/17/2024	The licensee will have a spreadsheet with all mandatory trainings for all staff, which will include the last date completed. This will be implemented on 12/17/24. And will be held by the licensee in the manger's office. The licensee will be updated all trainings are completed.	Licensee
R190 Plan of Correction accepted by Jo A Evans RN on 1/9/25	Sent an updated background check list (entities) to HR. Verified with HR understanding of what was being requested.	12/30/2024	The licensee will have all staff sign for their background checks by the end of October yearly and send them over to HR by November 1st yearly. All requests for background checks will be completed by the end of November of each year for compliance.	Licensee
R200 Plan of Correction accepted by Jo A Evans RN on 1/9/25	New policies for the deficiencies of the home were written.	12/17/2024	The licensee will verify policies and procedures quarterly to verify all are organized in binders.	Licensee
R246 Plan of Correction accepted by Jo A Evans RN on 1/9/25	Staff was notified during staff meeting on 12/17/2024 of the new policies and procedures that were written up on food handling, storage, and expired food.	12/17/2024	The licensee and the team leader will do monthly checks, to verify all food is being labeled, stored, and thrown away in a timely manner.	Licensee / Team Leader
R247 Plan of Correction accepted by Jo A Evans RN on 1/9/25	Staff was notified during staff meeting on 12/17/2024 of the new policies and procedures that were written up on food handling, storage, and expired food.	12/17/2024	The licensee or the team leader will do weekly checks, to verify all food is being labeled, stored, and thrown away in a timely manner. Once it has been verified within 3 months, it will move to monthly checks.	Licensee / Team Leader

R266 Plan of Correction accepted by Jo A Evans RN on 1/9/25	1. Maintenance of the furniture within the home. 2. Staff bathroom is being locked at all times. Maintenance was notified, new lock on order. 3. Room has been reorganized for safe moving, along with storage areas for residents' items.	12/23/2024	1. Management measured furniture which were torn/ ripped to order covers to help preserve the furniture from wear and tear. Licensee will order new furniture to replace items. 2. Staff were notified of change required. Maintenance is ordering a new door handle that will be locked from outside at all times. 3. Team Leader/ Licensee to have daily checks to make sure safe access around room and storage of items	Licensee / Team Leader
R291 Plan of Correction accepted by Jo A Evans RN on 1/9/25	Maintenance contacted immediately to lower water temperatures within the residents' areas to below 120 degrees.	12/16/2024	As regulation state, water temperatures in residents' areas will not exceed 120 degrees. Water temperatures were turned down at this time of audit by maintenance. This was implemented 12/16/24, maintenance was called to facility when water temps were found to be above 120 degrees. Water heaters have been turned down. Manager, Shannon will be responsible for oversight and managing temperature logs that will be kept in the manager's office of every sinks' temperature to ensure compliance.	Licensee