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

July 29, 2024

Ms. Cathryn Belanger
Next Door
847 Pine Street
Burlington, VT 05401-4924

Dear Ms. Belanger:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 23, 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
	0530	A. BUILDING: _____ B. WING _____	C 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEXT DOOR	847 PINE STREET BURLINGTON, VT 05401

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T 001	Initial Comments On 5/21/24 the Division of Licensing and Protection conducted an unannounced on-site investigation of one facility reported incident. The following regulatory deficiencies were identified during the investigation:	T 001	Plans of Correction for all individual tags accepted by Jo A Evans RN 7/28/24. Please see attached document to review the accepted corrective actions.	
T 079 SS=E	V.5.16.b Resident Care and Services 5.16 Reporting of Abuse, Neglect or Exploitation 5.16.b The licensee and staff are required to report suspected or reported incidents of abuse, neglect or exploitation. It is not the licensee ' s or staff's responsibility to determine if the alleged incident did occur or not; that is the responsibility of the licensing agency. A residence may, and should, conduct its own investigation. However, that must not delay reporting of the alleged or suspected incident to APS. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to report suspected and/or reported incidents of resident abuse within the required timeframe to the Division of Licensing and Protection and to the Adult Protective Services for two applicable residents (Residents #1 and #2). Findings include: The Adult and Child Abuse Reporting Policy effective 4/24/23 listed in the Operations Manual for the Designated Agency that manages the home includes policies and procedures for Adult Abuse Reporting which state, "Any staff person of [the Designated Agency] who, in the context of Agency work, has a reasonable suspicion that	T 079	Colleen Beagle 7/26/24 Senior Manager	

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T 079	Continued From page 1 any vulnerable adult has been abused, neglected, or exploited must report the suspicion to Adult Protective Services (APS)", and "If the victim of the alleged abuse is a resident of a [Designated Agency] licensed facility, the licensing body must also be notified of the abuse report. " 1. There was a failure to notify the Division of Licensing and Protection and the Adult Protective Services regarding the suspected abuse of Resident #1 by the Program Manager of the home following: a. Direct Care Staff's observations of ongoing mistreatment of Resident #1 by the Program Manager regarding the potential transfer to another facility during March 2024. b. Direct Care Staff's reports to the Assistant Director of Residential Community Support Programs regarding the mistreatment of Resident #1 by the Program Manager on 3/4/24, 3/11/24, and 3/21/24. c. The Team Lead's report to a representative of the Designated Agency's Employee and Labor Relations team on 3/22/24 which included a written statement indicating there were incidents of mistreatment of Resident #1 by the Program Manager. d. A report was not received by the Division of Licensing and Protection regarding the allegations for Resident #1 until 3/27/24. Per record review, on 3/4/24 a referral was submitted for transfer of Resident #1 from the home to another facility. Following Resident #1's notification of this referral, Direct Care Staff observed ongoing interactions between the home's Program Manager and Resident #1 during which the Program Manager was reported by Staff to have repeatedly informed Resident #1 s/he did not have a choice regarding the potential	T 079	Catrina Beverly 7/26/24 Senior Manager	

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T 079	Continued From page 2 transfer from the home; which is not congruent with the Resident's Rights outlined in regulation 6.14.a Vermont Licensing and Operating Regulations for Therapeutic Community Residences effective 3/1/2022. Per record review, on 3/8/24 a Direct Care Staff emailed the Assistant Director of Residential Community Support Programs and reported that Resident #1 thought s/he was being kicked out of the home and forced to move as this was what the Program Manager had been telling the resident. The Staff stated Resident #1 " is very upset about this". On 3/11/24, the Staff notified the Assistant Director via email that Resident #1 had repeatedly expressed s/he did not want to move, and was told s/he had no choice. Per record review,on 3/22/24 a representative of the Designated Agency's Employee and Labor Relations contacted the home's Team Lead via email regarding a report s/he made that the Program Manager was telling a client they were "being forced to go against their will and that they have to deal with it" in addition to other inappropriate comments the Program Manager had made to residents of the home. On 3/22/24 the Team Lead responded to the email confirming s/he and 2 other Direct Care Staff had witnessed the Program Manager telling Resident #1 s/he "has no choice with moving". Per record review, on 4/4/24 the Employee and Labor Relations rep requested a written statement from the Team Lead about an incident with Resident #1 "around March 4". The Team Lead's responded, "This wasn't a one time incident", and described an incident "on 3/4/24 or the following day" when s/he witnessed the Program Manager telling Resident #1 "you do not	T 079	Cathryn Berger 7/26/24 Senior manager	

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T 079	Continued From page 3 have a choice, bud" after Resident #1 expressed s/he did not want to move and explained why. The Team Lead reported Resident #1's was in "a state of distress" and "asking why [s/he's] getting kicked out and what [s/he] did wrong" following this incident; and stated, "There have been many other comments worded the same way or slightly differently to [Resident #1] since." During an interview commencing at 4:41 PM on 5/22/24, the Team Lead confirmed the Program Manager's mistreatment of Resident #1 regarding the potential transfer began in early March and was not limited to a single incident. During the interview on the afternoon of 5/22/24 the former Team Lead stated Resident #1 was observed to have an "uptake in anxiety and agitation" while the reported mistreatment was occurring. On the morning of 5/21/24 the Assistant Director of Residential Community Support Programs provided copies of the Designated Agency's internal investigation documents including a "Summary for [the Division of Licensing and Protection]" which stated staff had observed and reported concerning interactions between the Program Manager and Resident #1; and determined, "How [the Program Manager] spoke with Resident #1 was unprofessional and caused unnecessary distress." Per record review, a facility reported incident was received by the Division of Licensing and Protection on 3/27/24 when the Assistant Director of Residential Community Support Programs reported a verbal incident during which the Program Manager was witnessed by Staff commenting to Resident #1 that s/he would be forced to leave the home. The Assistant Director indicated this incident was reported to him/her on	T 079	Ashton Berger 7/26/24 Senior manager	

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T 079	Continued From page 4 3/21/24 by a Staff member who witnessed the incident. Per record review no additional reports made to the licensing agency regarding ongoing incidents observed by Staff and reported to the Administrator and the Employee and Labor Relations representative between 3/8/24 and 4/4/24. 2. There was a failure to report allegations of physical and verbal abuse of Resident #2 by an identified Direct Care Staff to the Division of Licensing and Protection and the Adult Protective Services. Per record review, Resident #2 filed a Grievance on 10/4/23 regarding a Direct Care Staff at the home who the resident identified by name. A letter from the Assistant Director of Residential Community Support Programs to Resident #2 dated 2/13/24 acknowledged this Grievance and stated, "Due to the serious nature of this concern, This grievance has been forwarded to our Human Resources team for an internal investigation, and if deemed necessary, relevant progressive discipline." On 1/1/24 the Program Manager received an email from one of the home's Staff reporting s/he had witnessed the same Direct Care Staff identified in the Grievance on 10/4/23 verbally abusing Resident #2 in a common area of the home and in front of other residents during the weekend of 12/30/23-12/31/24. The subject line of the email was "Urgent concerns regarding possible client abuse" and in the email the reporting Staff stated s/he witnessed the identified Staff telling Resident #2 s/he "had a screw lose ... needed to go back to the Doctors and change [his/her] meds ... there's something was not right up there ... to use [his/her] brain."	T 079	Cathryn Berger 7/26/24 Senior Manager	

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T 079	Continued From page 5 The Staff stated Resident #2 "was in tears and not understanding why the [staff identified by name] was talking to [him/her] like that." The Staff who reported this incident to the Program Manager stated s/he had reported the incident to the Assistant Director of Residential Community Support Programs via phone call during the weekend of 12/30/23-12/31/23. On 1/3/24 the Program Manager forwarded this email to two staff from the Designated Agency's Employee and Labor Relations. The Program Manager stated the Staff who was witnessed verbally abusing Resident #2 had a history of "rude, abrasive, and borderline abusive language previously, and the issue has become more prevalent in recent months." Per record review Resident #2 filed a Grievance Form on 1/12/24 which stated "A certain staff called me names and put their hands on me". Resident #2 identified the same staff previously reported as abusive on this Grievance form. In a letter dated 2/13/24 the Assistant Director of Adult Residential Community Support Programs notified Resident #2, "After careful review of your grievance, we have come to the following decision: Due to the serious nature of this concern, this grievance has been forwarded to our Human Resources team for an internal investigation ..." Per record review; the Staff identified in Resident #2's Grievances and an incident of verbal abuse of Resident #2 was issued a verbal warning and assigned Goals/Expectations" including "Refrain from using language that is degrading, demeaning, or hurtful in the workplace" and "Maintain professional manner when interacting with clients, treating them with respect and consideration" in response to the findings of the	T 079	Cathryn Bourgeois 7/26/24 senior manager	

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T 079	Continued From page 6 Designated Agency's internal investigation. Per record review the Staff identified as abusive towards Resident #2 was included on the list of home's current staff provided for review on request on the morning of 5/21/24. 3. During an interview commencing at 12:57 PM on 5/23/24 the Assistant Director was requested to provide documentation of reports made to the Division of Licensing and Protection and the Adult Protective Services (APS) regarding the Program Manager's ongoing mistreatment of Resident #1 and repeat incidents of abuse of Resident #2 by a Direct Care Staff of the home. The Assistant Director failed to provide documentation of reports made to the licensing agency and APS as requested. During the interview on the afternoon of 5/23/24 the Assistant Director of Residential Community Support Programs acknowledged the failure to report to the Division of Licensing and Protection and the Adult Protective Services as required. In conclusion this deficient practice is a risk for more than minimal harm to all facility residents due to the failure to report suspected or reported allegations of abuse, neglect, and exploitation to the Division of Licensing and Protection and the Adult Protective Services, which is required in order to ensure residents are protected from harm and to ensure allegations are investigated when deemed appropriate by State Agencies. The failure to report multiple incidents of suspected staff to resident abuse within 48 hours of occurrence resulted in Resident #1's and Resident #2's continued vulnerability to mistreatment without oversight and protection from the State Agencies created to protect the	T 079	Cathy Belanger 7/26/24 Senior manager	

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T 079	Continued From page 7 resident's rights.	T 079		
T 085 SS=G	VI. 6.1 Residents' Rights VI. Resident Rights 6.1 Every resident shall be treated with consideration, respect and full recognition of the resident ' s dignity, individuality, and privacy. A residence may not ask a resident to waive the resident ' s rights. A resident has the right to exercise any rights without reprisal. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure one applicable resident (Resident #1) was treated with consideration, respect and full recognition of the resident's dignity and individuality by a facility staff member. Findings include: Per review of the Designated Agency the manages the home's Operations Manual effective 9/12/23: a. Principle 01. - Responsibility for Client Welfare states, "Our primary duty is to do no harm, and our commitment is to work toward improving the health and well-being of individuals, families and our community." b. 1.01 Commitment to Clients states, " ... staff's primary responsibility is to promote the well-being of clients." c. 1.03 Harassment states, " ...employees will not engage in behavior that is harassing or demeaning to persons with whom they interact in their work for any reason ... Staff should use appropriate and respectful language in all communications to and about	T 085	Kathryn Bluster 7/26/24 Senior Manager	

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T 085	Continued From page 8 clients. " Resident #1 is diagnosed with debilitating mental and physical health conditions and is dependent on the staff of the home for support with housing, and other basic needs. Resident #1 was informed by the Program Manager of the home that a referral was made for a potential transfer to another facility owned by the same Designated Agency that manages the home on 3/4/24. This referral was made without Resident #1's knowledge and consent. Resident #1 was previously a resident of the facility s/he was referred to prior to his/her residence at the home, and experienced significant conflict with other residents while residing at the other facility. When Resident #1 expressed that s/he did not want to leave his/her current home, which is not a permanent housing residence, and transfer to the other facility s/he was informed by the Program Manager that s/he did not have a choice regarding the potential transfer. On multiple occasions, Direct Care Staff at the home observed and reported the Program Manager responding to Resident #1's distress regarding the transfer by telling the resident s/he did not have personal choice regarding this matter. The Program Manager's actions were not consistent with the policies and procedures of the home and the Designated Agency; the Vermont Licensing and Operating Regulations for Therapeutic Community Residences; and Resident's Rights which define and protect Resident #1's right to be involved in discharges and transfers, and the right to treated with dignity and respect. Additionally, the Program Manager's communications with Resident #1 regarding the potential transfer evidence a failure to	T 085	Cathryn Beuyer 7/26/24 Senior Manager	

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T 085	Continued From page 9 demonstrate competency in the skill of effective and respectful interactions with residents. During an interview commencing at 10:10 AM on 5/21/24, Resident #1 recalled an interaction with the Program Manager regarding the referral and potential transfer stating, "I didn't feel good about the talk, it was demanding, like I didn't have any options about it". Resident #1 stated s/he "felt scared and doesn't want to be homeless or left out on the street". S/he expressed concern about being arrested and stated s/he has experienced incarceration. At approximately 11:40 AM on 5/21/24 Resident #1's Case Manager stated after this interaction with the Program Manager, Resident #1 left messages on his/her phone with concerns about losing relationships with staff and clients at the home. During an interview commencing at 4:41 PM on 5/22/24, a Staff member confirmed the Program Manager's mistreatment of Resident #1 regarding the potential transfer began in early March and was not limited to a single incident. This Staff member reported witnessing the Program Manager's mistreatment on multiple occasions and stated Resident #1's response to these incidents was "an uptake of anxiety and agitation". Additionally, on 3/8/24 another Staff member notified the Assistant Director of Residential Community Support Programs that Resident #1 thought s/he was being kicked out of the home and forced to move, as this was what the Program Manager had been telling the resident. This Staff member stated Resident #1 " is very upset about this". On 3/11/24, this Staff notified the Assistant Director that Resident #1 had repeatedly expressed s/he did not want to move and was told s/he had no choice.	T 085	Colleen Beaupre 7/26/24 Senior Manager	

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T 085	Continued From page 10 Per record review, an internal investigation of the Program Manager's conduct by the Designated Agency that manages the home's Employee and Labor Relations determined the Program Manager's mistreatment of Resident #1 caused unnecessary distress to the resident. During an interview commencing at 12:57 PM on 5/23/24, the Assistant Director of Residential Community Support Programs acknowledged the Program Manager's mistreatment of Resident #1. In closing, this deficient practice is cited as actual harm level abuse resulting from the Program Manager's failure to engage in respectful and effective interactions with Resident #1; to ensure Resident #1's right to be included in the referral process/discharge planning; and to provide care with consideration of Resident #1's individual needs, treatment goals, and abilities. Actual harm is evidenced by objective reports from 2 Staff who observed the negative impact of recurring mistreatment of Resident #1 by the Program Manager including increased anxious behavior and agitation. Actual harm is also evidenced by Resident #1's subjective reports of feeling concern and fear of losing his/her home, being arrested, doing something wrong that caused the potential transfer, and the possible loss of supportive and meaningful relationships with staff and other residents.	T 085	Cathy Burgess 7/26/24 Senior manager	

Carolyn Scott, LMHC, M.S.
State Long Term Care Manager,
Division of Licensing and Protection,
HC 2 South, 280 State Drive,
Waterbury, VT, 054671-2306

July 24th, 2024

Listed below is the Plan of Correction for the deficiencies cited in the Investigation at Next Door TCR performed on May 23rd, 2024.

T-079 – V.5.16.b Resident Care and Services

Action Taken –

Program manager cited in statement of deficiency has ended employment at the agency as of April 23rd, 2024. New Senior manager will receive direct supervision from Assistant Director of Residential on an ongoing basis to supplement agency training on resident rights. Program staff have already retaken incident reporting training.

Measures put in place to ensure deficiency does not recur –

Any further instance of misconduct will be reported to DLP/APS if applicable and investigated by our internal Employee Labor Relations Team. Based on feedback from adult protective services an in person training hosted by adult protective services is preferred to standard mandated reporter training due to system updates and reporting changes. We will be doing in-person APS reporting training for all staff with [redacted], and [redacted] from APS. This training will occur on August 7th. This was approved in discussion with DLP staff on 6/8/24.

Monitoring –

Staff training will be monitored by the program manager, and tracked for completion. Trainings will be run and completed during staff team meetings. Staff unable to attend will be asked to complete trainings independently with compliance tracked via Mastery.

Completion –

Trainings indicated in the "measures" section will be completed on August 7h, 2024. Incident report training has already been completed. T079 Plan of Correction accepted by Jo A Evans RN on 7/28/24

T-085 – VI.6.1 Residents Rights

Action Taken –

Manager cited in Statement of Deficiency has ceased employment as of April 23rd, 2024. Grievance workflow updated as of May 28th, 2024. Internal investigation into the report was conducted by

agency Employee Labor Relations team. Program staff were asked to complete The clients rights training in mastery. Program staff were also asked to complete the incident reporting training in mastery. Both trainings were completed by all staff on or before 7/24/24.

Measures put in place to ensure deficiency does not recur –

Manager cited in Statement of Deficiency no longer employed by agency. All incidents of concern for Abuse / Neglect / Exploitation will be reported to Adult Protective Services / Division of Licensing and Protection prior to or concurrent with internal investigation.

Monitoring –

Critical incident system will be used to track compliance with reporting. Program senior manager will track training compliance.

Completion–

Completed on 7/24/24 T085 Plan of Correction accepted by Jo A. Evans RN on 7/28/24