

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

August 7, 2017

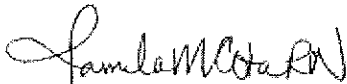
Ms. Helen Bishop, Manager
Our House At Park Terrace
48 South Main Street
Rutland, VT 05701-4163

Dear Ms. Bishop:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on June 27, 2017. 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
Licensing Chief



JUL 25 2017

PRINTED: 07/06/2017
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0146	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2017
NAME OF PROVIDER OR SUPPLIER OUR HOUSE AT PARK TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 48 SOUTH MAIN STREET RUTLAND, VT 05701	
(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)
R100	Initial Comments: An unannounced on-site complaint investigation was conducted on 6/27/17 by the Division of Licensing and Protection. There were regulatory findings.	R100	
R181 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the licensee failed to comply with regulatory requirements that states they shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and	R181	as per memo of 6/25/15 we continue to follow protocol 6/27/17 Per memo and regulations. Continued Scrutiny and close watch over staff - All money has been removed from the home and families are aware of this per letter of 7/12/17 - managers to monitor for compliance.

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

DATE FORM

5899

UOD611

If continuation sheet 1 of 6

R181 - R224 POCs accepted 7/31/17 B. B. NEILL / jmc

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R181	Continued From page 1 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. Findings include: During review of five (5) employee files for Criminal Background checks it was found that one employee reviewed, Staff #1, had a conviction of felony charges in October 2015 and was given probation for Grand Larceny of greater than \$500.00 (five hundred dollars). The facility decided to employ this caregiver 8/15/16, the owner confirmed on 6/27/17 at 12:50 PM that after receiving letters of recommendation, s/he hired the employee.	R181		6/27/17
R191 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12 Records/Reports 5.12.c A home must file the following reports with the licensing agency: 5.12.c.(1) When a fire occurs in the home, regardless of size or damage, the licensing agency and the Department of Labor and Industry must be notified within twenty-four (24) hours. A written report must be submitted to both departments within seventy-two (72) hours. A copy of the report shall be kept on file. 5.12.c.(2) A written report of any accident or illness shall be placed in the resident's record. Any untimely deaths shall be reported and a record kept on file.	R191	<p>R181</p> <p>* Addendum *</p> <p>See Criminal background Surveyor stated</p> <p>October 2015 when in fact it was</p> <p>October 2005</p> <p>See Criminal History report</p>	

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R191	Continued From page 2 5.12.c. (3) A report of any unexplained absence of a resident from a home for more than 12 hours shall be reported to the police, legal representative and family, if any. The incident shall be reported to the licensing agency within twenty-four (24) hours of disappearance followed by a written report within seventy-two (72) hours, a copy of which shall be maintained. 5.12.c.(4) A written report of any breakdown or cessation to the home's physical plant's major services (plumbing, heat, water supply, etc.) or supplied service, which disrupts the normal course of operation. The licensee shall notify the licensing agency immediately whenever such an incident occurs. A copy of the report shall be sent to the licensing agency within seventy-two (72) hours. 5.12.c. (5) A written report of any reports or incidents of abuse, neglect or exploitation reported to the licensing agency. 5.12.c. (6) A written report of resident injury or death following the use of mechanical or chemical restraint. This REQUIREMENT is not met as evidenced by: Based on staff interviews, the facility failed to file a written report regarding an allegation of exploitation to the licensing agency for one resident, Resident #1. Findings include: During interview with the house manager, s/he stated that on 6/16/17 it was discovered that Resident #1 had missing money from the accounting of resident's petty cash. On the morning of 6/16/17, Resident #1 had a total of \$240.00 (two hundred forty dollars) missing from	R191			
		R191	The event should have been reported - All managers are aware of what should have happened but didn't - and will not allow this to repeat itself		6/22/17

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STATE FORM

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R206	Continued From page 4 was kept for safe keeping by the staff and it was said that only his/her two un-cashed checks were present and not his/her cash for \$240.00 (two hundred forty dollars). Resident #1 further stated that when s/he reviewed the accounting sheet, there had been \$100.00 (one hundred) taken from his/her account on 6/11/17 without his/her knowledge and that the initials that was on the accounting sheet were not his. Interview with the house manager at 10:30 AM, s/he stated that during the immediate investigation it was discovered that the money was missing and an accounting sheet was also missing s/he reported it to the owner and his/her understanding was that the owner would handle the investigation and report it. Review of the facility policy states that 'Licensee and staff are mandated reporters and as such, must report any case of suspected abuse, neglect or exploitation to the Adult Protective Services (APS) within 48 hours of learning of the incident, as required by 33 V.S.A 6093. The house manager confirmed that the two caregivers and him/herself were aware of the policies. Review of the training record presented that all caregivers involved were educated on mandated reporting 1/4/17. Interview with the owner at 11:25 AM confirmed that it is the expectations of the staff and facility to report allegations and that it was discovered that the allegation was founded, but there is no evidence that a report was made to the appropriate agencies.	R206			
R207 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.b The licensee and staff are required to	R207 R207	SEE 206		

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R207	Continued From page 5 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 home may, and should, conduct its own investigation. However, that must not delay reporting of the alleged or suspected incident to Adult Protective Services. This REQUIREMENT is not met as evidenced by: The facility and staff failed to report an incident or exploitation for one resident, Resident #1 during and after an internal investigation involving theft of money. Findings include: During interview with Resident #1, it was presented that on June 15, 2017, s/he overheard the staff doing an accounting of the money that was kept for safe keeping by the staff and it was said that only his/her two un-cashed checks were present and not his/her cash for \$240.00 (two hundred forty dollars). Resident #1 further stated that when s/he reviewed the accounting sheet, there had been \$100.00 (one hundred) taken from his/her account on 6/11/17 without his/her knowledge and that the initials that was on the accounting sheet were not his. Interview with the house manager at 10:30 AM, s/he stated that during the immediate investigation it was discovered that the money was missing and an accounting sheet was also missing s/he reported it to the owner and his/her understanding was that the owner would handle the investigation and report it. Review of the facility policy states that 'Licensee and staff are mandated reporters and as such, must report any case of suspected abuse, neglect or exploitation to the Adult Protective Services (APS) within 48 hours of learning of the incident, as required by 33 V.S.A.	R207	R207 See R206		

If continuation sheet 7 of 8

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R224	Continued From page 7 be taken by someone for their own use. The facility holds spending money for some of the residents that won't use the provided lock boxes and during accounting of his/her money on 6/16/17, it was discovered that s/he had no cash to count. When s/he inquired about where his/her money went, the facility began an investigation. After a review of the accounting sheet with Resident #1 by the facility, s/he stated that on 6/11/17 s/he had not removed \$100.00 (one hundred dollars) and his/her initials had been forged. Further investigation showed that a total of \$240.00 (two hundred forty dollars) were missing. Through the facility investigation it was discovered that a caregiver, Staff #1 had taken the money for his/her own use and admitted to the facility that they had indeed taken that money.	R224			