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

August 21, 2018

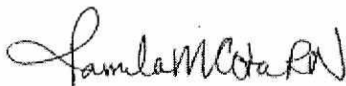
Ms. Lois Langlois, Manager
Rivers Edge Community Care Home
5 Hunt Street
Bennington, VT 05201

Dear Ms. Langlois:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 23, 2018.** 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

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
	0085	A. BUILDING: _____ B. WING _____	C 07/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE COMMUNITY CARE HOME	5 HUNT STREET BENNINGTON, VT 05201

(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 on-site complaint investigation was conducted on 7/23/18 by the Division of Licensing and Protection. There were regulatory findings.	R100		
R179 SS=D	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, the	R179		

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — M Whitmire RN — TITLE — (X6) DATE 8/6/18

R179 - R224 POCs accepted 8/15/18 BBartell RN/PMC

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
	0085	A. BUILDING: ______ B. WING ______	C 07/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE COMMUNITY CARE HOME	5 HUNT STREET BENNINGTON, VT 05201

(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 1 facility failed to ensure that staff complete at least twelve hours of training each year for one of three employees that provides direct care to the residents. Additionally, one of three direct care staff did not show evidence of training in all mandatory topics. Findings include: Per review of the annual training records for direct care staff, there was no evidence that mandated twelve hours of training had been provided to one of three employees nor was there evidence that Employee #1 had completed any of the mandatory required trainings. The Registered Nurse/manager stated at 10:30 AM on 7/23/18, that the Employee #1 would not meet the facility based mandatory trainings and s/he would have to set aside time to complete the trainings with Employee #1 and further stated that even though all other staff had completed the training, Employee #1 had not met with him/her yet to complete the trainings.	R179	8-6-18 R179 INSERVICES SCHEDULED MONTHLY. STAFF THAT HAVE NOT COMPLETED INSERVICES WILL BE REQUIRED TO COMPLETE BEFORE BEING SCHEDULED TO WORK ANY SHIFTS. RN WILL ENSURE COMPLIANCE WITH INSERVICES EFFECTIVE IMMEDIATELY	
R206 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.a The licensee and staff shall report any case of suspected abuse, neglect or exploitation to the Adult Protective Services (APS) as required by 33 V.S.A. §6903. APS may be contacted by calling toll-free 1-800-564-1612. Reports must be made to APS within 48 hours of learning of the suspected, reported or alleged incident. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the	R206		

PRINTED: 07/30/2018
FORM APPROVED

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
	0065	A. BUILDING: ______ B. WING ______	C 07/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE COMMUNITY CARE HOME	5 HUNT STREET BENNINGTON, VT 05201

(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
R206	Continued From page 2 facility failed to report an allegation of abuse to the appropriate State Agency within the required time frame. Findings include: An allegation of verbal and physical abuse was made known to the Registered Nurse (RN)/manager on 5/22/18 by a resident and per interview with the RN at 10:35 AM on 7/23/18, s/he had not reported the allegation. S/he stated that she was made aware of the allegation the following day and did not feel it needed to be reported because the resident had left the facility and the employee resigned when an investigation was started by the RN to gather information. After review of the regulation with the survey team, the RN stated that the incident report should have been reported. It was further confirmed by a night shift care giver on 7/23/18 at 12:38 PM that s/he was a witness to an incident of verbal abuse and had not reported to the management or the appropriate State Agency.	R206	ALL ALLEGATIONS OF VERBAL + PHYSICAL ABUSE WILL BE REPORTED TO THE APPROPRIATE STATE AGENCY INSERVICE FOR ALL STAFF RE: POLICIES + PROCEDURES REPORTING ABUSE, NEGLECT + EXPLOITATION COMPLETED DATE 8/14/18 BY RN R206 + R224	
R224 SS=D	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on staff interview the facility failed to protect one resident in the applicable sample, Resident #1, from verbal abuse. Findings include:	R224		

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
	0085	A. BUILDING: ______ B. WING ______	C 07/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE COMMUNITY CARE HOME	5 HUNT STREET BENNINGTON, VT 05201

(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
R224	Continued From page 3 An allegation of verbal abuse was made by Resident #1, stating that on 5/21/18 around 11:00 PM, a care giver took a cup of coffee away from him/her and started to yell at them and call them names. During interview on 7/23/18 at 12:36 PM, with night shift care giver (#2), s/he stated that on 5/21/18 at approximately 11:00 PM, his/her co-worker (#1) took a cup of coffee away from Resident #1 and told him/her that they couldn't have anymore coffee and threw it out in the garbage and then told Resident #1 not to drink the coffee that was meant for the staff. S/he further stated that there was a verbal exchange between caregiver #1 and Resident #1 that included "swearing, yelling and name calling". Care giver #2 stated that it upset Resident #1 so much that they went to their room and packed their belongings, called for a ride and left the facility. Interview with caregiver #1 provided confirmation that s/he took the cup of coffie and threw it away and then got upset with Resident #1 when they started calling him/her names. Caregiver #1 also confirmed that Resident #1 was so upset that they packed their belongings, took their medications, called for a ride and left the facility around 1:00 AM on 5/22/18.	R224		