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

September 12, 2018

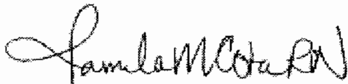
Ms. Doris Fregeau, Manager
Roy Mountain House
118 Mosquitoville Road
Barnet, VT 05821-9534

Dear Ms. Fregeau:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 13, 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
	546	A. BUILDING: ____ B. WING ____	C 08/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROY MOUNTAIN HOUSE	118 MOSQUITOVILLE ROAD BARNET, VT 05821

(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
T 001	Initial Comments The Division of Licensing and Protection conducted an unannounced on site investigation of two facility self-reported incidents on 8/13/2018. The following regulatory violations were identified.	T 001		
T 023 SS=D	V. 5.5.a Resident Care and Services 5.5 General Care 5.5.a Upon a resident's admission to a therapeutic community residence, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. The home's manager shall provide every resident with the personal care and supervision appropriate to his or her individual needs. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the residence failed to provide the necessary care and services in order to meet the personal and psychosocial care needs for 1 of 3 residents in the sample. (Resident #1). Findings include: Resident #1, admitted to the residence in 2015, required supervision at the residence and in the community due to a history of assault and physically aggressive behaviors. Per Resident #1's Community Safety Plan/ Behavior Support Plan dated 2/10/2018, Resident #1 required, "arms length supervision" at all times in the community by residence support staff. Additional court-ordered restrictions included that Resident	T 023	See attachment	

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]

TITLE: Senior Director of Licensed Residential Services, Northeast Kingdom Human Services

(X6) DATE: 9/4/18

T023 - T051 POC's accepted 9/7/18 MBolton, RN/PMC

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T 023	Continued From page 1 #1, "shall not buy, have, or consume" alcoholic beverages and was not permitted to drink or possess alcohol at the residence. Per review of Residential Shift notes, on 7/12/2018, Resident #1 was reported to be intoxicated at the residence and became, "drunk and violent". Physically aggressive behaviors included kicking the kitchen pantry door, making verbal threats toward staff, and punching a window. Resident #1's behavior resulted in staff calling the police for emergency assistance. During an interview, the Manager confirmed that residential staff were expected to maintain eyes on supervision in the community in order to prevent Resident #1 from buying or consuming alcohol. The failure to provide Resident #1 with supervision required to maintain his/ her personal and psychosocial needs was confirmed with the residence Manager and Registered Nurse on the afternoon of 8/13/2018.	T 023		
T 032 SS=E	V.5.7.b Resident Care and Services 5.7 Treatment Plan 5.7.b The residence shall ensure that the treatment plan reflects steps to be taken to solve identified problems, either by direct service at the residence or indirectly by referral to a community resource. The treatment plan shall be completed within fourteen (14) days of admission. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the residence failed to ensure that treatment plans	T 032	See attachment	

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T 032	Continued From page 2	T 032		

included interventions to solve identified problems for 3 out of 3 residents in the sample (Resident #1, Resident #2, and Resident #3). Findings include:

1.) Resident #1 was admitted to the residence in 2015. Per record review, Resident #1 required supervision in the community and per court order, "may not drink or possess alcohol." Per review of Residential Shift notes, Resident #1 became physically aggressive and destroyed property at the residence during an episode of alcohol intoxication on 7/12/2018. Resident #1's Community Safety Plan/ Behavior Support Plan dated 2/10/2018 included expectations of staff to supervise Resident #1 in the community and at the residence. However, the plan had not been updated or reviewed since Resident #1 had obtained and consumed alcohol on 7/12/2018. Per interview, the Manager confirmed that Resident #1's activities had been restricted and community outings had been limited as a safety measure following the episode of physical aggression and property destruction. However, Resident #1's treatment plan did not include these updated changes to guide and enforce staff member's interventions with Resident #1.

2.) Resident #2 was admitted to the residence in 2013. Per record review, Resident #2 had a history of physical aggression and property destruction and required staff supervision in order to re-direct escalations in behavior. Resident #2's Community Safety Plan/ Behavior Support Plan dated 8/4/2016 included expectations of staff to assist Resident #2 with anger management and verbal threats of harm towards others. Per review of Residential Shift notes, Resident #2 had engaged in verbal aggression and physically threatening behavior toward other residents

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T 032	Continued From page 3 requiring intervention from staff. Per record review, Resident #2 " became upset and agitated at times" and had an episode of, "getting out of control" on 7/10/2018. Resident #2 had a previous episode of verbal conflict and physically threatening behavior with another resident on 5/2/2018. However, the treatment plan had not been updated after these episodes, and did not include specific interventions for staff to implement when Resident #2 was in conflict with other residents. 3.) Resident #3 was admitted to the residence in 2016. Per record review, Resident #3 had a history of behavior and aggression requiring staff supervision in the community and at the residence. Resident #3's Community Safety Plan/ Behavior Support Plan dated 2/20/2018 included interventions to address, "anger management and impulse control" problems. Resident #3 experienced conflict with other residents on 5/2/2018 and 7/10/2018 resulting in physically aggressive behavior and attempts to strike others. Resident #3's treatment plan had not been updated to address the specific issue of conflict with other residents and interventions for staff to utilize to de-escalate potentially aggressive behavior. The lack of updates to the treatment plans for Resident #1, Resident #2 and Resident #3 was reviewed with the Manager and Registered Nurse on the afternoon of 8/13/2018.	T 032		
T 051 SS=E	V.5.9.a Resident Care and Services 5.9 Staff Services 5.9.a There shall be sufficient number of	T 051	See attachment	

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T 051	Continued From page 4	T 051		

qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to ensure prompt, appropriate action in cases of injury, illness, fire or other emergencies.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the residence failed to ensure there were sufficiently qualified personnel to provide necessary care and maintain a safe and healthy environment at all times. This has the potential to effect all residents. Findings include:

1.) Per review of Residential Shift notes and residence critical incident reports, Resident #2 and Resident #3 engaged in verbal threats and acts of physical aggression on multiple dates, which had the potential outcome of causing injury or harm to themselves or others. During an incident on 5/2/2018, Resident #2 and Resident #3 engaged in a physical altercation while being transported to an appointment in the community, which included attempts to grab one another's hair and clothing. Resident #2 and Resident #3 were accompanied at the time by one staff member. On 7/10/2018, Resident #2 and Resident #3 experienced conflict at the residence, which included verbal threats of harm and physical contact including attempts to grab, punch at and hit each other on the chest. Per residential staff notes, employees attempted to implement strategies including verbal de-escalation and encouraged the residents to calm themselves by "taking space" in their rooms.

2.) Per review of Residential Shift notes, Resident #1 was able to obtain and consume alcohol at the

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T 051	Continued From page 5 residence on 7/12/2018. Resident #1 became verbally threatening and physically aggressive. Resident #1's behavior included threats of harm to staff and destruction of property in the home, resulting in law enforcement being called to the home. The residence provides care and services for individuals with complex mental health and psychosocial needs. While direct care staff receive training in Respectful Communication and General Supervision of residents, there was no evidence of training in crisis management to assist staff with learning skills to maintain a healthy and safe environment for all residents. During an interview on the morning of 8/13/2018, the residence Manager confirmed that staff do not receive crisis management training at this time, but that "training in de-escalation skills may be helpful" to prevent verbal conflict from escalating to physical altercations at the residence.	T 051		

Facility: Roy Mountain House
Date of Survey: 8/13/18
Plan of Correction Date: 8/27/18; revised 9/6/18

T023
V.5.5.a –RESIDENT CARE AND SERVICES
5.5 General Care
Plan of Correction:

- The staff member responsible for the identified incidents has been terminated.
- The interim Residential Manager completed a review of all existing support plans. Support Plans have been updated and will be reviewed monthly. Updates will be completed annually or sooner if indicated.
- All residential staff will be trained on the updated support plans on, or before, 9/26/18.
- The licensee will provide additional oversight by conducting reviews of support plans at least quarterly, and will provide sporadic covert supervision to ensure adherence to protocols.
- Date corrective action implemented: Immediate and ongoing

T032
V.5.7.b-RESIDENT CARE AND SERVICES
5.7 Treatment Plan
5.7.b
Plan of Correction:

- The interim Residential Manager completed a review of all existing support plans. Support Plans have been updated and will be reviewed monthly. Updates will be completed annually or sooner if indicated.
- All residential staff will be trained on the updated support plans on, or before, 9/26/18.
- The licensee will provide additional oversight by conducting reviews of support plans quarterly or more frequently if warranted.
- Date corrective action implemented: Immediate and ongoing

T051
V.5.9.a RESIDENT CARE AND SERVICES
5.9.a Staff Services

- The interim Residential Manager will continue to ensure that a sufficient number of residential staff are on duty and available to provide supports in accordance with the residents' existing support plans.
- All residential staff will be provided with updated training, including training in crisis management and resident support plans on 9/26/18
- The licensee will provide additional monitoring of staffing levels and training needs through monthly reviews.
- Date corrective action to be implemented: Immediate, with efforts ongoing; staff training on 9/26/18.

9/6/18