

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

March 17, 2014

Ms. Susanne Shapiro, Administrator
West River Valley Assisted Living Residence
PO Box 341
Townshend, VT 05353-0341

Provider #1007

Dear Ms. Shapiro:

Enclosed is a copy of your acceptable plans of correction for the unannounced onsite investigation of a complaint and two self-reports conducted on January 8, 2014 and completed on **January 9, 2014**. 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

PC:ne

Enclosure

Division of Licensing and Protection

RECEIVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1007	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	Division of FEB 24 14 Licensing and Protection	(X3) DATE SURVEY COMPLETED C 01/09/2014
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NAME OF PROVIDER OR SUPPLIER
WEST RIVER VALLEY ASSISTED LIVING RESII

STREET ADDRESS, CITY, STATE, ZIP CODE
**PO BOX 341
TOWNSHEND, VT 05353**

(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
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R100	Initial Comments: An unannounced onsite investigation of a complaint and two self-reports was conducted on 1/8 & 9/2014 by the Division of Licensing and Protection. There was a regulatory deficiency identified as a result of the investigation. Findings include:	R100	In light of the two staff witnessed abuse allegations presented to the administrator on 8/9/13 and 9/16/13 the facility reviewed Adult Abuse, Neglect, and Exploitation of vulnerable adults with all staff members during report times between shifts, at a staff meeting on 9/5/13, and during a mandatory in-service on General Care of residents on 11/21/13. In addition, we have scheduled the annual Residents Rights in-service 2 months early: it will be held today, 1/30/14, whereas last year it was held 3/20/13. We will touch on the topics of abuse, neglect, and exploitation during today's session with Ombudsman, Nancy Hood.	
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 record review and staff interview the facility failed to report a case of suspected staff to resident abuse for Resident #1 within 48 hours as required. Findings include: Per record review Staff #1 was reported to have been witnessed on 8/9/2013 by the Property Manager and Maintenance Assistant hollering at Resident #1 (R#1) and then "pushing" the resident into a chair. The two witnesses reported the incident to facility administration and the staff member was counseled. No report was made to Adult protective Services (APS). On 9/16/2013 a staff member reported an incident which took place on 9/8/13 in which Staff	R206	In addition, the administrator has been careful in reporting any situation that has any slight suspicion of this nature since the August 2013 incidents. Administrator has reiterated to all staff how a suspicion does NOT have to be substantiated before reporting an episode, AND that we as a facility are NOT allowed to do self investigation alone, but always in conjunction with a report to APS. Our staff policy was reviewed and finessed. The updated Training section in the Abuse Policy reads: "Training: During orientation, the new employee will review the Abuse Policy and Procedures. All employees are then trained yearly on Residents Rights and Abuse Policy. Inclusive in this training are approaches to deal with aggressive behaviors of residents, reporting procedures without fear of reprisal, recognition of precipitating factors that may lead to abuse, and what constitutes abuse, neglect and misappropriation of resident property." During our monthly resident council meeting on 1/9/14, the administrator reviewed with residents how we are mandated reporters, and residents were encouraged to always let the facility management know if there is anything at all going on that might be considered abusive. Residents were made aware of the facility investigation and findings.	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Suzanne Chaplin

TITLE

Executive Dir.

(X6) DATE

1/30/14

STATE FORM

8892

4C7111

If continuation sheet 1 of 2

R206 POC accepted 3/14/14 mtg qms RN/pmc

pmc

Division of Licensing and Protection

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R206	Continued From page 1 #1 was described as rough and rude with R #1 which was witnessed by the staff member. Facility administration assured that Staff #1 was not scheduled to work as soon as they were made aware of the incident and called the staff member to a meeting. Staff #1's employment was terminated. No report was made to APS. In an interview on 1/9/2014 at 11:30 A the facility Administrator confirmed that neither incident was reported to APS by the facility.	R206		