

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

October 1, 2013

Ms. Kristine Kupcha, Administrator  
Copley House Community Care Home  
379 Washington Highway  
Morrisville, VT 05661

Provider #: 0139

Dear Ms. Kupcha:

Enclosed is a copy of your acceptable plans of correction for the unannounced onsite investigation of two complaints and three entity self reports conducted on **August 13, 2013**. 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

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Division of  
Licensing and  
Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0139</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	SEP 12 13 Licensing and Protection	(X3) DATE SURVEY COMPLETED  C <b>08/13/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COPLEY HOUSE COMMUNITY CARE HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>379 WASHINGTON HIGHWAY MORRISVILLE, VT 05661</b>
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R100	Initial Comments:  An unannounced onsite investigation of two complaints and three entity self-reports was conducted by the Division of Licensing and Protection from 8/12/13 through 8/13/13. There were no findings related to the allegations in the two complaints. Regulatory violations related to the three self-reports were cited as follows.	R100	All residents will have a written plan of care developed with the nurse. All plans will be signed by a licensed caregiver. This charge will be implemented immediately. All residents will have a plan of care by 12/1/13. A chart review of all charts has begun as of 8/19/13 and will be included bi-monthly to ensure all charts are up to date.	
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES  5.9.c (2)  Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being;  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the nurse failed to oversee the development of a written plan of care for two of five residents in the sample (Residents #2 and #3). Findings include:  1. Per record review on 8/12/13, the written plans of care for Resident #2 (6/17/13) and Resident #3 (5/30/13) were signed as completed by an unlicensed caregiver. There was no evidence that the nurse had overseen the development of the written plans of care. In an interview at 9:30 AM on 8/13/13, the Registered Nurse confirmed not having overseen or signed the written plans of care for Resident #2 (dated 6/17/13) or Resident #3 (dated 5/30/13).	R145		

R145 POC accepted 9/12/13  
JHosmer RN/PMC

Division of Licensing and Protection  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*[Signature]*  
STATE FORM 6899

TITLE  
*Clinical Coordinator*  
VMV011

(X6) DATE

If continuation sheet 1 of 4

PMC

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R206  R206 SS=E	<p>Continued From page 1</p> <p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.18 Reporting of Abuse, Neglect or Exploitation</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the home failed to assure that two incidents of suspected abuse were reported [within 48 hours of awareness] to Adult Protective Services (APS) as required by 33 V. S. A. 6903. Findings include:</p> <p>1. Per review of the staff log book and an incident report (signed and dated 7/7/13), a caregiver documented witnessing an incident at 6:00 PM on 7/1/13 wherein Resident #1 was holding by the wrists Resident #2, holding Resident #2 up against a wall in the entrance hallway. During an interview on 8/12/13 at 2:30 PM, The witnessing caregiver reported having heard Resident #2 yelling "NO! Stop!" before actually seeing the two residents up against the wall. The caregiver further confirmed that s/he delayed making the report of the incident until 7/7/13.</p> <p>2. Per review of the staff log book and an incident report (dated and signed on 7/7/13), caregiver B documented being told by caregiver A that Resident #3 reported having received an unwelcome touch (in the genital area over</p>	R206  R206	<p>Amandatory training was given on 8/29/13 to go over the procedure of reporting any case of suspected abuse, neglect or exploitation to Adult Protective Services. The expectation that all reports must be made within 48 hours was stressed. On going check ins will be conducted during the first staff meeting of the month starting 9/12/13.</p> <p>R206 POC accepted 9/12/13 JHosmer RN/PNL</p>	
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R206	Continued From page 2  clothing) at 7:30 PM on 7/5/13. During an interview on 8/12/13 at 2:30 PM, caregiver B confirmed having delayed reporting the incident until 7/7/13. The administration in turn delayed reporting the incident to APS until 7/9/13. The manager confirmed the delayed report in an interview on 8/12/13 at approximately 2:00 PM.	R206	Since the unwanted sexual contact by a resident to another resident, specific plans of care focusing on unwanted sexual contact have been developed for this particular resident. This plan will be discussed once a month at case reviews which include the treatment team. In addition, the plan will be discussed with staff members on an on-going basis to make adjustments as necessary.	
R224 SS=E	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.	R224		
	This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to prevent Resident #1 (who has a behavior plan for using his/her body to intimidate both staff and other residents) from physically abusing Resident #2, and also making unwanted sexual contact with Resident #3. Findings include:  1. Per review of the staff log book and an incident report (signed and dated 7/7/13), a caregiver documented witnessing an incident at 6:00 PM on 7/1/13 wherein Resident #1 was holding by the wrists Resident #2, thus holding Resident #2 up against a wall in the entrance hallway. During an interview on 8/12/13 at 2:30 PM, the witnessing caregiver reported having heard Resident #2 yelling "NO! Stop!" before actually seeing the two residents in the hallway. Per record review, a written behavioral plan had been in place since 1/13/2013 which called for			

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R224	<p>Continued From page 3</p> <p>Resident #1 to lose an outing for displaying a list of behaviors, including any physical contact with residents that is not welcome, and using your body to intimidate residents.</p> <p>2. Per review of the staff log book and an incident report (dated and signed on 7/7/13), caregiver B documented being told by caregiver A that Resident #3 reported at 7:30 PM on 7/5/13 having received an unwelcome touch in the genital area (over clothing). Resident #3 used a slang term in identifying where Resident #1 had touched him/her. During an interview on 8/12/13 at 2:30 PM, caregiver B confirmed that Resident #3 was very upset about the unwelcome touch which s/he identified as the genital area and spent the entire evening in his/her room, not coming down for the evening medication pass.</p>	R224	<p>As part of the plan, the resident who was making the unwanted pass also a plan which includes more frequent check ins by night staff and is receiving education suited for his cognitive level on the importance of appropriate and appropriate physical behaviors.</p> <p>R224 POC accepted 9/12/13 JHsmerrn/pmc</p>	
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