

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 15, 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 on-site investigation of an entity self-reported incident conducted on **September 3, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0139	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/03/2013
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NAME OF PROVIDER OR SUPPLIER COPLEY HOUSE COMMUNITY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 379 WASHINGTON HIGHWAY MORRISVILLE, VT 05661
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R100	Initial Comments: An unannounced on-site investigation of an entity self reported incident was conducted by the Division of Licensing and Protection on 09/03/13. The following are Residential Care Home regulatory violations.	R100	<i>Previous assessments inspection found that assessments had not been completed on time. As per the survey completed on 5/13/13 a mostly correct review is conducted to assure all Resident Assessments contain current information of that resident and completed on the appropriate date.</i>	
R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to assure that an annual reassessment was completed within the required timeframe for one of three residents in the sample (Resident #1) Findings include: Per record review on 09/03/13, Resident #1 was admitted on 09/18/01. Per review of the Resident Assessment, the last one completed was on 09/17/11. Per interview on 09/03/13 at 1:03 PM, the registered nurse stated that the annual assessment was probably done and is still in the Main office and confirmed that the annual reassessment was not found for Resident #1 as required by the regulation.	R136	<i>Any outdated or incorrect resident assessments will be and have been reviewed, amended or a new assessment completed and filed. A mostly correct review began on 6/17/13 and all outdated and incorrect is being corrected.</i>	
R139 SS=D	V. RESIDENT CARE AND HOME SERVICES	R139		

Division of Licensing and Protection
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE **10/1/13**

STATE FORM 6899 9EQD11 If continuation sheet 1 of 8

R136, R139, R145, R164, R165, R188, + R208 POC's accepted 10/10/13 SEMMONS RN/PMC

PMC

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R139	<p>Continued From page 1</p> <p>5.8 Physician Services</p> <p>5.8.c Any refusal of medical care and the reasons for the refusal must be documented in the resident's record. If the resident has an attending physician, the physician shall be notified.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home failed to document the reasons for medication refusals by 1 of 3 applicable resident of the targeted sample and to notify the attending physician of these refusals (Resident #1). Findings include the following:</p> <p>1. Per record review and on 09/03/13, Resident #1 refused to take medications on July 8, 12, 18, 19, 28, 29, and 31 as needed for behaviors and other medical concerns. Although the medication administration record (MAR) shows that the medication was not given on the above dates, it does not show the reasoning for the refusals nor any indication in the progress notes or log book regarding the reasons for refusal. It was not evident that the resident's noncompliance with medications was consistently reported to the resident's physician. Per interview on 09/03/13 at 1:03 P.M. the nurse confirmed that staff did not report to the physician the reason and refusals.</p>	R139	<p>After inspection, a log book containing notification of medication refusals has been kept beginning at case #1 on 9/5/13. The log book contains all concerns as well as medication refusals that are discussed with the attending physician. In addition reasons for refusals have been to be added to the MAR. This has been added to med. training</p>	
R145 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.9.c (2)</p> <p>Oversee development of a written plan of care for</p>	R145		

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R145	Continued From page 2 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 staff interview and record review, the facility failed to develop a written plan of care for 1 of 3 residents in the sample (Resident # 1). Findings include: Per record review on 09/03/13 there was no revision to the plan of care for Resident #1's repeated aggressive behaviors towards staff and other residents . Per interview at 9:30 A.M. the Administrator stated "I've been a manager for 6 months now and [Resident #1] has a cycle where [s/he] gets this way....the case manager left about 2 weeks ago...not sure what we are planning to do...not sure if there is a specific care plan because [s/he] refuses to follow one anyway". The current ICP [individual care plan] is dated 05/31/13 however the resident has had multiple incidents since that time. The manager stated that a draft of a care plan was developed in August [date unknown] however it has yet to be signed and/or approved by the Clinical Coordinator, Psychiatrist and CRT personal. S/he confirmed that there is no revision to the plan of care for Resident #1's repeated aggressive behaviors towards staff and other residents at this time. Also see R-208 *This is a repeat finding from 08/13/13	R145	<i>As per written response to 5/13/13 visit, individuals upon admittance to CH will have a plan of care specifically designed for identified needs as stated in the resident's assessment, based on the abilities of that resident. This will be completed no more than 7 days after the plan is needed, when addressing new behaviors 14 days after new admittance/assessment. All client charts will be updated by 10/31/13.</i>	
R164 SS=F	V. RESIDENT CARE AND HOME SERVICES	R164		

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R164	<p>Continued From page 3</p> <p>5.10 Medication Management</p> <p>5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:</p> <p>(2) A registered nurse must delegate the responsibility for the administration of specific medications to designated staff for designated residents</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, the Registered Nurse failed to delegate the responsibility for the administration of specific medications to designated staff for designated residents. This has the potential to affect all residents.</p> <p>Per interview on 09/03/13 at 1:03 P.M., the RN stated that regarding medication changes for residents, "I find out when I come in during the week, the staff do not call when a med is changed." This allows unlicensed staff to administer new medications or new doses of medications to residents without being delegated by the RN to do so. Delegation is for specific medications for each resident and is not a "blanket approval" for staff to be able to administer all medications. S/he confirmed not always supervising unlicensed staff nor a means of communication for follow up and delegation for medication changes.</p> <p>Reference: Vermont State Board of Nursing - THE ROLE OF THE NURSE IN DELEGATING NURSING INTERVENTIONS POSITION STATEMENT. Last Revised May 2013.</p>	R164	<p>All medication changes will be called into the registered nurse before they are administered. A new log sheet will be kept to track medication changes and notification of the registered nurse. This will begin immediately. The log will be reviewed bi-weekly in case periods.</p>	
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R165	Continued From page 4	R165		
R165 SS=F	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.10 Medication Management</p> <p>5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:</p> <p>(3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for:</p> <p>i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects;</p> <p>ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications;</p> <p>iii. Assessing the resident's condition and the need for any changes in medications; and</p> <p>Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interviews the Registered Nurse (RN) failed to monitor and evaluate the designated staff performance in carrying out the nurse's instructions and failed to establish a process for routine communication regarding changes in medications. This has the potential to effect all residents. Findings include:</p> <p>1. Per interview on 09/03/13 at 1:03 P.M., the RN stated that any post testing of medication</p>	R165 R165	<p>The registered nurse accepts proper administration of medications.</p> <p>The registered nurse holds critical information and information regarding the administration of medications.</p> <p>When new the facility has new employees, the registered nurse will, starting 10/7/13, supervise all staff at least once a week to ensure proper administration of medication.</p> <p>Dr. [Name] supervised medication administration the registered nurse will</p>	

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R165	Continued From page 5 administration of unlicensed staff is supervised someone who is not a nurse but "is in nursing school". This violates Vermont Board of Nursing recommendations regarding delegation, and specifically violates the recommendations regarding the "responsibilities of the delegating nurse". The RN also stated that regarding medication changes for residents, "I find out when I come in during the week, the staff do not call when a med is changed." This allows unlicensed staff to administer new medications or new doses of medications to residents without being delegated by the RN to do so. S/he confirmed not always supervising unlicensed staff nor a means of communication for follow up for medication changes.	R165	<i>evaluate and teach staff proper medication administration.</i>	
R188 SS=C	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(2) A record for each resident which includes: resident's name; emergency notification numbers; name, address and telephone number of any legal representative or, if there is none, the next of kin; physician's name, address and telephone number; instructions in case of resident's death; the resident's assessment(s); progress notes regarding any accident or incident and subsequent follow-up; list of allergies; a signed admission agreement; a recent photograph of the resident, unless the resident objects; a copy of the resident's advance directives, if any completed; and a copy of the document giving legal authority to another, if any.	R188		

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R188	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and confirmed by the manager, the home failed to obtain a photograph of one resident of three residents and failed to have current progress notes for three of three residents. [Residents #1, #2 & #3] Findings include:</p> <p>1. Per record review on 09/03/13 at 9:30 A.M. Resident #2, who was admitted on 05/02/11 did not have a photograph present in the record. Additionally, Resident #1 and Resident #3, who were admitted in 2001 [greater than 12 years ago] did not have current pictures in their charts.</p>	R188	<p>All residents have been photographed and new photos have been placed in their charts as of 10/1/13.</p>	
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R208 SS=E	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.18 Reporting of Abuse, Neglect or Exploitation</p> <p>5.18.c Incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse, or if an injury requiring physician intervention results, or if there is a pattern of abusive behavior. All resident-to-resident incidents, even minor ones, must be recorded in the resident's record. Families or legal representatives must be notified and a plan must be developed to deal with the</p>	R208		
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R208	<p>Continued From page 7 behaviors</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the home did not report to the Division of Licensing and Protection (DLP) a pattern of resident to resident incidents in a timely manner in for 1 of 3 applicable records reviewed, nor did the home develop a plan to deal with the behaviors. (Residents #1) Findings include:</p> <p>Per record review on 09/03/13 a pattern of aggressive behaviors involving Resident #1, was not reported as required nor was a plan developed to deal with the behaviors. The aggressive behaviors occurred, per the log book and incident reports, on July 3, 4, 5, 7, 8, 13, 12, and 25 as well as August 4th and 5th, 2013. Of these 10 events of pushing, shoving, threatening, slapping and hitting other residents and staff, the Home reported to DLP three times. The manager during interview stated that a care plan was not revised ... "not sure what we are planning to do... not sure if there is a specific care plan because [s/he] refuses to follow one anyway". The Manager confirmed at that time that not all incidents were reported to DLP nor was a plan developed to deal with the behaviors.</p> <p>Also see R-145</p>	R208	<p>All staff received training on APS reporting 6/6/13. The rules for reporting are reviewed at the first staff meeting of the month. We continue to work on reporting within the 48 hour time frame. This is an ongoing process.</p>	
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