

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

June 25, 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-report conducted on **May 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0139	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	JUN 14 13 Licensing and Protection	(X3) DATE SURVEY COMPLETED C 05/13/2013
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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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(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 an entity self-report was completed by the Division of Licensing and Protection on 5/13/13. Based on information gathered, regulatory violations were cited as follows.	R100	Managers will be trained to complete Resident Assessments upon admission, with in 14 days. These assessments will be updated annually or when a client's functionality is impaired, or a client is hospitalized for a period of time. A checklist has been made for documentation for residents upon admission. Managers will be responsible for monitoring the completion of documentation. This training will be completed before 7/1/13. Resident's Charts have been checked at for up to date assessments as of 6/13/13 and all charts will have up to date resident assessments by 7/1/13.	
R134 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7 Assessment 5.7.a An assessment shall be completed for each resident within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The resident's abilities regarding medication management shall be assessed within 24 hours and nursing delegation implemented, if necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to complete an assessment within 14 days of admission for 1 of 3 residents in the sample (Resident #2). Findings include: 1. Per record review on 5/13/13, Resident #2 was admitted to the home on 10/1/12. The comprehensive assessment for Resident #2 was signed as completed by the Registered Nurse on 10/24/13. During an interview on 5/13/13 at 2:00 PM, the Administrator confirmed that the assessment was completed more than 14 days after admission.	R134		
R135 SS=D	V. RESIDENT CARE AND HOME SERVICES	R135		

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Supple Clinical Coordinator
(X6) DATE: 6/13/13
If continuation sheet 1 of 7

STATE FORM

6899

LERB11

R134, R135, R145, R208, + R224 POC's accepted 6/17/13

JHsmerrn | PMC

PMC

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R135	Continued From page 1 5.5 Assessment 5.7.b If a resident requires nursing overview or nursing care, the resident shall be assessed by a licensed nurse within fourteen days of admission to the home or the commencement of nursing services, using an assessment instrument provided by the licensing agency. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the Registered Nurse (RN) failed to complete an assessment consistent with the physician's diagnosis and orders within 14 days of admission for 1 of 3 residents in the sample (Resident #2). Findings include: 1. Per record review on 5/13/13, Resident #2 was admitted to the home on 10/1/12. Diagnoses included schizoaffective disorder and Obsessive Compulsive Disorder. The comprehensive assessment for Resident #2 was signed as completed by the Registered Nurse on 10/24/13. During an interview on 5/13/13 at 2:00 PM, the Administrator confirmed that the assessment was signed as completed by the RN more than 14 days after admission.	R135	<i>Monthly record reviews will ensure all Resident Assessments contain current status and information. Any outdated or incorrect Resident Assessments will be reviewed, amended (or a new assessment) will be completed and filed. A copy will remain in the chart's chart at Copley House. Monthly record reviews will begin 6/17/13 and all outdated or incorrect information will be corrected before 7/1/13.</i>	
R145 SS=E	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	R145		

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R145	<p>Continued From page 2</p> <p>independence and well-being;</p> <p>This REQUIREMENT is not met as evidenced by: Based on information gathered, the home failed to develop a written plan of care for 1 of 3 residents in the sample (Resident #2) which was based on the identified need to monitor the resident for assaultive behavior toward others. Findings include:</p> <p>1. Per record review on 5/13/13, Resident #2 was admitted to the home on 10/1/12. A document dated 12/7/12 indicated that this resident required court ordered treatment due to a history of noncompliance and assaultive behavior. Further documents dated 2/13/13, 2/18/13, and 2/21/13 include documentation of aggression toward staff, including hitting, scratching, and kicking, and comments in the pertinent history section describe a history of assaultive behavior when symptoms are more active. The established history upon admission of assaultive behavior was not addressed on the written plan of care dated 11/14/12. On 4/11/13, written documentation on an incident report and two witness statements showed that Resident #2 assaulted Resident #1, grabbing him/her in the chest and neck area. No care plan changes for Resident #2 were developed subsequently in order to address the need for staff to monitor or intervene for the safety of residents. On 4/12/13 Resident #2 hit a staff person on the nose with a fist, per written witness statement and incident report. Again, there is no evidence of care plan development following the incident, regarding the aggressive behaviors of Resident #2. Per incident report and witness written statements, on 4/20/13, Resident #2 pulled Resident #1 from his/her wheelchair and hit him/her, requiring three</p>	R145	<p>attending the training, which is signed along w/ the copy printed from the website will be kept in the training/policy binder at Copley House.</p> <p>Upon admission to CH, the client will have a plan of care specifically agreed toward needs identified in the resident's assessment based on abilities of that resident. This plan of care will be completed within 14 days of the completion of the resident's assessment. All charts will be looked at for a plan of care by 6/28/13. All client charts will be updated by with plans of care by 7/26/13.</p>	

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R145	Continued From page 3 staff to pull Resident #2 off Resident #1. During an interview on 5/13/13 at 2:00 PM, the Administrator confirmed that the written plan of care for Resident #2 did not address a history of assaultive behavior prior to admission, nor a pattern of assaultive behaviors by Resident #2 toward staff and other residents in the period 2/13/13 through 4/20/13.	R145			
R208 SS=D	<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 behaviors</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home failed to report in a timely manner a pattern of assaultive behavior toward others for 1 of 3 residents in the sample (Resident #2). Findings include:</p> <p>1. Per record review on 5/13/13, Resident #2 was admitted to the home on 10/1/12, having diagnoses including schizoaffective disorder and obsessive compulsive disorder. A document dated 12/7/12 indicated that this resident required court ordered treatment due to a history of treatment noncompliance and assaultive</p>	R208	<p>A mandatory training was held on 6/6/13 to train all Copley House staff on APS procedures. APS policies are on display in several areas of the house. Staff were trained on mandated reporting; how to report abuse/neglect/learn to self, others or properly. Refreshers trainings will be held quarterly to ensure all staff remain aware of the responsibility of mandated reporting. A list of employees</p>		

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R208	<p>Continued From page 4</p> <p>behavior. Further case management documents dated 2/13/13, 2/18/13, and 2/21/13 included documentation of aggression toward staff, including hitting, scratching, and kicking, and comments in the pertinent history section of each described a known history of assaultive behavior when symptoms are more active. The established history upon admission 10/1/13 of assaultive behavior was not addressed on the written plan of care dated 11/14/12. On 4/2/13 Resident #2 hit a staff person, per review of the incident report. On 4/11/13, written incident and witness documentation showed that Resident #2 assaulted Resident #1 by grabbing him/her in the chest and neck area.</p> <p>Per record review, this incident of 4/11/13 was not reported to Adult Protective Services (APS) or the Survey and Certification (S & C) agency until 4/22/13. There is no evidence to indicate that care plan changes for Resident #2 were developed subsequently in order to address the need for staff to monitor Resident #2 for aggression, nor how they might intervene for the safety of other residents. On 4/12/13 Resident #2 hit a staff person on the nose with a fist, per the incident report. Again, there is no evidence of care plan development regarding the aggressive behaviors of Resident #2, nor a report to APS regarding the pattern of assaultive behaviors of 4/2, 4/11 and 4/12/13. On 4/20/13, Resident #2 pulled Resident #1 from his/her wheelchair and hit him/her, requiring three staff to pull Resident #2 off Resident #1. Resident #1 required medical evaluation, and Resident #2 required removal to hospital by law enforcement. During an interview on 5/13/13 at 2:00 PM, the Administrator confirmed that the written plan of care for Resident #2 did not address a history of, nor a pattern of, assaultive behaviors by Resident #2</p>	R208			

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R208	Continued From page 5 toward staff and other residents during the period 2/13 to 4/20/13, and that the initial report to state authorities of assaultive behavior occurred on 4/22/13.	R208		
R224 SS=D	<p>VI. RESIDENTS' RIGHTS</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home failed to assure that 1 of 3 residents in the sample (Resident #1) was free from physical abuse. Findings include:</p> <p>1. Per record review on 5/13/13, Resident #2 was admitted to the home on 10/1/12, having diagnoses including schizoaffective disorder and obsessive compulsive disorder (OCD). A document dated 12/7/12 indicated that this resident required court ordered treatment due to a history of treatment noncompliance and assaultive behavior prior to admission. Further incident and case management documents dated 2/13/13, 2/18/13, and 2/21/13 documented aggression toward staff, including hitting, scratching, and kicking, and comments in the pertinent history section described a history of assaultive behavior when symptoms are more active. The established history upon admission of assaultive behavior was not addressed on the written plan of care dated 11/14/12. Written documentation of 2/18/13 indicates that staff made Lamoille County Mental Health aware they</p>	R224	<p><i>All staff members were trained on what abuse, neglect and exploitation on 4/6/13, as well as what is considered a restraint. In addition, reporting procedures were explained and demonstrated.</i></p> <p><i>Quarterly trainings will be held. Next training for abuse, neglect and exploitation as well as reporting will be held 9/12/13.</i></p>	

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R224	Continued From page 6 were concerned about an escalation of behaviors by Resident #2, noting that s/he was undergoing medication reductions. On 4/11/13, written documentation on an incident report and by two staff witnesses shows that Resident #2 assaulted Resident #1, grabbing him/her in the chest and neck area, in an attempt to take cigarettes from him/her. During an interview on 5/13/13, the medication aid confirmed that Resident #2 engaged in cigarette seeking behavior with other residents due to his/her restricted access to cigarettes as per physician orders. Per record review, this assault incident of 4/11/13 (Resident #2 to Resident #1) was not reported to Adult Protective Services (APS) or the Survey and Certification (S & C) agency until 4/22/13. There was no evidence to indicate that care plan changes for Resident #2 were developed subsequent to the 4/11/13 incident which would address the need for staff to monitor Resident #2 or intervene for the safety of residents. On 4/20/13, written witness statements and incident reports document that Resident #2 pulled Resident #1 from his/her wheelchair and repeatedly hit him/her, requiring three staff to pull Resident #2 off Resident #1. Resident #1 required medical evaluation, and Resident #2 required removal under handcuffs by law enforcement personnel. During an interview on 5/13/13 at 2:00 PM, the Administrator confirmed that Resident #2 assaulted Resident #1 on 4/11/13 and 4/20/13.	R224			