



AGENCY OF HUMAN SERVICES  
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection  
103 South Main Street, Ladd Hall  
Waterbury VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 241-2345  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 241-2358

September 21, 2011

Suzanne Shapiro, Administrator  
Hilltop House  
65 Harris Ave  
Brattleboro VT 05301

Dear Ms. Shapiro:

Enclosed is a copy of your acceptable plans of correction for the unannounced onsite complaint investigation concluded on **August 3, 2011**. 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,

A handwritten signature in cursive script that reads "Pamela M. Cota".

Pamela M. Cota, RN, BS  
Licensing Chief

Enclosure: As noted above.



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____  AUG 2011 Licensing and Protection	(X3) DATE SURVEY COMPLETED  C <b>08/03/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HILLTOP HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>65 HARRIS AVENUE BRATTLEBORO, VT 05301</b>
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R100	Initial Comments:  An unannounced onsite complaint investigation was begun on 8/2/11 and concluded on 8/3/11 to determine regulatory compliance with State of Vermont Residential Care Home Regulations. Issues were identified that required immediate corrective action regarding resident to resident abuse (R206, R208 and R224). Findings include:	R100	See attached Plans of Correction.	
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 independence and well-being;  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to assure the development of Resident specific care plans for 4 applicable residents in the survey sample (Resident #1, Resident #2, Resident #3, and Resident #4). Findings include:  1. Per record review on 8/2/11, Resident #1 has experienced a recent general decline in both cognitive and physical functioning. The plan of care did not instruct staff regarding this decline in ability to care for daily needs although staff notes indicate a need to provide bathing, hygiene and dressing assistance. There is no specific instruction to staff regarding reduction of anxiety. During interview that afternoon, the Administrator confirmed that Resident #1 has declined in self	R145		

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

TITLE  
*Administrator*

(X6) DATE  
*8/19/11*

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R145	Continued From page 1  care and cognitive abilities and that the care plan does not reflect those changes.  2. Per record review on 8/2/11, Resident #2 has exhibited behaviors including yelling and potential physical aggression towards Resident #1 for the past 3 months. The plan of care does not include specific instruction/strategies to staff to intervene / reduce frequency of incidents. During interview that afternoon, the Administrator confirmed that the plan of care for Resident #2 does not address this resident's needs in these areas.  3. Per record review on 8/3/11, Resident #3 was at risk of falls due to an unsteady gait and the use of a walker for mobility. During the prior 6 months this resident had experienced 2 falls. There was no plan of care directing staff in specific strategies to reduce the risk of falls for this resident. During interview that morning, the RN (Registered Nurse) confirmed that Resident #3 was at risk for falls and that the plan of care did not address this risk.  4. Per record review on 8/3/11, Resident #4 was at risk of falls due to an unsteady gait and the use of a walker for mobility. During the prior 6 months Resident #4 had experienced 2 falls. There was no plan of care directing staff in specific strategies to reduce the risk of falls for this resident. During interview that morning, the RN (Registered Nurse) confirmed that Resident #4 was at risk for falls and that the plan of care did not address this risk.	R145		
R179 SS=F	V. RESIDENT CARE AND HOME SERVICES  5.11 Staff Services	R179		

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R179	<p>Continued From page 2</p> <p>5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following:</p> <ul style="list-style-type: none"> <li>(1) Resident rights;</li> <li>(2) Fire safety and emergency evacuation;</li> <li>(3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid;</li> <li>(4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation;</li> <li>(5) Respectful and effective interaction with residents;</li> <li>(6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and</li> <li>(7) General supervision and care of residents.</li> </ul> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to ensure that staff demonstrated competency regarding mandatory abuse/neglect reporting requirements. Findings include:</p> <ul style="list-style-type: none"> <li>1. Per record review of 2 residents (Resident #1 and Resident #2), there were several recorded incidents of potential physical and/or verbal abuse. All staff members, including administration, failed to demonstrate competency in the facility policy and procedure regarding abuse/neglect reporting processes. During interview on the morning of 8/3/11, the Registered Nurse confirmed that no staff member</li> </ul>	R179		

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R179	Continued From page 3  had demonstrated competency in this area involving these 2 residents by reporting concerns to the appropriate agencies.	R179		
R200 SS=F	V. RESIDENT CARE AND HOME SERVICES  5.15 Policies and Procedures  Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to develop a policy and procedure around unusual incidents / accidents. Findings include:  1. Per record review on 8/3/11, there was no policy and procedure advising staff regarding specific steps, including communication, around unusual incident / accident reporting and documentation requirements. During interview that morning, the Registered Nurse confirmed that there is no policy and procedure in place to advise staff regarding documentation and communication of unusual incidents / accidents.	R200		
R203 SS=D	V. RESIDENT CARE AND HOME SERVICES  5.17 Death of a Resident  5.17.a In those deaths in which the law applies (such as an unexpected, untimely death), pursuant to 18 V.S.A. §5205 (a), the manager	R203		

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R203	Continued From page 4  shall be responsible for immediately notifying the regional medical examiner  This REQUIREMENT is not met as evidenced by: Based on staff interview and interview, the home failed to immediately notify the regional Medical Examiner following the death of Resident #3. Findings include:  1. Per record review on 8/3/11, Resident #3 died suddenly on 2/14/11. The record contained no indication of notification of the Medical Examiner of this death. During interview that morning, the Administrator confirmed that the Medical Examiner was not immediately notified of this death.	R203		
R205 SS=D	V. RESIDENT CARE AND HOME SERVICES  5.17 Death of a Resident  5.17.c When a resident dies unexpectedly or within 48 hours of a fall or injury, in addition to notifying the medical examiner, the licensee shall send a report to the licensing agency with the following information:  (1) Name of resident; (2) Circumstances of the death; (3) Circumstances of any recent injuries or falls; and (4) A list of all medications and treatments received by the resident during the two (2) weeks prior to the death.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the	R205		

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R205	Continued From page 5  home failed to notify the licensing agency of the death of Resident #3 within 48 hours of a fall. Findings include:  1. Per record review on 8/3/11, Resident #3 had fallen on 2/13/11 and was treated at the Emergency Room for head laceration and bruised ribs. An upper respiratory infection was discovered at that time. On 2/14/11, Resident #3 was found unresponsive by staff and later pronounced dead by rescue personnel. There was no notification to the Division of Licensing and Protection within 48 hours of this event. During interview later that morning, the Administrator confirmed that notification had not been made within the required timeframe.	R205		
R206 SS=J	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 staff interview and record review, the home failed to assure that 3 potential incidents of physical abuse, ongoing potential verbal abuse, and a neglect to protect the involved residents (Resident #1 and Resident #2) from such were reported within 48 hours to APS (Adult Protective	R206		

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R206	Continued From page 6 Services) as required. Findings include:  1. Per record review on 8/2/11, there were 3 instances of potential physical abuse between Resident #1 and Resident #2 that were not reported to APS. The record also indicates ongoing verbal altercations with hurtful statements between these residents. Per record review on 8/2/11, nursing progress notes indicated nearly daily verbal arguments between Resident #1 and Resident #2. The first incidence of this was on 4/28/11 and stated "...Shouting and what sounded like hitting". A second potential physical altercation was documented on 6/26/11 and stated "...[Resident #1 stated Resident #2] may have whacked him/her with his/her cane across his/her groin...[Resident #1] was weeping in the bedroom & for an hour or two afterwards. S/he complained of pain across his/her groin-where s/he had been "hit" - but no bruise observed". A third incident occurred on 7/9/11 documented in a progress note as "At 4:15 [Resident #2 and Resident #1] were out in the parking lot, arguing. [Resident #2] raised his/her cane to strike [Resident #1] when [a staff member] grabbed it & stopped him/her". Per interviews on 8/2/11 and 8/3/11 the Administrator and the RN (Registered Nurse) confirmed there were no provisions in place to protect either resident from this situation, that the residents continue to share a room, and that no staff member had reported these incidents.	R206		
R208 SS=J	V. RESIDENT CARE AND HOME SERVICES  5.18 Reporting of Abuse, Neglect or Exploitation  5.18.c Incidents involving resident-to-resident abuse must be reported to the licensing agency if	R208		

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R208	<p>Continued From page 7</p> <p>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 staff interview and record review, the home failed to report a resident's allegation (Resident #1) of abuse by another resident (Resident #2) nor was a plan of care developed to address the behaviors. Findings include:</p> <p>1. Per record review on 8/2/11, nursing progress notes indicated nearly daily verbal arguments between Resident #1 and Resident #2. The first incidence of this was on 4/28/11 and stated "...Shouting and what sounded like hitting". A second potential physical altercation was documented on 6/26/11 and stated "...[Resident #1 stated Resident #2] may have whacked him/her with his/her cane across his/her groin... [Resident #1] was weeping in the bedroom &amp; for an hour or two afterwards. S/he complained of pain across his/her groin-where s/he had been "hit" - but no bruise observed". A third incident occurred on 7/9/11 documented in a progress note as "At 4:15 [Resident #2 and Resident #1] were out in the parking lot, arguing. [Resident #2] raised his/her cane to strike [Resident #1] when [a staff member] grabbed it &amp; stopped him/her". During interview with the Administrator on 8/2/11 at 3:05 PM, it was confirmed that each of these incidents occurred and that no report had been filed with the Division of Licensing and Protection nor APS following each individual incident or this</p>	R208		

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R208	Continued From page 8  pattern of behaviors. During interview on 8/3/11, the RN (Registered Nurse) confirmed that there was no behavioral plan of care for either resident.	R208		
R224 SS=J	<p><b>VI. RESIDENTS' RIGHTS</b></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 staff interview and interview, the home failed to assure that Resident #1 was free from mental, verbal or physical abuse. Findings include:</p> <p>1. Per record review on 8/2/11, nursing progress notes indicated nearly daily verbal arguments between Resident #1 and Resident #2. There were also 3 documented incidents of potential physical altercations between the 2 residents. Resident #1 was assessed with moderate to severe dementia and Resident #2 was assessed with mild dementia. The first documentation of potential physical abuse was on 4/28/11 and stated "...Shouting and what sounded like hitting". A second potential physical altercation was documented on 6/26/11 and stated "... [Resident #1 stated Resident #2] may have whacked him/her with his/her cane across his/her groin...[Resident #1] was weeping in the bedroom &amp; for an hour or two afterwards. S/he complained of pain across his/her groin-where s/he had been "hit" - but no bruise observed". A third incident occurred on 7/9/11 documented in a progress note as "At 4:15 [Resident #2 and Resident #1] were out in the parking lot, arguing. [Resident #2]</p>	R224		

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R224	Continued From page 9  raised his/her cane to strike [Resident #1] when [a staff member] grabbed it & stopped him/her". During interview and record review with the Administrator on 8/2/11 at 3:05 PM, it was confirmed that each of these incidents occurred per the record and that no report had been filed with the Division of Licensing and Protection nor APS following each individual incident or this pattern of behaviors.	R224		
R270 SS=D	IX. PHYSICAL PLANT  9.2 Residents' Rooms  9.2.c Each bedroom shall have an outside window.  (1) Windows shall be openable and screened except in construction containing approved mechanical air circulation and ventilation equipment. (2) Window shades, venetian blinds or curtains shall be provided to control natural light and offer privacy.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the home failed to assure that 2 applicable residents had a fully functional window with screen (Resident #3 and Resident #4). Findings include:  1. Per observation during environmental tour on 8/2/11, the window in Resident #3's room had a single window without a screen. This window was covered with a storm window that does not open to allow air flow into the room. There was also no screen in place in the room of Resident #4. Finally, a hall window on the second floor used to	R270		

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R270	Continued From page 10  ventilate the area was missing a screen. The Administrator confirmed each of these observations as they were identified during the tour.	R270		

## Hilltop House Inc. Plan of Correction following onsite complaint investigation on August 2<sup>nd</sup> and 3<sup>rd</sup> 2011

ID Prefix		ID prefix tag	Providers's plan of correction	Complete date
		R145	<p>RN/Administrator hold weekly care planning meetings to ensure every resident care plan will be updated appropriately and according to any clinical changes. Immediately after survey RN has reviewed and updated all resident care plans. (Resident #4 actually had fall risk care plan, that surveyor did not see—see attached care plan dated 4/18/2011)</p>	Ongoing and
			<p>Care plans are mandatory work tools for resident aides and care plans will be reviewed with resident aides by RN at resident aide meeting on 8/25/11.</p>	8/18/11
			<p>Fall risk and incident reporting in-service will be held during the first 2 weeks of September for all resident aides and direct care staff. Last time a fall risk in-service was held was in July 2010.</p>	8/25/11
			<p>Every resident who is at risk or has had any falls at all will have a care plan to address this and to prevent further incidents.</p>	9/15/11
		R179	<p>R145 POC Accepted 8/22/11 C.Laraway RN/ P.Mcota RN</p> <p>At staff meeting 8/9/11 a review of policy regarding abuse, neglect, and exploitation was conducted by administrator and RN. This policy was not actually reviewed by surveyor when she was at this facility, but a copy is attached to this plan of correction.</p>	8/18/11
			<p>Administrator had communicated with long term care ombudsman consulting her to some of the aforementioned incidents surrounding resident #1 and #2. Ombudsman had given the advice that reporting to APS was not pertinent. Administrator will not rely on ombudsman but go directly to APS with any similar situations, and has done so also in the past with other issues.</p>	8/9/11
			<p>Staff in-service on adult abuse, neglect, and exploitation and reporting procedure has been scheduled to take place for all direct care staff on 8/31/11 by attorney Elizabeth Angostini.</p>	
			<p>R179 POC Accepted 8/22/11 C.Laraway RN/ P.Mcota RN</p>	8/31/11

		R200	<p>Procedure around unusual incidents/accidents reviewed with staff at staff meeting on 8/9/11. A written policy will be developed/reviewed with Board of Directors no later than 9/15/11.</p> <p>Documentation and communication in-service will be conducted during Resident aide meeting on 8/25/11</p> <p><i>R200 POC Accepted 8/22/11 C. Laraway RN / P. Metcalf RN</i></p>	8/9/11 9/15/11 8/25/11
		R203	<p>At the time of death of resident #3 administrator was unaware of the requirement to notify medical examiner of an unexpected death/untimely death. Although administrator was present when this death happened, and the resident had been seen in the emergency room less than 24 hours before the death occurred, it might not have seemed untimely to this writer at the time. DLP was notified 8 days after the death occurred and the medical examiner was notified as well.</p> <p>Administrator has reviewed the Licensing Regulations for residential care homes after this survey, and this will be a once only occurrence. Administrator now fully understands the reporting responsibility for an unexpected death within 48 hours of a fall.</p> <p><i>R203 POC Accepted 8/22/11 C. Laraway RN / P. Metcalf RN</i></p>	2/22/11
		R205	<p>At the time of death of resident #3 administrator was unaware of the requirement to notify DLP of a death occurring within 48 hours of a fall. DLP was notified by letter on 2/22/11 (death happened on 2/14/11).</p> <p>Administrator has reviewed the Licensing Regulations for residential care homes after this survey, and this will be a once only occurrence. Administrator now fully understands the reporting responsibility for an unexpected death within 48 hours of a fall.</p> <p><i>R205 POC Accepted 8/22/11 C. Laraway RN / P. Metcalf RN</i></p>	2/22/11
		R206	<p>At staff meeting 8/9/11 the circumstances around resident #1 and #2 were addressed. Administrator and RN indeed had communicated with both staff, residents themselves, and family members ongoing, and daily instructions/guidelines were given verbally to resident aides. In the future, RN and administrator will be sure to promptly update resident care plan and report to APS promptly when there is any suspected, reported, or alleged incidents of abuse, neglect, or exploitation. Administrator had indeed involved resident family members, lawyer who held DPOA status for resident #1 for financial</p>	

		R208	<p>matters, and asked for an appointment of either guardian or medical DPOA so that this facility would be able to transfer resident #1 to appropriate facility.</p> <p>At staff meeting on 8/9/11 the facility policy on abuse, neglect and exploitation including reporting responsibilities was/will be reviewed again on staff meeting on 8/25/11. Copy of this policy has been provided to each staff member and will be given to new staff also for review upon hire.</p> <p>With the added pressure of the surveyor at the facility on 8/3/11 we were able to, through the lawyers involved during the month of July, to get an emergency Probate Court hearing where guardianship process got initiated, and the same day in the afternoon resident #1 was transferred successfully to memory unit at a nursing home.</p> <p>In a potential future situation like this, administrator will involve DLP at a much earlier time, in order to avoid similar situations, and to avoid being out of compliance with state regulations for residential care homes.</p> <p><i>Radio POC Accepted 8/22/11 Claraway RN Purota RN</i></p> <p>On staff meeting 8/9/11 the circumstances around resident #1 and #2 were addressed. Administrator and RN indeed had communicated with both staff, residents themselves, and family members ongoing, and daily instructions/guidelines were given verbally to resident aides. In the future, RN and administrator will be sure to promptly update resident care plan and report to APS promptly when there is any suspected, reported, or alleged incidents of abuse, neglect, or exploitation. Administrator had indeed involved resident family members, lawyer who held DPOA status for resident #1 for financial matters, and asked for an appointment of either guardian or medical DPOA so that this facility would be able to transfer resident #1 to appropriate facility.</p> <p>All facility resident care plans have been reviewed by facility RN after the investigation, and been updated as appropriate. Care plan meetings will be held monthly between administrator and RN, and RN will give appropriate instructions to resident aides as</p>	<p>8/9/11</p> <p>8/25/11</p> <p>8/3/11</p> <p>8/9/11</p> <p>8/25/11</p>
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			<p>changes occur.</p> <p>At staff meeting on 8/9/11 the facility policy on abuse, neglect and exploitation including reporting responsibilities was/will be reviewed again on staff meeting on 8/25/11. Copy of this policy has been provided to each staff member and will be given to new staff also for review upon hire.</p> <p>8/9/11</p> <p>8/25/11</p>	
			<p>Staff in-service on adult abuse, neglect, and exploitation and reporting procedure has been scheduled to take place for all direct care staff on 8/31/11 by attorney Elizabeth Angostini.</p> <p>8/31/11</p> <p>R208 POC Accepted 8/22/11 CLaraway RN / PMota RN</p>	
	R224		<p>At staff meeting 8/9/11 the circumstances around resident #1 and #2 were addressed. Administrator and RN indeed had communicated with both staff, residents themselves, and family members ongoing, and daily instructions/guidelines were given verbally to resident aides. In the future, RN and administrator will be sure to promptly update resident care plan and report to APS promptly when there is any suspected, reported, or alleged incidents of abuse, neglect, or exploitation. Administrator had indeed involved resident family members, lawyer who held DPOA status for resident #1 for financial matters, and asked for an appointment of either guardian or medical DPOA so that this facility would be able to transfer resident #1 to appropriate facility.</p> <p>8/9/11</p>	
			<p>All facility resident care plans have been reviewed by facility RN after the investigation, and been updated as appropriate. Care plan meetings will be held monthly between administrator and RN, and RN will give appropriate instructions to resident aides as changes occur.</p> <p>Ongoing and as often as needed to be in compliance and keep residents safe and free from mental, physical and verbal abuse, neglect, or exploitation</p>	
			<p>At staff meeting on 8/9/11 the facility policy on abuse, neglect and exploitation including reporting responsibilities was/will be reviewed again on staff meeting on 8/25/11. Copy of this policy has been provided to each staff member and will be given to new staff also for review upon hire.</p> <p>8/25/11</p>	

		R270	<p>Staff in-service on adult abuse, neglect, and exploitation and reporting procedure has been scheduled to take place for all direct care staff on 8/31/11 by attorney Elizabeth Angostini.</p> <p>R224 POC Accepted 8/22/11 Claraway RN/AMotorRN</p> <p>Resident #3 was the deceased resident and the window mentioned in this report must have been confused with another resident room. There were two windows during the environmental tour that needed screens, resident #4 and another resident not named in this report. These two windows had screens installed immediately following the inspection. Resident #4 was where the storm window had to be removed and replaced with screen. This was done as well.</p> <p>Hall window on second floor also has had screen installed.</p> <p>R270 POC Accepted 8/22/11 Claraway RN/AMotorRN</p>	<p>8/31/11</p> <p>8/5/11</p> <p>8/5/11</p> <p>8/8/11</p>
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# Hilltop House



A Level III Residential Care

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Homereport t

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## ABUSE, NEGLECT AND EXPLOITATION POLICY

All residents of Hilltop House have the right to be treated with respect, consideration and full recognition of his/her dignity, individuality and privacy. It is the responsibility of each employee to guarantee and protect this right for the resident. Failure to do so may constitute abuse, neglect or exploitation. (See attached sheet for definitions covered under the Adult Abuse statute.)

All employees are responsible for reporting any case of suspected abuse, neglect or exploitation to Adult Protective Services (APS). The report must be made within 48 hours of learning of the suspected, reported or alleged incident. The incident can be staff to resident, resident to resident or in some instances resident to staff.

The reporter can contact APS directly by calling 1-800-564-1612 or can report the alleged incident to the administrator or the resident manager who will contact APS. Regardless of the contact method there are forms which must be completed and given to the administrator.

According to Residential Care Regulations, "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."

### Attachments:

Definitions Covered under the Adult Abuse Statute  
Adult Protective Services Reporting Form  
Resident to Resident Reporting Form