VERMONT

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

Division of Licensing and Protection
103 South Main Street
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

July 7, 2015

Ms. Ann Schumacher, Manager
Farm House
102 S Winooski Ave
Burlington, VT 05401

Dear Ms. Schumacher:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 27, 2015.** 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

JUN 2 9 2015

PRINTED: 06/11/2015
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	0544		C 05/27/2015

NAME OF PROVIDER OR SUPPLIER: FARM HOUSE

STREET ADDRESS, CITY, STATE, ZIP CODE: 5899 VT ROUTE 116, STARKSBORO, VT 05487

(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
T 001	Initial Comments	T 001		
	An unannounced on-site survey to investigate a facility mandated self-reported incident was completed by the Division of Licensing and Protection on 5/27/15. The following regulatory violations were related to the self-report and unrelated Therapeutic Care Residence regulatory requirements.		-Resident 1's staff was trained on personal care needs, medications, side effects, drug interactions, mobility, verbal ability, sleep patterns, dietary concerns and 64 oz. fluid restriction by Charlotte Fury, RN.	3/17/2015
			Resident 1 was provided a 1:1 staffing pattern upon admission during the hours of 8am-10pm. Overnight staffing coverage (10pm-8am) was increased from 1 staff to 2 staff.	3/30/2015
T 023 SS=D	V. 5.5.a Resident Care and Services	T 023	-Training (both verbally and in writing) on behavioral challenges, interventions, and supports was provided by Ann Schumacher, BCaBA, Team Lead of the Farm Program. In addition, information initially trained by Charlotte Fury, RN was re-emphasized.	3/30/2015
	5.5 General Care			
	5.5.a Upon a resident's admission to a therapeutic community residence, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. The home's manager shall provide every resident with the personal care and supervision appropriate to his or her individual needs.		-Immediately upon learning of the previous night's situation, Team Lead instructed the Residential Manager to ensure that the identified SUB staff involved in the abusive interaction was removed from all upcoming work shifts until further notice and APS was notified in writing. This probationary SUB staff was terminated on 5/3/2015.	4/30/2015
			-Resident 1 was provided the opportunity, over several days after her fall, to see her primary care physician, Dr. Caulkins. After two days, Resident 1 agreed to see a Doctor to check the hematoma on the back of her head. The Doctor did not feel there was any treatment needed.	5/1/2015
	This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, staff failed to provide the necessary services to meet the resident's personal, psychosocial, medical and nursing care needs for 1 applicable resident in the sample. (Resident #1). Findings include:		-Resident 1 received a swallow study at UVMC to determine the texture and size of food items necessary to prevent choking or aspiration. Although the study found no significant swallowing deficit, it was recommended, due to Resident 1's age and normal decline in digestion, food items could be cut into smaller pieces and any dry food could be slightly moistened for easier ingestion. Staff have the use of a food dicer.	5/26/2015
	The Manager of the home failed to assure that Resident #1 received safe and appropriate personal, medical and nursing care after sustaining an unwitnessed fall during the evening. 1. Per interview (5/27/15) with one of the caregivers who provided care on the evening in question, the resident was in the downstairs living		Request for Human Resources to provide posters for instruction on how to correctly use the Heimlich Maneuver. Although staff receive this training during 1stAid/CPR, the posters would serve as a visual/how to display.	6/22/2015

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ann Schumacher

TITLE: Team Lead, Farm Program

(X6) DATE: 6/22/2015

T023 - T146 POC acceptable, 7/1/14 MBottomRN/pmc

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T 023	Continued From page 1 room of the home unattended when staff heard the resident calling for help. Upon entering the room, staff observed the resident on the floor, partially leaning forward on the first step of stairs leading up to the next level of the home (the upper living room). The resident was asked if he/she was hurt and replied that 'I hit my head and I'm bleeding'. The resident's history included a history of falls, episodic dizziness, use of a walker due to limitations in mobility and a history of behaviors whereby they would, at times, sit themselves on the floor at will. When staff were interviewed about the procedure when a resident has an unwitnessed fall and states that they hit their head and cannot get up on their own, the staff caregiver said that he/she 'assessed' the resident and didn't note any sign of injury. This caregiver was not a licensed health professional, trained to 'assess' a person for injury. The care giver said they felt the resident's head and felt no bumps and saw no bruises. The caregiver said that they offered their arm to help the resident to stand up but the resident didn't take it. Per progressed notes dated 4/29/15 and 4/30/125 (the fall was on the evening of 4/29/15); the resident was notes to be on the floor "refusing to get up on his/her own.....for at least 2 hours." When staff present that night were interviewed, they said that they are supposed to leave the resident on the floor for 20 minutes or so, if he/she 'puts themselves on the floor purposefully'. This directive was part of a behavioral plan written to help staff manage the resident's behavior. However, since this was an unwitnessed fall with a report of possible head trauma, staff should have called crisis per interview with the Manager, per current facility policy. Per interview with the Manager and the Clinical Leader (5/27/15) there is no procedure to address	T 023	-All Farm House staff received an in-depth training by Charlotte Fury, RN. This training included teaching staff (verbally and through role play practice) how to do a safe, full body check in the event of a fall or accident. A new protocol was written and trained using a Falls Assessment Accident Tool as a reference. This included ways to increase the identification of an injury, determination of needed steps following the identification and the potential need for Emergency Medical Personnel. A new documentation sheet was created to follow and check the Resident over a 72 hour period after a fall or accident. The protocol and documentation sheets will be posted in the staff office as well as in a protocol binder. Additional emphasis was placed on notification of a fall/accident to the Residential Manager and/or On-Call Crisis. Residential Manager will be responsible for the oversight of this protocol. -Nurse Charlotte trained staff on incontinence care, skin integrity, toileting and personal care. -Resident 1 has an assessment scheduled with VNA to determine the necessary level of support in regard to incontinence care, mobility, gait belt and independence. A request for on-sight training related to assistance with falls, safe body mechanics, back safety and transfers will be sought by Occupational Therapy and/or Physical Therapy at this VNA meeting. -A written instruction detailing chain of notification for any situations that are identified as emergent by Howard Center management will be formatted for easy access by residential staff. Howard Center on-crisis number will be posted in the residential home office for easy access and these protocols will be outlined each week in the weekend notes that are disseminated each Friday. -An eye exam will be scheduled for Resident 1 to ensure her visual acuity to assist with prevention of falls.	6/23/2015 6/23/2015 6/25/2015 6/25/2015 7/1/2015

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T 023	Continued From page 2 resident accidents/falls with potential for injury (stated hit head). When the Manager is not present in the facility, staff are to call the crisis line to report any after hours events. In this case, staff did not know whether or not the resident had sustained a significant head or other type of injury, and no EMT/Rescue Personnel were called to evaluate the resident prior to moving him/her. (There was no policy regarding when to 911/EMT/Rescue). Staff called and left a telephone message for the Manager, stating that the resident was on the floor and wouldn't get up. The Manager stated that they did not receive the message until the following morning. Ultimately, when the night shift staff arrived on 4/29/15, a caregiver assisted the resident to stand and brought the resident to the bathroom for care due to an episode of bowel incontinence. Per interview with the caregiver on duty on 4/29/15 (and per the progress notes), the resident had stated to staff while on the floor that he/she needed to have a bowel movement. The resident was not assisted at that time and was incontinent of stool. A progress note of 4/30/15 noted "This staff felt a lump on (Resident #1) head". Per review of the Incident Report completed 4/30/15 by the Clinical Leader, event of 4/29/15, 0830 hours, "Staff reported that -------- was on the floor , screaming, cursing.... was encouraged to move from the floor to the recliner and refused.....would not participate in initiating the move to the chair and was left to sit on the floor for a lengthy period of time." The report noted that the size of the bump (hematoma) on the resident's head, was '2-3 inches on the back of the head.'. The fact that staff assumed that the resident was refusing to get up and the resident maintained that they couldn't get up without significant (physical) assistance was confirmed with the Manager and	T 023		

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T 023	Continued From page 3 the Clinical Team Lead on 5/27/15 at 5:30 P.M. 2. Per interview with a night shift caregiver working on 4/29/15, and per progress note of 4/30/15, 0800 hours, staff confirmed that the resident was distraught about the bowel incontinence and (the resident) stated they "asked previous staff for help to go to the bathroom.....very unsteady and ...arms and legs were very shaky....". The caregiver who found the resident on the floor stated in a written statement regarding the event that he/she did not feel that they had been provided with adequate training to assist a resident who had fallen on the floor. They did not observe this procedure as part of their training to care for Resident #1, who was admitted with a history of previous falls. Two care givers interviewed on 5/27/15 also stated that they had not received training in the provision of incontinence care, since the resident was usually independent with managing their briefs.	T 023		
T 032 SS=D	V.5.7.b Resident Care and Services 5.7 Treatment Plan 5.7.b The residence shall ensure that the treatment plan reflects steps to be taken to solve identified problems, either by direct service at the residence or indirectly by referral to a community resource. The treatment plan shall be completed within fourteen (14) days of admission. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the	T 032	-An active Treatment Plan was in place upon Resident 1's transition to the Farm House. The plan was reviewed on 5/22/2015. A Needs Re-assessment was completed on 6/18/2015 and a new Treatment Plan will be written to include goals for medical needs and health and well-being. -All Treatment Plans will be completed within 14 days of new admission per TCR regulations. A checklist will be formatted to list all necessary documentation upon admission to the residence. Residential Manager and Team Lead will be responsible for appropriate documentation and plans.	Ongoing

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T 032	Continued From page 4 treatment plan for 1 applicable resident in the sample was not completed within 14 days of admission as required. (Resident #1). Findings include: Per review of the Treatment Plan for Resident #1 on 5/27/15, it was signed as completed/approved by the Manager on 5/22/15 at 10:16 AM. The Treatment Plan was also not current to address all of the resident's needs. An additional Support Plan, dated 3/30/15, included care needs for the resident which were incomplete for some areas. The resident has episodic urinary incontinence, per the history from the previous home and needs assistance from staff with personal care. The resident also has a history of unsteadiness while ambulating and falls, and uses a walker to get around safely. The plan also failed to provide specific interventions regarding what to do in case of an unwitnessed fall with possible injury. Staff interviewed after such a fall occurred on 4/29/15, allowed the resident to remain on the floor, agitated and yelling, for over 2 hours. Staff stated they did not feel prepared to know how to properly lift someone off of the floor and there are no medically trained staff present at the home on most days to assess the resident after a fall. The only statements on the plan related to falls risk include: "Remember that he/she does have mobility issues and may legitimately fall. This should look entirely different than his/her attention seeking drops."	T 032	-All trainings, medical contacts outlined in the previous section will address the treatment plan deficiency identified. A Personal Support Plan to include all of the areas related to mobility, incontinence, falls, emergency evaluations, etc. will be rewritten and trained.	7/6/2015
T 052 SS=E	V.5.9.b.1.2.3.4.5.6.7 Resident Care and Services 5.9 Staff Services 5.9.b. The residence must ensure that staff demonstrate competency in the skills and	T 052		

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T 052	Continued From page 5 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: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents This REQUIREMENT is not met as evidenced by: Based on staff interview, policy/procedure review and record review, the facility failed to assure that all staff were trained in how to respond to resident medical/accidental events, including specific actions to take to ensure resident safety. Staff also lacked specific training in how to provide safe and appropriate personal care, including incontinence care and safe body mechanics training for lifting and assisting with transfers for	T 052	See above plan for correction.	

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T 052	Continued From page 6 one resident with impaired mobility. (Resident #1). Findings include: Per staff interviews during a survey subsequent to a facility self-report of alleged resident abuse, staff stated that they did not receive adequate training in how to provide physical assistance to Resident #1, who had an unsteady gait and a history of falls. The resident had an unwitnessed fall on 4/29/15 and stated that he/she hit their head and 'it was bleeding'. Staff did look at the head and did not see any blood. Staff present at the time were not sure if the fall was intentional or accidental and allowed the resident to remain on the floor for over 2 hours. Staff failed to call the crisis line to report the incident and failed to call 911 to have the resident assessed for possible injury by medical staff. There was no plan to direct staff in cases where an unwitnessed accident could result in a significant injury to a resident. Staff's directives to move the resident after such an accident could result in further injury to a resident in the case of a fractured bone, for example. The staff interviewed also stated that they did not feel that they received adequate training in completion of personal care, including incontinence care. They lacked experience providing care to someone with this level of physical need. Although the RN providing medication oversight did write up a plan for some of the resident needs, it was not in sufficient detail to assure that the needed care would be provided. Staff stated that there were no demonstrations of personal care procedures. Refer also to 0023	T 052		

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T 071	Continued From page 7	T 071		
T 071 SS=C	V.5.13 Resident Care and Services	T 071		
	5.13 Policies and Procedures Each residence must have written policies and procedures that govern all services provided by the residence. A copy shall be available for review at the residence upon request.			
	This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to develop a policy/procedure to direct staff on how to proceed in emergency/accident situations where a resident potential for significant injury is present. The lack of a policy for emergency situations affected 1 resident of the home, with the potential to affect all residents of the home. The facility's P/P for Abuse Reporting also failed to direct staff in what process to follow after witnessing resident abuse in the home and assure protection of the resident. (Resident #1). Findings include: Per staff interviews after an unwitnessed resident fall with a stated hit to the head, staff failed to follow facility procedure and call the crisis line for further direction. Staff called and left a message for the Manager, not stating that the resident had fallen and hit their head, just stating that the resident was on the floor and wouldn't get up. During interviews with the Manager and the Clinical Leader, there was no facility policy for staff to call 911/EMT/Rescue in cases where a resident has an unwitnessed accident and there may be an unknown injury requiring medical assessment, prior to attempting to move the resident. The current policy states to lift the		Policy and procedures are in place and trained yearly for Howard staff. These trainings include but are not limited to: client rights, code of ethics, emergency site plan, incident reporting, universal precautions, worker safety training, health and wellness guidelines, abuse, neglect and exploitation, specialized care procedures. -A protocol binder allocated for quick referencing for falls/accidents, incontinence care, abuse reporting, incident report writing, emergency responses including accessing EMS and Howard Center On-Call will be formulated and accessible in the Farm House office.	7/6/2015

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T 071	Continued From page 8 resident up after 20 minutes on the floor (if the resident cannot rise independently) and then assess for injury. The staff are not medical personnel and cannot assess for injury prior to lifting and may cause further injury by this action. Regarding the facility's P/P for Abuse Reporting, there was no information to direct staff who witness resident abuse in how to proceed to assure that the perpetrator is no longer in the presence of the resident victim. The policy states that staff should call hi/her supervisor. In a case of witnessed verbal abuse towards a resident of the home by other staff present, staff failed to assure that the alleged perpetrator immediately left the home and failed to consult at that time with the Supervisor/Manager. The policy is not readily available to staff to review in case needed (no paper copy available) and it took the Clinical Leader over 8 minutes to find the on-line policy when asked for a copy by the surveyor. The policy also failed to provide the phone number or on-line site for reporting of Adult Abuse for this adult care home. The lack of written policies/procedures to address these issues was confirmed during interview with the Manager and the Clinical Leader on the afternoon of 5/27/15. Refer also to 0023 and 0052	T 071	-All staff is trained annually on abuse, neglect and exploitation per Howard Center policy and TCR regulations. Ensure that phone number to Adult Protective Services is posted in Farm House office 1-800-564-1612 and staff is aware of its location.	6/26/2015
T 087 SS=D	VI. 6.3 Residents' Rights VI. Residents' Rights 6.3 Residents may retain personal clothing and possessions as space permits, unless to do so would infringe on the rights of others, would create a danger to others, would create a security risk or would create a fire, health or safety	T 087		

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T 087	Continued From page 9 hazard. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that the resident's right to retain personal possessions was maintained regarding one applicable resident in the sample. (Resident #1). Findings include: Per staff interviews and document review on 5/27/15, a caregiver removed Resident #1's personal TV from the lower level living room after the resident sustained an unwitnessed fall on 4/29/15 and refused to get up from the floor. Staff stated that they believed he/she could assist with getting themselves up or get themselves up on their own and allowed the resident to remain on the floor for an extended period of time (over 2 hours). The resident became very agitated and was yelling loudly. Staff removed the personal TV in an attempt to force the resident to comply with their directions to get up off of the floor. During interview with the Clinical Leader on 5/27/15 at 12:23 PM, he/she confirmed that staff violated the resident's right to personal possessions by removing the TV from the lower living room on 4/29/15. Refer also to 0023 and 0052.	T 087	-Responsible staff member met with Residential Manager and Team Lead to discuss the TV removal. Staff member was trained on the resident's right to personal possessions. Removal of personal possessions may only be as a result of an infringement on the rights of others, creation of a danger to others, a security risk or creation of a fire, health or safety hazard. -All staff received in writing an explanation of resident's rights as it is applicable to personal possessions. -Resident Rights were discussed further with staff at the Farm House team meeting. -Residential Manager will be responsible for ongoing training with newly hired staff and will maintain written documentation of trainings.	4/30/2015 4/30/2015 5/5/2015 7/1/2015
T 146 SS=E	IX.9.1.a Physical Plant 9.1 Environment 9.1.a The residence must provide and maintain a safe, functional, sanitary, homelike and comfortable environment.	T 146		

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T 146	Continued From page 10	T 146		
	This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain a sanitary environment in all areas of the residents' home. Findings include: Per observations of the home on 5/27/15 at 10:50 AM, the following areas of the home were not kept clean and sanitary: The downstairs living room rug was badly stained with dark material and had multiple frayed edges near the hallway door; the hallway and laundry room floors were visibly soiled with accumulated dust; the 2 bathrooms in the home were not clean, with a build-up of soap residue in the bathtub/shower area; the floor of the upstairs bathroom was soiled, the outside of the tub area/glass doors were soiled and also the sink and toilet were not clean. Per interview with the Manager, the downstairs area laundry/hallway floor area was not included on a daily/weekly cleaning schedule. The soiled areas were confirmed with the manager at the time of the observations.		Infection control/universal precautions is trained on an annual basis with all Howard Center staff. Residential Manager will implement and hold accountable a house chore list and check sheet that will list daily/weekly chores to be shared between staff members and signed off accordingly. Residents will assist as they are able and as part of treatment plans, but it is the responsibility of the staff and Residential manager to ensure cleanliness. -A facilities work order was initiated for deep cleaning of the downstairs rug on the lower level of Farm House.	7/10/2015 6/24/2015