

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

May 21, 2014

Mr. Edgar Greason, Administrator  
Country Village Community Care Home  
99 Atkinson Street  
Bellows Falls, VT 05101-1302

Dear Mr. Greason:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 15, 2014**. 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,



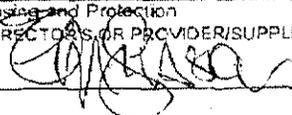
Pamela M. Cota, RN  
Licensing Chief

PC:jl

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  C 04/15/2014
NAME OF PROVIDER OR SUPPLIER  COUNTRY VILLAGE COMMUNITY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 99 ATKINSON STREET BELLOWS FALLS, VT 05101		
(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
R100	Initial Comments:  An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on 4/15/14. There were findings with this investigation.	R100	Please see attached Plans of correction.	
R206 SS=D	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 record review and staff interviews the facility failed to report to Adult Protective Services within 48 hours of an incident. Findings include the following:  1.) On February 15, 2014, Resident # 9 was involved in an incident involving a staff member. The staff member attempted to intervene to curb a behavior that Resident # 9 was exhibiting, by placing her hand over her mouth. The facility did not report the incident to Adult Protective Services until February 18, 2014. The owner/administrator confirmed that the report was not filed in a timely manner.	R206		
R207 SS=A	V. RESIDENT CARE AND HOME SERVICES	R207		

Division of Licensing and Protection  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE  


(X5) DATE  
5-11-14

Division of Licensing and Protection

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R207	Continued From page 1  5.18 Reporting of Abuse, Neglect or Exploitation  5.18.b The licensee and staff are required to report suspected or reported incidents of abuse, neglect or exploitation. It is not the licensee's or staff's responsibility to determine if the alleged incident did occur or not; that is the responsibility of the licensing agency. A home may, and should, conduct its own investigation. However, that must not delay reporting of the alleged or suspected incident to Adult Protective Services.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to report suspected or reported incident of abuse to Adult Protective Services. Findings include the following:  1.) Per record review of Resident # 9, an incident allegedly occurred between Resident #9 and another female resident. Progress note dated 2/12/14 presents that a verbal altercation occurred and then Resident #9 yelled that she was kicked. Confirmation was made by the owner/administrator that the incident was not reported because the staff did not feel that the incident actually occurred.	R207		
R213 SS=E	VI. RESIDENTS' RIGHTS  6.1 Every resident shall be treated with consideration, respect and full recognition of the resident's dignity, individuality, and privacy. A home may not ask a resident to waive the resident's rights.	R213		

*Edgar Greason* 5/11/14

PRINTED: 04/28/2014  
FORM APPROVED

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R213	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to treat a resident with dignity and respect. The followings include:</p> <p>1.) Based on review of records an incident occurred on 2/15/14 in which a staff member placed his/her hand over the mouth of Resident #9 in an attempt to curb a behavior that was being exhibited. At 10:55 AM per interview with staff member involved in incident, he/she did place his/her hand over the mouth of Resident #9 because Resident #9 was verbalizing about an occurrence that happened and the staff member did not feel that it needed to be discussed in front of all the other residents. Per interview with Resident #9 at 1:35 AM, he/she was very upset that someone had put their hand over his/her mouth, no matter what the reason.</p> <p>2.) Resident # 1 and Resident #2 have requested to keep their bedroom door open, yet per interview with staff, the owner/administrator has told them that the door must be kept closed. Review of posted Resident Rights and of the House Rules, there is no indication that represents that doors to bedrooms must be kept closed. At 1:35 PM per interview with owner administrator, a notice was given to Resident #1 and Resident #2 on March 29, 2014, that indicated beginning May 1, 2014, the door to their room was to be kept closed. The reason that the door was to be closed was, 'the door being open does not present to guests with the image the facility wants to portray.' The bedroom is set back in an alcove and away from public view. Confirmation was made by the owner/administrator that h/she had presented the</p>	R213		

*Edgar Greason* 5/11/14

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R213	Continued From page 5  letter and that it doors being required to be closed is not presented in the House Rules or the Resident Rights.  3.) At 12:55 PM, per interview with Resident #1, the owner/administrator will do a daily room inspection and h/she does not always wait for one of them to give permission to come in, but h/she will just walk in. Resident #1 addressed an instance where the owner/adm nistrator knocked, did nct wait for a reply and entered the room. H/she proceeded to go to the bathroom and his/her roommate was in there with no pants or underpants on. Resident # 2 confirmed this at 3:15 PM per interview and further stated that it happened about a week ago and that h/she never apologized, but turned around and went out. At 4:16 PM per interview with owner/administrator, h/she confirmed that there was an incident when both room occupants had diarrhea, he knocked walked in and saw that Resident #2 was not dressed and left. Resident #2 has diagnoses which include Schizophrenic affective disorder and claustrophobia.	R213		

*Edgar Greason* 5.11.14

Country Village Community Care Home

Plan of correction for survey conducted 4.15.2014

R206

We have written a new policy for Abuse, Neglect and Exploitation

Staff meeting to review new policy and State Regulations

Policies will be reviewed on a quarterly basis

Correction date; May 31 2014

R207

We have written a new policy for Abuse, Neglect and Exploitation

Staff meeting to review new policy and State reporting requirements

Policies will be reviewed on a quarterly basis

Correction date; May 31 2014

R213

We have written a new policy for Abuse, Neglect and Exploitation

Staff meeting to review new policy and State Regulations. We will develop a plan to review changes in the Home with Resident participation.

Policy will be reviewed on a quarterly basis and as needed

Correction date; June 30, 2014

R206, R207 + R213 POC's accepted 5/16/14 B Bortell FR/PML