VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
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AGENCY OF HUMAN SERVICES

Survey and Certification Voice/TTY (802) 241-0480
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Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

May 15, 2025

Jonathan Phyfe, Manager
Roadhouse
5 Giudici Street
Barre, VT 05641-3410

Dear Mr. Phyfe:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 8, 2025**. 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.

If you have any questions, please feel free to contact me at (802) 585-0995.

Sincerely,

Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0615	A. BUILDING: _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROADHOUSE	5 GIUDICI STREET BARRE, VT 05641

(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 On 4/8/25 the Division of Licensing and Protection conducted an unannounced on-site annual survey and an investigation of one complaint. There were no regulatory deficiencies identified related to the complaint investigation. The following regulatory deficiencies were identified during the annual survey:	R100	Corrective actions for all tags cited accepted by Jo A Evans RN on 5/14/25. Please see the attached document to review corrective actions submitted for individual tags.	
R163 SS=F	5.9.c (6) Nursing Services For each resident requiring nursing overview, administration of medication, or nursing care, the registered nurse must: Ensure that resident's medications are reviewed periodically and that all resident medications have either a supporting medical diagnosis or problem; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to ensure resident's medication orders include a supporting diagnosis or the problem(s) the medication is intended to treat for 3 out of 3 sampled residents (Residents #1, #2, and #3). Findings include: The home's Medication Orders Policy states medication lists "need to" reflect current medications and diagnoses. Per record review the most recent medication orders on file for 3 out of 3 sampled residents do not include supporting diagnoses and/or the problem(s) the medications are intended to treat. All 3 residents provider's current Medication List for scheduled medications and the resident's individually prescribed PRN (as needed)	R163		

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R163	Continued From page 1 medications did not include this required information; and only the only the home's Standing Orders for PRN medications included the diagnosis or problem the medication is intended to treat. This finding was confirmed by the Program Manager at 5:25 PM on 4/8/25.	R163		
R225 SS=F	5.12. b (4) Records/Reports The home must keep and maintain the following records: The results of the criminal record and adult abuse registry checks for all staff: This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to complete criminal record and abuse registry checks as required for 5 out of 5 sampled staff. Findings include: Policies and procedures governing completion of staff background checks were not on file and available for review on request. At 10:53 AM on 4/8/25 the Program Manager was requested to provide documentation of criminal record and abuse registry checks on file and available for review for a sample of 5 staff. Per review of the documents provided for review by the Human Resources Department of the organization that manages the home, criminal record and abuse registry checks were not completed as required for 5 out of 5 sampled staff.	R225		

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R225	Continued From page 2 These findings were confirmed by the Program Manager at 2:25 PM on 4/8/25.	R225		
R342 SS=F	5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy must be available at the home for review upon request by residents and their representatives, advocacy organizations and the licensing agency. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to develop, and maintain on file and available for review, policies and procedures governing all services provided by the home. Findings include: During the survey conducted on 4/8/25 the Program Manager was requested to provide policies governing areas of service provided by the home including completion of staff background checks, maintenance of the home's living environment, and management of resident's personal funds by the home. On the afternoon of 4/8/25 the Program Manager confirmed policies and procedures governing these areas of service were not on file and available for review.	R342		
R401 SS=F	9.1.a Environment The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This includes outdoor areas that are used by residents.	R401		

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R401	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to provide care in a sanitary, comfortable, and homelike environment related to the condition of the second floor shower stall. Findings include: Policies and Procedures governing maintenance of the home's living environment were not on file and available for review on 4/8/25. During a tour of the home commencing at 10:45 AM on 4/8/25 the shower stall in the resident's bathroom was observed to be poorly maintained and in poor repair. The floor of the shower staff was darkened with stains that appeared to be mildew. The framework, trim and caulking around the interior and exterior of the shower stall were chipping, discolored by rust and mildew, and in need of repair or replacement. The wall around the shower head was observed to have been partially repaired, however the hole in the wall around the shower arm pipe was visible and the patch of white spackling paste around one side of the shower arm had not been painted to match the bathroom wall. These findings were confirmed by the Program Manager at 11:00 AM on 4/8/25.	R401		
R455 SS=F	11.2 Resident Funds and Property If the home manages the resident's finances, the home must keep a record of all transactions, provide the resident with a quarterly statement, and keep all resident funds separate from the home or licensee's funds.	R455		

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R455	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to provide all applicable residents or their responsible parties with a quarterly statement regarding personal funds managed by the home. Findings include: Policies and procedures governing management of resident's personal funds managed by the home were not on file and available for review on 4/8/25. Per interview with the Program Manager and record review, the personal funds of both current residents of the home and a third resident who was recently discharged from the home are/ were managed by the Program Manager per the written signed request of the 3 sampled residents or their responsible parties. At 12:00 PM on 4/8/25 the Program Manager confirmed quarterly reporting of personal funds managed by the home are not provided to all applicable residents of the home including the 2 current residents an one recently discharged resident (Residents #1, #2, and #3) .	R455		

Roadhouse Plan of Correction site survey of April 8, 2025

R163 5.9.c (6) Nursing Services

For each resident requiring nursing overview, administration of medication or nursing care, the registered nurse must ensure that resident's medications are reviewed periodically and that all resident medications have either a supporting medical diagnosis or problem.

"Based on staff interview and record review, there is failure to ensure resident's medication orders include a supporting diagnosis or the problem the medication is intended to treat for 3 out of 3 residents… On the most recent medication orders on file for 3 out of 3 sampled residents do not include supporting diagnoses and/or the problem(s) the medications are intended to treat.

POC: For all current, and future residents of the Roadhouse residential program, the supervisory RN will review each resident's medication list on a monthly basis, or more frequently as medication or other medical changes present, to ensure that said medication lists remain accurate and fully up to date, at all times. Furthermore, as part of that ongoing review process, the RN will provide medical diagnosis and/or the medical problem(s) each specific medication is intended to treat and have such ready and available for review upon request by licensing authorities or other relevant parties, as appropriate.

The effective date of this correction action will be May 1, 2025.

R163 Plan of Correction accepted by Jo A Evans RN on 5/14/15

R225 5.12.b (4) Records/Reports

The home must keep and maintain criminal and adult abuse registry checks for all staff.

"Based on staff interview and record review, there is failure to complete criminal record and abuse registry checks as required for 5 out of 5 sampled staff."

POC:

Subject: POC for background checks deficiencies found re: RCH & ALR Licensing Regulations in re-licensing survey for Roadhouse
Date: April 30, 2025
Submitted: [redacted], Director of HR

In accordance with section 5.11.e of the Vermont Residential Care Home and Assisted Living Residence Licensing Rules, "(t)he licensee must not have on staff a person who

Name removed by DLP 5-5-2025

has had a substantiated charge of abuse, neglect or exploitation involving a child or an adult, nor a person who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction, whether within or outside of the State of Vermont…The licensee must take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references, contacting the Division of Licensing and Protection, the Department for Children and Families and the Department of Public Safety's Vermont Criminal Information Center (VCIC) or another national background check vendor to see if prospective employees are on the Vermont abuse registries or have a record of convictions in any state or territory…All background checks must be rechecked based on facility policy. The policy must include, at a minimum an annual re-check of Vermont criminal and abuse registries, and an annual re-check of all jurisdictions if a staff member has worked or lived in another state since the initial background check was completed and/or does so on a regular basis…"

1. **Action taken/to be taken to correct the deficiencies:**

    a. In November 2024, WCMHS identified that it was not conducting national criminal background checks or annual re-checks in compliance with DAIL and Licensing rules. As such, we immediately began implementation of administrative systems and utilization of a third-party service provider to conduct all required background checks and registry searches, including national criminal and Vermont Criminal Information Center (VCIC) background checks and searches of the U.S. DHHS OIG List of Excluded Individuals/Entities (LEIE List) and sex offender registries. Vermont Child Protection Registry and Vermont Adult Abuse Registry check requests continue to be submitted by WCMHS HR staff.

    WCMHS is now fully in compliance with the scope of background checks, as required by the Vermont RCH & ALR Licensing Rules to which WCMHS is subject.

    Administrative processes by which these background checks will be conducted on an annual basis are currently being implemented.

    While we are unable to retroactively correct staff files for previous years, staff background checks files are currently under review and will be updated to comply with all relevant licensing requirements.

    b. WCMHS's background checks processes and protocols will be formalized, documented, and communicated as an agency-wide policy.

2. **Measures/systemic changes to ensure continued compliance:** All required background checks are conducted for new employees at the time of initial hire and periodically thereafter, and will be conducted according to agency protocols and policy.

Due to the highly confidential nature of employee background checks and records, files with the results of completed background checks are securely filed and maintained by Human Resources and are/will be made available upon request to authorized representatives of the licensing agency.

3. **Ongoing monitoring to maintain compliance:** Administrative systems have been implemented to comply with requirements for collection and maintenance of background check information. Periodic, internal file audits will be performed to ensure compliance.

   The policy will be reviewed periodically alongside a review of licensing requirements to ensure ongoing alignment of agency practices and licensing regulations.

4. **Dates by which corrective action will be completed:**

   a. Background checks and files for current WCMHS employees working at Roadhouse are under review by HR. Employees will be contacted to provide authorization to conduct any additional checks to be completed. The expected date by which all files will include documentation of required checks is May 30, 2025.

   b. The WCMHS background checks protocols will formalized as a (revised) policy by May 15, 2025, subject to finalization and internal approval. The revised policy will reflect compliance with all funding, licensing, legal, and regulatory requirements.

R225 Plan of Correction accepted by Jo A Evans RN on 5/14/25.

R342 5.15 Policies and Procedures

Each home must have written policies and procedures that govern all services provided by the home. A copy must be available at the home for review upon request.

“Based on staff interview and record review, there is a failure to develop and maintain on file and available for review, policies and procedures governing all services provided by the home… On the afternoon of 4/8/25 the Program Manager confirmed policies and procedures governing these areas of service (‘staff background checks, maintenance of the home’s living environment and management of resident’s personal funds by the home’) were not on file and available for review.”

POC: The program manager will organize, and have available for review upon request by the licensing authority or other interested parties, written policies governing all areas of service provided by the home, including but not limited to the completion of staff background checks, maintenance of the home's living environment, and management of resident's personal funds by the home.

The effective date of this correction action will be June 1, 2025.

R342 Plan of Correction accepted by Jo A Evans RN on 5/17/25.

R401 9.1.a Environment

The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment.

"Based on observation and staff interview, there is failure to provide care in a sanitary, comfortable and homelike environment related to the condition of the second-floor shower stall. Findings include: the shower stall was observed to be poorly maintained and in poor repair. The floor of the shower was darkened with stains that appeared to be mildew. The framework, trim and caulking around the interior and exterior…are in need of replacement. The wall around the shower head was observed to be partially repaired however, the spackling paste around one side of the shower arm pipe had not been painted to match the wall."

POC: The facility manager will oversee the immediate repair and cleaning requirements of the second-floor shower stall, to ensure that this area of the home meets the mandated requirement, that the home maintains a sanitary and comfortable homelike condition, including the general repair as needed, of the facility. Thereafter, the facility manager will implement a weekly inspection protocol, including staff accountability by use of a sign off document, indicating that all bathroom and bathing areas are maintained in a clean and sanitary condition and are repaired/maintained promptly and with quality work performed.

The effective date of this corrective action will be May 1, 2025.

R401 Plan of Correction accepted by Jo A Evans RN on 5/17/25.

R455 11.2 Resident Funds and Property

If the home manages the resident's finances, the home must keep a record of all transactions, provide the resident with a quarterly statement, and keep all resident funds separate from the home or licensee's funds.

"Based on staff interview and record review, there is a failure to provide applicable residents of their responsible parties with a quarterly statement regarding personal funds managed by the home."

POC: The program manager will provide a quarterly report of all financial transactions concerning any and all resident's personal funds that are managed by the home, as requested by themselves or their responsible party. Such funds will be maintained in a secure location, separate from any other funds used for the operation of the program and/or facility, or any other funds not belonging to the residents whose funds are being managed by the residential program. A written statement outlining this available support service is contained within the admission agreement to the Roadhouse program. An initial report of financial transactions will be provided to residents and/or responsible parties no later than May 12, 2025. Thereafter, quarterly reports will be submitted on a quarterly basis starting on July 1. 2025.

The effective date of this corrective action will be May 12, 2025.

R455 Plan of Correction accepted by Jo A Evans RN on 5/17/25.