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
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

November 4, 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 **October 13, 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 10/13/2025

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 10/13/25, the Divison of Licensing and Protection conducted an unanounced on site investigation of one faclity reported incident. The following deficiencies were identified:	R100		
R159 SS=D	5.9.c (2) Nursing Services For each resident requiring a nursing overview, administration of medication, or nursing care, the registered nurse must: Develop a person-centered written plan of care within 14 days after admission, in accordance with the nursing process and professional standards of practice, for each resident that is based on abilities and needs as identified in the resident assessment. The resident, and if the resident chooses, resident representatives such as family or close supports, must be invited and allowed to participate in care planning meetings. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being, and must be revised as the resident?s abilities and needs change This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to update care plans for one Resident and the facility failed to identify significant changes for 1 of 1 Residents (Resident #2). Findings include: Per record review of the facilities "Critical Incident Form" dated 8/30/25, it reports that Resident #1 went to the office and was very agitated and	R159		

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R159	Continued From page 1	R159		

stated that Resident #2 had punched Resident #1 in the head multiple times. Staff made sure that the residents remained seperated from each other. Staff also encouraged Resident #1 to go to the hospital to be evaluated as Resident #1 is on blood thinning medication, no injuries were observed. Resident #1 was taken by emergency medical services (EMS) at 7:30 AM to be evaluated at the hospital.

Per record review of a progress note dated 8/30/25, it states that Resident #2 went to the hospital to be evaluated after the incident that had occured that morning. When the resident returned the note states Resident #2 did "well avoiding another resident who [they] had been in conflict with earlier".

Per record review of an emergency addendum note dated 9/19/25, it identifies that Resident #2 assaulted another resident 2 weeks prior and within the past 24 hours had "engaged in property destruction" and wrote threats to harm people at the residential program and to set the house on fire. It also reveals that Resident #2 was transportated to the Emergency Department and was awaiting psychiatric hospitalization.

Per record review of a discharge note from a hospital dated 9/30/25 , it revealed that Resident #2 was admitted on 9/22/25 and discharged on 9/30/25 and then returned back to the home.

Per record review on 10/13/25, Resident #2's last resident assessment was completed on 2/1/25. This assessment identifies Resident #2 was never verbally or physically abusive to others. Per interview with the manager on 10/13/25 at 11:21 AM, s/he confirmed that Resident #2 had multiple significant changes from their baseline and that

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R159	Continued From page 2 there have been no resident assessments completed after these significant changes occurred of assault, property destruction, and a psychiatric hospitalization. Per record review on 10/13/25, Resident #2's care plan was not updated to address aggressive behaviors demonstrated on Resident #1 and the within the home. Per interview with manager on 10/13/25 at 1:22 PM, they confirmed that Resident #2's care plans was not updated after a confirmed incidents of increased threatening behaviors demonstrated by Resident #2.	R159		
R232 SS=D	5.12.c (5) Records/Reports Any reports, allegations, or incidents of abuse, neglect, exploitation of residents or misappropriation of resident property must be reported to the licensing agency. i. The licensee and staff must report any case of suspected abuse, neglect or exploitation of a resident to Adult Protective Services (APS). A separate report must also be made to the licensing agency. APS may be contacted by calling toll-free 1-800-564-1612. The licensing agency may be contacted by calling toll-free 1-888-700-5330. The home must make the reports to APS and to the licensing agency immediately but not later than within 48 hours of learning of the suspected, reported or alleged incident. ii. In addition to filing the reports as described above, a home must conduct its own investigation and must take immediate steps to prevent further abuse, neglect or exploitation	R232		

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R232	Continued From page 3 from occurring. The results of the home ' s investigation must be reported to the licensing agency within 5 business days from the date of the initial report of the allegation. The home's investigation and determination must not delay reporting of the alleged or suspected incident to Adult Protective Services and to the licensing agency. iii. Incidents involving resident-to-resident abuse must be reported to the licensing agency any time a resident alleges, or the licensee or staff observe or suspect, verbal, physical or mental abuse; sexual abuse, if an injury has resulted; or if there is a pattern of abusive behavior. (A) All resident-to-resident incidents, even minor ones, must be recorded in the resident ' s record. (B) The home must notify legal representatives and families (if permitted) about the incident(s) and must document the report and the plan the home developed to address the behaviors. the following reports with the licensing agency: This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to report an allegation of abuse within the required 48 hours and failed to complete and submit an investigation report to the state licensing agency within five days of an allegation of abuse, to the division of licensing and protection. Per review of facility policies titled, "Road House Policies and Procedures" with a date of 2/20/14 it states, "Road House staff will report any case of suspected abuse, neglect, or exploitation to the Adult Protective Services (APS) as required by 33	R232		

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R232	Continued From page 4 V.S.A ... Reports must be made to APS within 48 hours of learning of the suspected, reported or alleged incident ... Road House will conduct its own investigation. That will not delay reporting of the alleged or suspected incident to Adult Protective Services. Road House will report incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse ...".This policy is inconsistent with the Licensing Rules. Per review of the facility reported incident, the Divisons of Licensing and Protection's intake form has a received date of 9/2/25 and the date of an resident to resident altercation (resident #1 and resident #2) that resulted in resident #2 physical assaulting Resident #1 on 8/30/25. Per interview with the manager on 10/13/25 at 2:27 PM, they confirmed they did not report within the 48 hour required time frame to the Division of Licensing and Protection. Upon request for a copy of the facility investigation of the incident that occurred on 8/30/25, the manager of the home provided a "critical incident form" completed for which described the incident to be sent to the Dept.of Mental Health (DMH) and did not address the immediate steps to prevent further abuse by Resident #2 . Per record review and interview with the manager on 10/13/25, the home did not complete or submit a follow up report of the facility investigation to the state licensing agency. Per interview with the manager on 10/13/25 at 10:56 AM, they confirmed that it is their responsibility to complete and submit facility reports and investigations of any allegations of abuse and that they did not perform these tasks.	R232		

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R360 SS=D	6.12 Resident's Rights Residents must be free from mental, verbal or physical abuse, neglect, and exploitation. Residents must also be free from restraints and seclusion as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure one Resident (Resident #1) was free from mental, verbal or physical abuse. Per review of facility policies titled, "Road House Policies and Procedures" with a date of 2/20/14 it states, "Residents will be free from mental, verbal or physical abuse, neglect, and exploitation". This policy aligns with Licensing Rules. Per record review of the facilities "Critical Incident Form" dated 8/30/25, it reports that Resident #1 went to the office and was very agitated and stated that Resident #2 had punched Resident #1 in the head multiple times. Staff made sure that the residents remained seperated from each other. Staff also encouraged Resident #1 to go to the hospital to be evaluated as Resident #1 is on blood thinning medication, no injuries were observed. Resident #1 was taken by emergency medical services (EMS) at 7:30 AM to be evaluated at the hospital. Per record review of a progress note dated 8/30/25, it states that Resident #2 went to the hospital to be evaluated after the incident that had occured that morning. When the resident returned the note states Resident #2 did "well avoiding another resident who [they] had been in conflict with earlier".	R360		

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R360	Continued From page 6 Per review of a progress note in Resident #1's record from 8/30/25, it identifies that Resident #1 started yelling about how Resident #2 punched them in the head multiple times. Per interview with the manager on 10/13/25 at 1:01 PM, they confirmed that Resident #2 punched Resident #1 in the head.	R360		

Deficiency Statement Plan of Correction (POC)

Survey Date: October 13, 2025

Facility Name: Roadhouse

Deficiency Tag	How the deficiency was corrected	How other potential residents identified, and corrective action taken	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R159	The resident care plan was updated on 10/16/25.	Care plan update requirements will be reviewed during scheduled staff meetings regularly, to ensure that each resident's individual plan is updated as per current regulatory requirements.	10/16/2025	If a residents' needs or abilities change, the manager and nurse will update the individual care plan to reflect the change. The manager will ensure that identified members of support are invited to participate in a care planning meeting.	Manager and nurse of the facility.
		R159 accepted by LTCM on 11/3/25			

Deficiency Statement Plan of Correction (POC)

Survey Date: October 13, 2025

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R 232	APS and DLP reporting requirements were reviewed, including what information to report and the prescribed time frame for compliance. Telephone numbers to both APS and DLP for reporting purposes have been posted for easy reference by staff members.	All staff members model respectful communication and interpersonal engagement between all members of the Roadhouse community. Each involved resident was interviewed separately and in a private location, to investigate this event and to identify precipitating factors such that future occurrences are less likely. Other residents potentially exposed to this event were interviewed on August 30, 2025. No other reporting was required based upon those interviews.	9/9/2025	Any reports, allegations, of abuse, neglect, exploitation of residents or misappropriation of resident property will be reported to the licensing agency, APS and DMH. The manager will write out the guidelines for the above, including reporting timelines. The manager will review this information with staff and post it in the staff room. Roadhouse will initiate and document an internal investigation if abuse, neglect or exploitation is suspected, ensuring the safety of all residents. R232 accepted by LTCM on 11/3/25	Program Manager

Deficiency Statement Plan of Correction (POC)

Survey Date: October 13, 2025

Facility Name: Roadhouse

Deficiency Tag	How the deficiency was corrected	How other potential residents identified, and corrective action taken	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R 360	Supervision expectations of all residents at the facility were reviewed with all staff members. Proactive behavioral support plan was developed and reviewed. House manager, or designee, will participate in regular and ongoing case review meetings with case management personnel, no less than monthly, to provide updated information to additional treatment team members, on a regular ongoing basis, to quickly identify and initiate appropriate and immediate action steps to mitigate any observed or suspected instances of mental, verbal, neglect, exploitation or physical abuse within the residence. Initiate available discharge options if individual safety cannot be guaranteed.	Respectful language and communication will be modeled by residential staff, promoting respectful interactions between all members of the Roadhouse community. Staff will immediately report and investigate any report or observation of any mental, verbal, physical abuse, neglect or exploitation occurring in the residence, at any time. If suspected, or reported, any incident of potential mental, verbal, physical abuse, neglect or exploitation will be reported immediately to the APS as well as DLP and local law enforcement personnel.	9/9/2025	Individual treatment and behavioral support plans will be reviewed at monthly staff meetings including any recent disposition changes. Proactive consultation with the WCMHS crisis intervention team to advise of potential Sx escalation, which may lead to abusive conduct between residents.	Program Manager

	Resident #2's behavioral support plan was reviewed and amended to provide ongoing practice of distress tolerance management techniques, as these are identified contributing factors to Resident #2's aggressive behaviors.			R360 accepted by LTCM on 11/3/25	