



AGENCY OF HUMAN SERVICES  
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING  
Division of Licensing and Protection

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Voice/TTY (802) 241-2345  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 241-2358

July 2, 2010

Mr. James Macdonald, Administrator  
Second Spring  
118 Clark Road  
Williamstown, VT 05679

Dear Mr. Macdonald:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **May 27, 2010**. 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 "Suzanne E. Leavitt RN, MS".

Suzanne Leavitt, RN, MS  
Assistant Director



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0386</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/27/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>SECOND SPRING</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>118 CLARK ROAD WILLIAMSTOWN, VT 05679</b>		
(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 onsite complaint investigation was conducted on 5/11/10 and 5/12/10 and completed on 5/27/10 by the Division of Licensing and Protection. The following regulatory violation was cited.	R100		
R213 SS=D	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.  This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure every resident was treated with consideration, respect and full recognition of the resident's dignity and individuality for 1 applicable resident. (Resident #1) Findings include:  Per review on 5/11/10 a facility progress note dated 6/20/09 Resident #1 told facility staff "I feel threatened" after staff witnessed Resident #1 descending stairs within the RCH with Resident #2 "...tight behind him". Resident #1 "...exclaimed to Resident #2 "you better not trip me" and "You'd better not threaten me". On 6/25/09 an Incident/Accident Report stated "Resident #2 walked behind Resident #1 and hit him behind the head with his knuckles". On 6/26/09 Resident #1 wrote to administrative staff at the RCH stating he had been treated with a lack of consideration and respect and the lack of recognition of his dignity and individuality. "Recently I have been kicked several times,	R213		

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R.213  
7/2/10  
P.O.C Accepted  
Dr. Dee Tutark  
Attached

Division of Licensing and Protection

*James MacDonald, Program Director 6/15/10* TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Division of Licensing and Protection

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R213	Continued From page 1  slapped in the head several times, provoked and verbally abused over the course of one and a half weeks. I would like this abuse to end". Per incident report dated 7/5/09 staff report Resident #2 deliberately hit Resident #1's leg with a cupboard door. Staff response to Resident #2 was "Normally this kind of thing would not be considered an incident, however historically you have targeted Resident #1". Per "Behavioral Safety Order Form" dated 6/27/09 for Resident #2 staff describe Behavioral Concerns "Alleged threatening and hands on behaviors to other resident (Resident #1)".  Per "Behavioral Safety Order Form" dated 7/09/09 Resident #2 was observed throwing a basketball at Resident #1 twice, hitting the resident in the knee and back. On 7/31/09 Progress notes state Resident #1 was "bumped/nudged by Resident #2. On 8/9/09 a progress note states " Resident #1 came in the door from outside. As Resident #1 quietly walked by, Resident #2 changed his direction and began to follow Resident #2 down hallway. Resident #2 picked up pace until he was next to Resident #1 and then swung his leg out in an attempt to trip/kick Resident #1. Later on the same day, Resident #2 "...aggressively slammed into Resident #1's with his shoulder and elbow". Per Incident/Accident Report dated 8/11/09 at 0105: "I looked out the window and saw Resident #2 run over to Resident #1 who was seated in a lawn chair in front of the smoke shack. Resident #2 pushed the chair and Resident #1 over towards the smoke shack and appear to bend over Resident #1 and strike him while Resident #1 was on the ground". Resident #1 sustained minor injuries and Resident #2 was removed from the facility by the Vermont State Police.	R213		

Division of Licensing and Protection

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R213	Continued From page 2  Throughout the course of events between Resident #1 and Resident #2, the facility staff applied various actions to include brief 1:1, 15 minute checks and "Eyes on" with staff remaining within 50 feet of Resident #2. However, the interventions and assessments of the ongoing issues between the 2 residents was ineffective, resulting in repeated episodes which eventually accelerated into a physical altercation on 8/11/09. Although Resident #1 filed grievances with administrative staff, Resident #2's behaviors remained an ongoing challenge for both the staff and other residents who resided at the facility.	R213		

**Second Spring Plan of Correction**  
**Resident's Rights – R213**  
**6-15-10**

*Quintanash*  
*7/2/10 P.O.C. Accepted*

Corrective Action	How Monitored	Person Responsible	Completion Date
<p>1. Second Spring will follow the Resident Grievance Process (See attached) for all complaints and grievances filed by residents to ensure the identified issue is dealt with in an efficient and effective manner.</p>	<p>1. Each filed complaint/grievance will be reviewed as outlined in Resident Grievance Process</p>	<p>1. Complaint and Grievance (CG) Coordinator, Program Director</p>	<p>1. 7-30-10</p>
<p>2. Training will be provided to residents to ensure they are aware and understand how to access the Resident Grievance Process. This currently occurs at admission and training will occur quarterly.</p>	<p>2. Record of completion will be kept in Grievance and Appeals Binder.</p>	<p>2. CG Coordinator, Program Director</p>	<p>2. 8-31-10 (1<sup>st</sup> quarterly training)</p>
<p>3. Staff will receive training in the Resident Grievance Process upon hire and every six months.</p>	<p>3. Record of completion will be kept in Grievance and Appeals Binder.</p>	<p>3. CG Coordinator, Program Director</p>	<p>3. 8-31-10 (1<sup>st</sup> 6 mo. training)</p>
<p>4. The new Program Director will be trained and CG Coordinator retrained in the Grievance and Appeals Process provided through OVHA.</p>	<p>4. Documentation of completed training from Kerri Anderson, OVHA Health Programs Administrator</p>	<p>4. CG Coordinator, Program Director</p>	<p>4. 8-31-10</p>
<p>5. Staff will receive mandatory reporting training through Adult Protective Services.</p>	<p>5. Documentation of completed training from APS</p>	<p>5. Nurse Manager, Program Director</p>	<p>5. 9-30-10</p>

<p><b>6. Staff will receive training on resident's rights through DRVT. Resident's will be offered the training also.</b></p> <p><b>7. To ensure effective and safe intervention in the event of physical aggression between residents Second Spring will utilize the following interventions:</b></p> <ul style="list-style-type: none"> <li>• <b>1:1 monitoring of resident will be implemented immediately until assessment of risk completed by Clinical Team and determination is made that resident is able to return to less restrictive monitoring.</b></li> <li>• <b>APS and L&amp;P notified of incident</b></li> <li>• <b>In addition, dependent on severity of physical aggression, the following interventions may be utilized:</b> <ul style="list-style-type: none"> <li>✓ <b>Emergency Services called to conduct a screening to assess for hospitalization</b></li> <li>✓ <b>Call for Police intervention</b></li> <li>✓ <b>Resident Designated Agency notified to ask for assistance to appeal to court to revoke ONH</b></li> <li>✓ <b>Second Spring Emergency Eviction Process implemented</b></li> </ul> </li> </ul>	<p><b>6. Documentation of completed training from DRVT</b></p> <p><b>7. Filing and Review of Incident Report</b></p> <p><b>Monitoring log filled out in 15 minute intervals by 1:1 staff</b></p> <p><b>Documented in Incident Report, Review by Program Director</b></p> <p><b>Documented in Incident Report, review by Program Director</b></p>	<p><b>6. Nurse Manager, Program Director</b></p> <p><b>7. Nurse Manager, Program Director</b></p> <p><b>Nurse Manager, Clinical Director, Medical Director</b></p> <p><b>Nurse Manager/designee, Program Director</b></p> <p><b>Nurse Manager/designee, Program Director</b></p>	<p><b>6. 9-30-10</b></p> <p><b>7. 7-30-10</b></p>
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<ul style="list-style-type: none"><li>• <b>Following aggressive acts, staff will follow up with residents exposed to the incident to assess the effects of the incident and provide support, as needed</b></li></ul>	<b>Documented in Incident Report, review by Program Director</b>	<b>Clinical Director, Program Director</b>	
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