

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  C <b>06/16/2009</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SECOND SPRING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>118 CLARK ROAD WILLIAMSTOWN, VT 05679</b>
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R100 Initial Comments:

An un-announced onsite complaint investigation was conducted on 6/04/09 by the Division of Licensing and Protection and completed on 06/16/09. The following deficiencies were cited.

R145 V. RESIDENT CARE AND HOME SERVICES  
SS=D

5.9.c (2)

Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being;

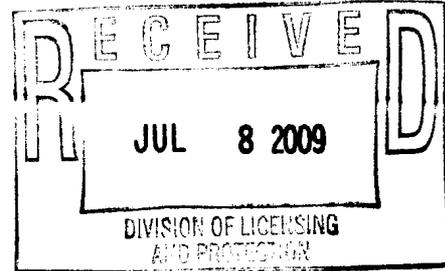
This REQUIREMENT is not met as evidenced by:

Based on record review and interview, the facility failed to develop a written plan of care based on individual need for 1 applicable resident (Resident #1) Findings include:

1. Although Resident #1 demonstrated a history of difficult and challenging behaviors which the Residential Care Home (RCH) was appraised of prior to the resident's admission, the Treatment Team failed to initiate within the "Items of Attention/Crisis Plan" an individualized plan of care to facilitate behavioral management and interventions. The team failed to address the frequency of Resident #1's visits to his/her storage units, a place where the resident enjoyed organizing, reviewing and retrieving possessions. Per record review on 06/04/09, Resident #1 was admitted on 05/14/07. Per review of "14 day Progress Notes" on 5/17, 05/21 and 05/22/07, upon Resident #1's request, facility Recovery

R100

R145



① Each New Resident has an initial Recovery 7-9-09 meeting on admission and regular meetings after the initial for updates on issues of concern. These Recovery Plans are

Division of Licensing and Protection

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

STATE FORM

TITLE

*Deborah Reddick RN - Director*

(X6) DATE

*2-7-09*

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R145 Continued From page 1

staff transported the resident to visit his/her storage units, where the resident spent 1 to 2 hours reviewing possessions and was described by staff to be "...upbeat and pleased to be going on an outing to his/her storage unit..." On 05/23/07 Resident #1 was misinformed by day Recovery staff that "...an outing to his storage unit was possible today by the evening shift...". However, evening staff plans for the resident on 05/23/07 did not include transporting the resident for a visit to his/her storage unit. As a result, Resident #1 "...expressed anger and frustration". On 05/25/07, a "14 day Progress Note" describe the resident as "angry...yelling about the inconsistencies of decision-making here regarding outings". On 05/25/07 a plan was initiated, but the plan did not address the frequency or duration of visits to the storage unit.

2. Per review of "14 Day Progress Note, on 05/14/07 during the dinner meal Resident #1 "...became agitated at dinner when s/he choked on food..... left the room swearing about not having (their) teeth." and ".....(the resident)....was given assistance by staff to cut up his/her food and was able to consume adequate amounts...it may be helpful to offer (the resident) some privacy during meals. Part of his/her difficulty may have been from frustration and embarrassment at not being able to chew (their) food while sitting with others for dinner meal". Per review of "Items of Attention/Crisis Plan" although dental work was identified as a problem, no immediate plan was developed to ensure food was served at an appropriate texture, consistency and to accommodate the issue of the resident being edentulous (with the exception of having 2 teeth of his own) by offering privacy.

R145

Monitored on a regular basis by The Director, Associate Director and Case Management. 7-2-09

R145 7/16/09  
P.O.C Accepted  
DeLutash, RN

② Nursing Notes now done on a weekly basis monitoring health and behavioral concerns. Any clients who do not have a PCP in the area are set up with the Plainfield Health Clinic for primary care. Diets as ordered by AD. 7-7-09

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R145	<p>Continued From page 2</p> <p>3. Per record review, on 06/18/07 Resident #1 was readmitted to the RCH after requiring admission to the psychiatric hospital on 06/02/07 as a result of escalating behaviors and noncompliance with taking medications. Prior to hospital discharge, a preplacement meeting transpired on 06/15/07 which included hospital and RCH staff and a representative from Vermont Protection and Advocacy. Guidelines agreed upon included a "...box stall in the barn will be designated as "resident's room"...which would be an area where s/he can bring much as s/he wants from (his/her) storage area, work on projects.....". Per review of Psychotherapy Management note dated 06/18/07, the Psychiatrist states "Work toward (resident's) strengths: give him/her a space in the barn". However, some recovery staff expressed safety concerns regarding the use of the barn and the quantity of items to be brought from the storage units to the barn. Per interview on 06/04/09 at 3:40 PM the RCH manager confirmed other locations on the facility property were being considered as an alternative storage area. An alternative location for the resident was not formally established within the "Items Of Attention/Crisis Plan" as agreed prior to the discharge of Resident #1 from the hospital.</p> <p>4. Per review, the facility failed to develop within the "Crisis Plan" specific written guidelines for the management of Resident #1's ongoing demands to smoke in several locations outside on the facility grounds. Resident #1's 2nd admission to the RCH was plagued with smoking issues, however no Crisis Plan was developed to ensure all Recovery and treatment staff had defined guidelines that were made explicitly clear to Resident #1 regarding specific locations where smoking was prohibited or permitted. Per</p>	R145	<p>③ AS stated ID#) 7-7-09 Each new resident has an initial Recovery Plan on admission with regular updated meetings to determine Needs of the resident.</p> <p>② R145 7/16/09 - POC Accepted J. DeTosh, RN</p> <p>④ Crisis plan now generated from the 7-7-09 Recovery Plan to meet the individual's needs. Smoking only allowed at smoking shack for Residents at this time.</p>

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R145	Continued From page 3  interview on 06/04/09 at 12:55 PM the employee trainer/environmental supervisor stated that when the facility first opened around the time period of Resident #1's first admission, he recalled no smoking policy but noted the unwritten rule allowed for smoking in the "smoke shack". Per interview on 06/16/09 at 10:11 AM the RCH manager also confirmed no written policy was developed prior to 11/19/08, but that residents were not allowed to smoke on the porch or in the house.	R145	
R150 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.9.c (7)</p> <p>Assure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken;</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review the RCH nurse failed to take action when a resident voiced complaints regarding specific health issues. (Resident #1) Findings include:</p> <p>1. Per review on 06/04/09 of "progress notes" dated 06/26/07, written by Recovery staff states Resident #1 "...expressed being upset about painful urination during the middle of the night and problems with bowel movement also his/her tooth is still bothering (the resident).....". In addition, the staff member also added under "general comment" on the same date " This is the second time (the resident) has complained of tooth ache within the last week to this staff. Is this something we are able to check into (whether it is legitimate pain and can we setup a doctor's</p>	R150	<p>⑤ Weekly progress notes now done by nursing, addressing items of attention including medical issues if any. Plainfield Health Clinic available for any Residents medical</p>

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R150	Continued From page 4 appointment). "  Per review of progress notes, the RCH nurse failed to document if any action was taken as a result of the resident's health complaints and the attending physician failed to note any communication from the RCH nurse regarding the resident's complaints except to note the resident complained to the physician regarding the prescribe medication caused difficult urination.	R150	Cont- Needs. Ongoing monitoring from Director - Associate Director.  7/16/09 R150 POC Accepted DeDeLush	