

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

January 31, 2012

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

Provider #: 0386

Dear Mr. Macdonald:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **December 13, 2011**. 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, MS
Licensing Chief

PC:ne

Enclosure



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0386	JAN 11 12 Licensing and Protection (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/13/2011
--------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER SECOND SPRING	STREET ADDRESS, CITY, STATE, ZIP CODE 118 CLARK ROAD WILLIAMSTOWN, VT 05679
----------------------------------------------------------	-------------------------------------------------------------------------------------------

(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 visit was completed on 12/13/11 by the Division of Licensing and Protection to conduct the annual re-licensing survey which included a complaint investigation. The following regulatory deficiencies were identified:	R100	<i>See Attached</i>	
R114 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.3 Discharge and Transfer Requirements 5.3.a Involuntary Discharge or Transfer of Residents (2) In the case of an involuntary discharge or transfer, the manager shall: i. Notify the resident, and if known, a family member and/or legal representative of the resident, of the discharge or transfer and the specific reasons for the move in writing and in a language and manner the resident understands at least 72 hours before a transfer within the home and thirty (30) days before discharge from the home. If the resident does not have a family member or legal representative and requests assistance, the notice shall be sent to the Long Term Care Ombudsman, Vermont Protection and Advocacy or Vermont Senior Citizens Law Project. ii. Use the form prescribed by the licensing agency for giving written notice of discharge or transfer and include a statement in large print that the resident has the right to appeal the home's decision to transfer or discharge with the appropriate information regarding how to do so.	R114		

Division of Licensing and Protection

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

[Signature]

12-31-11

TITLE **Director**

(X6) DATE

Amc

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0386	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/13/2011
NAME OF PROVIDER OR SUPPLIER SECOND SPRING		STREET ADDRESS, CITY, STATE, ZIP CODE 118 CLARK ROAD WILLIAMSTOWN, VT 05679		
(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
R114	Continued From page 1 iii. Include a statement in the written notice that the resident may remain in the room or home during the appeal. iv. Place a copy of the notice in the resident's clinical record. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to assure that Resident #9's signed admission agreement was in compliance with regulatory requirements for notice prior to involuntary discharge from the facility. Findings include: Per record review on 12/12/11, Resident #9's Admission Agreement, signed on 9/27/11, stated under II.b. that "for non-payment, we may discharge you after 14 days notice". The Vermont Residential Care Home Licensing Regulations state that a resident must be given a 30 day written notice before involuntary discharge from the home. During interview on 12/13/11 at 1:15 PM, the Administrator confirmed that the currently used resident admission form incorrectly stated that residents may be discharged for nonpayment (involuntarily) with 14 days notice.	R114		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 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;	R145		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0386	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/13/2011
NAME OF PROVIDER OR SUPPLIER SECOND SPRING		STREET ADDRESS, CITY, STATE, ZIP CODE 118 CLARK ROAD WILLIAMSTOWN, VT 05679		
(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
R145	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, nursing staff failed to develop care plans which reflected resident care needs for 3 of 6 residents in the targeted sample. (Residents # 7, 9 and 14) Findings include: 1. Per record review, Resident # 7 has a history of a sleep disorder and utilizes a C-Pap(continuous positive airway pressure) machine at night. This mode of treatment involves equipment which assists the resident with improved respiratory ventilation. The care plan failed to address the residents needs related to this treatment and disorder. This was confirmed on the morning of 12/13/11 with nursing staff. 2. Per record review on 12/12/11, Resident #9's written care plan failed to address all of the identified assessed needs. This was confirmed during interview with the charge nurse and the Resident Care Coordinator on 12/13/11 at 11:30 AM 3. Per record review on 12/13/11, Resident #14, who was admitted to the facility on 12/1/11, had no initial written plan of care. This was confirmed during interviews with the charge nurse and the Resident Care Coordinator at 11:53 AM the same day.	R145		
R149 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (6) Maintain a current list of all treatments for each	R149		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0386	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/13/2011
NAME OF PROVIDER OR SUPPLIER SECOND SPRING		STREET ADDRESS, CITY, STATE, ZIP CODE 118 CLARK ROAD WILLIAMSTOWN, VT 05679		
(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
R149	Continued From page 3 resident that shall include: the name, date treatment ordered, treatment and frequency prescribed and documentation to reflect that treatment was carried out; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, nursing staff failed to develop a treatment plan for 1 applicable resident who utilized a respiratory/breathing device each night while sleeping. (Resident # 7) Findings include: Per record review, Resident #7 has a history of a sleep disorder and has been prescribed to utilize a C-Pap (positive airway pressure) machine. This mode of treatment involves equipment which assists the resident with improved respiratory ventilation. The nursing staff failed to develop a treatment plan for the use of the C-Pap machine to include the frequency of cleaning and disinfecting the tubing and face mask, the disinfecting solution to be used, the changing of equipment and who is responsible for the ongoing oversight and monitoring the use and care of the equipment. Per interview on the morning of 12/13/11, a staff nurse confirmed the home had failed to develop and manage a treatment plan for Resident #7's use of the C-Pap machine.	R149		
R162 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record.	R162		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0386	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/13/2011
NAME OF PROVIDER OR SUPPLIER SECOND SPRING		STREET ADDRESS, CITY, STATE, ZIP CODE 118 CLARK ROAD WILLIAMSTOWN, VT 05679		
(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
R162	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the RCH failed to ensure supporting diagnosis or problem statement was documented for medications administered by staff for 2 of 6 Residents. (Resident # 1, 2) Findings include: 1. Per record review Resident #1 physician's orders for: Lisinopril 10 mg PO Daily, Propranolol 40 mg PO Daily, and Protonix 40 mg PO Daily were without a supporting diagnoses for the use of each medication prescribed. 2. Resident #2 had an order for Oil of Evening Primrose 1000 mg PO 3 X daily (TID) and Vitamin B 6 25 mg PO TID with no supporting diagnosis. This was confirmed with the Clinical Director on the afternoon of 12/13/11.	R162		
R165 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for: i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects; ii. Establishing a process for routine communication with designated staff about the	R165		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0386	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/13/2011
NAME OF PROVIDER OR SUPPLIER SECOND SPRING		STREET ADDRESS, CITY, STATE, ZIP CODE 118 CLARK ROAD WILLIAMSTOWN, VT 05679		
(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
R165	Continued From page 5 resident's condition and the effect of medications, as well as changes in medications; iii. Assessing the resident's condition and the need for any changes in medications; and Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RN responsible for medication delegation failed to provide evidence for teaching delegated staff proper techniques for medication administration and failed to provide evidence of monitoring and evaluating the delegated staff performance for medication delegation. Findings include: Per record review there is no documentation in the Delegation manual which reflects delegation by the RN for four out of five staff reviewed. Per staff interview on 12/13/2011 at 11:30 AM the Training Coordinator stated that there were no records available other than those found in the manual.	R165		
R179 SS=C	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights;	R179		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0386	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/13/2011
NAME OF PROVIDER OR SUPPLIER SECOND SPRING		STREET ADDRESS, CITY, STATE, ZIP CODE 118 CLARK ROAD WILLIAMSTOWN, VT 05679		
(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
R179	Continued From page 6 (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the RCH failed to ensure the 12 hours of required training included infection control and first aid training. Findings include: Per record review of education records for 5 staff members, trainings include bloodborne pathogens and CPR. Per interview on 12/12/2011 the Training Coordinator stated the facility had not included infection control components, such as handwashing and handling contaminated materials (among others), in the staff trainings. S/he also stated in an interview on 12/13/2011 at 11:45 AM that, other than an initial CPR certification for some staff, the facility has not trained staff in accident response and first aid.	R179		
R181 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect	R181		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0386	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/13/2011
NAME OF PROVIDER OR SUPPLIER SECOND SPRING		STREET ADDRESS, CITY, STATE, ZIP CODE 118 CLARK ROAD WILLIAMSTOWN, VT 05679		
(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
R181	<p>Continued From page 7</p> <p>or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one 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. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the licensee failed to complete all the required background checks for 3 of 6 employee files reviewed. Additionally, 1 of 6 employees with a record of criminal convictions was retained . Findings include:</p> <p>Per review of the personnel files of 6 randomly selected current staff on 12/13/11, 3 staff files lacked evidence that all of the Vermont RCH required background checks were completed. An additional employee personnel file showed that the staff person had a record of criminal convictions and there was no evidence of a letter to the Licensing Agency to request a variance. These regulatory violations were confirmed during interview with the Director of Operations at 2:55 PM on 12/13/11.</p>	R181		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0386	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/13/2011
NAME OF PROVIDER OR SUPPLIER SECOND SPRING		STREET ADDRESS, CITY, STATE, ZIP CODE 118 CLARK ROAD WILLIAMSTOWN, VT 05679		
(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
R266	Continued From page 8	R266		
R266 SS=E	<p>IX. PHYSICAL PLANT</p> <p>9.1 Environment</p> <p>9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the Residential Care Home (RCH) failed to maintain a safe and sanitary environment in all areas of the home. Findings include:</p> <p>Per observations during the initial tour of the home on 12/12/11 commencing at 10:30 AM accompanied by the Training and Facilities Coordinator, the following unsafe and/or unsanitary conditions were noted:</p> <p>a. Resident rooms and/or bathrooms had soiled floors and bathroom fixtures including sinks, toilets and tub/showers. (Rooms 6, 7, 13 and 15). In addition, the floor in the bathroom of room 13 had multiple layers of worn floor covering, with areas of the subfloor exposed, making the surface unable to be properly sanitized.</p> <p>b. Furnishings in the common areas were noted to be dust laden (including bookcases, tables, chests). Floor surfaces in common areas, including bathrooms, had a build up of dirt around the room/hallway perimeters.</p> <p>c. Multiple ceiling light fixtures contained remains of flies. Ceiling fan covers in resident bathrooms were dusty.</p> <p>d. In room 6A, multiple extension cords were observed laying on the floor surrounding the resident's bed area. In room 3A, use of several</p>	R266		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0386	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/13/2011
NAME OF PROVIDER OR SUPPLIER SECOND SPRING		STREET ADDRESS, CITY, STATE, ZIP CODE 118 CLARK ROAD WILLIAMSTOWN, VT 05679		
(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
R266	Continued From page 9 extension cords created clutter and a tripping hazard. The above observations were confirmed during interview with the Training and Facilities Coordinator at the time of the tour.	R266		
R303 SS=D	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.d There shall be an operable telephone on each floor of the home, at all times. A list of emergency telephone numbers shall be posted by each telephone. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide an operable telephone on the second floor of the facility. Findings include: During tour of the RCH on 12/12/11 at 10:00 AM it was confirmed by the Training and Facilities Coordinator a telephone was not available for use on the second floor nor were emergency numbers posted.	R303		
R313 SS=B	XI. RESIDENT FUNDS AND PROPERTY 11.1 A resident's money and other valuables shall be in the control of the resident, except where there is a guardian, attorney in fact (power of attorney), or representative payee who requests otherwise. The home may manage the resident's finances only upon the written request of the resident. There shall be a written	R313		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0386	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/13/2011
NAME OF PROVIDER OR SUPPLIER SECOND SPRING		STREET ADDRESS, CITY, STATE, ZIP CODE 118 CLARK ROAD WILLIAMSTOWN, VT 05679		
(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
R313	Continued From page 10 agreement stating the assistance requested, the terms of same, the funds or property and persons involved. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RCH failed to obtain a written request for assistance with finances for 2 applicable residents in the sample. (Residents #11 and 14) Findings include: Per review on 12/13/11 of the RCH's accounting of resident finances, there were records of money transactions for Residents #11 and #14; however there was no evidence the RCH obtained written consent to assist with the management of each resident's finances. Staff was unable to provide evidence of a consent being received.	R313		

Second Spring Plan of Correction

Site Survey

12/13-14/2011

Deficiency and Corrective Action	How Monitored	Person Responsible	Completion Date
<p>1. R114, 5.3 Discharge and Transfer Requirements, 5.3a Involuntary Discharge and Transfer Requirements: Policy and procedures to be followed as written in L&P regulations as well as using prescribed forms. Admission Agreement will be changed from incorrect language; “for non-payment, we may discharge you after 14 days notice.” To; “for non-payment, we may discharge you after 30 days written notice.”</p>	<p>1. Residential Care Coordinator will be responsible for process being followed and data collected to ensure that timelines are followed precisely. Director to write and sign off on all correspondence.</p>	<p>1. Residential Care Coordinator, Residential Care Home Director</p>	<p>1. 1-31-12</p>
<p>2. R145, 5.9.c (2) All Resident Care Plans will be corrected and updated. Each resident will have a resident care plan developed reflecting the full scope of need assessed at admission.</p>	<p>2. Residential Care Coordinator and nursing staff will review each record to ensure compliance and thoroughness. Quality Assurance team will review compliance on at least a quarterly basis</p>	<p>2. Residential Care Coordinator, Nursing, Residential Care home Director</p>	<p>2. 1-31-12</p>
<p>3. R149, 5.9.c (6) Correct deficiency in 1 resident’s nursing care plan immediately to ensure that C-Pap treatment plan is developed and managed according to doctors Orders and L&P regulations. Review all other resident</p>	<p>3. Nursing will develop and monitor treatment process. Quality Assurance Team will review quarterly.</p>	<p>3. Nursing staff</p>	<p>3. 1-31-12</p>

<p>treatment plans to ensure compliance</p> <p>4. R162, 5.10 Medication Management, 5.10. c. Supporting diagnosis will be documented in resident record to support physician's med orders.</p>	<p>4. Clinical Director and Psychiatrist will ensure that all medication orders have a documented supporting diagnosis.</p>	<p>4. Clinical Director, Medical Director</p>	<p>4. 1-31-12</p>
<p>5. R165, 5.10 Medication Management, 5.10. d RN will ensure that all staff are trained on medication procedures and medication designation is signed off for each staff delegated.</p>	<p>5. RN signed documentation for each staff person delegated.</p>	<p>5. RN Med Delegation trainer, Facilities and Training Coordinator.</p>	<p>5. 1-31-12</p>
<p>6. R179, 5.11 Staff Services, 5.11.b Infection Control and First Aid training will be added to the 40 hour plus training process for staff and updated as required.</p>	<p>6. Documentation of completed training in employee training file</p>	<p>6. RN Nurse, Facilities and Training Coordinator</p>	<p>6. 2-31-12</p>
<p>7. R 181, 5.11 Staff Services, 5.11.d. Employee files will be updated to include proper documentation of background checks and will apply for waivers with the licensing chief to retain employees cited as not meeting L&P regulations. If licensing chief does not approve waiver for these employees their employment with Second Spring will be immediately terminated.</p>	<p>7. All employee records will be reviewed and updated to ensure L&P compliance. Waivers letters will be sent to Licensing Chief</p>	<p>7. Human Resources Director, Operations Director.</p>	<p>7. 1-31-12</p>
<p>8. R266 Physical Plant, 9.1 Environment, 9.1.a. All safety and sanitary deficiencies will be corrected immediately. Cleaning and maintenance procedures will be updated and</p>	<p>8. Policy and procedure implemented and tracked by Facilities Coordinator to ensure</p>	<p>8. Facilities and Training Coordinator, Operations Manager</p>	<p>8. 1-31-12</p>

<p>implemented to ensure compliance with L&P regulations.</p> <p>9. R 303 Physical Plant, 9.11 Disaster and Emergency Preparedness, 9.11.d. A resident phone will be installed on the second floor of the facility that is accessible to all residents.</p> <p>10.R 313 Resident Funds and Property, 11.1, A written request for assistance with finances will be obtained and maintained on record for all residents requesting assistance.</p>	<p>compliance.</p> <p>9. Phone installed</p> <p>10. Review of documentation on file will be done each quarter to ensure that financial assistance requests are accurate and up to date</p>	<p>9. Facilities and Training Coordinator</p> <p>10. Residential Care Coordinator</p>	<p>9. 1-31-12</p> <p>10. 1-31-12</p>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------	--------------------------------------

R114, R145, R149, R162, R165, R179, R181, R266, R303, + R313 POC's accepted 1/30/12 Fm McIntosh RN / Fm Cotar N