VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
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

March 12, 2024

Adelit Rukomangana, Manager
Second Spring North
1071 Vt Route 15
Underhill, VT 05489-9341

Dear Mr. Rukomangana:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 12, 2024.** 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0611	A. BUILDING: _____ B. WING _____	02/12/2024

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SECOND SPRING NORTH	1071 VT ROUTE 15 UNDERHILL, VT 05489

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R100	Initial Comments: On 2/12/24 the Division of Licensing and Protection conducted an unannounced on-site relicensure survey. The following regulatory deficiencies were identified:	R100	Plans of Correction for all individual tags accepted by Jo A Evans RN 3/12/24 SEE ATTACHED DOCUMENT TO REVIEW CORRECTIVE ACTIONS FOR EACH INDIVIDUAL TAG.	
R147 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (4) Maintain a current list for review by staff and physician of all residents' medications. The list shall include: resident's name; medications; date medication ordered; dosage and frequency of administration; and likely side effects to monitor; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure all PRN (as needed) medication orders include a specific dose and frequency of administration. Findings include: Policies and procedures for the administration of PRN medications provided for review on request during the survey on 2/13/24 do not address the requirement for the specific dose and frequency of administration including the amount of time between administration of doses to be listed in all provider orders for PRN medications. Per review of the February 2024 Medication Administration Records and prescriber's orders, the following PRN medication orders for 2 out of 3 sampled residents did not include the specific dose and frequency of administration:	R147		

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R147	Continued From page 1 1. Resident #1: a. "TUMS 200 mg calcium (500 mg) chewable tablet Take 2 tablet by oral route 1-2 as needed Not to exceed 10 tablets in 24 hours", which does not include a specific frequency of administration. This order also does not identify the symptoms the medication is intended to treat. b. "Hydrocortisone 1% topical cream Apply a small amount to affected area as needed for itchiness. Not to exceed 3 times in 24 hours", which does not include the amount of time between doses. c. "Cherry Cough Drops Take 1-2 lozenges by mouth for sore throat or cough. Not to exceed 15 in 24 hours" which does not include a specific dose and the amount of time between doses." 2. Resident #2: a. "Gabapentin 100 mg capsule Take 2 tablets by oral route twice daily as needed for anxiety/restlessness", which does not include that amount of time between doses. b. "Cherry Cough Drops Take 1-2 lozenges by mouth for sore throat or cough. Not to exceed 15 in 24 hours" which does not include a specific dose and the amount of time between doses." c. Adult Tussin Cough Congestion DM 10 mg-100 mg/5 ml oral liquid" "Take 7 ml every 6-8 hours needed for cough", which does not include a specific frequency of administration. d. "TUMS 200 mg calcium (500 mg) chewable tablet Take 2 tablet by oral route 2 as needed Not to exceed 10 tablets in 24 hours", which does not include a specific frequency of administration. This order also does not identify the symptoms the medication is intended to treat. On the afternoon of 2/12/24 the Registered Nurse confirmed these findings.	R147		

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R147	Continued From page 2 In conclusion this deficient practice is a potential risk for more than minimal harm for all residents due to administration of PRN medications at a dose and/or frequency that is ineffective or in excess of the amount required to address the symptoms the medication is intended to treat.	R147		
R163 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.5 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (1) A registered nurse must conduct an assessment consistent with the physician's diagnosis and orders of the resident's care needs as required in section 5.7.c This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to complete resident assessments according to section 5.7c of the Vermont State Residential Care Home Licensing Regulations effective 10/3/2000 for 2 applicable residents (Residents #1 and #2). Findings include: During the survey on 2/12/24 Policies and Procedures related to Resident Assessments were not on file and available for review on request. 1. Per record review Resident #1 was admitted to the facility on 7/11/19. An annual reassessment completed in 2023 was not on file and available for review in Resident #1's record.	R163		

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R163	Continued From page 3 2. Per record review, Resident #2 was discharged from the home on 12/8/23. Following a brief stay at another facility, Resident #2 was readmitted to the home on 12/21/23. On the afternoon of 2/12/24 the Registered Nurse confirmed an annual reassessment completed in 2023 was not on file and available for review in Resident #1's record; and an admission assessment was not completed for Resident #2 following readmission to the home on 12/21/23. In conclusion this deficient practice is a potential risk for more than minimal harm to all facility residents due to the failure to assess the current abilities and needs of the resident.	R163		
R167 SS=F	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: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use.	R167		

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R167	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure development of written plans for the administration of PRN (as needed) psychoactive medications by staff other than a nurse. Findings include: The facility's Psychotropic (Psychoactive) PRN Administration Protocol effective August 2016 states, "Psychotropic medications ordered "as needed" by the duly authorized licensed practitioner, shall not be administered unless the duly authorized licensed practitioner has provided detailed behavior-specific written instructions, including symptoms that might require use of medication, exact dosage, exact time frames between dosages and the maximum dosage to be given in a twenty-four (24) hour period." The facility's protocol does not include the effects and unintended side effects of the psychoactive medication as required information in the written plans for the administration of psychoactive PRN medications by staff other than a nurse. Per record review written plans for the administration of Psychoactive PRN medications by staff other than a nurse were not on file and available for review during the survey on 2/12/24. On the afternoon of 2/12/24 the Registered Nurse stated s/he was not aware the written plans are required, and confirmed the required plans had not been developed. At 4:13 PM on 2/13/24 the Registered Nurse confirmed 5 out of 8 applicable residents were prescribed psychoactive medications as needed. In conclusion this deficient practice is a potential risk for more than minimal harm to all applicable	R167		

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R167	Continued From page 5 facility residents due to administration of PRN psychoactive medications by staff other than a nurse without the necessary information to administer the medications as the provider intended, and accurately monitor and report the medication's effects.	R167		
R173 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h. (1) Resident medications that the home manages must be stored in locked compartments under proper temperature controls. Only authorized personnel shall have access to the keys This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure medications requiring refrigeration were stored a locked compartment. The facility's Storing and Wasting Medications policy effective 7/1/15 states, "Under all circumstances medications should be locked up. " During the course of the survey on 2/12/24 the medication refrigerator in the nursing office was observed to be without a locking mechanism, resulting in medications which were unsecured and accessible to anyone who enters the nursing office. This finding was confirmed by the	R173		

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R173	Continued From page 6 Registered Nurse on the afternoon of 2/12/24. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents resulting from unauthorized access to medications.	R173		
R176 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (4) Medications left after the death or discharge of a resident, or outdated medications, shall be promptly disposed of in accordance with the home's policy and applicable standards of practice. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review there was a failure to dispose of expired medications promptly. Findings include: Per review of the organization's policies and procedures for storing and wasting medications effective July 1, 2015 and additional policy and procedures for an associated organization effective April 2017; the policies and procedures provided for review on the afternoon of 2/12/24 do not include information related to prompt disposal of outdated medications. On the afternoon of 2/14/24 the following outdated medications were observed to be stored in the medication cart : 1. Senna 8.6 mg tablets expired on 12/9/23 for	R176		

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R176	Continued From page 7 Resident #1. 2. Senna 8.6 mg tablets expired on 8/3/23 for Resident #2. 3. Melatonin 3 mg tablets expired on 11/16/23, Diphenhydramine 25 mg tablets expired on 11/16/23, and Calcium Antacid 500 mg tabs expired 11/1/23 for Resident #3 4. House Stock Milk of Magnesia expired on 10/2023. These findings were confirmed by the Registered Nurse on the afternoon of 2/12/14. In closing this deficient practice is a risk for more than minimal harm for all facility residents due to medications remaining accessible for administration beyond the date the expiration date.	R176		
R179 SS=F	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; (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	R179		

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R179	Continued From page 8 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 there was a failure to ensure 5 out of 5 sampled staff completed all required yearly trainings. Findings include: On 2/12/24 Policies and Procedures related to staff trainings were not on file and available for review. Per review of the training records, 5 out of 5 sampled staff failed to complete all required yearly trainings. All 5 sampled staff did not complete the required emergency preparedness and first aid trainings during the previous year, and 1 out of 5 sampled staff also did not complete the required training in Respectful and Effective Interactions with Residents. At approximately 6:40 PM on 2/12/24 these findings were confirmed by the Operations Manager. This deficient practice is a potential risk for more than minimal harm for all facility residents due to inadequate staff education and training to safely and effectively provide resident care.	R179		

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R188	Continued From page 9	R188		
R188 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(2) A record for each resident which includes: resident's name; emergency notification numbers; name, address and telephone number of any legal representative or, if there is none, the next of kin; physician's name, address and telephone number; instructions in case of resident's death; the resident's assessment(s); progress notes regarding any accident or incident and subsequent follow-up; list of allergies; a signed admission agreement; a recent photograph of the resident, unless the resident objects; a copy of the resident's advance directives, if any completed; and a copy of the document giving legal authority to another, if any. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure a signed admission agreement was on file and available for review for 1 out of 3 sampled residents (Resident #1); and a recent photograph was on file for 1 out of 3 applicable residents (Resident #3). Findings include: 1. Per record review, Resident #1's record did not include a signed Admission Agreement. 2. Per record review, Resident #3's resident record did not include a recent photograph or documentation of the resident's refusal to allow a photograph to be taken and maintained on file in	R188		

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R188	Continued From page 10 his/her record. These findings were confirmed by the Registered Nurse on the afternoon of 2/12/24. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents due to the failure to ensure each resident is notified of and is in agreement with the services provided by the facility, fees charged for services, and the resident's discharge rights; and the failure to maintain a current photo of a resident on file for identification purposes as needed.	R188		
R190 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) 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 was a failure to complete criminal record and abuse registry checks as required for 4 out of 5 sampled staff. Findings include: On 2/12/24 Policies and Procedures related to completion of staff criminal record and abuse registry checks were not on file and available for review. Per record review, criminal record and abuse registry checks were not completed as required for 4 out of 5 sampled staff. These findings were confirmed by the Operations Manager at	R190		

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R190	Continued From page 11 approximately 6:40 PM on 2/12/24. In conclusion this deficient practice is potential risk for more than minimal harm for all residents, as the requirement for criminal background and abuse checks is intended to ensure all residents are free from the risk of harm.	R190		
R200 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to develop written policies that govern all services provided by the home, and to maintain a copy of the home's policies and procedures on file and available for review on request. Findings include: On the morning of 2/12/24 the Manager of the home was requested to provide an electronic or paper copy of the facility's Policies and Procedures Manual. Copies of specific policies and procedures related to potential deficient practices identified during the survey were requested throughout the survey process. On the morning of 2/12/24 the Manager of the home confirmed a manual of facility policies and procedures was not available for review. During the survey process specific policies and	R200		

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R200	Continued From page 12 procedures related to resident assessments, medication administration, staff trainings and background checks, resident records, and the facility environment were not on file and available for review on request. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents due to failure to provide accessible information and clear instructions related to tasks staff are required to perform.	R200		
R291 SS=F	IX. PHYSICAL PLANT 9.6 Plumbing 9.6.d Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to maintain water temperatures at or below 120 degrees Fahrenheit in areas of the home accessible to residents. Findings include: On 2/12/24 the Manager of the home confirmed policies and procedures related to water temperatures in areas accessible to residents had not been developed, including policies and procedures for conducting checks of water temperatures in the home on a regular basis.. During a facility tour of the home commencing at 12:09 PM on 2/12/23, water temperatures in areas of the home accessible residents were observed to be greater than 120 degrees Fahrenheit as follows:	R291		

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R291	Continued From page 13 Main floor shared bathroom: 122.4 degrees Fahrenheit Upstairs shared bathroom: 125.2 degrees Fahrenheit Downstairs shared bathroom: 128.1 degrees Fahrenheit These findings were confirmed by the Manager of the home during the facility tour. Due to the immediate and substantial risk to all residents of the home immediate corrective action was requested. Following the immediate corrective action of adjusting the boiler, water temperatures in the home the water temperatures were observed to be sustained below 120 degrees Fahrenheit as follows: Main floor shared bathroom: 118.5 degrees Fahrenheit Upstairs shared bathroom: 118/8 degrees Fahrenheit Downstairs shared bathroom: 119.5 degrees Fahrenheit These findings were confirmed by the Director of Operations at 2:15 PM on 2/12/24. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents due to the risk for burns associated with water temperatures above 120 degrees Fahrenheit.	R291		
R303 SS=F	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness	R303		

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SECOND SPRING NORTH	1071 VT ROUTE 15 UNDERHILL, VT 05489

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R303	Continued From page 14 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 there was a failure to maintain a phone on each floor of the home with emergency numbers posted beside the phones. Findings include: On 2/12/24 the Manager of the home confirmed a policies and procedures for ensuring phones with emergency phone numbers posted beside them are accessible to residents and visitors at all times and on each floor of the home. During the facility tour commencing at 12:09 PM on 2/12/24 it was observed the only phone accessible to residents was on the main floor of the home, and the upper and lower floors of the home were without phones. This finding was confirmed by Manager of the home during the facility tour on 2/12/24. In conclusion this deficient practice is a risk for more than minimal harm to all facility residents due to the failure to ensure phones with emergency numbers are accessible to residents and visitors on each floor of the home at all times.	R303		

Deficiency Statement Plan of Correction (POC)

Survey Date: February 12, 2024

Facility Name: Second Spring North

Deficiency Regulation	How the deficiency was corrected	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R147 Plan of Correction Accepted on 3/12/24 by Jo A. Evans RN	Resident #1 and Resident #2 prn medication prescriptions were updated to reflect the specific dose and frequency of administration	03/07/2024	An audit form was created to be completed by the nurse on a regularly basis; this will be performed 1 x month, ongoing.	Nursing, Provider, and Director of Compliance
R163 Plan of Correction Accepted on 3/12/24 by Jo A. Evans RN	Resident Assessments have been completed for Resident #1 and Resident #. Resident Assessments for all Residents have been reviewed and completed if necessary.	03/05/2024	Nursing has created a calendar to reflect all Resident Assessment due dates. The calendar will alert them 30 days prior to the due date	Nursing, Director of Compliance
R167 Plan of Correction Accepted on 3/12/24 by Jo A. Evans RN	The Provider updated the PRN psychoactive protocol to include desired effects/undesired side effects	03/06/2024	Education provided to Nursing staff and Med. Delegated staff. Provider and Nursing staff will review protocol on a regular basis and update as necessary	Nursing, Provider, and Director of Compliance
R173 Plan of Correction Accepted on 3/12/24 by Jo A. Evans RN	A locking mechanism for the medication refrigerator was ordered on 2/21/24 and was installed on 2/28/24.	03/01/2024	An audit form was created to be completed by the nurse on a regular basis; this will be performed 1xmonth, ongoing	Nursing, Director of Compliance
R176 Plan of correction accepted by Jo A Evans 1/18/23	All expired medication was disposed of per agency policy on 2/12/24	03/01/2024	An audit form was created to be completed by the nurse on a regular basis; this will be performed 1xmonth, ongoing	Nursing, Director of Compliance
R179 Plan of Correction Accepted on 3/12/24 by Jo A. Evans RN	The training records were reviewed for the 5 sample staff; staff completed trainings that were required. Required trainings for all staff have been reviewed and staff have been notified to complete all required trainings; as necessary.	03/04/2024	Education to Staff and Program Directors was given around the importance of trainings and to complete on time. Human Resources will run a monthly report on all required trainings and follow up with staff to ensure completion.	Human Resources, Director of Compliance
R188 Plan of Correction Accepted on 3/12/24 by Jo A. Evans RN	Resident #1 reviewed and signed an admission agreement on 3/1/24.	03/01/2024	An admission audit has been created for all new admissions, ensuring that admission agreements and photographs have been completed.	Director of Compliance

Pronoun removed by DLP 3/6/24

	Resident #3 agreed to have [redacted] picture taken and was loaded into the EHR system on 3/1/24 Admission Agreements and photographs for all current residents have been reviewed and updated if necessary.			
R190 Plan of Correction Accepted on 3/12/24 by Jo A. Evans RN	Criminal record and abuse registry checks were completed for the 4 out of 5 staff that were sampled. The results were emailed to Surveyor on 2/13/24 and 2/15/24. Criminal record and abuse registry checks were completed for all current staff to ensure they are up to date.	03/01/2024	Human Resources created an onboarding checklist, which includes background screens. Human Resources or Compliance Director will audit screens 1 x month, ongoing.	Human Resources, Director of Compliance
R200 Plan of Correction Accepted on 3/12/24 by Jo A. Evans RN	All agency Policies and Services are being reviewed by Human Resources and the Director of Compliance on 3/6/24. Policies will be updated as necessary and approved by the Board of Directors; no later than end of 04/2024	Projected Completion date of final Policy Handbook: no later than 05/01/2024	Policies and Services will be reviewed annually	Human Resources, Director of Compliance
R291 Plan of Correction Accepted on 3/12/24 by Jo A. Evans RN	A water temperature gauge was ordered on 3/1/24	03/01/2024	An audit form was created to check water temperatures in areas that are accessible to residents; this will be performed 1 x week, 3 months, and 1 x month ongoing,	Program Director
R303 Plan of Correction Accepted on 3/12/24 by Jo A. Evans RN	Two phones were ordered on 02/20/2024; and have been delivered. Signs have been created with emergency numbers. Installation of phones is scheduled for 03/15/2024	To be completed by: 03/15/2024	An audit will be performed; 2 x months, 3 months; 1 x month, ongoing	Director of Compliance, Program Director