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

October 3, 2023

Ms. Beatrice Birch, Manager
Inner Fire
26 Parker Road
Brookline, VT 05345

Dear Ms. Birch:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 24, 2023**. 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,

Carolyn Scott, LMHC, M.S.
State long Term Care Manager

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0662	A. BUILDING: _____ B. WING _____	C 08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNER FIRE	26 PARKER ROAD BROOKLINE, VT 05345

(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
T 001	Initial Comments An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on 8/22/23 and completed on 8/24/23. The following regulatory violations were identified:	T 001		
T 023 SS=G	V. 5.5.a Resident Care and Services 5.5 General Care 5.5.a Upon a resident's admission to a therapeutic community residence, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. The home's manager shall provide every resident with the personal care and supervision appropriate to his or her individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Therapeutic Community Residence (TCR) failed to provide the necessary services to include supervision and monitoring checks to ensure the psychosocial and safety needs of the resident were met for Resident #1, who was experiencing a major mental health decline. Findings include: Per record review, Resident #1 had resided at the TCR since October 2020. Upon admission, s/he took part in required therapies, enjoying outdoor activities, improving communication skills, diet and expanding his/her understanding of mental health challenges. Shortly after admission, and with Resident #1's agreement, the attending D.O.	T 023		

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T 023	Continued From page 1 (Doctor of Osteopath) began tapering a prescribed antipsychotic medication, Clozapine. Over the course of several months Resident #1's dose was decreased from 150 mg to 25 mg of Clozapine. During this period of tapering, Resident #1 initially tolerated the medication decrease, but began to have an increase in audio hallucinations and a need to take walks off the property. By July 2023 and due to presenting symptom concerns it was determined by the DO, the medication needed to be tapered up with Resident #1 receiving an increase dose of 75 mg of Clozapine. However, during this time period Resident #1 reconfirmed s/he had an increase in "internal stimuli" experiencing "mental noise". On 7/17/23 at approximately 11:30 AM Resident #1 ran off the TCR property into a thick wooded/mountain area which surrounds the TCR location. Staff attempted to follow but were unable to maintain contact. Resident #1 remained missing and in the elements without food or water for over 24 hours. Later in the afternoon of 7/17/23 the State Police were notified and a television news station reported Resident #1 as a missing person. Resident #1 was identified by an individual who had seen the "missing person" report on the afternoon of 7/18/23 and subsequently reported the observation resulting in Resident #1 being returned to the TCR. Resident was described upon return to be "....tired, with lots of cuts on his/her arms.." Staff at the TCR recognized that Resident #1 required close monitoring and attempts to provide 1:1 observations were initiated and additional counseling was provided. However, staffing availability; the distinct environmental setting made close monitoring difficult and unsuccessful. On 7/21/23 Resident #1 again eloped from the TCR property fleeing into the wooded,	T 023		

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T 023	Continued From page 2 mountainous areas surrounding the TCR. It was another 24 hours before Resident #1 was found walking on a main road by the attending DO and returned to the TCR. S/he was described as "...tired, dirty and hungry...". On 8/6/23 Resident #1 left the TCR property at 6:30 PM, ignoring staff's request to remain. Resident #1 returned 4 hours later. Again on 8/8/23 Resident #1 left the TCR property, becoming agitated when staff attempted to follow. Resident #1 assaulted the staff member, punching the staff member in the face. The resident returned 4 hours later. On 8/9/23 Resident #1 ran off the TCR property and was later found by police 24 miles away from the TCR appearing physically exhausted. It was evident from the pattern of behavior which transpired over several weeks, the staff was unable to maintain a safe, secure environment and appropriate supervision for the setting provided at the TCR. Resident #1, was experiencing an increase in audio hallucinations and need to flee the boundaries of the TCR and was unable to maintain agreements for safety plans. As a result the resident was repeatedly placing him/her/self in harms way by fleeing into wooded and mountainous environment without food, water or awareness of where s/he was traveling or ability to seek emergency assistance. After multiple elopements and escalation of his/her psychiatric illness, Resident #1 was discharged from the TCR on 8/10/23.	T 023	POC Accepted T-023 10/2/23 M. McIntosh, RN	
T 037 SS=D	V.5.8.c Resident Care and Services 5.8 Medication Management	T 037		

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T 037	Continued From page 3 5.8.c Staff shall not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's or other licensed health care provider's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, there was a failure by the RN (Registered Nurse) to obtain admission physician medication orders for 1 applicable resident. (Resident #2) Findings include: Resident #2 was admitted to the TCR on 8/21/23. As of 8/22/23 no physician orders had been received for Resident #2's medications/supplements although staff were assisting with the medications the resident had brought with him/her at the time of admission. Medications included Lurasidone 40 mg (used to treat mental/mood disorders); Niacin/B 3; Ascorbic Acid/Vit C; Nicotine gum; and MCT Powder (keto diet supplement). The RN confirmed on the afternoon of 8/22/23, s/he had not obtained physician orders for the newly admitted resident.	T 037	POC Accepted T-037 10/2/23 M. McIntosh, RN	

T023

5.5.a Upon a resident's admission to a therapeutic community residence, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. The home's manager shall provide every resident with the personal care and supervision appropriate to his or her individual needs.

Since the founding of Inner Fire,every individual has their individual schedule and knows what they are doing from 6:15am until 9pm.

Our approach to supporting an individual's ***psychosocial needs*** *is unique. Our responsibility is to help awaken the soul faculties of thinking, feel and willing. Every individual needs to feel recognized, loved, and respected. With this arises trust and a deeper self-respect and appreciation for who one is striving to become. Life becomes an empowering process of discovery. As time passes, an individual's needs evolve depending on their aims. By engaging in the Inner Fire program, we can in time see where additional focus needs be given. During our weekly Seeker Care Group meetings, we recognize where emphasis needs be given. For example, those who are more in-their-heads, excarnated, fearful and hearing voices, would need more grounding, practical work, to get them back-in- their-body and focused in the present, and upon what is at hand.*

Personal needs: *Out of respect for the individual and their big decision to commit to the yearlong Inner Fire program, each potential Seeker comes for a 3 Day Visit to get a sense as to whether they feel safe and comfortable enough to dare to work through the deeper issues which have led to their mental health/soul health challenges. Once they have been accepted into the comprehensive program, all aspects of their body, soul and spirit are addressed.* ***The physical and meaningful practical work*** *calls upon fine and gross motor skills, they become empowered as they are constantly learning. The rhythm of the day and the order of the program helps develop a sense of deeper security and through being-needed, their self-confidence grows, and they carry more responsibility.* ***The artistic and verbal therapies*** *stir the feeling realm of sympathies and antipathies which in turn leads to them practicing claiming their voices. We help individuals dare to claim their feelings and then experience the freedom that comes with then choosing what to do with them. We are not our feelings. Feelings are simply indications. All individuals engage in all aspects of the program. We do not meet individuals by their diagnosis as too often they are misdiagnosed. Each individual is recognized as a creator and therefore as striving human beings who need to be listened to and supported to digest and work through soul or physical traumas.*

Medications and nursing: *Most individuals arrive with medications, some with none. After a three-week adjustment period, an individual can then indicate their wish to begin to taper from their medications. The tapering is very slow. Each individual is respected and listened to as we, our doctor and nurse honor the insights of the individual and feel their engagement is empowering and very important. We stay in the moment and work with challenges which may arise. No decisions are made in the abstract. The nursing needs are also individual. Medication and nursing needs are recorded in individual binders and files.*

T023:

The manager has focused on and trained the staff (guides) regarding "prevention", and always when a new guide joins the Community. Over the years, during our weekly meetings the consciousness of the team of Guides has deepened. ***Action:*** *Nevertheless, the manager will make sure specific, preventative training regarding learning how to better detect signs an individual may display if they are losing their center and spiraling-out happen every other month, beginning October 4th.*

Since the August departure of Seeker #1 (Resident #1), the manager has met with individual guides and reflected with them as to how the Community could have better kept watch and supported resident #1.

Action: *Every morning and at times during the day, guides and therapists will be reminded to not let a resident, in need of extra care, out of their sight. Guides were aware of this important action, but one guide 'slipped'.* ***New action:*** *So, we will make sure that* ***more reminders are given,*** *and there will be no lax with the mandate until the manager gives directions to let-up.*

If a Seeker (resident) has been unintentionally triggered by a Guide, the initial NVC meeting will be called as soon as possible but certainly within the same day and, ***new action:*** *for at least the 3 following days the Seeker and Guide will meet with a third person, to make sure any other issues which arise will be discussed and reconciliation made. Appreciating resolving issues take time.*

If a Seeker has left the premises, ***new action:*** *we will first contact Search and Rescue before the police. In deeper discussion this was recommended.*

The manager will ***new action:*** *personally meet with HCRS Crisis in Brattleboro and share the work Inner Fire is doing so as to create a better understanding for if matters arise in the future where extra support is needed. HCRS was called upon in this recent case but our situation was not deemed a crisis and so no support was given.*

During the admissions process we will, ***new action:*** *take the time to discuss and emphasize the need for family to respond immediately if a crisis arises for the sake of their loved one and the whole Inner Fire community. They would come and take their loved one to where he/she may receive more intense care than Inner Fire is able to give.*

New action: *I, the manager, have connected with an organization which conscientiously assists in the transition process when someone may have to leave Inner Fire for whatever reason and their family cannot help out.*

As has been done, our doctor may feel the need to raise the medication dose so help the individual 'feel the ground under their feet.' The manager will continue to share any greater concerns with the doctor.

All the new action steps have already been taken, and our other actions remain in place.

It is important to acknowledge that many of the medications are addictive and therefore the tapering process is very individual and can be very challenging. We accept people into the program who reflect the will to be proactive in their healing journey and wish to carry responsibility for their healing journey knowing that we cannot make anyone do anything, nor should we, and know that we do not fix anyone as they are not broken. We are wise 'midwives' supporting, encouraging, and loving each striving

individual through their self-birthing to where they can reclaim their lives and reengage as constructive and enthusiastic citizens.

The manager (executive director) will monitor the above actions, ensuring that they are followed by checking in daily with all Guides (staff), the doctor and nurse as well as conversing with the individual in need of such attention.

POC Accepted
T-023 10/2/23
M. McIntosh, RN

ID: T 037

Action: Requested and obtained the documentation for the Physician's order for Resident #2 9/18/2023.

Policy Change: Prior to seeker admission, potential seekers are required to mail or email Inner Fire the physician's order for their medication as part of their admission's application. This will be added to our admission application and will be added to the admission check list followed by the Seeker Care Coordinator.

Monitored by: Beatrice Birch

Completion date: 10/4/2023

POC accepted
10/2/23 T-037
M. McIntosh, RN