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

December 16, 2024

Melinda Hurlburt, Manager
Safe Haven
4 Highland Avenue
Randolph, VT 05060

Dear Ms. Hurlburt:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 14, 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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0529	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN	4 HIGHLAND AVENUE RANDOLPH, VT 05060

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T 001	Initial Comments On 10/14/24 the Division of Licensing and Protection conducted an unannounced on-site annual relincensure survey. The following regulatory deficiencies were identified:	T 001		
T 037 SS=F	V.5.8.c Resident Care and Services 5.8 Medication Management 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 is a failure to maintain medication orders signed by a physician or other licensed health care provider on file and available for review for 3 out of 3 sampled residents (Residents #1, #2, and #3); and a failure to ensure medication orders include a supporting diagnoses or problem statement for 2 out of 3 sampled resident's medications (Residents #1, and #3). Findings include: The home's Medication Policy is not consistent with this regulation and does not include the requirement to maintain physician's written, signed orders with supporting diagnosis or problem statements for all resident medications. 1. Per record review written signed orders including the medication, dose, route, and	T 037		

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T 037	Continued From page 1 frequency of administration are not maintained on file for the following medications administered to Resident #1: Albuterol, Advair Diskus, Rexulti, Tylenol and Tums. A partial list of current diagnoses is on file in Resident #1's record, however specific supporting diagnoses or problem statement for each individual medication was not on file and available for review for all of Resident #1's medications. 2. Per record review written signed orders including the medication, dose, route, and frequency of administration are not maintained on file for the following medications administered to Resident #2: Acetaminophen, Melatonin, Levitiracetam, and Topiramate. 3. Per record review written signed orders including the medication, dose, route, and frequency of administration and a supporting diagnosis or problem statement are not maintained on file and available for review on request for the following medications administered to Resident #3: Fluoxetine, Clozaril, and Ibuprofen. These findings were confirmed by the Manager on the afternoon of 10/14/24.	T 037		
T 049 SS=F	V.5.8.h.4 Resident Care and Services 5.8 Medication Management 5.8.h.4 Medications left after the death or discharge of a resident, or outdated medications, shall be promptly disposed of in accordance with the residence ' s policy and applicable standards of practice and regulations.	T 049		

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T 049	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure prompt disposal of outdated medications. Findings include: Policies and procedures governing the disposal of outdated medications have not been developed by the home. 1. At 11:39 AM on 10/14/24 expired medications stored in the home's first aid kit were observed to be expired including 2 containers of Narcan Nasal Spray expired 2/2024. This finding was confirmed by the Manager during the check of the home's first aid kit on the morning of 10/14/24. 2. At 2:39 PM on 10/14/24 an expired Advair Discuss inhaler was observed to be stored in the medication container for Resident #1. This finding was confirmed by the Manager during the medication storage check in the section of home designated for Crisis support on the afternoon of 10/14/24.	T 049		
T 050 SS=D	V.5.8.h.5 Resident Care and Services 5.8 Medication Management 5.8.h.5 Narcotics and other controlled drugs must be kept in a locked cabinet in a locked room. Narcotics must be accounted for on a daily basis. Other controlled drugs shall be accounted for on at least a weekly basis. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there	T 050		

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T 050	Continued From page 3 was a failure to ensure controlled substances are accounted for on at least a weekly basis for one applicable resident (Resident #2). Findings include: The home's Medication Policy indicates Residents ("Guests") will count controlled substances other than narcotics weekly with staff present to verify the count. Per review of Resident #2's Log Sheet on file for the controlled substance Zolpidem (Ambien, sleep aid), the last date this medication was counted was 8/5/24. Per record review this medication was discontinued on 8/9/24, and there is no indication on the Log Sheet that this medication was wasted after it was discontinued. Staff on duty confirmed this finding at 4:55 PM and stated that the residents were responsible for the count.	T 050		
T 052 SS=F	V.5.9.b.1.2.3.4.5.6.7 Resident Care and Services 5.9 Staff Services 5.9.b. The residence 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;	T 052		

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T 052	Continued From page 4 (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, hand washing, 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 completion of all required yearly trainings for 5 out of 5 sampled staff. Findings include: The home's Training/Professional Development policies and procedures are not consistent with the licensing requirements for yearly trainings. Per review of training records on file and available for review for a sample of 5 staff, all required yearly trainings were not completed by 5 out of 5 sampled staff. This finding was confirmed by the Manager at 2:29 PM on 10/14/24.	T 052		
T 054 SS=D	V.5.9.d Resident Care and Services 5.9 Staff Services	T 054		

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T 054	Continued From page 5 5.9.d The licensee shall not have on staff a person who has had a charge of abuse, neglect 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 residence 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 and the Department for Children and Families in accordance with 33 V.S.A. §6911 and 33 V.S.A. §4919 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure written documentation on file and available for review indicating the decision to hire 1 applicable staff with a substantiated Vermont Criminal Information Center (VCIC) criminal record finding does not pose a risk to facility residents per the Division of Licensing and Protection's memorandum entitled "Background Check Process" sent to all Therapeutic Care Residences on June 25, 2015. Findings include: The home's Background Checks policy is not consistent with this regulatory requirement.	T 054		

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T 054	Continued From page 6 Per review of criminal record checks on file and available for review for a sample of 5 staff, the VCIC criminal record checks for 1 out of 5 sampled staff included a substantiated finding which does not exclude the applicable staff from employment at the home. At approximately 1:15 PM on 10/14/24, the Director of Human Resources and Compliance for the organization that manages the home confirmed a letter was not on file in the applicable staff's personnel file indicating the decision to hire the staff does not pose a risk to the home's residents.	T 054		
T 062 SS=F	V.5.10.b.4 Resident Care and Services 5.10 Records/Reports 5.10.b.4 The results of the criminal record and 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 ensure all criminal record and abuse registry checks were completed as required for a sample of 5 staff. Findings include: The home's Background Checks policy and procedures state the organization will implement and adhere to background checks in accordance with the Vermont State Legislation. Per review of criminal record and abuse registry checks completed for a sample of 5 staff, all required background checks were not completed as required for 5 out of 5 sampled staff. This	T 062		

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T 062	Continued From page 7 finding was confirmed by the Director of Human Resources and Compliance for the organization that manages the home at 3:28 PM on 10/14/24.	T 062		
T 071 SS=F	V.5.13 Resident Care and Services 5.13 Policies and Procedures Each residence must have written policies and procedures that govern all services provided by the residence. A copy shall be available for review at the residence upon request. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to develop policies and procedures governing areas of service provided by the home. Findings include: During the course of the survey conducted on 10/14/24, the Manager was asked to provide policies and procedures governing the following areas of service for review: a. Labeling and Storage of Perishable Items b. Disposal of Outdated Medications c. Obtaining Physician's written signed orders for medications d. Ensuring all medication orders include a supporting diagnosis or a problem statement e. Resident Care/Treatment Plans f. Resident Intake Summaries On the afternoon of 10/14/24 the Manager confirmed policies and procedures governing these areas of service had not been developed by	T 071		

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T 071	Continued From page 8 the home.	T 071		
T 073 SS=F	V.5.14.b Resident Care and Services 5.14 Transportation 5.14.b The residence shall provide or arrange transportation to medical services as needed by residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to provide or arrange transportation to medical services as needed for all residents ("Guests") of the home. Findings include: Per record review, the home's Transportation and Scheduling of Appointments policy effective June 2022 states the purpose of the policy as, "Guests will be responsible for maintaining needed services, and arranging transportation needs in order to facilitate ongoing care." This document also states, "It is the policy ... to ensure that guests get to their scheduled appointments and work with the staff to identify transportation options available to them". Procedures listed in this policy include: a. Residents working with their applicable treatment team to explore available transportation options b. Case Management's responsibility for helping coordinate reasonable transportation to and from appointment c. The resident's responsibility for setting up reasonable transportation with their case manager with sufficient time to ensure rides to	T 073		

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T 073	Continued From page 9 their appointments. During an interview commencing at 5:37 PM on the Manager of the home stated transportation to appointments is not provided to residents of the home, with the exception of residents admitted into the home's 2 crisis beds for whom transportation is "sometimes" provided. The Manager confirmed transportation to medical services is not provided or arranged by the home statingthat the home is not responsible for getting them to medical appointments and don't guarantee any transport .	T 073		
T 074 SS=F	V.5.14.c Resident Care and Services 5.14 Transportation 5.14.c The residence shall provide or arrange transportation for residents to a practical number of appropriate community functions and shall have a written policy that states the number and duration of such transports that will be considered reasonable. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to provide or arrange resident transportation for outings in the community and to develop a written policy stating the number and duration of transports provided by the home. Findings include: Per record review, the home's Transportation and Scheduling of Appointments policy effective June 2022 does not address provision or arrangement	T 074		

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T 074	Continued From page 10 of transportation for community functions. During an interview commencing at 5:37 PM on 10/14/24 the Manager confirmed the home does not provide transportation for residents, and indicated the public bus is an option that is free of charge.	T 074		
T 092 SS=D	VI.6.8 Residents Rights VI. Residents Rights 6.8 A resident may file a complaint or voice a grievance without interference, coercion or reprisal. Each residence shall establish an accessible written grievance procedure for resolving residents ' concerns or complaints that is explained to residents at the time of admission and posted in a prominent, public place on each floor of the residence. The grievance procedure shall include at a minimum, time frames, a process for responding to residents in writing within ten (10) days, and a method by which each resident filing a complaint or grievance will be made aware of the designated Vermont protection and advocacy organization as an alternative or in addition to the residence's grievance mechanism. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure a written response to a grievance filed by one applicable resident (Resident #3) within ten days. Findings include: The home's Grievance Policy is included on the Grievance Form and is consistent with this	T 092		

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T 092	Continued From page 11 regulation. Per record review, Resident #3 filed a Grievance on 1/16/24 stating s/he felt harassed by a staff member. Resident #3's record does not include a written response to this grievance. During an interview commencing at 5:37 PM on 10/14/24, the Manager confirmed Resident #3 filed this grievance and stated s/he was unable to confirm if a written requested had been provided to Resident #3. On the morning of 10/15/24 the Co-Manager of the home provided email records regarding resolution of this grievance which did not include documentation of a written response to Resident #3.	T 092		
T 127 SS=F	VII.7.2.b Nutrition and Food Services 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperature. Hot foods shall be kept hot at 135 degrees F and cold foods shall be kept at 41 degrees F or cooler. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure perishable foods and beverages are labeled with the dates the items are opened or prepared. Findings include: Policies and procedures governing storage and labeling of perishable foods have not been developed by the home. During a tour of the home's kitchen and dining	T 127		

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T 127	Continued From page 12 areas commencing at 11:05 AM on 10/14/24, the following perishable foods and beverages were observed to be stored without labels indicating the dates the items were opened or prepared: 1. In the kitchen refrigerator: Milk, almond milk, condiments, dressings, sauces, jellies, butter, cheeses, deli meats, and containers of prepared foods in the refrigerated section. Open boxes of hot pockets, pancakes, ice cream, mozzarella sticks, prepared meat items, and bags of frozen vegetables in the frozen section. 2. In the kitchen cabinets: Containers of rice, oats, cereals, pasta, crackers, syrup, honey, oil, snack items, soy sauce, and hot sauce. 3. In a refrigerator located in the dining room: Raw hamburger and chicken, pepperoni, chocolate sauce, and shredded cheese. These findings were confirmed by the Manager of the home during the tour on the morning of 10/14/24.	T 127		

T 037 SS=F

The policy for Chris's Place and Safe Haven will be changed to ensure that individuals admitted into the program have signed medication orders that include a problem statement or diagnosis. The referral form and process will be changed to reflect this requirement and indicate that if there is no current, active, order the medication will be disposed of or returned to the client's residence and not stored at the program. Re-education training will be provided to staff which will be completed by 12/12/2024. Immediate corrective action has begun, and all missing medication orders will be collected by 11/15/2024. We've implemented a plan that meets the regulatory standard and are awaiting board approval for official policy change. Board will be meeting in January for final approval.

Completed Policy approval Date 01/31/2025

T037 Plan of Corrections accepted by Jo A Evans RN on 12/14/24

T 049 SS=F

The admission forms and process for Chris' Place and Safe Haven will be changed to ensure that individuals admitting into the program do not bring expired medications to the residence. It will be noted on the referral form that should an individual bring expired medication, the medication will be disposed of or returned to the client's residence. A medication disposal training will be provided to staff and completed no later than 12/08/2024. To properly dispose of medications Safe Haven and Chris's Place will utilize the medication mailer program. To remedy the current issue management will verify with resident that all medications in need of disposal have been disposed of and updated in appropriate files by 11/8/2024. A review of the program's first aid kit will occur on an annual basis to identify and replace any expired medication. We've implemented a plan that meets the regulatory standard and are awaiting board approval for official policy change. Board will be meeting in January for final approval.

Completed Policy approval Date 01/31/2025

T049 Plan of Correction accepted by Jo A Evans RN on 12/14/24

T 050 SS=D

Safe Haven and Chris's Place policy 9.07 Medication Management states that narcotics are secured in the facility under double lock and accounted for daily. All other controlled substances are counted at least weekly. Staff will be retrained on expectations and procedures in the policy and the policy will be amended to include instructions on the disposal of medications if they are discontinued to be completed by 12/12/2024. We've implemented a plan that meets the regulatory standard and are awaiting board approval for official policy change. Board will be meeting in January for final approval.

Completed policy approval Date 1/31/2025

T050 Plan of Correction accepted by jo A Evans RN on 12/14/24

T 052 SS=F

To address the current missing trainings, staff trainings will be held at staff meeting 3 times a month. To prevent further incident, a review of staff trainings will be conducted monthly and individual plans can be created as needed to ensure all staff are in compliance. Individual plans will be made with staff that need extra support to meet deadline.

Complete Date 12/12/24

T052 Plan of Correction accepted by Jo A Evans RN on 12/14/24.

T 054 SS=F

Agency policy will be updated to ensure any substantiated findings during background checks include a letter indicating the organization has determined the finding does not pose a risk to the facility residents and does not exclude the applicable staff from employment at the program. For instances where this

may occur, a letter will be placed in the employee's Human Resources file to address this. For the staff member identified at the time of the review, a letter will be placed in their HR file by 11/15/24. We've implemented a plan that meets the regulatory standard and are awaiting board approval for official policy change. Board will be meeting in January for final approval.

Completed Policy approval Date 01/31/2025

T054 Plan of Correction accepted by Jo A Evans RN on 12/14/24

T 062 SS=F

CMC Human Resources has begun collecting the background checks that were identified as missing during the site visit. All background checks that are missing will be fully collected by 11/15/2024.
To ensure continued compliance with DLP regulations, the Acute Care Housing and Residential Coordinator will make regular checks to the website to ensure no updates to regulations are missed.

Complete date 11/30/2024

T062 Plan of Correction accepted by Jo A Evans RN on 12/14/24.

T 071 SS=F

Managers and Director of the programs are currently working on policy review and will be updating program policies to meet areas of discrepancy. Trainings will be provided to staff on updated policy information and will be completed by 12/12/2024. We've implemented a plan that meets the regulatory standard and awaiting board approval for official policy change. Board will be meeting in January for final approval.

Completed Policy approval date 01/31/2025

T071 Plan of Correction accepted by Jo A Evans RN on 12/14/24

T 073 SS=F

We encourage autonomy for the guests and provide support to the individuals to establish rides via the bus, case managers, public transportation, natural supports, and Medicaid rides. The program will continue to support individuals to establish their own rides, assist with setting up transportation, and provide in house transportation whenever possible. Should all other avenues fail to secure a ride for the residents CMC will assure transportation access to regional providers. Program management either Acute Care Coordinator or Residential House Manager will ensure regulations regarding transportation are being upheld by delegated staff. The program will ensure that each guest has access to transportation for appointments with regional providers. Completed on 11/08/2024

T073 Plan of Correction accepted by Jo A Evans RN on 12/14/24

T 074 SS=F

We encourage autonomy for the guests and provide support to the individuals to establish rides via the bus, case managers, public transportation, natural supports, and Medicaid rides. The program will continue to support individuals to establish their own rides, assist with setting up transportation, and provide in house transportation whenever possible. Should all other avenues fail to secure a ride for the residents CMC will assure transportation access to regional providers. Program management either Acute Care Coordinator or Residential House Manager will ensure regulations regarding transportation are being upheld by delegated staff. The program will ensure that each guest has access to at least 3 community events/outings per a quarter. Completed on 11/8/2024

T074 Plan of Correction accepted by Jo A Evans RN on 12/14/24

T 092 SS=D

Written responses for grievances are not handled in house by the residence but are addressed and followed up by the Clara Martin Center Grievance and Appeals Coordinator. To ensure future compliance, when a resident expresses a complaint or grievance, the residence will offer to assist the resident with completing the Agency grievance form. After completion, the residence will offer to assist the resident with sending the form to the Grievance and Appeals Coordinator. Residence management, either the Acute Care Coordinator or Residential House Manager, will ensure a follow up letter is mailed to the resident within five calendar days via direct communication with the Grievance and Appeals Coordinator. A dated and sealed copy of the response letter will also be sent to the residence to keep on file in the program. Should further information be required staff will contact the Grievance and Appeals Coordinator to provide the required information to the requesting agency.

Complete date 11/8/2024

T092 Plan of Correction accepted by Jo A Evans RN on 12/14/24

T 127 SS=F

All identified items at the time of the site visit are now labeled appropriately, and those that cannot be accurately labeled have been disposed of. An updated training will be provided to staff and residents of the programs to include opened on dates and item labels on all goods from the cabinets, fridge, or freezer that are opened. Staff will complete weekly inspections of cabinets and the refrigerators to ensure continued compliance.

Complete date 11/8/2024

T127 Plan of Correction accepted by Jo A Evans RN on 12/14/24