



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

December 4, 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 **November 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,

A handwritten signature in black ink, appearing to read "Carolyn Scott".

Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0611	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/12/2024
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NAME OF PROVIDER OR SUPPLIER SECOND SPRING NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1071 VT ROUTE 15 UNDERHILL, VT 05489
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R100	Initial Comments: On 11/12/24 the Division of Licensing and Protection conducted an unannounced on-site investigation of one facility reported incident. The following regulatory deficiencies were identified during the investigation:	R100		
R136 SS=E	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.7. Assessment</p> <p>5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to complete Resident Assessments in response to significant changes in behavior for 2 applicable residents (Resident #1 and Resident #2). Findings include:</p> <p>The home's Required Resident Records policy effective 2/1/24 is consistent with this regulatory requirement.</p> <p>1. Per record review, the only Resident Assessment on file in Resident #1's record is an Admission Assessment signed as completed the day of his/ her admission to the home on 7/5/24. Resident #1's Admission Assessment indicates Resident #1 is never physically abusive to others and never resists care.</p>	R136		

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE Director of QA and Compliance (X6) DATE 12/3/24

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R136	<p>Continued From page 1</p> <p>Per record review, Resident #1 has a history of hospitalization due to psychiatric decompensation including incidents of verbal and physical aggression towards staff and other patients. Per Notes on file from the Discharging Hospital received by the home during Resident #1's admission process, episodes of physically aggressive and abusive behaviors towards others had not occurred for approximately 4 months prior to his/her admission to the home.</p> <p>Per staff interview and record review Resident #1 engaged in multiple incidents of aggressive and abusive behaviors directed at other residents and staff during a period of approximately 2 months leading up to an incident during which Resident #1 physically assaulted another resident on 10/28/24. Per Staff interviews and record review, the incident on 10/28/24 began with Resident #1 targeting another resident (Resident #3) and quickly escalated to Resident #1 redirecting his/her aggression towards a Staff member s/he frequently targets who was attempting to diffuse the situation. As Resident #1 physically advanced towards the Staff member, another resident (Resident #2) stepped between them to prevent Resident #1 from physically assaulting the Staff. Resident #1 responded by shoving Resident #2 in an attempt to get to the Staff member, then yelled at Resident #2 for stopping him/her from "beating up" the Staff.</p> <p>Additionally, following admission to the home Resident #1 has refused medications for extended periods of time. Per record review an Incident Report dated 9/24/24 indicated Resident #1 had refused medications since 8/12/24. While the right to refuse medications is a protected resident's right identified in the licensing regulations, it is important to note refusing</p>	R136		

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R136	<p>Continued From page 2</p> <p>medications is identified on the Resident Assessment form provided by the licensing agency as an example of resistance to care.</p> <p>Per record review, significant change assessments were not completed by a Registered Nurse in response to significant changes in Resident #1's presentation including physically assaultive behavior and resistance to care.</p> <p>2. Per record review the most recent Resident Assessment on file in Resident #2's record is an annual re-assessment completed on 3/8/24 which indicated s/he is never verbally abusive and never socially inappropriate.</p> <p>Per Staff interviews and record review, Resident #2 has demonstrated significant behavioral changes following development of a romantic relationship with another resident (Resident #1) and development of a persistent belief that a resident (Resident #3) has stolen missing items belonging to Resident #1. Per interviews with Administrative Staff conducted on 11/12/24, Resident #2 was preparing for discharge prior to these behavioral changes.</p> <p>Staff Notes document episodes of Resident #2 engaging in verbally aggressive and abusive behaviors directed towards Resident #3 including yelling, cursing, and name calling. Resident #2 has also demonstrated socially inappropriate behavior described by Staff as "possessive" regarding the common area of the home adjacent to his/her room and Resident #1's room which s/he considers their own personal space. Per record review, Resident #2 has stated "This is our apartment area; you are not allowed to be here; you need to get out now" to Resident #3, and informed Staff "I will keep harassing [Resident #3]</p>	R136		

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R136	<p>Continued From page 3</p> <p>until [s/he] leaves". This shared space is adjacent to the main floor resident bathroom and the nursing office where resident's medications are administered.</p> <p>Per record review, significant change assessments were not completed by a Registered Nurse in response to significant changes in observed in Resident #2's presentation including verbally abusive and socially inappropriate behaviors.</p> <p>At approximately 5:00 PM on 11/12/24 the Director of Quality Improvement and Compliance confirmed Resident Assessments were not completed in response to Resident #1's and Resident #2's significant changes observed and documented by Staff.</p> <p>Please refer to tag 145.</p>	R136		
R145 SS=E	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.9.c (2)</p> <p>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;</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure development of plans of</p>	R145		

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R145	<p>Continued From page 4</p> <p>care which describe care and services necessary to maintain independence and well-being for two applicable residents (Resident #1 and Resident #2). Findings include:</p> <p>The home's Required Resident Records policy effective 2/1/24 is consistent with this regulatory requirement and states, "Nursing staff are responsible for updating care plans as needed..."</p> <p>1. Resident #1 was admitted to the home on 7/5/24 with multiple psychiatric diagnoses and a history of traumatic experiences. Per Staff interviews and record review Resident #1 has a repeatedly targeted another resident (Resident #3) due to a persistent belief Resident #3 stole his/her wallet. Per Staff Notes Resident #1 has a history of leaving items in the common areas of the home; and making accusations of theft when items are missing. Per interview on the afternoon of 11/12/24, an Administrative Staff stated when the wallet was initially discovered missing Resident #1 expressed s/he may have left the wallet behind during on an outing. Staff have conducted 2 searches of Resident #3's room and personal belongings with consent, during which the missing items were not found.</p> <p>During Resident #1's episodes of targeting Resident #3 s/he has demonstrated aggressive and abusive behaviors including yelling, cursing, name calling, and threats of physical harm. Per Staff interviews and record review, an incident occurring on 10/28/24 that began with targeting Resident #3 quickly escalated to Resident #1 redirecting his/her aggression towards a Staff member s/he also frequently targets who attempted to diffuse the situation. As Resident #1 physically advanced towards the Staff another</p>	R145		

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R145	<p>Continued From page 5</p> <p>resident (Resident #2) stepped between then to prevent Resident #2 from physically assaulting the Staff. Resident #1 responded by shoving Resident #2 in an attempt to get to the Staff, then yelled at Resident #2 for stopping him/her from "beating up" the Staff member.</p> <p>Per record review, the Behavioral Support Plan, Care Plan, and Treatment Plan on file in Resident #1's record do not address specific needs related to the persistent belief Resident #3 stole his/her wallet. Although the Behavioral Support Plan dated 10/25/24 states "consistent, clear, healthy boundaries are a key aspect of [Resident #1's] treatment", all three plans of care do not include specific instructions for a clear and consistent staff response to verbal and physical aggressions related to this issue. Incident Reports provided for review on 11/12/24 indicate risk for harm to others observed by staff leading up to the incident on 10/28/24 including:</p> <p>a. 8/13/24: Resident #1 threw 2 bowls at Staff and stated to Staff, "You don't think I can put my hands on you [name calling/cursing] because I can"</p> <p>b. 8/21/24: Staff notified crisis services regarding multiple incidents involving Resident #1 with "potential to escalate to higher acuity"</p> <p>c. 8/26/24: Resident #1 stated, "I've had enough and this time I'll hit with someone [sic]" to the Program Director</p> <p>d. 9/2/24: Staff documented medication refusals for over 3 weeks, which is identified as a "Warning Sign" in Resident #1's Introduction to New Resident form provided to Staff on admission. This incident form also indicated</p>	R145		

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R145	<p>Continued From page 6</p> <p>Resident #1 was observed targeting a specific staff, spraying the staff with perfume, and threatening to punch staff in face as s/he "moved in closer and closer"</p> <p>e. 9/9/24: Staff documented "no meds for 4 weeks", and Resident #1's statement to staff to "watch out [name calling/cursing]"</p> <p>f. 9/24/24: Staff documented refusal of oral medications, including a prescribed oral anti-psychotic, since 8/12/24.</p> <p>Resident #1's Treatment Plan identified "some aggressive language and posturing" as an item of attention on 8/20/24, however specific goals and interventions to address risk for harm to others in response to threats of physical harm, yelling, name calling and cursing directed towards residents and staff are not included in the plans of care on file. Additionally, as of 11/12/24 all plans of care on file for Resident #1 had not been updated to include goals and interventions related to actual physical aggression/abuse and harm to others in response to the incident on 10/28/24. The persistent belief Resident #3 has stolen missing personal items, and subsequent aggressive and abusive behaviors directed towards Resident #3 are not identified and addressed in Resident #1's Behavioral Support Plan, Care Plan, and Treatment Plan provided for review on request on 11/12/24.</p> <p>2. Resident #2 was admitted to the home on 11/22/22 with a diagnosis of Schizophrenia. Per Resident #2's Behavioral Support Plan s/he has a history of engaging in interpersonal relationships that can cause harmful behaviors. During an interview commencing at 11:33 AM on 11/12/24, an Administrative Staff stated Resident #1 and</p>	R145		

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R145	<p>Continued From page 7</p> <p>Resident #2 quickly became friends and secluded themselves from other residents soon after Resident #1 was admitted to the home, and both residents state they are in a romantic relationship. Per Resident #2's Treatment Plan, the couple engage in intense arguments which have been identified as a safety concern. Per Administrative Staff, Resident #2 was in the process of preparing for discharge prior to engaging in a romantic relationship with Resident #1, and has decompensated while engaging in this romantic relationship at the home.</p> <p>Per record review, Resident #2 also has a persistent belief that Resident #3 has stolen missing personal items including Resident #2's wallet and a phone charger. This belief was not alleviated by two searches of Resident #3's room and personal belongings conducted by Staff. Per Staff interviews and record review, Resident #2 has demonstrated behavioral changes related to the belief Resident #3 stole the missing items and has engaged in ongoing conflict with Resident #3 including confronting, targeting, threatening, and harassing Resident #3. Resident #2 has also demonstrated behavior described by Staff as "possessive" of the common area adjacent to his/her room and Resident #1's room which s/he considers their own personal space. Per record review, Resident #2 has stated "This is our apartment area, you are not allowed to be here; you need to get out now" to Resident #3, and informed Staff "I will keep harassing [Resident #3] until [s/he] leaves". This shared space is adjacent to the resident bathroom on the main floor of the home and the nursing office where resident's medications are administered. Per Staff Notes, Resident #2 has stated s/he "couldn't let the wallet and phone charger go" and expressed s/he perceives Resident #2 walking around the home</p>	R145		

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R145	<p>Continued From page 8</p> <p>and "even on our side (of the home)" as taunting and "rubbing it in".</p> <p>Per record review, the Behavior Plan, Care Plan, and Treatment Plan on file in Resident #2's record do not identify the persistent belief Resident #3 has stolen missing items, subsequent conflict with Resident #3; and potential for dangerous behaviors and harm to others as areas of focus. Specific goals and interventions to address actual behaviors demonstrated in response to conflict with Resident #3 are also not addressed in his/her plans of care. While Resident #2's Treatment Plan states, "[Resident #2] will maintain safe, non-violent or aggressive behavior /communication at all times", specific interventions are not identified in this plan to ensure a consistent staff response to aggressive behaviors and communications. The Treatment Plan on file was signed by Resident #2 and Staff on 10/7/24, however updates have not been made to this plan since 8/3/24. Per Staff Note dated 11/2/24, a protocol was "set in place" to initiate 1:1 support if Resident #2 "started to escalate again"; although a written protocol for staff response to escalation is not documented in Resident #2's plans of care provided by Administrative Staff for review on 11/12/24.</p> <p>At 4:07 PM on 11/12/24 the Director of Quality Improvement and Compliance confirmed the Behavioral Support Plans, Care Plans, and Treatment Plans on file and available for review in Resident #1's and Resident #2's records do not address specific needs and safety concerns related to the persistent belief Resident #3 has stolen missing personal items, and aggressive/abusive behaviors directed towards Resident #3.</p>	R145		

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R145	Continued From page 9 Please refer to tag 136.	R145		

Deficiency Statement Plan of Correction (POC)

Survey Date: November 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
R136	<p>On 11/20/24 Resident #1 Resident Assessment was updated to reflect change in behavior and resistance to care.</p> <p>On 11/19/2024 Resident #2 successfully discharged from Second Spring North.</p> <p>R136 Plan of Correction accepted by Jo A Evans RN on 12/4/24</p>	11/20/2024	<p>Nursing audited and reviewed all other Resident Assessments for Second Spring North Residents and updated them as necessary.</p> <p>An audit was created for Nursing and Clinical documentation, including Resident Assessments, and will be reviewed weekly for 3 months, then once a month thereafter.</p> <p>Nursing rounds format has been changed as of 11/21/2024 with a standing agenda item: "Any changes to behavioral plans, care plans, or clinical plans."</p>	Nursing and Director of QI and Compliance
R145	<p>On 11/22/2024 Resident #1 Plan of Care was updated to reflect the care and services necessary to assist the Resident to maintain independence and well-being.</p> <p>On 11/19/2024 Resident #2 successfully discharged from Second Spring North.</p> <p>R145 Plan of Correction accepted by Jo A Evans RN on 12/4/24</p>	11/22/2024	<p>Nursing audited and reviewed all other Plan of Care's for Second Spring North Residents and updated them as necessary.</p> <p>An audit was created for Nursing and Clinical documentation, including Resident Assessments, and will be reviewed weekly for 3 months, then once a month thereafter.</p>	Nursing, Clinical, and Director of QI and Compliance

			Nursing rounds format has been changed as of 11/21/2024 with a standing agenda item: "Any changes to behavioral plans, care plans, or clinical plans."	
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