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

June 28, 2024

Cheryl Jacobs, Manager
Second Spring South
Po Box 320
Richmond, VT 05477

Dear Ms. Jacobs:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 3, 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
	0386	A. BUILDING: _____ B. WING _____	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECOND SPRING SOUTH	PO BOX 320 RICHMOND, VT 05477

(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: On 6/3/24 the Division of Licensing and Protection conducted an unannounced on-site annual relicensure survey. The following regulatory deficiencies were identified:	R100		
R134 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7 Assessment 5.7.a An assessment shall be completed for each resident within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The resident's abilities regarding medication management shall be assessed within 24 hours and nursing delegation implemented, if necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to complete an admission assessment within 14 days for one applicable resident (Residents #1). Findings include: On the afternoon of 6/3/24 the Director of Quality Improvement and Compliance was requested to provide the home's policies and procedures that govern completion of resident assessments. The Director of Quality Improvement and Compliance confirmed policies and procedures governing this area of service had not been developed. Per record review Resident #1 was admitted to the home on 5/16/24. His/her admission assessment was signed as completed on 6/3/24, eighteen days after admission to the home. This finding was confirmed by the Nurse Manager on	R134		

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R134	Continued From page 1 the afternoon of 6/3/24. In conclusion this deficient practice is a risk for more than minimal harm due to the failure to ensure timely identification of resident strengths, weaknesses, preferences, and needs which is the basis of resident care planning.	R134		
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 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.	R179		

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R179	Continued From page 2 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 trainings. Findings include: On the afternoon of 6/3/24 the Director of Quality Improvement and Compliance was requested to provide the home's policies and procedures for staff training. In response the Director of Quality Improvement and Compliance provided the [Organization that manages the home] Training Protocol, Document Number 108 effective 5/1/19 for review. The Summary section of this document states, "The purpose of this policy is to provide a framework for training and development that ensures that staff have necessary competencies to deliver on [the organization that manages the home's] specific job duties, strategic, and operational plans." The Protocols section of this document states, "The annual training plan... will be approved by the Senior Management Group (SMG) and communicated to all staff."; and the Internal Training Requirements section of this document states training will emphasize "Regulatory compliance requirements". The Training Protocol document provided for review on 6/3/24 does not indicate staff providing direct care to residents are expected to complete all yearly trainings required by the licensing agency; and the list of trainings included in this document does not include all yearly trainings required by the licensing agency. Per record review 5 out of 5 sampled staff did not	R179		

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R179	Continued From page 3 complete all required yearly trainings. This findings was confirmed by the Program Director at 1:13 PM on 6/3/24. 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		
R190 SS=E	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 ensure all required background checks were completed for 3 out of 5 sampled staff. Findings include: Per record review, the Background Checks policy and procedures effective 5/6/21 provided by the Director of Quality Improvement and Compliance for review on 6/3/24 states, "[The organization that manages the home] utilizes the Vermont State Subscription Service for rechecks of child abuse, adult abuse and national sex offender registries, criminal record convictions, and motor vehicle records. Each year, [the organization's] employee's records may be rechecked. " Per record review all required criminal record checks were not completed for 3 out of 5 sampled staff and all required abuse registry checks were not completed for 1 out of 5	R190		

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R190	Continued From page 4 sampled staff. These findings were confirmed by the Program Director at 1:48 PM on 6/3/24. In conclusion this deficient practice is a 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 ensure development of policies and procedures governing all areas of service provided by the home. Findings include: 1. During the annual relicensure survey conducted on 6/3/24 the Director of Quality Improvement and Compliance was requested to provide copies of policies and procedures related to areas of service for which deficient practices were identified during the survey process. In response to this request the Director of Quality Improvement and Compliance confirmed policies and procedures governing completion of resident assessments, handling and storage of dented cans, labeling of perishable foods and beverages, and maintenance of the home's living environment had not been developed by the	R200		

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R200	Continued From page 5 home. This finding was confirmed by the Director of Quality Improvement and Compliance on the afternoon of 6/3/24. 2. Additionally, per review of the policies and procedures provided for review on 6/3/24: a. Policies and procedures governing staff training did not identify all yearly trainings required by the licensing agency. b. Policies and procedures governing storage of perishable foods and beverages did not identify the regulatory requirement to maintain refrigerator temps at or below 40 degrees Fahrenheit. c. Policies and procedures governing water temperatures in areas of the home accessible to residents did not identify the regulatory requirement to maintain water temperatures in resident accessible areas at or below 120 degrees Fahrenheit. In conclusion these deficient practices are a potential risk for more than minimal harm for all facility residents due to failure to provide accessible information and clear instructions regarding tasks staff are required to perform.	R200		
R246 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.a Each home must procure food from sources that comply with all laws relating to food	R246		

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R246	Continued From page 6 and food labeling. Food must be safe for human consumption, free of spoilage, filth or other contamination. All milk products served and used in food preparation must be pasteurized. Cans with dents, swelling or leaks shall be rejected and kept separate until returned to the supplier. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure dented cans are rejected and kept separate from foods to be served to residents of the home. Findings include: The Director of Quality Improvement and Compliance was requested to provide the home's policies and procedures to ensure dented cans not stored with usable food and served at the home. On the afternoon of 6/3/24 the Director of Quality Improvement and Compliance confirmed policies and procedures governing this area of service had not been developed. During a tour of the kitchen commencing at 10:25 AM on 6/3/24 six dented #10 cans of tomatoes and two large dented cans of cream of mushroom soup were observed to be stored on the pantry shelves with undamaged cans and other foods to be served to residents. This finding was confirmed by the Program Director during the kitchen tour on the morning of 6/3/24. In conclusion, this deficient practice is a potential risk for more than minimal harm due to food borne illness for all facility residents.	R246		

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R247	Continued From page 7	R247		
R247 SS=F	VII. 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 temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure all perishable foods and beverages are dated with the dates the items were opened or prepared; and a failure to ensure all perishable items are stored at or below 40 degrees Fahrenheit. Findings include: 1. The Director of Quality Improvement and Compliance was requested to provide the home's policies and procedures for ensuring refrigerator temperatures remain at or below 40 degrees Fahrenheit. In response the Director of Quality Improvement and Compliance provided a copy of Document Number 114 effective 3/1/2024 for review. The Summary section of this document states, "This protocol is the ensure that all water, fridge, and freezer temperatures are within safe range." The Protocols section of this document states, "Fridge and Freezer temperatures will be checked twice daily by staff and recorded... For fridge and freezer temperatures, anything out of range will be documented and follow up is required and needs to be documented. If out of range, change the level and recheck within an hour. " The document provided for review on request	R247		

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R247	Continued From page 8 does not identify the requirement to maintain refrigerator temperatures at or below 40 degrees Fahrenheit. During a tour of the Kitchen and Dining areas of the home commencing at 10:25 AM on 6/3/24 the resident refrigerator and drink dispenser in the dining area of the home were observed to store perishable items above 40 degrees Fahrenheit. The drink dispenser was observed to store and dispense beverages as follows: a. Kiwi Strawberry beverage 44.8 degrees b. Tropical Mango beverage 42.8 degrees The resident refrigerator was initially observed storing perishable items at 45 degrees Fahrenheit during the tour commencing at 10:25 AM on 6/3/24. Following a thermostat adjustment a temperature recheck was conducted with the Director of Quality Improvement and Compliance at 12:15 PM on 6/3/24, during which the resident refrigerator temperature was observed to be 44 degrees Fahrenheit. Following an additional adjustment to the thermostat, a second recheck was conducted on the afternoon of 6/3/24, during which the refrigerator temperature was observed to be sustained at 35 degrees Fahrenheit. These findings were confirmed by the Director of Quality Improvement and Compliance on the morning and afternoon of 6/3/24. 2. The Director of Quality Improvement and Compliance was requested to provide the home's policies and procedures to ensure perishable items include identifying labels and are labeled with the dates the items were opened or prepared. On the afternoon of 6/3/24 the Director of Quality Improvement and Compliance	R247		

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R247	Continued From page 9 confirmed policies and procedures governing this area of service had not been developed. During a tour of the home's Kitchen and Dining areas commencing at 10:25 AM on 6/3/24 the following perishable items were observed without identifying labels and /or labels indicting the dates the items were opened or prepared: a. A refrigerator in the kitchen area was observed with a tray wrapped in foil without an identify label and a label with the date the item stored on the tray was prepared. The Kitchen Staff on duty stated the tray contained a birthday cake served the previous day. b. Shelving in the kitchen contained opened bottles of hot sauces, soy sauces, oils, vinegars, Mirin, and Hoisin sauce without labels indicating the dates these items were opened. A large opened undated container of Frank's Hot Sauce was observed to be stored on a shelf in the kitchen pantry. These findings were confirmed by the Program Director during the Kitchen tour on 6/3/24. c. The "low boy" refrigeration unit located in the dining room of the home was observed with opened undated items including 2 containers of Silk Soy Milk, 2 half gallons of lowfat milk; and multiple condiments and dressings. There were 2 containers of salad wrapped in plastic wrap which were without identifying labels and labels indicating when the salads were prepared. d. In the resident refrigerator located in the dining room, perishables without the date the items were opened included sauerkraut, lemon juice, containers of juice, jars of jam, cream cheese,	R247		

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R247	Continued From page 10 and hummus. A small condiment container with an unidentified red slaw-like item was without an identifying label and the date the item was prepared. The freezer in the resident refrigerator contained 2 opened containers of ice cream, 2 opened boxes of waffles, and an opened bag of battered fish which were without the dates these items were opened. These findings were confirmed by the Director of Quality Improvement and Compliance during the tour of the dining area on 6/3/24. In conclusion, these deficient practices are potential risks for more than minimal harm due to food borne illness for all facility residents.	R247		
R253 SS=F	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.c All food service equipment shall be kept clean and maintained according to manufacturer's guidelines This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure the home's kitchen equipment is kept clean. Findings include: The home's Food Sanitation Protocol, Document Number 218 effective 4/12/24, which was provided by the Director of Quality Improvement and Compliance for review on request on 6/3/24, includes a Summary section which states, "The purpose of this protocol is to provide a clear staff guideline for safe handling and sanitation of all	R253		

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R253	Continued From page 11 food and kitchen processes." The Protocols section of this document states, " All food service equipment shall be kept clean and maintained according to manufacturer's guidelines". During the tour of the Kitchen and Dining Area of the home commencing at 10:25 AM on 6/3/24 the following food service equipment was observed to be in need of cleaning: a. In the kitchen the gas oven and convection oven were observed with burnt on food and grease indicating the ovens were in need of cleaning. This finding was confirmed by the Program Director during the tour of the kitchen. b. In the Dining Area the microwave was observed with dried food spills on the interior walls and on the glass turntable, indicating the microwave was in need of cleaning. A Daily Cleaning Checklist provided for review by the Director of Quality Improvement and Compliance on the afternoon of 6/3/24 indicates the microwave in the dining room is to be cleaned after each meal. This finding was confirmed by the Director of Quality Improvement and Compliance during the tour of the Dining Area. In conclusion this deficient practice is a risk for more than minimal harm to all residents due to potential food contamination during preparation, and risk for fire and sanitation associated with improper oven maintenance.	R253		
R266 SS=F	IX. PHYSICAL PLANT 9.1 Environment	R266		

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R266	Continued From page 12 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure care in a safe, functional, and homelike environment related to the condition of the baseboard heater in the living room of the home. Findings include: On the afternoon of 6/3/24 the Director of Quality Improvement and Compliance was requested to provide the home's policies and procedures that govern maintenance of the home's living environment. The Director of Quality Improvement and Compliance confirmed policies and procedures governing this area of service had not been developed. During a tour of the home commencing at 10:25 AM on 6/3/24 a baseboard heater in the living room was observed to be rusted and in poor repair. The damaged covering on the baseboard heater was fastened together with screws in a manner which left the areas of the sharp edges of the exterior covering exposed. The covering was not flush with the baseboard heater, and was protruding downward and outward, leaving the interior components of the heater exposed and creating a risk for injury from contact with exposed sharp metal fins and piping which become hot and can cause serious burns when the heater is in use. This finding was confirmed by the Director of Quality Improvement and Compliance during the tour of the living room on 6/3/24, and	R266		

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R266	Continued From page 13 acknowledged by the Program Director on the afternoon of 6/3/24. In conclusion this deficient practice is a potential risk for more than minimal harm to all facility residents due to exposure to the unsafe condition of the poorly maintained and repaired baseboard heater.	R266		
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 ensure water temperatures were maintained at or below 120 degrees Fahrenheit. Findings include: The Director of Quality Improvement and Compliance was requested to provide the home's policies and procedures for ensuring water temperatures in resident accessible areas remain at or below 120 degrees Fahrenheit. In response the Director of Quality Improvement and Compliance provided a copy of Document Number 114 effective 3/1/2024 for review. The Summary section of this document states, "This protocol is the ensure that all water, fridge, and freezer temperatures are within safe range." The Protocols section of this document states, "Water temperatures will be checked weekly by staff and recorded...When any temperature is not in range, Operations will be notified and will look at the	R291		

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SECOND SPRING SOUTH	PO BOX 320 RICHMOND, VT 05477

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R291	Continued From page 14 water valve gauge and call a third party company if needed. " This document included 3 additional sections including Internal Training Requirements, Roles and Responsibilities, and Definitions which were left blank. The document provided for review on request does not identify the requirement to maintain water temperatures at or below 120 degrees Fahrenheit in all areas which are accessible to residents of the home. On the morning of 5/3/24 water temperatures were observed above 120 degrees Fahrenheit as follows: a. Resident Room #3 125.7 degrees b. Nursing office bathroom 124.9 degrees These findings were confirmed by the Program Director, Director of Operations, and Director of Quality Improvement and Compliance as the water temperatures were tested on the morning of 6/3/24. On the afternoon of 6/3/24 the water temperatures in all resident areas were observed to be sustained at or below 120 degrees Fahrenheit in resident accessible areas of the home following adjustments made to the boiler by the home's maintenance team. 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, and increased risk for burns with injuries resulting for vulnerable adults.	R291		

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Deficiency Statement Plan of Correction (POC)

Survey Date: June 3, 2024

Facility Name: Second Spring South

Deficiency Regulation	How the deficiency was corrected	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R134	A Resident Assessment Protocol has been created. Resident Assessments for all Residents have been reviewed and ensured they were met within the correct timeline R 134 Plan of Correction accepted by Jo A Evans RN on 6/28/24	6/17/2024	Nursing has created a calendar to reflect all Resident Assessment due dates. The calendar will alert them within the 14 days to complete as well as alert prior to renewals.	Nursing, Provider, and Director of Compliance
R179	The training records were reviewed for the 5 sample staff; staff are completing trainings that are required. Required trainings for all staff have been reviewed and staff have been notified to complete all required trainings; as necessary. R 179 Plan of Correction accepted by Jo A Evans RN on 6/28/24	All trainings to be completed by 7/1/2024	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, Program Director
R190	Criminal record and abuse registry checks were completed for the 4 out of 5 staff that were sampled. Criminal record and abuse registry checks were completed for all current staff to ensure they are up to date. R 190 Plan of Correction accepted by Jo A Evans RN on 6/28/24	06/13/2024	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	Policies and Protocols have been updated and created to reflect: Resident Assessments, handling and storage of dented cans, labeling of perishable foods and beverages, maintenance of the home's living environment, refrigerator temperatures, and water temperatures. R 200 Plan of Correction accepted by Jo A Evans RN on 6/28/24	6/17/2024	Policies and Protocols will be reviewed annually	Human Resources and Director of Compliance
R246	A Dented Can Protocol was created.	6/17/2024 6/3/2024	Education to Nutritional Staff was completed and a new protocol was set in place stating that staff are required	Director of Compliance and Nutritional Staff

	The six dented #10 cans of tomatoes and two large dented cans of cream of mushroom soup were removed from the premises. R 246 Plan of Correction accepted by Jo A Evans RN on 6/28/24		to review all deliveries coming in and separating all dented cans. An audit will be completed monthly.	
R247	**1.**The temperature Protocol was updated to reflect the required temperature range. The drink dispenser gauges for both the Kiwi Strawberry and Tropical Mango were changed and rechecked. The Resident refrigerator temperature was resolved on the day of Survey **2.**A Protocol was created for labeling of perishable foods and beverages. All items that were unlabeled and not dated were removed from the refrigerators and shelving including: tray wrapped in foil, hot sauces, soy sauces, oils, vinegars, Mirin, Hoisin sauce, and Frank's Hot Sauce. 2 containers of Silk Soy Milk, 2 half gallons of lowfat milk, multiple condiments and dressings, 2 containers of salad wrapped in plastic wrap. Sauerkraut, lemon juice, containers of juice, jars of jam, cream cheese, hummus, red slaw-like item, 2 opened containers of ice cream, 2 opened boxes of waffles, and an opened bag of battered fish. R 247 Plan of Correction accepted by Jo A Evans RN on 6/28/24	6/17/2024 6/3/2024 6/3/2024 6/17/2024 6/3/2024	Education to all Nutritional Staff was completed. Nutritional staff will go through all freezers and refrigerators on a daily basis to ensure all items are labeled properly. An audit will be completed weekly and monthly.	Nutritional Staff, Program Director or designee, and Director of Compliance
R253	Protocol #218 was updated. The gas and convection oven were thoroughly cleaned; along with the microwave. R 253 Plan of Correction accepted by Jo A Evans RN on 6/28/24	6/17/2024 6/4/2024	Education to all Nutritional Staff was completed. An audit will be completed weekly	Nutritional Staff, Program Director, Director of Compliance
R266	A Protocol was created for Home's Living Environment New baseboard heater parts were ordered on 6/17/2024 through a third party contractor, who will also install the new baseboard heater.	6/17/2024 Install no later than 7/1/2024	A weekly and monthly environmental audit will be conducted. R 266 Plan of Correction accepted by Jo A Evans on 6/28/24	Director of Compliance and Operations
R291	The temperature protocol was updated to reflect the regulatory range. All water temperatures were resolved prior to the end of Survey. R 291 Plan of Correction accepted by Jo A Evans RN on 6/28/24	6/17/2024 6/3/2024	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 or Designee