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 5, 2022

Ms. Mona Karia, Manager
Segue House
7 St Paul Street
Montpelier, VT 05602-3033

Dear Ms. Karia:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 17, 2022.** 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,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0504 | A. BUILDING: _____ B. WING _____ | C 08/17/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SEGUE HOUSE | 7 ST PAUL STREET MONTPELIER, VT 05602 |

| (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 |
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| T 001 | Initial Comments<br><br>An unannounced on-site complaint investigation was conducted on 8/17/22 by the Division of Licensing and Protection. The following regulatory violations were identified: | T 001 | | |
| T 023 SS=D | V. 5.5.a Resident Care and Services<br><br>5.5 General Care<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review the 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 mental health crisis. Findings include:<br><br>Per review of Staff and Nurse Notes Resident #1 was admitted to the TCR on 9/14/21 with a diagnosis of Schizoaffective Disorder. During May of 2022 s/he presented with increasing signs of declining mental health. On 5/19/22 Resident #1 was admitted to the hospital for inpatient care, where s/he remained until 7/1/22 when Resident #1 was discharged from the TCR to another | T 023 | If a resident's needs temporarily exceed the usually provided supports of the program, and they are unable to access a higher LOC, the program will temporarily enhance supports. This need will be assessed by staff, the program manager and the nurse in an ongoing way and be documented in the record. Enhancements may include, but not be limited to, increased direct observation, or temporarily enhanced staffing. Staff will document supports in their daily log notes.<br><br>Mona Karia | 9/20/22 |



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: MKaria — TITLE: Assistant Director of Residential Services — (X6) DATE: 9/20/22



T023 POC accepted 9/26/22 JEVans RN/PM

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| T 023 | Continued From page 1<br>residential facility.<br><br>On 5/10/22 staff documented a Team Meeting with Resident #1 to discuss episodes of "violent outbursts with property destruction, insomnia, and cheeking medications" (concealing medication in the mouth so it appears it was taken). Mouth checks after medication administration were initiated. It was noted several empty bottles of Tylenol were discovered in Resident #1's room. On 5/12/22 Resident #1 reported purchase and self-administration of Benadryl (antihistamine medication for symptoms of anxiety). On the overnight shift Resident #1 contacted Crisis services and stated s/he felt unsafe and was having "bad thoughts". Staff was advised by the Crisis Clinician to administer PRN Hydroxyzine. The medication was administered despite Resident #1's reported self administration of medication the same night. Documentation of a check in with the On Call Nurse to report self administration before administering medication was not provided. When assessed by the nurse on 5/13/22 Resident #1 stated s/he purchased Benadryl in an attempt to ease anxiety and help with sleep; and reported s/he was having audio hallucinations of voices insulting him/her. S/he presented with an elevated pulse, high blood pressure, sweating, and tremors in both arms; and informed the Nurse s/he had taken up to 30 tablets of Benadryl in a 24 hour time period. Resident #1 was transported to the Emergency Department for evaluation and returned home the same day. The facility failed to address the purchase and self administration of medications by initiating a plan for check ins on return from outings and room checks.<br><br>On 5/10/22 Resident #1 "flipped over" the patio table, punched the elevator, and was observed | T 023 | | |

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| T 023 | Continued From page 2 | T 023 | | |

going in and out of the house all night. During the night of 5/12/22 Resident #1 expressed "If people don't stop messing with me someone's going to get hurt ...I'm going to start breaking stuff.. I'm going to hurt someone" in response to belief someone had entered his/her room and taken cigarettes. His/her room was noted to smell like smoke during the night. On return from the Emergency Department on 5/13/22 s/he was noted to be agitated, experiencing chest pain, walking throughout the house without a shirt and with pants below his/her buttocks. S/he was noted to be increasingly dysregulated throughout the night. Over the next three days staff reported episodes of confusion, self talk, wandering in and out of the home, disorganized and aggressive behaviors, smoking in the home, insomnia, and repeatedly leaving the home during the night. A late entry Staff Note entered on 5/20/22 for the night of 5/16/22 indicated no significant events occurred during the shift, however loud crashing sounds were heard as Resident #1 searched for a lighter in his/her room; and staff observed signs of paranoia, aggression, and smoking in his/her room. On the night of 5/16/22 Resident #1 punched a wall in his room leaving a 2 foot wide hole in the wall, set a broom on fire with a lighter, and burned a hole in the dining room table with a cigarette. A Crisis Screener informed Resident #1 s/he would return to the facility with the police if there were any further incidents of property destruction or concerning behaviors, and it was determined Resident #1 could not be safely cared for in a Crisis Bed at another facility due to destructive behaviors and lack of day staff. Resident #1 was advised to "rest then address the problems in the morning". Despite safety concerns and need for a higher level of observation the facility failed to initiate frequent checks or provide 1:1 observation for the safety

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| T 023 | Continued From page 3<br>of Resident #1 and all other Residents.<br><br>The TCR staffing pattern allows 24 hour shifts, and due to staffing difficulties the home is frequently single staffed. Between 5/1/22 and 5/19/22 when Resident #1 was hospitalized there were 11 days when the overnight staff were scheduled for 24 hour shifts including the nights of 5/12/22, 5/13/22, and 5/16/22. At 2:40 PM on 8/17/22 the facility Administrator stated it was not ideal but acceptable for staff to work alone for 24 hours at the TCR as the nurse and program manager are always on call. The TCR failed to utilize on call staff to meet staffing needs to ensure safety and provide a higher level of observation during the time period when Resident #1 presented with destructive and dangerous behaviors. At 3:25 PM on 8/17/22 the Administrator stated "we are transitional, not a 1:1 facility ...staff don't necessarily know when things are happening, a lot of this happened when people didn't know." | T 023 | | |