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

November 20, 2023

Ms. Rachel Stark, Manager
Spring Lake Ranch
1169 Spring Lake Road, Po Box 310
Cuttingsville, VT 05738-0310

Dear Ms. Stark:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 23, 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.

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

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
	0526	A. BUILDING: _____ B. WING _____	10/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING LAKE RANCH	1169 SPRING LAKE ROAD, PO BOX 310 CUTTINGSVILLE, VT 05738

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T 001	Initial Comments On 10/23/23 the Division of Licensing and Protection conducted an unannounced on-site relicensure survey. The following regulatory deficiencies were identified:	T 001	Please see Corrective Actions for each individual tag in the attached document.	
T 036 SS=F	V.5.8.b Resident Care and Services 5.8 Medication Management 5.8.b The manager of the residence is responsible for ensuring that all medications are handled according to the residence's policies and that designated staff are fully trained in the policies and procedures. The manager shall assure that all medications and drugs are used only as prescribed by the resident's physician, properly labeled and kept in a locked cabinet at all times or, when a program of self-medication is in effect, otherwise safely secured. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure all medications are used only as prescribed by resident's physicians and all medications are stored in locked cabinets. Findings include: 1. During the tour of the Noyes Housing complex at approximately 1:00 PM on 10/23/23 a first aid kit containing medications was observed to be stored in an unlocked cabinet in the kitchenette area of Clover House. At 1:02 PM on 10/23.23 the Facilities Technician confirmed the first aid kit contained medications including Benadryl, Glucose tablets, and Aspirin which were not stored in a locked cabinet; and confirmed all of the facility homes and vehicles have first aid kits	T 036	T036 Plan of Correction accepted by Jo A Evans RN on 11/17/23.	

Rachel Stahl
Executive Director
Spring Lake Ranch

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T 036	Continued From page 1 containing the same medications. On the afternoon of 10/23/23 the Executive Director confirmed there were no signed prescriber's orders for the administration of the medications stored in the first aid kits to the facility residents. 2. During a tour of the Mattless House on the afternoon of 10/23/23 an unsecured tube of Denta 5000 prescription strength toothpaste was observed to be stored on the dresser in Resident #19's room. During the tour on 10/23/23 the Facilities Technician confirmed this medication was not stored in a locked compartment; and on the afternoon of 10/23/23 the Executive Director and Med Tech confirmed an assessment indicating Resident #19 is capable of self administration had not been completed. At 7:25 AM on 10/24/23 the Executive Director confirmed a written signed order allowing Resident #19 to store this medication in his/her room and to self administer this medication was not on file and available for review.	T 036		
T 040 SS=F	V.5.8.5 Resident Care and Services 5.8 Medication Management 5.8.5 Staff other than a nurse may administer PRN psychoactive medications only when the residence has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use.	T 040	T040 Plan of Correction accepted on 11/17/23 by Jo A Evans RN.	

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T 040	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to develop written plans for the use of PRN psychoactive medications administered by staff other than the nurse in the home for 18 applicable residents of the home (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, and #18). Findings include: Per review of the PRN medication lists provided by the Med Tech on the afternoon of 10/23/23, 18 residents of the home were currently prescribed psychoactive PRN medications to include Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, and #18. During interviews conducted on the afternoon of 10/23/23 the Med Tech and the Executive Director confirmed written plans for the administration of psychoactive PRN medications to the 18 applicable residents had not been developed by the Manager of Nursing Services.	T 040		
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;	T 052	T052 Plan of Correction accepted by Jo A Evans on 11/17/23.	

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T 052	Continued From page 3 (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, 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 the required yearly trainings for 5 out of 5 sampled staff. Findings include: Per record review 5 out of 5 sampled staff did not complete the required yearly trainings to include: a. 1 out of 5 staff did not complete trainings any of the required yearly trainings b. 4 out of 5 staff did not complete Emergency Response and First Aid training c. 5 out of 5 staff did not complete Mandatory reporting of Abuse, Neglect, and Exploitation training These findings were confirmed by the Human	T 052		

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T 052	Continued From page 4 Resources Manager at 3:32 PM on 10/23/23.	T 052		
T 062 SS=E	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 criminal background checks were completed as required for 4 out of 5 applicable staff. Findings include: During the course of the survey on 10/23/23 the Human Resources Manager was requested to provide documentation of completion of the required criminal background checks for a sample of 5 staff. At 3:45 PM the Human Resources Manager confirmed documentation of the required criminal background checks was not on file and available for review for 4 out of 5 sampled staff.	T 062	T062 Plan of Correction accepted by Jo A Evans on 11/17/23.	
T 092 SS=C	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	T 092	T092 Plan of Correction accepted by Jo A Evans on 11/17/23.	

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T 092	Continued From page 5 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 observation and staff interview there was a failure to post the grievance procedure on each floor of the facility's homes. Findings include: During the tour of commencing at 11:25 AM on 10/23/23 it was observed the facility's grievance policy was not posted in the homes where residents reside. This was confirmed by the Facility Technician during the tour of the homes, and by the Executive Director on the afternoon of 10/23/23.	T 092		
T 146 SS=F	IX.9.1.a Physical Plant 9.1 Environment 9.1.a The residence must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced	T 146	T146 Plan of Correction accepted by Jo A Evans on 11/17/22.	

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T 146	Continued From page 6 by: Based on observation and staff interview there was a failure to ensure care in a safe, functional, and clean environment. Findings include: 1. During a tour of the facilities commencing at 11:25 AM on 10/23/23 environmental concerns were observed : a. In the Elliot House cleaning products were observed to be stored under the sink in unlocked cabinet: to include Easy Off oven cleaner, disinfectant spray, and Terro Ant baits. Murphy's Oil Soap Spray, disinfectant sprays, Zep Citrus Cleaner, glass cleaner, insecticide spray, Goo Gone, and Roto Rooter Clog Remover were observed to be stored on an open framework shelf in the dining room . Armour All Protectant and Mother's Car Cleaner Wax were observed in a kitchenette; Lysol Clean and Fresh concentrate ,glass cleaner and disinfectant sprays were observed in the bathrooms; Additionally, the bathrooms were in need of cleaning, the bathroom garbage can was observed to be overflowing, and there were no paper towels in the bathroom dispenser. b. In the Noyes House Complex , which includes the Trillium and Clover houses, unsecured cleaning products including disinfectants, air fresheners, and glass cleaners were observed. A bathroom garbage can was observed to be overflowing. c. In the Mattless House dirty cups were observed in the kitchenette area which does not have a sink. The only option for washing dishes in this home was in the sink in the adjacent bathroom. Additionally, there were no paper towels in the bathroom.	T 146		

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T 146	Continued From page 7 d. In the Godley House complex, which includes the Cedar and Maple houses, cleaning chemicals were observed to be stored in an an unlocked cleaning closet and in a bathroom closet; bathrooms were observed to be without paper towels; and the kitchen sink in the Cedar House kitchenette was observed to be in need of cleaning. These findings were confirmed by the Facilities Technician during the facilities tour on 10/23/23. 2. During a tour of the Main Kitchen commencing at approximately 12: 20 PM on 10/23/23 cleaning chemicals including disinfectant sprays and a gallon of bleach were observed beneath and above the kitchen's 3 bay sink. A mop sink located between the kitchen and food storage areas was observed to contain a gallon of Simple Green floor cleaner with a second smaller container of Simple Green observed to be stored above the mop sink. These findings were confirmed during the kitchen tour on the afternoon of 10/23/23 by the Kitchen Manager, who also confirmed the kitchen and food storage areas of the home are open and accessible to residents.	T 146		

Deficiency Statement Plan of Correction (POC)

Survey Date: October 23, 2023

Facility Name: Spring Lake Ranch

Deficiency Regulation	How the deficiency was corrected	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
T 036 5.8.b 1	All medications were removed from first aid kits in houses and in vehicles.	11/08/2023	The Safety Coordinator and med room will no longer include OTC medications when packing first aid kits.	Safety Coordinator
T 036 5.8.b 2	Orders were signed by the Doctor for resident to self-administer and have in room.	10/24/2023	Residents are required to report to med room after every doctors/dentist appointment. Any prescriptions are collected and signed off by the prescriber. Regular reminders will be made to staff, driver and residents of this procedure.	RN
T 040 5.8.5	Written plans for psychoactive PRNS are being recorded in our EHR for each resident. (RN out on medical leave until 11/28. Indicators compiled by clinicians and documented in EHR by med room assistant. RN will review upon return).	Begun 11/08/23 and to be completed by 11/24/23	Med room protocol will include writing a resident specific plan for each PRN prescribed at the time it is prescribed.	RN
T 052 5.9.b a. b. c	Staff were notified via email on 11/08 and given 30 days to get into compliance.	12/08/2023	All trainings are assigned annually and are required for all staff. To ensure this is met, the HR Manager will review compliance quarterly and send out an email to those in arrears. In addition, annual raises will not be processed until all trainings are current for each staff.	HR Manager
T 062 5.10. b.4	Background checks to be ordered on all staff both state and national.	Begun 11/13 and all will be ordered by 11/20/23.	Both state and national background checks will be conducted annually on all staff by the HR Manager.	HR Manager
T092 6.8	Grievance policy was printed out from handbook and posted in each residence on each floor next to Resident Rights.	11/08/2023	Quarterly checks will be made by the Director of Operations to ensure signage remains in place.	Director of Operations
T146 9. 1. a. b. c. d. 9.1 2	All current clients have been reviewed by nursing staff and assessed as safe and a note has been made in their chart.	11/13/2023	All potential admits are carefully assessed for safety in order to be admitted and to remain in our program. A formal assessment will be made on	RN

	Housekeeping was made aware of the need for more thorough cleaning of bathrooms and kitchenettes as well as the need for more paper towels in the bathrooms.	10/24/23	initial intake specifying safety with regards to being in and around chemicals and included in the chart going forward. Housekeeping will train all new residential staff on best practices in terms of house cleaning and daily walkthroughs of residences.	Lead Housekeeper, Supervisor of Residential Staff

Rachel Stark
Executive Director

11/17/2023
Date

Corrective actions in this attachment accepted by Jo A Evans RN on 11/17/23.
Please refer to the Statement of Deficiency for acceptance of corrective actions for individual tags.