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
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Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

October 23, 2024

Candace Beardsley, Manager
Spruce Mountain Inn, Inc
Po Box 153, 155 Towne Avenue
Plainfield, VT 05667-0153

Dear Ms. Beardsley:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 24, 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

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
	0527	A. BUILDING: _____ B. WING _____	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRUCE MOUNTAIN INN, INC	PO BOX 153, 155 TOWNE AVENUE PLAINFIELD, VT 05667

(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
T 001	Initial Comments On 9/24/24 the Division of Licensing and Protection conducted an unannounced on-site annual relicensure 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 was a failure to obtain signed physician's orders for medications listed on the September 2024 Medication Administration Records for 3 out of 3 sampled residents (Residents #1, #2, and #3). Findings include: On the afternoon of 9/24/23 the Director confirmed policies and procedures to ensure signed orders are obtained for medications administered to residents were not on file and available for review. Per record review signed physician's orders were not on file and available for review for the following medications listed on the September 2024 Medication Administration Record: a. Resident #1's MAR indicated the medication	T 037		

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T 037	Continued From page 1 order for Hydroxyzine 25 mg by mouth as needed every 6 hours for anxiety/shakiness was discontinued. A physician's order to discontinue this medication was not on file and available for review. b. Resident #2's MAR listed the medication order for Vitamin D3 50,000 IUs to be administered once weekly. A signed physician's order was not on file and available for review for administration of this mediation. c. Resident #3's MAR listed the medication order for Junel Fe (hormone medication plus iron supplement) One tablet administered daily. A signed physician's order was not on file and available for review for administration of this mediation.. The Director confirmed these findings during a review of signed medication orders on file for Residents #1, #2, and #3 commencing at 4:25 PM on 9/24/24.	T 037		
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		

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T 052	Continued From page 2 (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 all required yearly trainings for 3 out of 5 sampled staff. Findings include: At 2:49 PM on 9/24/24 the home's Finance Manager confirmed written policies and procedures governing staff completion of the required trainings had not been developed . At 12:17 PM on 9/24/24 the Assistant Director and Finance Manager were requested to provide documentation of required trainings completed for a sample of 5 staff. Per review of the documents received, 3 out of 5 sampled staff did not complete all required yearly trainings. This finding was confirmed by the Finance Director at 2:34	T 052		

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T 052	Continued From page 3 PM on 9/24/24.	T 052		
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 completion of all required criminal record and abuse registry checks for 5 out of 5 sampled staff. Findings include: On the afternoon of 9/24/24 the home's Finance Manager confirmed written policies and procedures governing completion of the required staff criminal record and abuse registry checks had not been developed . At 12:17 PM on 9/24/24 the Assistant Director and Finance Manager were requested to provide documentation of criminal record and abuse registry checks completed for a sample of 5 staff. Per review of the documents received, all required criminal record and abuse registry checks were not completed as required for 5 out of 5 sampled staff. This finding was confirmed by the Finance Manager on the afternoon of 9/24/24.	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	T 071		

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T 071	Continued From page 4 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 all services provided by the home. Findings include: 1. On the afternoon of 9/24/24 the Finance Manager was requested to provide for review policies and procedures governing staff completion of required yearly trainings, and completion of of the required criminal record and abuse registry checks for all staff. On the afternoon of 9/24/24 the Finance Manager confirmed written policies and procedures governing staff trainings and background checks had not been developed by the home. 2. On the afternoon of 9/24/24 the Director was requested to provide for review policies and procedures to ensure signed physician's orders are obtained for medications administered to residents, and to ensure water temperatures are maintained at or below 120 degrees Fahrenheit in resident accessible areas of the home. On the afternoon of 9/24/24 the Director confirmed policies and procedures governing these areas of service had not been developed by the home.	T 071		

Spruce Mountain Inn Plan of Correction October, 2024

This is a plan of correction pursuant to the state audit on September 24th, 2024. Each deficiency is addressed below.

T 037 - V. 5. 8. C Resident Care and Services

5.8 Medication Management

5.8c 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: T 037 Based on staff interview and record review there was a failure to obtain signed physician's orders for medications listed on the September 2024 Medication Administration Records for 3 out of 3 sampled residents (Residents #1, #2, and #3).

• What action you will take to correct the deficiency?

- An audit will be performed to discover any instances in which regulation 5.8 is not adequately met. Prescribing physicians or licensed health care providers will be contacted and signed orders will be obtained for all client medications held in the possession of Spruce Mountain Inn.

• What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?

- A new policy has been written, stating the following; Spruce Mountain Inn will maintain signed orders for any resident medication held in the possession of Spruce Mountain Inn for the purposes of supporting residents with self-administration of medication. These orders will be signed by a physician or other licensed health care provider, and will include the supporting diagnosis or problem statement associated with that prescription.
- Prospective residents will be notified that any medication that they plan to take while enrolled in Spruce Mountain Inn must have a signed order of the kind described in state regulation 5.8. This order will be filed in the resident's electronic file.
- A formal request for a signed order of the kind described in state regulation 5.8 will be included in a small packet of information, to accompany a resident when they see an outside medical professional, so that in the event they are prescribed a medication, the prescriber can complete this specific signed order at the time of receipt of the medication.
- Spruce Mountain Inn will work with our consulting psychiatrist to ensure signed orders of the kind described in state regulation 5.8 are completed for all medications prescribed by that doctor. This will include standing orders for over the counter medications that Spruce Mountain Inn maintains as part of their general supply.

• How the corrective actions will be monitored so the deficient practice does not recur.

- Audits of signed orders will be completed weekly. Where needed, medication orders of the kind described in state regulation 5.8 will be pursued with the appropriate medical provider.
- Admission paperwork will be reviewed at the time of intake to ensure orders are complete.

• The dates corrective action will be completed.

- The new policy for prescription orders, the order request form, and the audit system will be fully complete and implemented by October 31st, 2024.

T 037 Plan of Correction accepted by Jo A Evans RN on 10/23/24

T 052 - 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; (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 3 out of 5 sampled staff.

• What action you will take to correct the deficiency?

- We notified (and re-notified) all staff of the training requirements outlined in state regulation 5.9b.
- We addressed holes in accounting (staff submitted confirmation of completed training for the last 12 months).
- We conducted any necessary make-up trainings for residential staff, and began the training cycle for any additional staff subject to the standard above.
- Directors, clinicians, residential counselors, and our nurse are all up to code.

• What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?

- We have generated a schedule of when trainings will be held, to ensure we remain in compliance with the standard outlined in state regulation 5.9b.
- We provided to our staff lists of trainings they have completed in 2024.

• How the corrective actions will be monitored so the deficient practice does not recur?

- Department managers and HR will be monitoring trainings throughout the year. Missed trainings will be monitored closely and make-up opportunities will be provided and required.

• The dates corrective action will be completed?

- There are a handful of staff who were not originally on the radar in terms of training. This group includes our bookkeeper, groundskeeper, chef, housekeeper, administrative assistant, and HR director. This group will be in compliance by September, 2025.
- All other staff are in compliance as of October 18, 2024.

T 052 Plan of Correction accepted by Jo A Evans RN on 10/23/24

T 062 - 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: T 062 Based on staff interview and record review there was a failure to ensure completion of all required criminal record and abuse registry checks for 5 out of 5 sampled staff.

• What action you will take to correct the deficiency?

- We had all staff members sign a permission form to conduct yearly checks. We will complete Vermont Adult and Child Abuse registry background checks by the end of October.
- We are working on securing an account with Vermont Criminal Information Center (VCIC). We will secure permission from our staff, and we will complete VCIC background checks by the end of November.

• What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?

- Application for new hires will include the yearly-check permission forms.
- A policy has been written and added to the new hire packet describing these guidelines.
- All background checks will be done on a designated day each year, independent of the previous check.

• How the corrective actions will be monitored so the deficient practice does not recur?

- The HR Director will maintain a spreadsheet and ensure new hires are added and in compliance with our policy.

• The dates corrective action will be completed?

- Vermont Adult and Child Abuse registry checks will be complete by October 31st, 2024.
- VCIC checks will be complete by November 30th, 2024.

T 062 Plan of Correction accepted by Jo A Evans RN on 10/23/24

T 071 - 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 all services provided by the home.

• What action you will take to correct the deficiency?

- Policies will be written to address the areas noted in the report (i.e., staff training, background checks, medication orders, and water temperature standards). These are included with this plan of correction, for your review.

• What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?

- An audit of State Regulations and Spruce Mountain Inn policies will be conducted to ensure policies are written and available, governing all services provided.

• How the corrective actions will be monitored so the deficient practice does not recur?

- A semi-annual review of the state regulations will be conducted by the Assistant Director to check for any changes to the regulations. Policies will be written or updated as necessary in response to changes to the state regulations.

• The dates corrective action will be completed?

- New policies in reference to the September, 2024 audit are complete as of October 18th, 2024.
- The review of current regulations and addition of new polices will be completed by November 30th, 2024.

T 071 Plan of Correction accepted by Jo A Evans RN on 10/23/24