

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 3, 2016

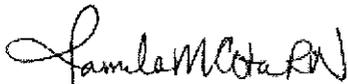
Ms. Angela Fereday-Parent,
Assist Program
851 Pine Street
Burlington, VT 05401

Dear Ms. Fereday-Parent:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 8, 2016**. 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
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0511	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/08/2016
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NAME OF PROVIDER OR SUPPLIER ASSIST PROGRAM	STREET ADDRESS, CITY, STATE, ZIP CODE 851 PINE STREET BURLINGTON, VT 05401
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(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 An unannounced onsite complaint investigation was conducted by the Division of Licensing and Protection on 08/29/16 and concluded on 09/08/16. The following are Therapeutic Community Residence (TCR) regulatory deficiencies.	T 001		
T 006 SS=C	V.5.2.a Resident Care and Services 5.2 Admission Agreements 5.2.a Prior to or at the time of admission, each resident, and the resident's legal representative if any, shall be provided with a written admission agreement which describes the daily, weekly, or monthly rate to be charged, the services that are covered in the rate, and all other applicable financial issues, including an explanation of the residence's policy regarding discharge or transfer when a resident's financial status changes from privately paying to paying with SSI benefits. The agreement must be written in a format that is accessible, linguistically appropriate, and available in large font. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to have a signed admission agreement for 2 of 2 records reviewed, Client #1 & #2, as required by regulation. Findings include:	T 006		

Division of Licensing and Protection LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Angela Sereday-Poent</i>	TITLE <i>Program Coordinator</i>	(X6) DATE <i>10/3/16</i>
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T006 - T999 POCs accepted 9/12/16 summonsed

Division of Licensing and Protection

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T 009	Continued From page 2 by: Based on staff interview and record review, the facility failed to implement the TCR requirement for the admission agreement to include a space for the resident to sign and date the receipt of information regarding advance directives upon admission to the home. Findings include: Per review on 08/29/16, the facility's admission agreement did not include a space for the resident's signature and date, acknowledging receipt of information regarding their right to form an advanced directive. During interview on the afternoon, the Program Manager confirmed that this requirement of the TCR regulations was not met.	T 009		
T 010 SS=C	V.5.2.e Resident Care and Services 5.2 Admission Agreements 5.2.e The residence must provide each resident with written information regarding how to contact the designated Vermont protection and advocacy organization, the patient representative, as applicable, and the Disability Law Project or the Mental Health Law Project, as applicable. The residence shall inform residents that these organizations are available also to assist with formulating an advance directive, if the resident wishes to do so.	T 010		
	This REQUIREMENT is not met as evidenced			

Division of Licensing and Protection

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T 010 Continued From page 3 T 010

by:
Based on record review and staff interview the residence failed to provide, for 2 of 2 clients, written information regarding how to contact the designated Vermont protection and advocacy organization, the patient representative, as applicable, and the Disability Law Project or Mental Health Law Project, as applicable. The residence failed to inform these clients that these organizations are available to assist with formulating an advance directive, if the client wishes to do so. Potentially all clients are affected. Findings include:

Per record review, it was discovered that the intake admission packet did not contain the necessary regulatory mandated information for clients' records # 1 and #2. Although information can be found in a Client Handbook, situated in the front office, staff acknowledged that clients have to ask for the information and no written information is given to the clients upon admission.

This is a repeat violation.

T 011 V.5.2.f Resident Care and Services T 011
SS=C

5.2 Admission Agreements

5.2.f The residence shall include a copy of its grievance policy in the admissions agreement.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and on record review the residence failed to have, in 2 of 2 records

Division of Licensing and Protection

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T 011 Continued From page 4 T 011

reviewed, a copy of the grievance policy in the admissions agreement.(Client #1 & #2) Findings include:

During record review on 08/29/16 it was discovered that the client admission agreement for two clients reviewed did not include information on the TCR's grievance policy. Per interview on the afternoon of 08/29/16 staff confirmed there is not a copy of its grievance policy in the admission agreement.

Also see T0092.

T 023 V. 5.5.a Resident Care and Services T 023
SS=G

5.5 General Care

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.

This REQUIREMENT is not met as evidenced by:
The TCR failed to provide for 1 of 2 clients reviewed the necessary services or supervision appropriate his or her individual needs. (Client #1)
Findings include:

1. Client #1 was admitted to the Assist TCR at 2:30 AM on 07/13/16, after hospitalization &

Division of Licensing and Protection

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T 023

Continued From page 5

observations for erratic behavior and suicidal ideation (SI). Client was assessed upon admission as "denying current SI"...and..."labile affect" [alternated between tearful and upbeat]. Evidence demonstrates that there was lack of supervision for Client #1 at several times throughout the day of 07/13/16.

Per the staff's training and protocol manual for 'job duties on the overnight [shift] states that Client safety checks must be done every hour if client is stable, more frequently based on acuity. The record shows a safety check at 03:30 AM and 05:30 AM only. There is no safety check at 04:30 AM or 06:30 AM.

In addition, per the "Welcome to Assist-guidelines to help make your stay successful" - states "all new admissions need to remain on the unit for the first 24 hours of their stay, unless accompanied by staff. This is for your safety. After 24 hours we will determine on a case by case basis whether you can leave the unit without staff. In some cases, even after the first 24 hours, we may ask you remain on the unit if there is any concern about your ability to keep yourself safe". Although, on page 3 it notes that the stay is voluntary and clients are able to leave the unit, further denotes, "after the first 24 hours".

Per the shift note dated 07/13/16, the client requested permission to go for a walk alone around (3:00 PM) and upon learning of Assist 24-hour policy, "client became escalated" and also expressed concerns about being under observation and not feeling that this is a voluntary stay. The shift note states "the Client presented with significant mood lability throughout the day". The Program Coordinator provided client with permission to leave the unit (without staff). At 3:47 PM the police were called by a friend reporting concern that Client #1 was upset and was going to hurt him/herself. The caller also

T 023

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T 023

Continued From page 6

noted that Client #1 was under 24-hour supervision at Assist. Police found Client #1 "appeared to be under stress and would fluctuate from crying and yelling to calm". At that time another friend (friend B) arrived and assured that Client #1 would be safe and brought back to Assist.

The Client returned around supper time (5:30 -6:00 PM) with friend B. The Critical Incident Report shows that friend B spoke to staff and was worried about the client and that client had mentioned wanting to hang [him/herself]. The friend was assured that the client would be safe on the unit. Around 6:30 PM The Client then asked to go smoke with the friend B and staff explained where the smoking boundaries were outside. Within 20 minutes, friend B returned and stated that [he/she] needed to head out...". No supervision nor re-assessment of self-harm statements was provided at that time. It further stated at 7:15 PM when the client had not returned staff went outside to check on client but was not seen. This was confirmed through interview with staff on 09/08/16 at 1:10 PM.

Per the policy and procedure manual for Suicide Intervention Strategy directs staff that all suicidal threats must initially be taken seriously and to evaluate, assess and determine if there is a plan or other risk factor, as well as other intervention. There is no evidence or written documentation that staff followed protocols after becoming aware of suicidal threats. The Police report noted that Assist staff called regarding client #1 missing and "was there for SI and had expressed intent to harm oneself". The client was found several days later, to have committed suicide.

T 023

T 033 V.5.7.c Resident Care and Services
SS=E

T 033

Division of Licensing and Protection

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T 033	<p>Continued From page 7</p> <p>5.7 Treatment Plan</p> <p>5.7.c The treatment plan shall contain clear and concise statements of at least the short-term goals the resident will be attempting to achieve, along with a realistic time schedule for their fulfillment or reassessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop, for 2 of 2 Clients, a treatment plan that contained clear and concise steps of at least the short- term goals the clients will be attempting to achieve, along with a realistic time table for their fulfillment or reassessment. (Clients # 1 & #2) Findings include:</p> <p>1. Per record review, Client #1 was admitted on 07/13/16 and Client #2 was admitted on 08/26/16, both with mental health issues. Per review of the Assist Intake Form, demonstrated on page 7, a pre-determined list of the treatment goals such as de-escalation, sleep management, develop coping skills, sleep regulation as well as other options listed. There are no clear and concise steps nor a time frame for their fulfillment of the short term goal.</p> <p>During interview on the morning of 08/29/16 when asked how clients achieve individualized treatment goals, staff noted that "if they're a CRT client, they come in with a treatment plan and we follow that, if not, we will assess every shift and then let the whole treatment plan know how they are doing". Staff were unable to state if there are clear or concise steps to meet the client's goals. Staff stated that "we try different things" but acknowledged the treatment plan did not contain</p>	T 033		
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T 033 Continued From page 8 T 033

clear and concise steps to achieve what these clients were attempting to achieve.

T 060 V.5.10.b.1.2.i.ii.iii.iv.v.vi.vii.viii.i Resident Care and SS=E Services T 060

5.10 Records/Reports

5.10.b The following records shall be maintained and kept on file:

(1) A resident register including all admissions to and discharges out of the residence.

(2) A record for each resident which includes:

i. The resident's name, emergency notification numbers, the name, address and telephone number of any legal representative or, if there is none, the next of kin;

ii. The health care provider ' s name, address and telephone number;

iii. Instructions in case of resident's death;

iv. The resident ' s intake assessment summary, identification of problems and areas of successful life function;

v. Data from other agencies;

vi. Treatment plans and goal, regular progress notes; supervisory and review conclusions, aftercare plan and discharge summary, appropriate medical information, and a resident

Division of Licensing and Protection

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T 060	<p>Continued From page 9</p> <p>information release form;</p> <p>vii. A signed admission agreement;</p> <p>viii. A recent photograph of the resident (but a resident may decline to have his or her picture taken. any such refusal shall be documented in the resident ' s record);</p> <p>ix. A copy of the resident ' s advance directives, if any were completed, and a copy of the document giving legal authority to another, if any.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the TCR failed to assure client records include all required information for 2 of 2 clients in the sample. This has the potential to affect all clients (Client #1 & #2) Findings include:</p> <p>1. Per review of the client's records during the on-site investigation, the following information was not found:</p> <p>a) Client #1's chart did not have instructions in case of the resident's death, next of kin, a copy of the Advance Directive or if information was given, and a recent photo and/or refusal. Although there was a pre-determined treatment plan, it did not contain clear and concise statements of the reflective steps to be taken to solve identified</p>	T 060		
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T 060 Continued From page 10

problems of needing stabilization, connecting to additional services as well as sleep and appetite regulation. In addition, cross-over notes, which provides additional supervisory or review conclusions, were not readily available nor part of the client's chart.

b) Client #2's chart did not have instructions in case of the resident's death, or a copy of the Advance Directive or further information for the Advance Directive, a recent photo and/or refusal. Although there was a pre-determined treatment plan, it did not contain clear and concise statements of the reflective steps to be taken to solve identified problems of needing de-escalation, diversion connect to community services, medication management, sleep regulation, and sobriety. In addition, cross-over notes, which provides additional supervisory or review conclusions, were not readily available nor part of the client's chart.

During conclusion of the investigation the Program Director confirmed that the Clients' charts did not contain all the required information.

T 060

T 068 V.5.10.e Resident Care and Services
SS=E

5.10 Records/Reports

5.10.e Reports and records shall be filed and stored by the residence in an orderly manner so that they are readily available for reference. Resident records shall be kept on file at least seven (7) years after the date of either the discharge or death of the resident

This REQUIREMENT is not met as evidenced

T 068

Division of Licensing and Protection

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T 068 Continued From page 11

by:
Based on observation and interviews reports and records were not filed and/or stored by the residence in an orderly manner so that they are readily available for reference. This has the potential to affect all clients. Findings include:

During the onsite investigation, on 08/29/16, cross over notes, which are a form of communication related to the clients' disposition, activities, treatments and summary conclusion, were not part of the clients records, and not readily available for reference. After a period of time, staff were able to print copies. Support Staff, as well as the Program Director, confirmed later in the day, that these cross-over reports are not readily available in the clients' charts for reference.

T 068

T 092 VI.6.8 Residents Rights
SS=C VI. Residents Rights

T 092

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 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.

Division of Licensing and Protection

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T 092	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the residence failed to have a written grievance procedure posted in a prominent, public place of the residence. Findings include: Based on observation during two days on site, the grievance procedure was not posted in a prominent public place. Per interview in the afternoon of 08/29/16, support staff stated that the information about grievance procedure is located in a client handbook, which is located in the front office. Additionally, staff reported "we go over all their rights at the time of admission" but confirmed this is not given to the clients but "they can ask for a copy". Staff confirmed that the handbook and a posting are not located in a prominent public place.	T 092
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T999 SS=B	Final Comments This REQUIREMENT is not met as evidenced by: 4.14 (f) The residence shall make written reports resulting from inspections readily available to residents and to the public in a place readily accessible to residents where individual wishing to examine the results do not have to ask to see them the residence shall post a notice of the availability of such written reports in a prominent place. If a copy is requested and the residence does not have copy machine, the resident shall inform the resident or member of the public that they may request a copy from the licensing agency and shall provide the address and	T999
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T999	Continued From page 13 telephone number of the licensing agency. This requirement is NOT MET based on the following: Based on observation and interviews the TCR did not have written reports from the recent inspections readily available nor posted in a prominent area. Finding include: 1. Per observation during the onsite investigation throughout the day of 08/29/16, the recent inspection report was not available or found in a prominent area. Per interview at that time, the Program Manager confirmed the above information was not posted in a prominent area or readily available.	T999		

SEP 30 2016

PLAN OF CORRECTION:

Deficiency: T006 V.5.2.a Resident Care and Services

5.2 Admission Agreements

We are amending our admission protocol to include information regarding our daily rate charged and services covered within that rate. We will also include information about our sliding scale fee. Every client being admitted will be asked to initial a checklist indicating that they received this information. This document will be scanned into the client's Electronic Health Record.

Timeline: December. 1, 2016

Deficiency: T009 V.5.2.d Resident Care and Services

5.2 Admission Agreements

We are amending our admission protocol to include information about an advance directive. Each client being admitted will be provided a copy of this information and be asked to initial a checklist indicating that they received this information. This document will be scanned into the client's Electronic Health Record.

Timeline: December. 1, 2016

Deficiency T010 V.5.2.e Resident Care and Services

5.2 Admission Agreements

We are amending our admission protocol and packet to include information regarding how to contact the Disability Law Project, Mental Health Law Project and Disability Rights Vermont. Each client being admitted will be asked to initial a checklist indicating that they have received this information. This document will be scanned into the client's Electronic Health Record.

Timeline: December. 1, 2016

Deficiency T011 V.5.2.f Resident Care and Services

5.2 Admission Agreements

We are amending our admission protocol and packet to include information regarding our grievance policy. Each client being admitted will be asked to initial a checklist indicating that they have received this information. This document will be scanned into the client's Electronic Health Record.

Timeline: December. 1, 2016

Deficiency T023 V.5.5.a Resident Care and Services

5.5 General Care

We are amending our nightly safety check protocol to reflect one hour safety checks.

We will continue to complete one hour safety checks on all clients on the unit throughout the night. These safety checks will be documented in individual client binders which will be kept on the unit during the clients stay and be scanned into the clients Electronic Health Record upon discharge. Staff will document in individual shift notes when a client refuses.

We are amending our admission protocol to revise our request for all clients to remain on the premises for the first 24 hours. The amended protocol will include our 24-hour policy and will stipulate that the Program Coordinator and/or her designee will reassess client upon request and need to leave the facility prior to 24 hours if appropriate. Program Coordinator and/or her designee will document in the clients Electronic Health Record the reason for the approved request.

All clients will continue to be required to sign out, provide contact information, location and timeframe of return.

Staff will continue to be re-trained on the policy and procedures for suicidal behaviors, assess for risk and intervention strategies.

Timeline: December 1, 2016

Deficiency T033 V.5.7.c Resident Care and Services

5.7 Treatment Plan

Below please see the 2014 response to this deficiency

We contest this deficiency. The vast majority of people admitted to this program are active Howard Center clients who have treatment plans in their electronic health record. Clients remain at ASSIST for an average of 4 days, which allows for much less time to identify short-term goals to achieve with a realistic time schedule. The regulations allow for 14 days allotted to conceptualize and complete a treatment plan.

We are, however, in the process of working with staff to implement individualized treatment plans for every client being admitted. A short term goal will be identified upon admission and daily shift notes will reflect progress towards this goal and the intervention utilized.

Timeline: December 1, 2016

Deficiency: T060 V5.10.b.1.

5.10b Records/ Reports. The following records shall be maintained and kept on file:

(2) A record for each resident which includes:

- i. The resident's name, emergency notification numbers, the name, address and telephone number of any legal representative or, if there is none, the next of kin.**

We will continue to make every effort to collect emergency numbers, name address and contact information for any legal representative, including information on the next of kin upon admission. We will document in shift notes when we are unable to collect this information. This information will be available in client's Electronic Health Record.

Timeline: December 1, 2016

- iii. Instruction in case of resident's death.**

We believe it would be inappropriate to address this issue in the context of our mission. We will be requesting a waiver for this item.

- vi. Treatment plans and goal, regular progress notes, supervisory and review conclusions, aftercare plan and discharge summary, appropriate medical information and a resident information release form.**

We continue to re-train staff in how to write effective SOAP notes. This will be reinforced during individual supervision and at weekly group supervision/staff meetings. While these are available in the Electronic Health Record, we recognize that their quality can be improved and reflect greater specificity in targeting problem behaviors. Discharge summaries are also available in the Electronic Health Record. Releases of information are kept on the unit during the client's stay and are forwarded to our Health Information Department after discharge. If this does not meet licensing requirements we will be requesting a waiver.

Timeline: December 1, 2016

- viii. A recent photograph of the resident (but a resident may decline to have his or her picture taken, any such refusal shall be documented in the resident's record)**

We have purchased a new camera and software system and will continue to take client photos upon admission. These photos will continue to be uploaded into each individual client's Electronic Health Record. All refusals will be documented in EHR.

Timeline: Complete

- ix. **A copy of the resident's advance directives, if any were completed, and a copy of the document giving legal authority to another, if any.**

Information on whether a client has an advance directive or not is available in the client's Electronic Health Record, this is part of our registration process. Staff will continue to encourage our client's to register their Advance Directives with the Vermont Directive Registry. We do not keep paper copies of Advance Directives at our site. If this does not meet licensing requirements we will be requesting a waiver.

Timeline: December 1, 2016

Deficiency: T068 V5.10.e Resident Care and Services

5.10.e Records/ Reports.

The above information is currently available in the Electronic Health Record. The practice of using cross-notes is no longer being used by ASSIST. Again, all documentation will be provided in a shift note and accessible in EHR.

Timeline: Complete

Deficiency: T092 VI.6.8

VI: Residents Rights

The grievance policy is posted in a prominent public place on the unit. We are amending our admission protocol to include information regarding the grievance policy and procedures. . Each client being admitted will be asked to initial a checklist indicating that they received this information.

Timeline: December 1, 2016

Deficiency: T999 4.14f

4.14(f) Inspection Reports

The written reports resulting from inspections are readily available to the residents and public. Current surveys are provided on the unit. Copies of past surveys are available upon request.

Timeline: Complete