

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

July 19, 2013

Mr. Roger Hamel, Administrator
LCMH Johnson Group Home
PO Box 406
Johnson, VT 05656

Provider #:0518

Dear Mr. Hamel:

Enclosed is a copy of your acceptable plans of correction for the unannounced onsite complaint investigation conducted on **May 21, 2013**. 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

PC: ne

Enclosure



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0518	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	JUN 27 13 Licensing and Protection	(X3) DATE SURVEY COMPLETED C 05/21/2013
--	---	---	---------------------------------------	--

NAME OF PROVIDER OR SUPPLIER LCMH JOHNSON GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 406 JOHNSON, VT 05656
--	--

(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 An unannounced onsite complaint investigation was conducted by the Division of Licensing and Protection on 05/21/13. The following are State Therapeutic Community Residence violations.	T 001		
-------	--	-------	--	--

*T-069
 POC accepted 7/18/13
 Shawn Chinnon RN*

T 069	VI.1.B.5. Common Model Program Standards Structural Components Director or Supervisor The director and/or supervisor shall assure that the number and type of staff is adequate to meet the treatment and management goals of the residence. This STANDARD is not met as evidenced by: Based on interview and record review the director and/or supervisor failed assure that the number and type of staff is adequate to meet the treatment and management goals of the residence. Finding include: 1. Per interview on 05/21/13 at 11:00 A.M. the Interim Administrator (IA) stated that there had been a lot of change and staff turnover. S/he stated that during weekend coverage or hours when there are no staff person who is delegated to give medications, then an on-call person would come in to dispense medications as needed. Per review of the medication administration record (MAR) and personnel files, a newly hired staff person who is not delegated to administer medications, administered medication to a resident. The resident went to the physician on 05/18/13 (Saturday) and had an order for a new prescription for pain medication. This Staff person attempted to call another staff person who is delegated, but was unable to reach that	T 069	<i>ALL employees working at THE JGH are listed and specified who has been delegated to administer MEDS. This list is attached to the front of the MAR. A copy of this list is attached. There are two employees who are going through the training process and should be delegated within the next two weeks. These two staff will not be administering medications until this process is complete. In addition, if one of these two non-delegated staff are scheduled to work a delegated staff will work this shift with them. Our medication administration/documentation training log is also attached. Two medication administration trainings have been given since 5/21st. Georgianne Carr, P.N., provided a five hour medication administration training on MAY 30th Attended by seven employees.</i>	
-------	---	-------	---	--

Division of Licensing and Protection <i>Ron D. Heald.</i> LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	<i>Grace At Home MANAGER</i> THE GRACE AT HOME MANAGER	(X6) DATE 6/25/2013
---	---	-------------------------------

PMU

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0518	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/21/2013
NAME OF PROVIDER OR SUPPLIER LCMH JOHNSON GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 406 JOHNSON, VT 05656		
(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 069	Continued From page 1 person. The Staff person called the nurse who stated to give the medication. This violates Vermont Board of Nursing delegation guidelines. Per interview with the nurse at 12:14 P.M., s/he stated s/he has not been asked to delegate medication to staff and did give the approval for the staff person to give the medication but was "not aware that this person was not trained". S/he stated that the medication should be given only by those staff who are trained. Per interview the later in the day, the IA confirmed there was inadequate staff to meet the residents' treatment.	T 069	There was a follow-up two hour training provided by Kimberly Codson, R.N., primarily around medication documentation, attended by seven employees. Curriculum documentation is available upon request. Ongoing monthly review of med. policy + procedures will be done 6/26/2013 during regularly scheduled staff meetings. RPH	
T 078	VI.1.C.9. Common Model Program Standards Structural Components Staff All staff members shall meet all applicable federal, local, or state requirements for their positions. This STANDARD is not met as evidenced by: Based on staff interview and record review, the home failed to assure that all staff members met the background check requirements for their positions. Findings include: 1. Per record review on 05/21/13, 2 of 8 staff records contained no evidence of the Vermont Criminal checks and/or Adult Protective Service abuse registry checks, and 1 of 8 staff records contained no evidence of any required background checks. In addition, 3 staff were working with residents prior to the back ground checks being completed. One staff was hired on 02/19/13 and the background check was completed 3 months later on 05/15/13. Two other staff's background checks were completed approximately one month after hire.		The plan to increase our nursing staffing as well. All background checks are current, up to date and on file at the J.G.H. Hiring practice from this point on will follow <u>employment policy attached</u> . A committee will be formed 6/26/2013 around JACHO Accreditation and will be responsible for monitoring adherence to our employment policy. RPH	6/26/2013 RPH

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0518	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/21/2013
NAME OF PROVIDER OR SUPPLIER LCMH JOHNSON GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 406 JOHNSON, VT 05656		
(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 078	Continued From page 2 Per interview at 1:33 P.M. the IA, Chief Operation Officer and Human Resources, confirmed that all required background checks were not completed prior to staff working independently with residents.	T 078			
T 095	VI.2.B.4.d. Common Model Program Standards Treatment Components Process--Progress Notes Summary progress reports are encouraged regularly and made a part of the resident record. This STANDARD is not met as evidenced by: Based on record reviews and interview, the progress notes for 5 of 5 residents in the sample (Resident #1 through #5) were not in the chart. Findings include; 1. Per record review on 05/21/13, monthly progress notes were not found after January 2013 for Residents #1 through #5 . Per interview at 2:30 PM, the IA stated that "the notes go to the (Agency) main office for review and input and then they return them to us but they have not come back". S/he also stated that there had been changes to staff and case managers and that things are past due. The IA at confirmed that the expectation is to have to have the monthly progress reports in the charts, which were not in the records. Also see T-102	T 095	<i>POC T-095 accepted 7/8/13 Susan L. Cummings</i> A full chart audit has taken place. All documentation will be completed no later than 7/12/13. Going forward, all documentation will be completed in a timely manner; the paperwork process has been changed to facilitate this. The Group Home Manager will be responsible for the oversight of the records at the Group Home and monitor for group home staff's adherence to process. THE Group Home Manager will do a monthly audit to monitor adherence to paperwork process.		
T 098	VI.2.B.5.b. Common Model Program Standards Treatment Components	T 098	Please see T095.	7/12/13	

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0518	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/21/2013
NAME OF PROVIDER OR SUPPLIER LCMH JOHNSON GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 406 JOHNSON, VT 05656		
(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 098	Continued From page 3 Process--Supervision and Review A resident's progress and treatment plan shall be reviewed regularly by appropriate staff and where indicated, by the resident(s) concerned. This STANDARD is not met as evidenced by: Based on record review, the residence failed to assure that timely review of the treatment plan of 2 of 5 residents (Resident #4 & #5) in the home was complete. Findings include: 1. Per record review on 05/21/13 , the Treatment plans for Residents #4 & #5 were overdue. The treatment plans for #4 was due in April 2013 and for Resident #5 the treatment plan was due February 2013. During interview that afternoon, the IA stated that there had been a lot of change in staffing and confirmed that the treatment plan and reviews were overdue.	T 098	PLEASE SEE T095 <i>POC T-098 accepted as per plan for T-095 Susan J. Emmerson RN 7/18/13</i>	7/12/13	
T 102	VI.2.B.6.b. Common Model Program Standards Treatment Components Process--Resident Records Resident records shall include the following: 1. intake assessment summary 2. identification of problems and areas of successful life function 3. data from other agencies 4. treatment plans and goals 5. regular progress notes 6. supervisory and review conclusions 7. aftercare plan and discharge summary 8. appropriate medical information 9. client information release form This STANDARD is not met as evidenced by: Based on record review and interview, the	T 102	PLEASE SEE T095 <i>POC T-102 accepted as per plan for T-095 Susan J. Emmerson RN 7/18/13</i>	7/12/13	

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0518	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/21/2013
NAME OF PROVIDER OR SUPPLIER LCMH JOHNSON GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 406 JOHNSON, VT 05656		
(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 102	Continued From page 4 Residence failed to ensure that all treatment components are included in the record of 5 of 5 residents. (Residents #1 - #5) Findings include: 1. Per record review on 05/21/13 , monthly progress notes were not found after January 2013 for Residents #1 through #5 . Per interview at 2:30 PM, the IA stated that "the notes go to the (Agency) main office for review and input and then they return them to us but they have not come back". The IA at confirmed that the expectation is to have to have the monthly progress reports in the charts, which were not in the records. In addition, Resident #2 was seen by a physician on 05/18/13 and prescribed pain medication. There is no information in the resident's record regarding the physician visit, any signs or symptoms of the pain nor treatment outcomes. The IA confirmed that this information should be noted on the daily log and resident's chart which did not happen. Also see T-0069 and T-0095	T 102	<i>Training will be provided to all Group Home staff around appropriate communication between shifts using resident communication logs and staff communication logs. This training will be provided by JGH Manager by _____ to full time staff and substitute staff, and _____ 7/17/13 monitored by Group Home Manager.</i>		