

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

May 8, 2014

Ms. Debra Olivetti, Administrator  
Middlesex Secure Residential Program  
1076 Us Route 2  
Middlesex, VT 05602-8840

Dear Ms. Olivetti:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 1, 2014**. 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,



Frances L. Keeler, RN, MSN, DBA  
Assistant Division Director  
State Survey Agency Director

FK:jl

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0610	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  C 04/01/2014
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NAME OF PROVIDER OR SUPPLIER  
**MIDDLESEX SECURE RESIDENTIAL PROGRAM**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**1076 US ROUTE 2  
MIDDLESEX, 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

An investigation of a facility-reported incident was conducted by the Division of Licensing and Protection on 04/01/14. The following are Therapeutic Community Residency (TCR) findings.

T 001

T 032 V.5.7.b Resident Care and Services  
SS=D  
5.7 Treatment Plan

5.7.b The residence shall ensure that the treatment plan reflects steps to be taken to solve identified problems, either by direct service at the residence or indirectly by referral to a community resource. The treatment plan shall be completed within fourteen (14) days of admission.

T 032

This REQUIREMENT is not met as evidenced by:  
Based on record review and interview the treatment plan was not completed within fourteen days of admission for one applicable resident. (Resident #1) Findings include:

1. Per record review on 04/01/14, Resident #1 was admitted on 12/31/13. Although the team attempted to meet on 01/14/14, the treatment plan was not reviewed, signed and dated until 01/27/14. The physician's signature was noted on 02/04/14. The Social Service Coordinator at 11:58 AM stated "January 1st was a holiday so that is why we were late" and confirmed although initiated on 01/14/14 was not completed as reviewed or verified by the resident and treatment team until signed /dated.

*POC accepted  
S. Commons, M. Kelly  
TCR/MSA DBA 5/8/14*

Division of Licensing and Protection  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Neha Olivetti, LICSW*

*Director - MTR*

*4/23/14*

Division of Licensing and Protection

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T 051 T 051 SS=D	<p>Continued From page 1</p> <p>V.5.9.a Resident Care and Services</p> <p>5.9 Staff Services</p> <p>5.9.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to ensure prompt, appropriate action in cases of injury, illness, fire or other emergencies.</p> <p>This REQUIREMENT is not met as evidenced by:                      Based on record review and interviews the TCR failed to ensure sufficient number of qualified personnel were available to adequately supervise residents during a community outing, resulting in the elopement of a resident. Findings include:</p> <p>1. Per review and interviews there was insufficient staff available to maintain a safe environment during an outing. Per review of the Policy and Procedures for Community Re-Entry/Outings dated 01/07/14 shows staff to resident ratios as 2 staff per 1-4 residents in a Supervised Group Community Outing with the driver included in the staff/resident ratio. Per the 1:1 Community Outings a resident may go out of the facility under the supervision of one assigned staff and a driver. Per the Outing/Activity Checklist NCF-33 and Log Out Binder shows a total of 3 staff for 4 residents. One of the residents was identified as 1:1 needing one staff, leaving 2 staff (which included the driver as part of the ratio) for the three supervised residents. At one point a supervised resident eloped leaving one staff for the 1:1 resident, one staff (which requires two staff) for the remaining 2 supervised residents, while one staff [driver] went to</p>	T 051 T 051		

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T 051	Continued From page 2  complete emergency phone calls.  The incident report states 2 staff escorted the three remaining residents into the ECHO center while waiting for the driver to report the elopement. Per interview of a residential staff person at 10:15 AM, s/he stated "Well no one was assigned really for the [1:1 resident] we just take turns, when [1:1 resident] wants to talk or show other staff we switch off". Per interview at 10:56 AM the Charge Nurse stated "I think when we had this emergency we didn't have enough staff because one of the staff was the driver and there was 1:1 with a resident".	T 051		
T 060 SS=D	V.5.10.b.1.2.i.ii.iii.iv.v.vi.vii.viii.i Resident Care and Services  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;	T 060		

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T 060	<p>Continued From page 3</p> <p>iv. The resident ' s intake assessment summary, identification of problems and areas of successful life function;</p> <p>v. Data from other agencies;</p> <p>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;</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 interviews the resident's chart did not contain documentation of supervisory and review conclusions regarding supervision level for one applicable resident. (Resident #1) Findings include:</p>	T 060		
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T 060	Continued From page 4  1. Per record review for Resident #1 on 04/01/14 there is no documentation of team meetings regarding supervision levels. Per the procedure for Levels of Autonomy and Supervision dated 01/09/14 states B) Safety Levels Lowering levels of supervisions will be considered after review by the treatment team, discussion with the resident and will require a written order. Resident #1 was admitted on 12/31/13. A physician order dated 01/15/14 states 'may go out with 2 staff to sign up for Adult education'. The 02/20/14 order states 'group supervision on site walks'. On 03/05/14 the order states 'group supervised community outings'. However, there is no evidence of treatment team reviews or discussions with the resident. Per interview the Administrator and Social Services at 12:28 PM confirmed that there was no documentation to show the level of supervision was based on clinical readiness and/or accordance with goals of treatment and that the outing was considered by the treatment team.	T 060		

**ID Prefix Tag # T032**

**V.5.7b Resident Care and Services**

**5.7 Treatment Plan**

**1) What action we are taking to correct the deficiency;**

Treatment plans will be reviewed, signed and dated within fourteen days of admission for all residents.

**2) What measures will be put into place or what systemic changes we are making to ensure that the deficient practice does not recur;**

The MTCR treatment team has initiated the use of an attendance record that is signed by all attending members of the treatment team to indicate that the treatment plan has been reviewed and a treatment plan meeting has occurred by the 14 day requirement.

**3) How the corrective actions will be monitored;**

The MTCR Program Director will complete chart reviews to insure that proper documentation and deadlines for completing initial treatment plans within the 14 day period are completed.

**4) Date corrective action will be completed.**

Corrective actions will be complete by 4/29/14.

**ID Prefix Tag # T 051**

**V.5.9.a Resident Care and Services**

**5.9 Staff Services**

**1) What action we are taking to correct the deficiency;**

We amended the "Community Outings Policy and Procedures" to address proper staffing levels, the procedures were then reviewed by all staff as a "read and sign" document. The On-Site Walk and Community Outing checklists were amended to include documentation that identifies the staff member specifically assigned to any resident(s) who requires one to one (1:1) observation when outside of the facility.

**2) What measures will be put into place or what systemic changes we are making to ensure that the deficient practice does not recur;**

The measures and systemic changes we are making are described under Question 1, "What action we are taking to correct the deficiency".

**3) How the corrective actions will be monitored;**

The MTCR Director will confirm in the chart reviews that the documentation of the treatment team decisions regarding supervision levels is included in the notes.

**4) Date corrective action will be completed.**

Corrective Actions were completed by 4/21/14.

Middlesex Therapeutic Community Residence  
 1076 US RT 2  
 Middlesex, VT 05633-7801  
 (802) 828-5800 phone  
 (802) 828-5821 fax

### FAX COVER SHEET

Date:	4/29/14	Time:	9:40 AM
Number of Pages:	8		
To:	Pamela Cote, RN	Fax:	802-871-3318
From:	Debra Olivetti, LICSW	Phone:	802-828-5810

**Message:**

Hello Pam,  
 Please find the POC'S for the MTCR,  
 resulting from the 4/1/14 incident and  
 investigation.  
 Thank you,  
 Deb Olivetti

The documents accompanying this transmission contain confidential information that may be legally privileged. This information is intended only for the use of individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party and is required to destroy this information after its stated need has been fulfilled.

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**ID Prefix Tag# T 060**

**5.10 Records/Reports**

**1) What action we are taking to correct the deficiency;**

The resident charts will include documentation of treatment team meetings, supervisory and review conclusions regarding supervision levels for residents, to include the clinical considerations and rationale for decisions regarding supervision levels. These decisions will also be discussed with the resident and a note will be written summarizing the meeting and placed in the resident chart. (Resident #1 who is referred to in T 060 discharged prior to this licensing investigation).

**2) What measures will be put into place or what systemic changes we are making to ensure that the deficient practice does not recur;**

The measures and systemic changes we are making are described under Question 1, "What action we are taking to correct the deficiency".

**3) How the corrective actions will be monitored;**

The MTCR Director will confirm in the chart reviews that the documentation of the treatment team decisions regarding supervision levels is included in the notes.

**4) Date corrective action will be completed.**

Corrective Actions were completed by 4/21/14.