

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

April 22, 2014

Mr. Alexander Leveille, Administrator  
Segue House  
7 St. Paul Street  
Montpelier, VT 05602

Provider #0504

Dear Mr. Leveille:

Enclosed is a copy of your acceptable plans of correction for the unannounced on-site re-licensing survey, as well as self-report and anonymous complaint investigations conducted on February 10, 2014 and concluded on **February 11, 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,



Pamela M. Cota, RN  
Licensing Chief

PC:ne

Enclosure

Division of Licensing and Protection

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Division of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0504	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	MAR 20 14 Licensing and Protection	(X3) DATE SURVEY COMPLETED  C 02/11/2014
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NAME OF PROVIDER OR SUPPLIER  SEGUE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 7 ST PAUL STREET MONTPELIER, VT 05602
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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  This REQUIREMENT is not met as evidenced by: An unannounced on-site re-licensing survey as well as self-report and anonymous complaint investigations were conducted by the Division of Licensing and Protection on February 10 & 11, 2014. The following are Licensing and Operations Regulations for Therapeutic Community Residences violations.	T 001		
T 022 SS=B	V.5.4.c Resident Care and Services  5.4 Discharge Requirements  5.4.c A summary of the resident 's stay at the facility shall be added to the resident record within two weeks of his or her leaving. The summary shall include the reason for leaving, areas in which progress, no progress, or regression was observed, and the medication the resident was prescribed at the time of leaving.  This REQUIREMENT is not met as evidenced by: Based on record review and interviews, there were no discharge summaries for 3 of 3 discharged residents in the sample. (Residents #2, #4 and #5) Finding include:  1. Per record review on 02/10/14 Resident #2 was admitted on 07/23/13 and was discharged on 12/31/13. There was no discharge summary for the reason for leaving, areas of progress/ no progress or regression and the medication the	T 022	T022  A discharge form will be created that provides a summary of the residents stay at Segue. The form will include the reason for leaving, areas of progress, no progress, or regression, and a list of medications at time of discharge. House manger & nurse will sign off on form within two weeks of discharge. Plan for medication management will be included in the discharge summary beginning 4/3/14.  T022 Poc accepted 4/14/14 Susan J. Emmons RN	4/3/14

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Coordinator* (X6) DATE *3/14/14*

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T 022	<p>Continued From page 1</p> <p>resident was prescribed at the time of leaving. Although a letter from the resident dated 12/06/13 stated that the resident wishes to vacate the room and 'hope to return to Second Spring to continue my recovery" no further information was noted. Per interview on 02/11/13 at 11:15 AM the Director confirmed that no discharge summary was in the record showing the above information.</p> <p>2. Per record review on 02/10/2014 Resident # 4 was admitted on 09/25/2012 and discharged on 11/15/2013. There was no discharge summary denoting the reason for discharge, areas of progress or regression, or medication reconciliation and follow up. It is noted only that the resident submitted a letter of intention to discharge via a 30 day notice. On 02/11/2014 the Director was unable to find records supporting documentation of a discharge summary.</p> <p>3. Per record review on 02/10/2014 Resident # 5 was admitted on 07/12/2013 and discharged on December 14, 2013. There is no discharge summary denoting the reason for discharge, areas of progress or regression, medication reconciliation or follow up. The resident did submit a 30 day notice to vacate. On 02/11/2014 the Director was unable to locate documented information specific to the resident's discharge.</p>	T 022		
T 032 SS=D	<p>V.5.7.b Resident Care and Services</p> <p>5.7 Treatment Plan</p> <p>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</p>	T 032		

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T 032	<p>Continued From page 2</p> <p>within fourteen (14) days of admission.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record record review and interview the TCR failed to ensure the treatment plan reflected steps to be taken to solve identified problems, either by direct service at the residence or indirectly by referral to a community resource for 1 of 5 residents in the sample (Resident #2) Findings include:</p> <p>1. Per record review on 02/11/14, Resident #2, with a diagnosis of Bi-polar Disorder, was admitted on 07/23/13. Per a Med Check Note from the Doctor dated 10/23/12 and the 06/18/13 Referral Form notes the resident as having "bizarre behaviors - manic, delusional, threatening and sexually inappropriate" but deemed appropriate for transition to a group home. The identification of problems and areas of successful life functions, which are used as a basis for development of a treatment plan and goals notes only the following; strengths; "wonderful, exuberant kind energetic", and for area of concerns; "talk to me during crisis".</p> <p>Although the daily progress notes and monthly notes show an increase in behaviors such as "mumbling to self, making slurs to females, deregulated and hypersexual" no treatment plan was noted for these identified problems. The treatment plan shows the resident working towards independent living by cooking one day per week and to work on interpersonal interaction by making eye contact, conflict resolution body posture and slowing speech. There are no reflective steps in the treatment plan for the</p>	T 032	<p>T032</p> <p>Identified problems will be reviewed and discussed at monthly team meetings. The need for further action will be identified as necessary. All proposed action(s) will be documented in the team meeting notes and the treatment plan. All treatment plan goals will be reviewed monthly by treatment team</p> <p>4/1/14</p> <p>4/1/14</p> <p>POC T032 accepted 4/14/14</p> <p><i>Susan J. Cummings PA</i></p>	4/1/14
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T 032	Continued From page 3  identified problem of the Bi-polar symptoms with the inappropriate behaviors. The House Manager at 12:15 PM stated that "staff were aware what to do when [the resident] acted this way" but confirmed the treatment plan did not reflect the steps of the identified problem of behaviors.	T 032		
T 033 SS=D	V.5.7.c Resident Care and Services  5.7 Treatment Plan  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.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop, for 1 of 5 Residents, a treatment plan that contained clear and concise statements of at least the short- term goals the resident will be attempting to achieve, along with a realistic time table for their fulfillment or reassessment. (Resident # 5) Findings include:  1. Resident # 5 was identified per staff progress notes as someone with significant issues with anger and someone who threatened other residents and staff continuously. There is no treatment plan recorded that provides information in the record that the staff had a plan in place to work with the resident in respect to anger and threatening demeanor. There are numerous staff notes depicting the resident as volatile, angry, aggressive, hostile, and threatening in September	T 033	T033  Treatment plan goals will be stated in terms that are observable and measurable. The treatment plan will state how the goals are to measured. The progress and time schedule for each goal will be reviewed monthly at treatment team meeting.  5/1/14  POC T.033 accepted 4/14/14  Sharon J. Emmerson RN	5/1/14

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T 033	Continued From page 4  and October of 2013, but the monthly Therapeutic Residence Report for both September and October of 2013 does not have an update or revision addressing a possible treatment attempt, or short or long term goals modified to deal with the behaviors. On 2/11/2014 at 11:30 AM the Director was not able to find supportive documentation as requested by the surveyor.	T 033		
T 035 SS=F	V.5.8.a.1.2.3.4.5.6.7.8 Resident Care and Services  5.8 Medication Management  5.8.a Each therapeutic community residence must have written policies and procedures describing the residence ' s medication practices. The policies must cover at least the following:  (1) If a therapeutic community residence provides medication management, it shall be done under the supervision of a registered nurse.  (2) Who will provide the professional nursing delegation if the residence administers medications to residents unable to self-administer and how the process of delegation is to be carried out in the residence.  (3) Qualifications of the staff who will be managing medications or administering medications and the residence's process for nursing supervision of the staff.  (4) How medications shall be obtained for	T 035	TO35  Medication Administration and Nursing 4/3/14 Policies and Procedures, addressing areas 5.8.a (1 thru 8) have been relocated to a central area in the staff office. An in-service reviewing the location and use of the P&Ps and completed AIMS forms will be held on or before 4/3/14.  <i>POC T035 accepted 4/14/14 Susan J. Emmons RN</i>	

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T 035	<p>Continued From page 5</p> <p>residents including choices of pharmacies.</p> <p>(5) Procedures for documentation of medication administration.</p> <p>(6) Procedures for disposing of outdated or unused medication, including designation of a person or persons with responsibility for disposal.</p> <p>(7) Procedures for monitoring side effects of psychoactive medications.</p> <p>(8) Procedures for assessing a resident's ability to self-administer and documentation of the assessment in the medical record</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews the TCR failed to have written policies and procedures describing the residence's medication practices. This has the potential to effect all residents. Findings include:</p> <p>Per request on 02/10/14 for the TCR's policies and procedures manual, a copy of the WCMH (Washington County Mental Health) policy and procedure book and the Segue Employee Guide were presented. Although some accepts of general procedures were found in those policies and procedures books, they were not specific to the nursing and medication services provided to the TCR residents.</p> <p>The nurse surveyor was unable to find procedures for assessing a resident's ability to self-administer and what is required for documentation of the assessment. There were no procedures for monitoring side effects of</p>	T 035		
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T 035	Continued From page 6  psychoactive medications, drug counts, the process for nursing supervision of the staff. Per interview on 02/11/14 at 11:00 AM the Director stated the nursing policy/procedure books were off-site and nurse was not available this week. S/he confirmed the policies and procedures describing the residence's medication were not available.  also see T0071	T 035		
T 042 SS=D	V.5.8.e.1.2.3.4.5. Resident Care and Services  5.8 Medication Management  5.8.e. Staff responsible for assisting residents with medications must receive training in all of the following areas before assisting with any medications from the registered nurse:  (1) The basis for determining "assistance" versus "administration".  (2) The resident's right to direct the resident ' s own care, including the right to refuse medications.  (3) Proper techniques for assisting with medications, including hand washing and checking the medication for the right resident, medication, dose, time, and route.  (4) Signs, symptoms and likely side effects to be aware of for any medication a resident receives.  (5) The residence ' s policies and procedures for	T 042	TO42  5.8.e Training records and levels of medication delegation of staff have been consolidated and placed in a central location in the staff office. 5.8.e (1 – 5) are addressed in the training records or/and medication / nursing policies & procedures. Locating and using this information will be included in an in-service for all staff on or before 4/3/14.  <i>POC T-042 accepted 4/14/14 Susan J. Emmons RN</i>	4/3/14

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T 042	<p>Continued From page 7</p> <p>assistance with medications.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews staff failed to receive training in all areas of medication management before assisting with any medications for 1 of 5 residents in the sample. (Resident #1) Findings include:</p> <p>1. Per interview on 02/10/14 at 9:00 AM the House Manager identified Resident #1 as self-administering insulin with staff 'assist this resident with the insulin but administers the other medications'. The House Manager at that time was unable to state the basis for determining assistance versus administration. There was no policy to identify assistance versus administration of medications at the TCR. Per record review the Resident's annual assessment dated 09/30/13 shows per Section O(d) that the resident was not clear as to communicating if the medication has desired or unintended side effects. The guidance in the assessment notes that a "no response to any of the questions indicates medication administration". Additionally, there was no documentation that the resident had had training regarding self-administration. Per interview on 02/14/14 at 1:45 PM the Director confirmed the lack of policy and procedures for the basis for determining "assistance" versus "administration" of medications.</p>	T 042		
T 052 SS=C	V.5.9.b.1.2.3.4.5.6.7 Resident Care and Services  5.9 Staff Services	T 052		

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T 052	<p>Continued From page 8</p> <p>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:</p> <ul style="list-style-type: none"> <li>(1) Resident rights;</li> <li>(2) Fire safety and emergency evacuation;</li> <li>(3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid;</li> <li>(4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation;</li> <li>(5) Respectful and effective interaction with residents;</li> <li>(6) Infection control measures, including but not limited to, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and</li> <li>(7) General supervision and care of residents</li> </ul> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews the TCR failed to have documented at least twelve (12) hours of training each year for each staff person providing direct care to residents for 5 of 5 staff.</p> <p>Based on staff interview and facility staff file</p>	T 052	<p>T052</p> <p>Staff will demonstrate continued competency in the skills and techniques necessary for their job performance. A minimum of twelve hours of training will be documented in a staff training log. This log will be kept at Segue house and reviewed quarterly by Program Administrator.</p> <p>11/1/14</p> <p><i>POC accepted T052</i> <i>4/14/14</i> <i>Susan J. Emmons RN</i></p>	11/1/14
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T 052	Continued From page 9  review the facility failed to demonstrate that 5 of 5 staff members reviewed had received at least (12) hours of annual training specific to resident rights, fire and safety and emergency evacuation, resident emergency response, mandatory reporting, respectful and effective communication with residents, infection control measures, and general supervision of residents. The facility Director confirmed on 2/11/2014 at 11:30 AM that the information was not available.	T 052		
T 054 SS=F	V.5.9.d Resident Care and Services  5.9 Staff Services  5.9.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the residence as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection and the Department for Children and Families in accordance with 33 V.S.A. §6911 and 33 V.S.A. §4919 to see if prospective employees are on the abuse registry or have a record of convictions.  This REQUIREMENT is not met as evidenced	T 054	T054  A locked personnel file will be maintained on-site that contains background check information.  5/1/14  POC T054 accepted 4/14/14  Sharon J. Emmerson RN	5/1/14

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T 054	Continued From page 10  by: Based on staff interview and staff file review the facility failed to provide the required documentation that 5 of 5 selected facility employees were checked through the APS adult background registry and through the Child Abuse Registry. Findings include:  A request for information regarding the necessary background information for employees selected for review brought only (2) files containing adult APS background, neither containing child abuse registry background information. Three of the five staff review requests had no APS adult background checks. All five staff reviews had no child abuse registry information. Per interview of the Director on 02/11/2014 at 11:15 AM, s/he confirmed that the files were not available.	T 054		
T 060 SS=F	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;	T 060	T060  (1) A digital register of all admissions and discharges will be maintained. All staff will receive training to be able to access this information on demand.  (2) The Treatment Plan book that is already in use will be amended to include: (i. thru ix.) This will be reviewed, Quarterly by supervisor or designee based on admission date 8/1/14  <i>POC T.060 accepted 4/14/14 Sara J. Cannon RN</i>	8/1/14

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T 060	<p>Continued From page 11</p> <p>ii. The health care provider ' s name, address and telephone number;</p> <p>iii. Instructions in case of resident's death;</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 interview the</p>	T 060		

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T 060	<p>Continued From page 12</p> <p>resident records failed to have some of the required information for 5 of 5 in the sample. This has the potential to effect all residents in the TCR. (Residents #1 - #5) Findings include;</p> <p>1. Per review of the resident's records during the two days of survey the following information was not found:</p> <p>a) All residents ( #1-#5) failed to have photos in the chart and no documentation of any such refusals.</p> <p>b) No documentation of discharge summaries were obtained for Residents #2, #4, #5</p> <p>c) No Advance Directives and/or or whether Advance Directive information was given for Residents #1 - #5</p> <p>d) No instructions in case of Resident's death for Residents #1 - #5</p> <p>e) No supervisory and review conclusions per the meeting with the resident were documented for Residents #1- #5</p> <p>f) Resident #1 had missing Progress notes for September 2013 as well as Monthly Team Meeting note for July, August, September, October and December 2013</p> <p>g) Treatment Plans for Residents #1 - #5 were not clear and concise with realistic time schedules for their fulfillment or reassessment. The treatment plans did not identify each resident's strengths or problems but were generalized and vague. For example all residents' treatment plans stated " to meet with their case manager..or staff to develop skills for independent living."</p> <p>Per interview on 02/11/14 at 11:45 AM the Director was unable to obtain all the required information for the residents' records. S/he confirmed at that time that the above information was not in the charts.</p>	T 060		
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T 071 SS=F	<p>V.5.13 Resident Care and Services</p> <p>5.13 Policies and Procedures</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview the TCR failed to have written polices and policies that govern all services. This has the potential to effect all residents. Findings include:</p> <p>1. Per request on 02/10/14 for the TCR's policies and procedures manual, a copy of the WCMH (Washington County Mental Health) policy and procedure book and the Segue Employee Guide were presented. Although some accepts of general procedures were found in those policies and procedures books, they were not specific to the services provided to the TCR residents. For example, the policies did not have information regarding transportation, laundry, medication/nursing management, pets in the home, and admission, discharge and transfers specific to the TCR regulations. Per interview on 02/11/14 at 11:00 AM the Director stated the nursing policy/procedure books were off-site and nurse was not available this week. The Director confirmed that the policy/procedure books were not written specific to TCR services.</p>	T 071	<p>T071</p> <p>Segue House Policies and Procedures book will be updated and a copy will be maintained at the facility. CSP Therapeutic Residence Director or designee will review for updates semi-annually.</p> <p>Nursing Policy and Procedure book for Segue has been relocated to a central space in the staff office, and an electronic folder containing these P&amp;Ps has been placed in the Shared Documents file on the computer system. Location and use of these P&amp;Ps will be reviewed in a staff in-service to be held on or before 4/3/14.</p> <p><i>POC T-071 accepted 4/14/14 Susan J. Emmons</i></p>	4/3/14
T 072 SS=C	<p>V.5.14.a Resident Care and Services</p> <p>5.14 Transportation</p>	T 072		

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T 072	<p>Continued From page 14</p> <p>5.14.a Each residence must have a written policy about what transportation is available to residents of the residence. The policy must be explained at the time of admission and included in the admission agreement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide 5 of 5 residents in the sample, with a written policy about what transportation is available to the residents in the facility. (Resident #1 - #5) Findings include:</p> <p>A review of the five sampled Residents' records showed that they had no transportation information or policy. Per interview of the Director on February 11, 2014 at 11:45 AM, s/he confirmed that the residents at the time of admission did not receive an explanation of what transportation is available. S/he also confirmed that there is no policy on transportation information.</p>	T 072	<p>T072</p> <p>Admission agreement will include the transportation policy explaining what transportation is available to residents of Segue House.</p> <p>7/1/14</p> <p>POC T-072 accepted 4/14/14 Susan S. Emmmons, RN</p>	7/1/14
T 078 SS=D	<p>V.5.16.a Resident Care and Services</p> <p>5.16 Reporting of Abuse, Neglect or Exploitation</p> <p>5.16.a The licensee and staff shall report any case of suspected abuse, neglect or exploitation to Adult Protective Services (APS) as required by 33 V.S.A. §6903. APS may be contacted by calling toll-free 1-800-564-1612. Reports must be made to APS within forty-eight (48) hours of learning of the suspected, reported or alleged incident.</p>	T 078		

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T 078	Continued From page 15  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to report an allegation of abuse for 1 of 5 records reviewed to adult protective services within forty eight hours of receiving the report or allegation. (Resident #5) Findings include:  Resident # 5 was admitted on 07/12/2013 with a diagnosis of Bipolar Disorder. It is reported in the staff progress notes on October 5, 2013 that s/he expressed concern to the staff that his roommate was sexually inappropriate in his presence, specifically that s/he was masturbating in front of him/her. A follow up progress note on 10/06/2013 again addresses the complaint made by the resident and the writer of the note writes, "I will have to make an APS report." The APS report is recorded as received on 10/09/2013, approximately 4 days or 96 hours after the complaint was made by the resident. No explanation was offered by the staff regarding why the report was late.	T 078	T078  Staff will receive additional training about mandated reporting. All reports will be reviewed quarterly by program Director  <i>POC T-078 accepted 4/14/14 Susan J. Emmons RN</i>	5/1/14
T 080 SS=D	V.5.16.c Resident Care and Services  5.16 Reporting of Abuse, Neglect and Exploitation  5.16.c Incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse, or if an injury requiring medical intervention results, or if there is a pattern of abusive behavior. All resident-to-resident incidents, even minor ones, must be recorded in the resident ' s record. Families or legal representatives must be notified and a plan must be developed to deal with the	T 080	T080  Staff will receive additional training about mandated reporting. All reports will be reviewed quarterly by program Director. At monthly team meeting identified problems will be reviews and discussed. The need for further action will be identified as necessary. All proposed action(s) will be documented in the team meeting notes and the treatment plan. All treatment plan goals will be reviewed monthly.  <i>POC T-080 accepted 4/14/14 Susan J. Emmons RN</i>	6/1/14

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T 080	<p>Continued From page 16 behaviors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and on staff interview, the facility failed to provide documentation that after a pattern of resident-to-resident incidents, a plan was developed to deal with the behaviors for 2 of 5 residents reviewed. (Residents#2 and #5). Findings include:</p> <p>1. Per review of the records for Resident #5 there was a resident-to-resident abuse allegation reported by the facility. There is no further documentation regarding if the facility had notified family or legal representatives, and did not have supportive documentation that a plan was developed to deal with the behaviors identified in the complaint investigation. Resident # 5 did not have documentation that a follow up plan was developed to deal with the behaviors identified in the complaint allegation. The behaviors associated with the complaint were long standing identified behaviors addressed in the staff progress notes and included the resident being hostile, threatening, and angry towards other residents and staff members. The resident's treatment plan was not revised or updated to detail staff efforts to provide a correction utilizing short and long term goals or specific therapeutic interventions. The Therapeutic Resident Director confirmed on 2/11/2014 that documentation in the record did not show that a plan was developed to deal with the resident's behaviors.</p> <p>2. Per record review on 02/11/14, Resident #2, was admitted on 07/23/13, with known behaviors of behaviors such as manic, delusional, threatening and sexually inappropriate.</p>	T 080		

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T 080	Continued From page 17  Although the daily progress notes and monthly notes show an increase in behaviors such as "mumbling to self, making slurs to females, deregulated and hypersexual", no treatment plan was noted for these identified problems. Per a Monthly Progress note dated October 13, 2013 states "[resident] have had a hard time at Segue throughout September...issues with [other residents] in the house and targeting with slurs, very deregulated and hypersexual". There are no documented plans for the identified problems of the on-going inappropriate behaviors towards other residents. The House Manager at 12:15 PM stated that "staff were aware what to do when [the resident] acted this way" but confirmed the treatment plan did not reflect the steps needed to deal with the identified problem of behaviors.	T 080		
T 113 SS=B	VII.7.1.a.1 Nutrition and Food Services  7.1 Food Services  7.1.a Menus and Nutritional Standards  7.1.a.1 Menus for regular and therapeutic diets shall be planned and written at least one (1) week in advance  This REQUIREMENT is not met as evidenced by: Based on observations and interview the TCR failed to have planned menu at least one week in advance. This has the potential to effect all residents. Findings include:  1. During the initial tour on 02/11/14 at 9:45 AM the menu posted for the week Tuesday February 11 - 17, 2014 had no food items for Wednesday the 12th, Friday the 14th, or Sunday the 16th.	T 113	T113  Menus will include breakfast/ lunch options. Posted one week in advance and will be reviewed weekly at the resident and staff house meeting.  4/1/14  <i>Doc T. 113 accepted 4/14/14 Susan J. Emmons RN</i>	4/1/14

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T 113	Continued From page 18  Additionally, no breakfast or lunch items are noted. Per review of the previous week menu no breakfast or lunch menu items are noted. Per interview at that time the House Manager stated that the residents help themselves to breakfast and lunch and that [s/he] hadn't had time to connect with the residents to see what they want, although, they are suppose to figure out the menu the prior week on Thursday. The Manager confirmed that the menu should have the breakfast and lunch options that are available and that the menu should've been completed at least one week in advance.	T 113		
T 129 SS=F	VII.7.2.d Nutrition and Food Services  7.2 Food Safety and Sanitation  7.2.d The residence shall ensure that food handling and storage techniques are consistent with the Food Safety Principles and Guidance for Consumers in the current Dietary Guidelines for Americans.  This REQUIREMENT is not met as evidenced by: Based on staff interview and per surveyor observation the facility failed to ensure that food handling and storage techniques were consistent with the Food Safety Principals and Guidance for Consumers in the current Dietary Guidelines for Americans. Findings include:  Per observation on 2/10/14 at 0940 AM it was discovered that the facility did not have a prescribed method in place for monitoring the perishable food and drink stored in the resident refrigerator. Two covered salads were found	T 129	T129  Staff will receive annual training food safety and handling House Coordinator will do weekly checks.  Training will be documented  5/1/14  <i>POC T-129 accepted</i> <i>4/14/14</i> <i>Susan J. Emmmus RN</i>	5/1/14

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T 129	Continued From page 19  without dates written on the covers. A left over "Alfredo" dish was labeled from January 29, 2013. A half-used pie plate of beef pot pie was uncovered and not dated. The pieces of cantaloupe appeared to be soft and moldy. The staff member conducting the facility tour confirmed that the retrieved food was out dated and readily disposed of them. When asked how s/he determined that the refrigerator needed to be checked for outdated items [s/he] responded that "usually the staff go into the refrigerator on Saturdays." The staff member confirmed that there was no organized method for monitoring the condition of the perishable items in the refrigerator.	T 129		
T 134 SS=F	VII.7.3.b Nutrition and Food Services  7.3 Food Storage and Equipment  7.3.b Areas of the residence used for storage of food, drink, equipment or utensils shall be constructed to be easily cleaned and shall be kept clean  This REQUIREMENT is not met as evidenced by: Based on observation and on staff interview the facility failed to maintain a clean and sanitary refrigerator in the facility kitchen. Findings include:  During the facility tour on 02/10/2014 at 0940 AM the resident refrigerator was observed to be unclean. There was also food debris and outdated food found inside of it. There was no cleaning schedule posted, and no record of the	T 134	T134  A cleaning schedule will be posted for both facility and resident refrigerators. This will be documented and review by house Coordinator.  6/1/14  <i>POC T-134 accepted 4/14/14 Susan J. Emmert RN</i>	6/1/14

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T 134	Continued From page 20  refrigerator being cleaned. The staff member directing the facility tour confirmed that there was no documented cleaning schedule or food maintenance schedule and [s/he] stated that staff "usually clean the refrigerator on Saturdays."	T 134		
T 142 SS=C	VIII. 8.1 Laundry Services  VIII. Laundry Services  8.1 The residence shall provide laundered bed and bath linens at least once a week.  This REQUIREMENT is not met as evidenced by: Based on observation and per staff interview the facility failed to provide laundered bed and bath linens at least once per week. Findings include:  Per observation while conducting the facility tour on February 10, 2014 at 10:00 AM it was noted that no laundry schedule was posted in the laundry area. The staff member directing the tour was asked how the facility staff is aware that the residents need to have clean linens or that they are changing their linens. [S/he] responded that the residents request linens as needed, but if they are not keeping up with their linen changes staff will notice it per visual or olfactory (smell) recognition. On February 10, 2014 at 10:00 AM the staff member guiding the facility tour confirmed that residents are not automatically or systematically receiving laundered bed and bath linens at least once per week.	T 142	T142  A laundry schedule will be posed in laundry area. Weekly room checks will be preformed to ensure that clean linens are on residents beds weekly. This will be documented by Coordinator or designee.  9/1/14  DOC T-142 accepted 4/14/14 Susan Q. Emmerson RN	9/1/14
T 146 SS=C	IX.9.1.a Physical Plant	T 146		

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T 146	<p>Continued From page 21</p> <p>9.1 Environment</p> <p>9.1.a The residence must provide and maintain a safe, functional, sanitary, homelike and comfortable environment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews the TCR failed to provide a clean and safe environment. This has the potential to effect all residents in the home. Findings include:</p> <p>1. During the initial tour on 02/10/14 at 9:30 AM, with the House Manager and Therapeutic Services Director, the following were observed: a) An accumulation of dirt and dust on all floors and carpets throughout the building. The bathroom on the second floor had dried yellow sticky material near the toilet bowl. Bedroom 202 had noticeable dust, dirt and debris on the carpet. Hallway and stairway to the third floor had a build up of dirt and dust. b) Cleaning solutions such as Lysol were unsecured in the first and second bathrooms. c) A build up of toothpaste and/or soap scum was noted on the first floor's bathroom mirrored cabinet shelf. Additionally several toothbrushes, also with a build up of dried toothpaste on them were on that shelf. A mop/bucket/cleaning solution was stored near the bathroom. This bathroom is used for all residents and visitors. Per interview with the person observed mopping the first floor common area at this time, stated that[s/he] "comes in three times a week for about</p>	T 146	<p>T146</p> <p>Two house cleaner have been hired and the house will be cleaned 5 days per week. Program coordinator oversees these cleaners. The coordinator will check whole house weekly to ensure house is being kept in a safe, functional, sanitary, and homelike, comfortable environment.</p> <p>4/1/14</p> <p><i>POC - 146 accepted 4/14/14 Susan J. Emmert RD</i></p>	4/1/14
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T 146	Continued From page 22  a hour", Monday is the first floor, Wednesday is the second floor and Friday is the third floor. Per interview with the House Manager and Director, stated that they did hire someone to come in and clean but stated that more cleaning is needed. They confirmed the above findings.	T 146		
T 187 SS=C	IX.9.11.c Physical Plant  9.11 Disaster and Emergency Preparedness  9.11.c Each residence shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented.  This REQUIREMENT is not met as evidenced by: Based on record review and interview the TCR failed to rotate fire drills among all times of day. This has the potential to effect all residents. Findings include:  Per review of the Fire Drill Log Book on 02/10/14, no night fire drills were conducted. From 01/29/13 until 01/21/14 fire drills were conducted at least quarterly, however, the times of day were either days ( 8:00 AM- 10:00 AM) afternoons (4:12 PM) or evenings ( 6:20 PM - 8:52 PM).	T 187	T187  Fire drill will be performed at varying times including mornings afternoon evenings and night hours between 11pm and 7am and logged in fire drill log. This log will be review by house Coordinator or designee to ensure compliance quarterly.  4/1/14  <i>Doc T-187 accepted 4/14/14 Susan J. Emmens RN</i>	4/1/14

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0504</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/11/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>SEGUE HOUSE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7 ST PAUL STREET MONTPELIER, VT 05602</b>		
(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 187	Continued From page 23  There were no drill held during the night hours which would be reflected from 11:00 PM - 6:00 AM. The Director at 2:14 PM confirmed that the night drills were not conducted.	T 187		
T999 SS=C	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 telephone number of the licensing agency.  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 initial tour on 02/10/14 at 9:45 AM the recent report statement was not available or found in a prominent area. Per interview at that time, the House Manager and Director stated that it should be posted on the bulletin board and confirmed the above information was not posted in a prominent area or readily available.	T999	T999  Current written reports from inspectors will be posted in a common area of the house. If a copy is requested staff will photocopy report and give it to resident.  4/1/14  <i>Doc T-999 accepted 4/14/14 Shirley S. Gammis, RN</i>	4/1/14

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0504</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>02/11/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SEGUE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7 ST PAUL STREET MONTPELIER, VT 05602</b>
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*Robert N. [Signature]* 3/14/14