

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

April 1, 2016

Mr. Alexander Leveille, Manager  
Segue House  
7 St Paul Street  
Montpelier, VT 05602-3033

Dear Mr. Leveille:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 16, 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



PRINTED: 02/29/2016  
FORM APPROVED

Division of Licensing and Protection		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0504	A. BUILDING: _____	B. WING: _____	02/16/2016
NAME OF PROVIDER OR SUPPLIER  SEGUE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 7 ST PAUL STREET MONTPELIER, 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
T 001	Initial Comments  An unannounced onsite re-licensing survey was conducted on 02/16/16 by the Division of Licensing and Protection. The following are Therapeutic Community Residence (TCR) regulatory findings.	T 001		
T 038 SS=D	V.5.8.d.1.2.3.i.iii.iv Resident Care and Services 5.8 Medication Management  d) if a resident requires medication administration, unlicensed staff may administer medications under the following conditions:  (1) A registered nurse must conduct an assessment of the resident's care needs consistent with the physician's or other health care provider's diagnosis and orders.  (2) A registered nurse must delegate the responsibility for the administration of specific medications to designated staff for designated residents.  (3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for:  i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects;  ii. Establishing a process for routine communication with designated staff about the resident's	T 038	T 038  Nurse delegation instructions for all medication changes, doctor's orders and special procedures will be documented on the Medication Change Delegation form. This form was amended and implemented at the Segue Staff meeting on 2/18/16 to read "Verbal Delegation received from RN;" with a text box for RN delegation instructions to be filled in as needed. Segue staff have been trained that the delegation instruction(s) box must be filled out with the specific nurse instruction(s) given at time of the RN's delegation. The RN's documentation will include monitoring of staff performance in recording and carrying out the nurse's delegation instructions.  The RN will ensure that there is proper documentation of the nurse's assessment of all resident care needs. The RN will include this evaluation as part of a revised Change in Medication Delegation Form to be implemented by 3/31/16.	3/31/16

Division of Licensing and Protection  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Algebra H. Hall* TITLE *Manager*

(X6) DATE 3/31/16

T038 - T052 POC's accepted 3/31/16 SEMMONS RN/pnu

PRINTED: 02/29/2016  
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0504	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  02/16/2016
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  
**SEGUE HOUSE**

STREET ADDRESS - CITY, STATE, ZIP CODE  
**7 ST PAUL STREET  
MONTPELIER, 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
--------------------	--	---------------	---	--------------------

T 038

Continued From page 1

condition and the effect of medications, as well as changes in medications;

iii. Assessing the resident's condition and the need for any changes in medications; and

iv. Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions.

This REQUIREMENT is not met as evidenced by:  
Based on record review and interviews the TCR did not follow some of the required conditions for medication administration by unlicensed staff. Findings include:

During the initial tour on 02/16/16 at 9:00 AM, the House Manager stated that unlicensed staff have been delegated to pass medication to the residents, and staff will call for any issues related to resident's conditions and medication questions. However, the following were noted:

a) During record review for Resident #2's MAR (Medication Administration Record) the resident received from 01/11/16 through 02/12/16, Omeprazole [for gastroesophageal reflux] at bedtime. The Drug Information Handbook, 8th edition, states that Omeprazole works best before meals, preferably before breakfast. Although this was discontinued on 02/12/16, there was no nursing assessment for this resident's care needs consistent with medication dosing time and the effect of medication.

b) Resident #2's bubble pack (pre-packaged medications from the pharmacy), was listed as

T 038

PRINTED: 02/29/2016  
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0504	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/16/2016
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  SEGUE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 7 ST PAUL STREET MONTPELIER, 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
--------------------	--	---------------	---	--------------------

T 038 Continued From page 2  
having three medications but only two were noted in the pre-packaged slots. There was scotch tape over those slots. When questioned about possible missing medication staff stated that the medication was discontinued, so it was removed for the bubble package and taped over. Staff stated that "the nurse knew it was discontinued". There was no documentation that the nurse instructed staff to open pre-packaged medication and re-package it.

I 038

During telephone interview at 3:03 PM the nurse stated that the pharmacy doesn't allow discontinued and/or unused medications to be returned, so the policy is that staff can destroy the medications. The nurse stated that the procedure is for staff to alert the nurse regarding changes and the nurse will instruct via the change in medication form. The nurse confirmed at that time that there was no documentation of the nurse's assessment of the resident's care needs for Omeprazole and monitoring and evaluating the designated staff performance in carrying out the nurse's instructions.

T 040 V:5.8.5-Resident Care and Services  
SS=D

T 040

5.8 Medication Management  
  
5.8.5 Staff other than a nurse may administer PRN psychoactive medications only when the residence has a written plan for the use of the PRN medication which describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the

T 040

The RN will review staff log notes monthly to determine that all PRN medications are being administered according to the

5/12/16

PRINTED: 02/29/2016  
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0504	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/16/2016
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  
**SEGUE HOUSE**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**7 ST PAUL STREET  
MONTPELIER, 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
--------------------	--	---------------	---	--------------------

T 040 Continued From page 3  
medication use

This REQUIREMENT is not met as evidenced by:  
Based on staff interview and record review, the home failed to assure that staff other than a nurse who administer PRN (as needed) psychoactive medications have a specific written plan which describes the specific behaviors the medication is intended to treat or correct or the specific results of the medication use. This deficiency affected 1 of 2 applicable residents in the total sample. (Resident #1). Findings include:

1. Per review of the physician orders for Resident #1, the resident had current orders, dated 11/25/15, for the psychoactive medication, Seroquel 50 mg every 12 hours PRN. The resident received on a dose nearly every evening, except 8 times, during a two month period, January and February 2016. There was no Behavior or Psychoactive Care Plan to direct staff on the specific behaviors identified as being treated or trying to correct. The MAR (Medication Administration Record), states "agitation" and "helped" (respectively) as to the reason and results. Staff progress notes did not show evidence of any specific behaviors. These findings were confirmed during interview at 2:15 PM on 02/15/16 with the House Manager.

T 040

established PRN order and corresponding Behavior Care Plan. RN will also make note of residents' PRN medication use in the monthly nursing notes.

Each resident's PRN sheet for psychoactive medication will be reviewed and updated. Behavior Care Plans corresponding to the administration of psychoactive PRN orders will be in place for identified behaviors. These will be based on the initial evaluation completed within two weeks of admission and reevaluated each month as needed. Psychoactive PRN sheets will be amended to include a field labeled "as evidenced by" in conjunction with the "reasons for medication administration" field now in place. Staff will note specific behaviors that residents are exhibiting.

Psychoactive PRN orders and accompanying Behavior Care Plans will be reviewed with all staff at the Segue House staff meeting by 5/12/16. Documentation expectations and procedures will be discussed with staff including modeling of appropriate log notes associated with the administration of psychoactive PRN medication.

T 052 V.5 9.3.1.2 3.4 5.6.7 Resident Care and Services  
SS=C  
5.9 Staff Services  
5.9 b. The residence must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before

T 052

PRINTED: 02/29/2016  
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0504	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  02/16/2016
NAME OF PROVIDER OR SUPPLIER  SEGUE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 7 ST PAUL STREET MONTPELIER, VT 05602	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IC PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETE DATE

T 052 Continued From page 4

providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following:

- (1) Resident rights;
- (2) Fire safety and emergency evacuation;
- (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid;
- (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation;
- (5) Respectful and effective interaction with residents;
- (6) Infection control measures, including but not limited to, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and
- (7) General supervision and care of residents

This REQUIREMENT is not met as evidenced by:  
Based on staff interview and record review, the facility failed to insure that at least twelve hours of training was provided each year for each staff person giving direct care to residents for 3 of 5 employee records reviewed. Findings include

- 1. Per review on 02/16/16 of the training records for 5 direct care staff, 3 of the 5 staff did not complete the required seven trainings prior to providing care. In addition, the documentation

T 052

T052

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. This training will include but not be limited to:

- (1) Resident rights;
- (2) Fire safety and emergency evacuation;
- (3) Resident emergency response procedures such as the Heimlich maneuver, accidents, police or ambulance contact and first aid;
- (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation;
- (5) Respectful and effective interaction with residents;
- (6) Infection control measures including but not limited to, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions, and
- (7) General supervision and care of residents

Training log will show total of hrs for each Staff each Yr.

6/1/16

PRINTED: 02/29/2016  
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0504	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  02/16/2016
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  SEGUE HOUSE	STREET ADDRESS - CITY - STATE, ZIP CODE 7 ST PAUL STREET MONTPELIER, 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
--------------------	--	---------------	---	--------------------

T 052	Continued From page 5  shows less than the required twelve hours of State required TCR trainings. Per interview on 02/16/16 at 12:15 PM the House Manager stated that the trainings "typically take 45 minutes to an hour" and confirmed not all required elements and/or 12 hours of trainings were completed.	T 052		
-------	---	-------	--	--