

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

September 13, 2012

Mr. Richard Keane, Administrator  
Serenity House  
98 Church Street  
Wallingford, VT 05773

Dear Mr. Keane:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 26, 2012**. 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:jj



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0524</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/26/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>SERENITY HOUSE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>98 CHURCH STREET WALLINGFORD, VT 05773</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 001	<b>INITIAL COMMENTS</b>  An unannounced on-site re-licensure survey and complaint investigation were conducted by the Division of Licensing and Protection on 06/25/12 & 6/26/12. The following are regulatory violations.	T 001	<i>See attached Plans of Correction.</i>	
T 003	<b>IV.A.2 Resident Care and Supervision</b>  <b>Medication</b>  The Director shall assure that all medications and drugs are: a. used only as prescribed by the resident's physician b. properly labeled and kept in a locked cabinet at all times or, when a program of self-medication is in effect, otherwise safely secured.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the Director failed to assure that 1 of 5 residents had current, signed medication orders. (Residents #1) Finding include:  1. Per review of the Medication Administration Records (MAR) for Resident #1, who received "as needed" (PRN) medications from the Standing Orders, there was no current signed physician's standing orders. The PRN medications, such as colace and melatonin were given on 12/10/10. Per interview on 06/26/12 at 1:25 PM the Nurse Manager stated that s/he assumed that the Standing Order Sheet was used for everyone but confirmed at that time, that the expectation is that the Standing Orders are supposed to be signed for each individual resident.	T 003		

Division of Licensing and Protection

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6889

819X11

If continuation sheet 1 of 5

*Pme*

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T 063	Continued From page 1	T 063		
T 063	VI.1.A.2.b. Common Model Program Standards  Structural Components--Governing Authority:  The bylaws and policies shall define: <ul style="list-style-type: none"> <li>· The qualifications for governing body membership;</li> <li>· The types of membership;</li> <li>· The method of selecting members;</li> <li>· The terms of appointment or election of members, officers and chairpersons of governing body committees; and</li> <li>· The frequency of governing body meetings and attendance requirements.</li> </ul> This STANDARD is not met as evidenced by: Based on interview and record review the Residence failed to have Structural components of the Governing Body. Finding include:.  1. Per review of the Governing Body Bylaws and policies there were no qualifications listed for the governing body membership, the method of selecting members, the terms of appointments other than for the officers and the attendance requirements. Per interview on 06/26/12 at 5:00 PM the COO (chief operating officer) acknowledged that most of the members are 'referred by other members, former client or family/friends of former clients... but there is no selection process or qualifications requirements". The COO also confirmed that attendance for a quorum and terms of appointment were not stated in the bylaws and policy for the Governing Body.	T 063		
T 089	VI.2.B.3.a. Common Model Program Standards  Treatment Components	T 089		

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T 089	Continued From page 2  Process-- Treatment plan The treatment plan shall reflect steps to be taken to solve identified problems, either by direct service at the residence or indirectly by referral to a community resource.  This STANDARD is not met as evidenced by: Based on record review and interview, the residence did not develop a comprehensive treatment plan for 5 of 5 applicable residents (Residents #1, #2, #3, #4, #5) that identified specific steps taken by residence staff to assist the residents. Findings include:  1. Per record review on 06/26/12, Residents #1 through #5 had identified problem areas that had no specific goals and interventions on the treatment plan. There was no planned interventions outlined in the immediate treatment plan for each individual for specific staff interventions that might be employed to meet the residents' needs. Per interview on 06/26/12 at 10:30 AM the Clinical Manager stated that when the residents are admitted they have a brief orientation to the programs and then in 'about four days' the case managers will start working on comprehensive care plans. The Clinical manager confirmed at this time that a treatment plan, which would identify all necessary care areas and specific staff interventions that might be employed to meet the resident's needs were not completed.  Also see 0090	T 089		
T 090	VI.2.B.3.b. Common Model Program Standards  Treatment Components Process-- Treatment plan	T 090		

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T 090	Continued From page 3  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 STANDARD is not met as evidenced by: Based on record review and staff interview, the residence failed to develop a treatment plans for 5 of 5 applicable residents that contained clear and concise statements of at least the short term goals the residents will be attempting to achieve or a time schedule for their fulfillment or reassessment. (Residents #1, #2, #3, #4 & #5) Findings include:  1. Per record review on 06/25/12 - 06/26/12 for Residents #1 through #5, there was no treatment plan that identified clear and concise short-term goals nor time frames for completion. Although a brief orientation, service plan and monthly summary was written, it did not identify specific goals, outcomes and steps needed for the treatment plan, nor time schedules for their fulfillment or reassessment. Per interview on 06/26/12 at 2:43 PM, the COO confirmed there was no treatment plan that identified short term goals or a time frame for completion.  Also see 0089	T 090		
T 100	VI.2.B.5.d. Common Model Program Standards  Treatment Components Process--Supervision and Review The director or supervisor shall be responsible for coordinating all treatment both in and outside residence.	T 100		

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T 100	Continued From page 4  This STANDARD is not met as evidenced by: Based on record review and interview, the Director failed to assure that treatment was provided according to the detox protocol for 1 applicable resident. (Resident #1)  1. Per review of physician's alcohol detox plan and the Residence's protocol for Alcohol Detox, Resident #1 was not assessed every 4 hours while in detox. Per the Detox plan and protocol #3 instructions, it states "alcohol withdrawal assessment every 4 hours while in detox". The Resident was in alcohol detox from 12/08/10 - 12/11/10. Per review of the Alcohol Withdrawal Scoring Sheet dated 12/09/10, Resident #1 was assessed at 02:15 AM and the next assessment was performed greater than 4 hours later at 8:15 AM. Additionally, the assessments on 12/10/10 occurred greater than 4 hours apart between 12:45 AM - 6:45 AM and 6:45 AM - 1:15 PM. Per interview on 6/26/12 at 1:15 PM, the staff nurse was unable to state why the assessment was not done and stated "that there is some confusion over how medication orders and assessment orders overlap". The Nurse Manager at 1:25 PM on 06/26/12 confirmed that the treatment was not followed as ordered.	T 100		

**Plan of Correction  
For  
Serenity House On-Site Survey  
Conducted June 26, 2012 by the Division of Licensing and Protection**

**Standard VI.A.2 – Resident Care and Supervision – Medication**

**Action to be taken** – Medication Administration Records (MAR) for PRN medication are required to have signed physician orders for each client present in the client record at the time of administration of medication. Serenity House will establish a check list, to be placed in individual client charts of PRN medication which the Medical Director can check off and sign to show official physician orders for the medications.

**Measure for change and monitoring**– The nurse manager, during routine random chart review will make certain this required check list is in the client’s chart. If the checklist is not in the chart the distribution of the PRN medication will be tracked back to the dosing nurse who will be disciplined accordingly.

**Date of corrective action complete** – August 12, 2012

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**Standard VI. 1.A.2.b – Governing - Authority – Bylaws**

**Action to be taken** – At the July 17, 2012 Recovery House, Inc. Board meeting it was decided that the Executive Committee would meet to review the bylaws and create updates to reflect clearer policies in the following areas:

- Qualification for governing body membership
- Method of selecting members
- Terms of appointment of all board members
- Attendance requirements

**Measure for change and monitoring** – Once bylaws are voted into place all new Board members will be educated on the bylaws as part of their orientation to the board for continued follow through on proper policies and procedures.

**Date of corrective action complete** - The changes will be presented to the Board of Directors at the September board meeting and voted on for implementation as of October 1, 2012.

**VI.2.B.3.a Common Model Program Standards- Treatment Components- Process- Treatment Plan (T089)**

**Action to be Taken-** Each client admitted to the Program receives an individual treatment plan that includes specific goals and interventions (methods for achievement). Our current treatment plan format allows for up to 6 goals, specific to ASAM dimensions, with each goal containing up to 3 objectives that include a method for achievement for each, as well as a start date and target

date for completion for each. The status of each objective is reviewed and updated on a minimum of a weekly basis through individual treatment plan reviews with their counselor as well as through the weekly Client Review/ Clinical Treatment Team meeting. Methods identified are to reflect the particular intervention being used for achievement of each objective and goal.

**Measure for Change and Monitoring-** The Clinical Supervisor will review each treatment plan to ensure that all components indicated above are included and are geared toward goal achievement. The Treatment Plan Review Forms that are completed by each counselor for each client will be reviewed weekly by the treatment team to ensure inclusion of goal/objective modifications, completions and status changes. Staff will be provided additional training on short-term treatment planning and goal setting.

**Date of Corrective Action to be Completed by-** October 1, 2012

**J VI.2.B.3.b Common Model Program Standards-Treatment Components-Process-Treatment Plan (T090)**

**Action to be Taken-** The Serenity House treatment plan model includes goals, objectives and methods, as well as start and completion dates. All treatment plans will include short-term goals that are individualized, measurable, achievable and time specific. Each treatment plan will include at least one goal that will be addressed and completed by the 7<sup>th</sup> treatment day.

**Measure for Change and Monitoring-** a The Clinical Supervisor will review the electronic record on daily basis to ensure each client admitted received a treatment plan which includes short-terms goals and related interventions that have at least one goal that will be achieved by the 7<sup>th</sup> treatment day.

**Date of Corrective Action to be Completed by-** September 1, 2012

**We request a review of the determination that deficiencies were present in the above noted regulatory standards: (TO89 and TO 90)**

At the time of the review, we were informed that the current regulations indicated that a treatment plan needed to be in place on the day of admission. Based on our review of the current regulations, which were shown to the reviewer to ensure they were the current regulations, under **Treatment Components-Process- Treatment Plan, 3.(b)**, the regulation does not indicate a specific timeline for completion of the treatment plan. Serenity House has consistently followed the standard of treatment plans being worked on and completed “**within 4 working days**”, which is in line with the standards of the Office of Alcohol and Drug Abuse Program and CARF (the Rehabilitation Accreditation Commission). All treatment plans include specific short terms goals, including timelines for completion (start and end dates), objectives, and methods and interventions for completion of the goals. Amongst the five charts that were reviewed, three treatment plans were completed within the four days, while the other two charts indicated the clients were no longer present in the facility by the end of day four.

VI.2.B.5.d - Common Model Program Standards – Treatment Components – Process – Supervision and Review

**Action Taken** – Detoxification protocols are being reviewed for updating by the organization Medical Director. When protocols have been signed off on by the Medical Director nursing staff will be trained in the practice of the protocols and sign off on their understanding of the protocols.

**Measures for change and monitoring** - The nurse manager, during random chart review will check to be sure that there have be no deviations from the written detox protocols. If variations are noted these will be researched to see if there were physician orders approving the variation. If there were no order for the variation the nurse who caused the variation will be disciplined appropriately.

**Date corrective action completed** – The Medical Director will have new protocols signed and nurses will be trained no later than September 9, 2012.

T003, T063, T089, T090 + T100 POC's accepted 9/10/12 SEMMONS RN/ Pmc