

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

June 29, 2016

Ms. Lynn Pilcher, Administrator  
Spring Lake Ranch  
1169 Spring Lake Road, Po Box 310  
Cuttingsville, VT 05738-0310

Dear Ms. Pilcher:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on May 11, 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

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 05/11/2016
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NAME OF PROVIDER OR SUPPLIER  SPRING LAKE RANCH	STREET ADDRESS, CITY, STATE, ZIP CODE 1169 SPRING LAKE ROAD, PO BOX 310 CUTTINGSVILLE, VT 05738
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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  An unannounced on-site survey was completed by the Vermont Division of Licensing and Protection on 5/11/16. The purpose of the survey was re-licensure and investigation of a facility self-report. The following regulatory violations are related to re-licensure and the facility self-report.	T 001		
T 008 SS=E	V.5.2.c Resident Care and Services  5.2 Admission Agreements  5.2.c If applicable, the agreement must specify the amount and purpose of any deposit. This agreement must also specify the resident's transfer and discharge rights, including provisions for refunds, and must include a description of the residence's personal needs allowance policy. Any change of rate or services shall be preceded by a thirty (30) day written notice to the resident and the resident's legal representative, if any.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the Therapeutic Community Residence (TCR) failed to provide an admission agreement which accurately reflected the required notification process to a resident if an increase in rates was to be initiated. Findings include:  Per review, the TCR's Financial Information and Service Agreement provided to residents upon admission stated, "Fees: The Resident fee for Spring Lake Ranch is currently \$ xxx per day and is subject to change with or without notice."	T 008	<p><b>T 008 Action to be taken:</b> An immediate change was made to the Service Agreement and Financial Information document to read "Fees: The Resident fee for Spring Lake Ranch is currently \$XXX per day and is subject to change at any time but will be preceded by a 30 day written notification to the resident and/or financially responsible party."</p> <p><b>T 008 Monitoring corrective action:</b> Only the Admissions Director will be able to make changes to the Agreement. It will be saved as a PDF such that no inadvertent changes can be made going forward. The Admissions Director will review annually.</p> <p><b>T 008 Date of corrective action:</b> The Service Agreement and Financial Information document were changed to comply with regulations on 5/31/16.</p>	

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

*Lynn J. Pilcher*

TITLE

*Executive Director*

(X6) DATE

06/20/16

STATE FORM

6888

RQP911

If continuation sheet 1 of 14

T008 - T999 POCs accepted 6/21/16 MBK/ARW/PMC

6/20/16

Division of Licensing and Protection

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T 008	Continued From page 1  Vermont TCR regulations require the TCR to provide the resident and/or responsible party for the resident, a 30 day notice prior to an increase in the daily and/or monthly rate. This information was confirmed during survey interview with the Executive Director.	T 008	<b>T 023 Request for Informal Dispute Resolution made by Spring Lake Ranch on May 27, 2016</b>  Supplemental Filing June 20, 2016.	
T 023 SS=G	V. 5.5.a Resident Care and Services  5.5 General Care  5.5.a Upon a resident's admission to a therapeutic community residence, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. The home's manager shall provide every resident with the personal care and supervision appropriate to his or her individual needs.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the TCR failed to provide the necessary services to meet the psychosocial and medical care needs for 1 of 5 residents in the sample. (Resident #1). Findings include:  Per staff interviews and record reviews subsequent to a mandated facility report regarding a significant adverse resident event, it was determined that the facility failed to meet Resident #1's psychological and medical needs by failing to provide necessary care and services related to the resident's recent history of suicide attempts. The Suicide/Harm Risk Assessment	T 023	Regarding T 023, which addresses the regulation of providing the necessary services to meet the psychosocial and medical care needs of residents, Spring Lake Ranch disputes the accuracy of the findings in the deficiency statement. Without admitting or denying anything, the facility proposes the following:  <b>T 023 Action to be taken:</b> Change to admission process. No one shall be admitted to SLR with known history of suicide attempt within past 12 months. Should a history of SI be revealed at any point in the admission process, the prospective resident will be screened out and referred elsewhere. Should SI present itself during current treatment here, an updated Risk Assessment shall be completed by Clinical Team Leader and reviewed with Clinical Director for appropriate disposition, including but not limited to safety contracting with the resident, consultation with crisis team and/or crisis screening. This may result in referral elsewhere.	

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T 023 Continued From page 2

dated 3/23/16, (done upon admission for all new residents) included a history of 2 suicide attempts, including one attempt coded as "one of high lethality", within the 4 four week period prior to admission to the facility. Although the resident seemed to be adjusting well to the facility, during the last week s/he was there, staff stated that they began to observe some worrisome behaviors. The resident ultimately committed suicide.

Based on reviews of the medical record and staff interviews throughout the 3 days of survey, all direct care staff, including weekend Duty Charge staff, were not informed of critical information regarding the residents risk of self harm; additionally, the risk was not addressed on the resident's Treatment Plan and Safety Plan.

The Treatment Plan, titled Resident Action Plan, developed by the team in concert with the resident, directs the resident's care and services. The Plan failed to identify and to address the resident's previous history of recent suicide attempts. Per review, there was no mention of the resident's self-reported signs (behaviors/actions) that may indicate s/he was at risk of harming themselves. There were no specific interventions to direct staff in how to proceed and what actions to take if they believed the resident was not safe or was displaying possible risky behavior. Although the initial Nursing Intake Assessment dated 3/15/16, stated that symptoms of an impending 'melt down' could include (per the resident's response) "Down mood, Isolative and Grumpy", this significant information was not included on either the Treatment Plan/Resident Action Plan or the Safety Plan.

A review of the Work Program Progress Notes

T 023

**T 023 Continued**

Upon admission of a new resident, the Admissions staff will write a summary of their verbal communication provided at staff meeting and include a copy in the Duty Folder and in the new resident's chart.

The Safety Contract has been revised. A copy of ALL safety contracts will be kept in the Duty Folder (as well as in the relevant resident's chart). At the beginning of each weekend day duty shift, the Duty staff person leading the shift will convene a meeting during which all staff working that day will review all safety contracts.

The Resident Action Plan has been revised. Any previous suicide attempts will now be noted and addressed on the Resident's Action Plan, and a Safety Contract automatically completed.

Any history of suicide attempts will be shared at weekly staff meeting, at weekly Resident Services meeting, and staff will be reminded to review Safety Contracts in the duty folder to become familiar with warning signs and actions to take.

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T 023	<p>Continued From page 3</p> <p>(completed weekly for each resident) for the week ending April 21-22, 2016 documented: "(Resident) was slow to get started...seemed lethargic and dejected. When I asked him/her about that, s/he deflected the question". The following day (4/22/16) the resident was noted to be uncharacteristically uninterested. On 4/23/16, the day's note stated that the resident was having an 'off' day, had breakfast off away from the others'... 'during check ins by staff responded with few words'... 'didn't seem to understand the questions'...concluding with 'Check to make sure s/he feels safe'.</p> <p>During interview with the Clinical Director, s/he stated that at the Friday afternoon meeting (4/22/16) to review pertinent resident(s) information jointly with the Duty Staff scheduled to work the weekend, it was discussed that Resident #1 was displaying worrisome, potentially risky symptoms and that Resident Advisor should re do the Safety Plan with the resident after the meeting. Per review of the Resident's Safety Plan dated 3/17/16, under the statement "Warning Signs that I may not be safe: (response) "Feeling deeply ashamed, not wanting to face the consequences". Although The Safety Plan included the resident's feelings when at risk and that s/he would ask for help if in immediate danger of hurting self, there were no actions listed for staff to take if there were any warning signs of isolative or irritable behaviors, or any other possible interventions for staff to initiate. Per review of the Safety Plan, an addendum added on 4/22/16 stated "Contracted for Safety, 9 PM". There were no changes made to the existing Safety Plan.</p> <p>During interview with the staff member working as Duty Staff (charge position) for the weekend, s/he</p>	T 023	<p><b>T 023 Monitoring corrective action:</b> The Clinical Director and Admissions Director will meet regularly to review that these practices are being met. The Clinical Director will oversee that all Safety Plans and Treatment Plans comply with state regulations and ensure that the information is conveyed to the weekend duty staff and contained in the Duty Folder.</p> <p><b>T 023 Dates corrective action will be completed:</b> The new forms were created on June 1<sup>st</sup>, 2016. Staff training in June and July 2016 will focus on updates to the forms, utilizing them effectively, and raising awareness and understanding of suicide and prevention.</p>	
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T 023	Continued From page 4  stated that s/he was not aware of the resident's recent suicide attempts when they reported to work as Duty Staff for the day shift on 4/24/16. Interviews with the Clinical Director and the Executive Director/Manager revealed that the home exchanged verbal communication to disseminate important resident information. In this case, the Treatment Plan/Resident Action Plan and Safety Plan, both failed to include important resident information regarding care needs.  On 4/24/16, the resident did not go the the main house for their medication and breakfast and a staff person was sent to check on them. The resident then went alone to an area of the ranch where there was a lack of supervision and few, if any, other residents or staff. When the resident failed to come to the main house for the noon meal, a search was subsequently initiated. The resident was found expired a short time later.  Refer also to T032.	T 023	Supplemental Filing June 20, 2016  Regarding T 032, which addresses the regulation of developing a treatment plan to solve identified problems, either by direct service or by referral, Spring Lake Ranch disputes the accuracy of the findings in the deficiency statement, and further disagrees that the facts outlined apply to the therapeutic community residence regulation cited.  Specifically, the Initial Treatment Plan and Risk Assessment were conducted during the first 7 days following admission and included in detail steps necessary to address the identified problems for which the resident sought services.  Without admitting or denying anything, nor accepting the accuracy of the survey finding related to the TCR regulations, Spring Lake Ranch proposes the following:	
T 032 SS=G	V.5.7.b Resident Care and Services  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.  This REQUIREMENT is not met as evidenced by:	T 032	T 032 Action to be taken: The Resident Action Plan has been revised. Any previous suicide attempts will now be noted and addressed on the Resident's Action Plan, and a safety contract automatically completed.	

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T 032	<p>Continued From page 5</p> <p>Based on staff interview and record review, the TCR failed to assure that the treatment plan for 1 of 5 residents in the sample included the steps necessary to address identified problems and failed to complete the plan within fourteen days of admission. (Resident #1). Findings include:</p> <p>Per record review, Resident #1 was admitted to the facility on 3/15/16 with a recent history of 2 suicide attempts within the previous month. Based on interviews with staff who worked with the resident throughout his/her stay, not all staff were aware of the resident's significant history of self-harming behavior. The Treatment Plan, titled Resident Action Plan, failed to identify this issue and failed to provide information for staff to help identify when the resident may be at increased risk of self-harm. The Initial Nursing Assessment (3/15/16), included the resident's self-described signs/symptoms that indicate when s/he may be starting to 'melt down'; these signs were not included on the Resident Action Plan. Additionally, the Resident Action Plan was not completed until 4/8/16, greater than 14 days after admission. These concerns were confirmed during interviews with the Clinical Director and Executive Director. Refer also to T023.</p>	T 032	<p><b>T 052 Action to be taken:</b> Development and implementation of a comprehensive training plan that is integrated into job expectations for individual employees through SLR's performance management system. The training plan includes an orientation process for all new employees to introduce them to Spring Lake Ranch. This will include all training required for licensing. An annual calendar has been developed so that all required topics are reviewed and refreshed by all staff at least once per year.</p>	
T 052	<p>V.5.9.b.1.2.3.4.5.6.7 Resident Care and Services SS=C</p> <p>5.9 Staff Services</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</p>	T 052	<p><b>T 052 Measures to ensure that the deficient practice doesn't recur:</b> The Human Resources Director will work with supervisors in each department to bring to their attention any employees who are not current with training requirements. The expectation / objective that each staff member participates in a minimum of 12 hours of training each year is included in performance evaluations. Spring Lake Ranch is committed to providing training and development for all employees.</p>	

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T 052	<p>Continued From page 6</p> <p>residents. The training must include, but is not limited to, the following:</p> <ol 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> </ol> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the TCR failed to assure all direct care staff were provided 12 hours of training on a yearly basis and before providing direct care to residents. Findings include:</p> <p>Per review on 5/10/16 of training records for 2 of 5 direct care staff, the required 12 hours of annual training had not been documented as being completed. One staff member, the RN, had not completed training for Abuse/Neglect &amp; Exploitation and Respectful/Effective Communication. A second employee failed to</p>	T 052	<p><b>T 052 Monitoring corrective action:</b> Spring Lake Ranch has implemented a Human Resource system that includes a record of all training, licenses, and certifications for every individual employee. The system provides reports on a regular basis and upon request so that training participation can be monitored. A printed version of the report will be included with performance evaluations to show training that the person has participated in.</p> <p><b>T 052 Date of corrective action:</b> The new training system will be discussed with supervisors the week of June 6<sup>th</sup>, 2016 and implemented thereafter to meet the regulatory training requirements.</p>	
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T 052	Continued From page 7  complete Fire Safety training. The omissions were confirmed on the morning of 5/10/16 with the TCR Human Resources associate.	T 052		
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;  iv. The resident's intake assessment summary, identification of problems and areas of successful life function;  v. Data from other agencies;  vi. Treatment plans and goal, regular progress notes; supervisory and review conclusions, aftercare plan and discharge summary,	T 060	<p><b>T 060 Action to be taken:</b> All psychiatry notes are now being written in EHR, which electronically signs and locks the original document upon signing. These documents are then saved in SLR dropbox storage as a read only PDF file. All internal staff documentation is printed off, hand signed and added to the resident's chart. The paper chart remains the chart of record until such time as SLR moves to an EHR.</p> <p>In addition to the SLR Weekly Progress Note, the session SOAP notes and the Weekly Crew Notes, there is now a Spring Lake Ranch Chart Note. The new chart note includes specific behaviors/comments that the resident does/says, and staff assessment of the situation. Guidelines have been written to help staff identify when a Chart note is needed including the requirement of documentation on the day behaviors were observed.</p> <p>As part of the Admissions process the resident picture will be taken in the first 24 hours.</p>	

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T 060	<p>Continued From page 8</p> <p>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 staff interview and record review, the TCR failed to assure that the medical records for 1 of 5 resident included a picture of the resident and regular progress notes. (Resident #1). Findings include:</p> <p>Per review of Resident#1's medical record, there were some notes that were not signed or dated for authentication and a lack of regular staff progress notes describing observed changes in the resident's behaviors. During interview with the psychiatrist, he confirmed that the unsigned notes were written by him and that the method of transferring the notes resulted in the lack of signature. Regarding regular progress notes by staff, the Clinical Director confirmed that staff do not routinely document notes in the medical</p>	T 060		
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T 060	Continued From page 9  record on the day the information was noted or observed. This has resulted in a lack of documented subjective and objective information regarding the resident's care and services.	T 060		
T 061 SS=D	V.5.10.b.3.i.ii.iii.iv. Resident Care and Services  5.10 Records/Reports  5.10.b.3. Progress notes that document a resident's progress and current status in meeting the goals set by the treatment plan, as well as efforts by staff members to help the resident achieve these stated goals, shall be made a part of the resident record.  i. All entries that involve subjective interpretation of a resident's progress should be supplemented with a description of actual behavioral observations supporting the interpretation.  ii. If a resident is receiving services at an outside resource, the residence shall attempt to secure a written copy of progress notes and resident records from that source. These shall be attached to the resident record.  iii. Summary progress reports shall be written regularly and made part of the resident record.  iv. Whenever possible residents should be encouraged to contribute to their own progress notes.	T 061		

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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 061	<p>Continued From page 10</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the TCR failed to assure that the medical records contained progress notes/entries related to subjective behavioral observations of the resident by staff, and information regarding staff's observations and care provision. The failure affected 1 of 5 residents in the targeted sample. (Resident #1). Findings include:</p> <p>Per interview with the Clinical Director, during a meeting with staff scheduled to work the weekend of 4/23/16 - 4/24/16, held on 4/22/16, staff expressed increasing concerns for the Resident #1's safety and well-being. The team noted that some staff reported some isolative behaviors and unusual quietness or withdrawal during the previous week. This information was not documented in the medical record at the time it was reported, not were staff actions in response to the information. The information shared at the meeting and the subsequent phone calls regarding resident information for staff over the weekend were also not documented in the record. The Executive Director/Manager and Clinical Director stated that it has not been their practice to include progress notes on a daily basis, regardless of information shared regarding resident care and observations; the information had been shared mostly verbally.</p> <p>During the week leading up to the resident's suicide, staff had noted that s/he was displaying some isolative behaviors that were not documented at the time in the medical record. This omission was confirmed during interviews with the Clinical Director and the Manager. Refer also to T 023 and T 032.</p>	T 061	<p><b>T 061 Action to be taken:</b> In addition to the SLR Weekly Progress Note, the session SOAP notes and the Work Program Progress Notes, there is now a Spring Lake Ranch Chart Note. The new chart note includes specific behaviors/comments that the resident does/says, and staff assessment of the situation. Guidelines have been written to help staff identify when a Chart note is needed including the requirement of documentation on the day behaviors were observed.</p> <p>Work Program Progress Notes do contain subjective behavioral observations and are included in the resident records.</p>	
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Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0526	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 05/11/2016
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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	T 088 Action to be taken: A simple 'contract (Chore Service Agreement) will be created, naming the chores and the corresponding compensation. The contract will be issued by the Admissions Department upon admission of a new resident, and following an explanation the resident signature will be obtained on the contract at that time. The contract will be kept in the resident's file.	(X5) COMPLETE DATE
T 088 SS=E	<p>VI. 6.4 Residents' Rights</p> <p>VI. Residents' Rights</p> <p>6.4 A resident shall not be required to perform work for the licensee. If a resident chooses to perform specific tasks for the licensee the resident shall receive reasonable compensation which shall be specified in a written agreement with the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the TCR failed to provide written agreements for residents who engage in specific tasks for compensation at the home. Findings include:</p> <p>Per interview with the Assistant Business Manager, several staff sign up for daily specific tasks to be completed for a set fee, paid by the facility. The facility had failed to provide written agreements with each resident in the program, indicating their desire to participate in the "Chores for Pay Program". This information was confirmed with the Asst. Business Manager.</p>	T 088	<p><b>T 088 Measures to ensure the deficiency does not recur:</b> This will be a new admission's protocol and will be documented accordingly, remaining the same unless instructed otherwise by the State.</p> <p><b>T 088 Monitoring corrective action:</b> The 'contract' and the appropriate signature will be part of the admission process and a necessary component of the resident's file. The Program Director who oversees the Chores Program will be periodically spot check to make sure chore agreements are completed.</p>	
T 187 SS=E	<p>IX.9.11.c Physical Plant</p> <p>9.11 Disaster and Emergency Preparedness</p> <p>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</p>	T 187	<p><b>T 088 Date corrective action will be completed:</b> The Chore Service Agreement was created on June 1<sup>st</sup>, 2016 and will be implemented and signed by all residents in the chore program by June 10<sup>th</sup>, 2016. All incoming residents will sign the agreement as part of the admission process.</p>	

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T 187 Continued From page 12

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 staff interview and record review, the TCR failed to rotate fire drills among all times of day to include nights and failed to include the participation of staff during the process of some of the fire drills that were performed. Findings include:

Per review of Monthly Fire Drills for 2015 and 2016, there was a failure to conduct fire drills during the night hours, as required. Although fire drills were performed at the various residences throughout the TCR campus during Morning, Afternoon and Evening, it was also identified that drills were conducted at specific locations during a time when staff and residents were not present and unable to demonstrate their ability to participate and direct a fire drill. Examples include drills conducted on 2/11/16 at 10:00 AM at Noyes building; at 11:30 AM at Godley building; 10:30 AM at Matless building where documentation indicates "all staff out on work crews". Per telephone interview on the morning of 5/10/16 the Director of Maintenance confirmed the documentation and noted the challenges of the TCR residence model and performing drills at specific times when either staff and/or residents are available to participate in the required times for quarterly fire drills.

T999 Final Comments  
SS=G

T 187

**T 187 Action to be taken:**  
The Physical Plant Director will include on his annual calendar a plan to conduct fire drills at least quarterly during the four timeframes noted. The fire drills will occur with residents and staff present to ensure that individuals are able to participate in and direct a fire drill appropriately. Given the deficiency in conducting the midnight to 6 AM fire drill, this drill will be conducted for all resident houses during the month of June, 2016.

**T 187 Monitoring corrective action:**  
The Physical Plant Director will include in his supervision a review of fire drills and related documentation to ensure this regulation is being met.

**T 187 Date by which corrective action will be completed:**  
July 1<sup>st</sup>, 2016.

T999

Division of Licensing and Protection

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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	C T 999 Request for Informal Dispute Resolution, made by Spring Lake Ranch on May 27 <sup>th</sup> , 2016.	(X5) COMPLETE DATE
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T999	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>4.12, Responsibility and Authority (C) The manager shall not leave the premises without delegating necessary authority to a competent staff person at least 18 years of age. Staff left in charge shall be qualified by experience to carry out the day to day responsibilities of the manager, including being sufficiently familiar with the needs of the residents to ensure that their care and personal needs are met in a safe environment. Staff left in charge shall be fully authorized to take necessary action to meet those needs or shall be able to contact the manager immediately if necessary.</p> <p>This requirement is NOT MET as evidenced by:</p> <p>Based on staff interview, the manager failed to assure that weekend staff in charge were sufficiently familiar with the needs of all of the residents to ensure the safety of 1 of 5 residents in the sample on one weekend in April. (Resident #1) Findings include:</p> <p>Per interview with the Duty Charge staff who was in charge for the date of 4/24/16, s/he confirmed that they had not been previously aware of Resident #1's recent history of significant suicide attempts. There was information passed on from the weekend report that the resident was presenting some concerning behaviors and should be monitored. However, the resident history of self-harming behaviors was not addressed on the Treatment Plan/Resident Action Plan nor the Safety Plan, which were both available for weekend staff.</p>	T999	<p>Supplemental Filing June 20, 2016</p> <p>Spring Lake Ranch disputes the accuracy of the findings in the deficiency statement. Without admitting or denying anything, nor accepting the accuracy of the finding, Spring Lake Ranch proposes the following action:</p> <p><b>T 999 Action to be taken:</b> The Safety Contract has been revised. A copy of ALL safety contracts will be kept in the Duty Folder (as well as in the relevant resident's chart). At the beginning of each weekend day duty shift, the Duty staff person leading the shift will convene a meeting during which all staff working that day will review all safety contracts.</p> <p>The Resident Action Plan has been revised. Any previous suicide attempts will now be noted and addressed on the Resident's Action Plan, and a safety contract automatically completed.</p> <p>Any history of resident suicide attempts will be shared at weekly staff meeting, at weekly Resident Services meeting, and staff will be reminded to review Safety Contracts in the duty folder to become familiar with warning signs and actions to take.</p>	
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