VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
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AGENCY OF HUMAN SERVICES

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

May 15, 2025

Cheryl Jacobs, Manager
Second Spring South
Po Box 320
Richmond, VT 05477

Dear Ms. Jacobs:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 7, 2025**. 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.

If you have any questions, please feel free to contact me at (802) 585-0995.

Sincerely,

Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0386	A. BUILDING: _____ B. WING _____	C 04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECOND SPRING SOUTH	PO BOX 320 RICHMOND, VT 05477

(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
R100	Initial Comments An unannounced on-site relicensure survey was conducted by the Division of Licensing and Protection on April 7, 2025, during which two complaints were investigated. No deficiencies were found for the re-licensing survey, however, deficiencies were identified for the on site investigation. The deficincies identified are as follows:	R100		
R224 SS=H	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the Residential Care Home (RCH) failed to ensure Resident #1 was free from mental, verbal and physical abuse after identifying an increase in verbal and physically aggressive behaviors exhibited by Resident #2 and directed toward Resident #1. Findings include: Per record review of the facility's Admissions Policy on 4/7/25 at 11:00 AM, the Policy states that resident activities are to be monitored to prevent harm to the resident and others. Per record review at 12:07 PM on 4/7/25, records indicate that goals for Resident #1 include providing a structured and safe environment to reduce anxiety and encourage participation in milieu activities. Resident #1 has been living at	R224		

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R224	Continued From page 1 the facility for a year and a half. Per record review and staff interviews, Resident #2 has resided in the facility since admission on 3/5/24. Per staff interviews and record review, the facility had knowledge that Resident #2 exhibited escalating disruptive behaviors over a period of more than three months, directed toward both residents and staff. These behaviors included threatening verbal outbursts, the use of profane language, excessive yelling, incoherent vocalizations and physical altercations involving another resident. Resident #2's behaviors were repeatedly directed at Resident #1 on several occasions. Per interview with a Team Leader conducted at 10:13 AM on 4/7/25, it was confirmed on 3/31/25, Resident #2 demonstrated an act of physical aggression directed at Resident #1. The Team Leader further stated that the aggressive behavior exhibited by Resident#2 is a new onset. Per Facility Incident Tracker Report document dated 1/27/25, staff had previously directed Resident #2 not to enter the rooms of other residents; however, on the evening of 1/27/25, at 10:10 PM, Resident #2 entered Resident #1's room without consent. Both Resident #1 and facility staff instructed Resident #2 to leave the room. Despite these directions, Resident #2 approached Resident #1, who was in bed at the time, and physically struck Resident #1 in the face. After striking Resident #1 in the face, Resident #2 was escorted downstairs by staff. A staff member contacted their supervisor, who instructed them to notify a mental health screener. A Mental Health Screener arrived at 11:00 PM. Per continued Facility Incident Tracker Report dated 1/27/25, while Resident #2 was being evaluated, both Staff and the Screener	R224		

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R224	Continued From page 2 maintained a safe distance due to Resident #2's dysregulated behavior. According to documentation, staff made multiple attempts to de-escalate Resident #2 using verbal redirection which was unsuccessful. At 11:51 PM, Resident #2 was transported by Emergency Medical Services to the hospital for further evaluation. Resident #2 was then transferred to an Acute Inpatient Psychiatric Facility for a higher level of care. After a 29-day inpatient stay, Resident #2 was discharged and returned to the home on 2/25/25. Per interview conducted with Resident #1 on 4/7/25 at 11:30 AM, in the presence of a Facility Manager, Resident #1 reported that Resident #2 entered their room without consent and punched them on the left side of their face near the nose. Resident #1 said that Resident #2 physically attacked them and verbally berated them. Resident #1 further stated, due to the unpredictable nature of Resident #2's behavior, they now keep their door closed and always locked. Resident #1 described the ongoing situation with Resident #2 as "bizarre" and asserted that Resident #2's aggressive behavior felt unfair. Resident #1 additionally reported that, on a separate occasion, Resident #2 raised a fist in a threatening manner, used profane language, and repeatedly directed aggressive and threatening verbal statements toward them. Resident #1 disclosed that they avoid attending meals when Resident #2 is heard yelling before and during mealtimes. Resident #1 further expressed frustration, stating that the Mental Health Screeners arrive but take no action, and that Resident #2 appears to need help but continues to direct anger toward them despite Resident #1 not having done anything to provoke them. Per interview, a Manager present during	R224		

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R224	Continued From page 3 this discussion confirmed Resident #1's statements were consistent with their knowledge and observations, and affirmed the accuracy of Resident #1's verbal account. Per Record Review and Resident Interview conducted on 4/7/25, an incident occurred at approximately 6:12 PM on 3/31/25. Resident #2 was observed angerly making accusations about Resident #1. Upon seeing Resident #1 across the lobby standing on the second step of the stairs, Resident #2 charged toward Resident #1. Per facility documentation, staff intervened by physically positioning themselves between the two residents. Resident #1 proceeded upstairs to their bedroom, while staff impeded Resident #2's access to the stairs. Resident #2 remained at the base of the staircase yelling and stating, "I'm going to kill you" directed at Resident #1. In response to the threatening behavior, facility staff contacted the Mental Health Screeners and the Vermont State Police, who subsequently questioned Resident #2 regarding the incident. To maintain resident safety, staff isolated Resident #2 in the living room by closing the doors. Per interview, Resident #1 recalled the incident, stating that staff had to intervene because Resident #2 was charging and raising a fist at me. Per Facility Incident Tracker Report dated 3/31/25 at 6:59 PM, Resident #2 was documented as exhibiting a fixation on Resident #1, and directing profane and abusive language specifically toward Resident #1, while yelling at a volume audible throughout the facility. Per interview on 4/7/25, a Staff Member confirmed the yelling Resident #2 continues to do throughout the facility, with behavior specifically targeting Resident #1.	R224		

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R224	Continued From page 4 Per staff interview on 4/7/25 at 1:37 PM, a Staff Member reported that the ongoing situation between Resident #1 and Resident #2 has created a distressing environment for both residents and staff throughout the facility. The staff member reported that Resident #1 indicated avoidance of communal areas due to perceived threat and remains in their room to avoid interactions with Resident #2. Per staff interview conducted at 2:00 PM on 4/7/25, the Staff Member acknowledged awareness of Resident #2's threatening behaviors toward Resident #1 and recalled an instance where the dining room door was locked intentionally, to allow Resident #1 to eat a delayed meal safely. The Staff Member stated that Resident #1 had not come to dinner that day due to fear of encountering Resident #2, so food was given to them after the scheduled mealtime. Resident #1 expressed appreciation for being able to eat in a secured dining area without fear of Resident #2's presence. Per observation and additional staff interviews, the facility has made efforts to separate Resident #1 and Resident #2; however, staff acknowledged that maintaining complete separation at all times is not feasible due to the facility's shared spaces. Staff also reported Resident #2 has been placed under one-to-one observation when outside of their bedroom. In summary, the facility failed to protect Resident #1 from a pattern of mental, verbal and physical abuse by Resident #2, resulting in both physical and emotional harm to Resident #1, as evidenced by an incident of physical assault, repeated verbal and physical threats, and ongoing fear that has led to Resident #1's isolation from common activities they should be able to access freely and	R224		

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R224	Continued From page 5 safely.	R224	R224 Accepted on 5/14/25 Susan Gregoire RN	

Deficiency Statement Plan of Correction (POC)

Survey Date: April 7th 2025

Facility Name: Second Spring South

Deficiency Regulation	How the deficiency was corrected	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R224	1. Supervision status was reviewed 2. Behavioral Support Plan revision 3. Implemented bi-weekly treatment team meetings 4. Medication review 5. Partnership with WCMH 6. Review of medical chart 7. Discharge options R224 Accepted on 5/14/25 Susan Gregoire RN	1. 4/11/2025 2. 5/1/2025 3. 5/1/2025 4. 4/3/2025 5. 5/1/2025 6. 4/9/2025 7. 5/2/2025	1. Resident #2 safety status was changed to 1:1 at all times, both in the program and community; indefinitely 2. Resident #2's behavioral support plan was reviewed and revised offering more detailed supports and information around resident #2's behaviors. This also includes proactive steps for supports. 3. Although treatment team meetings were occurring for resident #2, they have been increased to bi-weekly meetings; which meeting notes are scribed and scanned into the EMR 4. Resident #2 had a change and increase in medication. Resident #2's injectable medication changed to long acting and went from once a month to every 2 weeks. An additional oral dose of medication was added. 5. CSC met with WCMH Screeners and developed a plan for additional support when staff call for Resident #2; Screeners will be coming on-site when called. 6. The Nurse Practitioner conducted an extensive medical chart review for resident #2. From the completion of that review resident #2 was referred to several consults and testing. 7. Actively looking for other placement for resident #2; collaborating with DMH and WCMH.	Clinical Director, Program Director, Nurse Practitioner, and Director of QI and Compliance