From: Renner, Jamie
To: Renner, Jamie
Subject: Re: A few questions for you
Date: [redacted]

Sean,

I just wanted to thank you and Wendy again for meeting yesterday. I'm going to digest the information and materials you provided me (re Spring Village) and then will get back to you (likely in the next week or two) with any follow up questions and to discuss potential next steps.

-Jamie

On [redacted], Sean Londergan <SLondergan@vtlegalaid.org> wrote:

> Ok.
> See you then.
>
> **From:** Renner, Jamie [mailto:Jamie.Renner@vermont.gov]
> **Sent:** [redacted]
> **To:** Sean Londergan <SLondergan@vtlegalaid.org>
> **Subject:** RE: A few questions for you
> Thanks. It's a 5 min drive from the senior center to you, so I'll be there around 1:40.
> Talk to you soon.
> -Jamie
>
> **From:** Sean Londergan <SLondergan@vtlegalaid.org>
> **Sent:** [redacted]
> **To:** Renner, Jamie <Jamie.Renner@vermont.gov>
> **Subject:** RE: A few questions for you
> Jamie:
> I can meet after your meeting at the Senior Center.
> To provide some context I have attached 2 documents:
>
> 1. Statement of Deficiencies (date August 30, 2017). This provides a look into some of the issues that were occurring at the residential care facility (Spring Village) last summer. Problems (discovered/cited by DAIL) include a facility admissions process whereby staff (Memory Care Director) were not getting input from medical staff pre-admission (the result being that the facility was unable to demonstrate that it was not accepting individuals as residents who required nursing home level of care).
> 2. A description (provided by Spring Village) of services and programs provided by Spring Village through its memory care program/unit (see page 1 where in the facility's statement outlining its philosophy states *"As such, Spring Village is able to provide care from the beginning of one's memory care journey to the end."*)
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> Hopefully, the documents help some. Promises were made verbally, as I understand it. I think that it is fair to say that Spring Village has not communicated well with residents and family members.

I appreciate you talking the time to try and understand this matter.
Sean

From: Renner, Jamie [mailto:Jamie.Renner@vermont.gov]
Sent: [redacted]
To: Sean Londergan <SLondergan@vtlegalaid.org>
Subject: RE: A few questions for you

Sean,
I would be interested to discuss this further. Do you have time to talk next week? I'll be at the Champlain Senior Ctr. from 12-130 on Tues. Could you meet after that? I'd be happy to swing by your office, if you were around. In advance of our meeting, it would be helpful to understand better where/how these alleged promises were made. Were they in writing? Could I see copies of any relevant writings?
-Jamie

From: Sean Londergan <SLondergan@vtlegalaid.org>
Sent: [redacted]
To: Renner, Jamie <Jamie.Renner@vermont.gov>
Subject: A few questions for you

Hello Jamie:
I hope all is well.
When we met last week (I think it was last week), I mention a matter involving an elderly man [redacted] was a resident at a residential care home.
I mentioned this situation because the man felt as though the residential care home made promises to him about [redacted] being able to age in place and being able to stay at the facility for the rest of her life. The man does not feel as though the facility kept its promises made.
He feels very strongly that his experience with the facility was not right.
In addition, he believes that his ([redacted]) experience with the facility is not unique.
In fact, the Vermont Ombudsman Project has recently begun to receive complaints from other families from the same facility who describe similar circumstances – a family is told prior to admission that their loved ones can age in place, but now for reasons that don't make sense given what was said and promised prior to admission, the family is being told that their family member is being discharged because the facility can no longer meet the care needs of the resident.
The elderly man asked my office for attorneys in Vermont who work with families who have experiences like his with a long-term care facility.
I would not be able to provide him with a list of attorneys – but I was going to recommend that he could make a complaint to the AG's office.
Do you think that would be appropriate?
Or do you know of a more appropriate place he could reach out to?
Would you want to talk to him?
If you did want to talk to him, the VOP (myself and the ombudsman who is working with families at the facility) could be part of the call, if that would be helpful. But if not helpful, that is fine.
Let me know your thoughts, when you are able.
Or if you would like to discuss further, just let me know.
Thank you very much.

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Sean Londergan
State Long Term Care Ombudsman
Long Term Care Ombudsman Project
Vermont Legal Aid
264 North Winooski Avenue
Burlington, VT 05401
slondergan@vtlegalaid.org
800-899-2047
802-383-2227

From: Sean Londergan
To: Renner, Jamie
Subject: RE: A few questions for you
Date: [redacted]

Ok.
See you then.

From: Renner, Jamie [mailto:Jamie.Renner@vermont.gov]
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To: Sean Londergan <SLondergan@vtlegalaid.org>
Subject: RE: A few questions for you
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relevant writings?

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From: Sean Londergan <SLondergan@vtlegalaid.org>

Sent: [redacted]

To: Renner, Jamie <Jamie.Renner@vermont.gov>

Subject: A few questions for you

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The elderly man asked my office for attorneys in Vermont who work with families who have experiences like his with a long-term care facility.

I would not be able to provide him with a list of attorneys – but I was going to recommend that he could make a complaint to the AG's office.

Do you think that would be appropriate?

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From: Renner, Jamie
To: "Sean Londergan"
Subject: RE: A few questions for you
Date: [redacted]

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From: Sean Londergan
To: Renner, Jamie
Subject: RE: A few questions for you
Date: [redacted]
Attachments: Spring Village at Essex 2567 8-30-17.pdf
Spring Village Memory Care Unit.pdf

Jamie:
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VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury VT 05671-2060
http://www.dlp.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
To Report Adult Abuse: (800) 564-1612
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line:(888) 700-5330

[redacted]

Emma Gonsalves, Manager
Spring Village At Essex
6 Freeman Woods
Essex, VT 05451

Dear Ms. Gonsalves

The Division of Licensing and Protection completed a follow-up survey and complaint investigation at your facility on **August 30, 2017**. The purpose of the survey was to determine if your facility was in compliance with Vermont Residential Care Home Regulations. The survey statement is enclosed. This survey found the most serious deficiency in your facility to be deficiencies that constitute actual harm that is not immediate jeopardy. You must submit a plan of correction. Please write/type the Plan of Correction in the space provided to the right. A completion date for each plan of correction must be indicated in the far right hand column. Attach additional pages if necessary.

Please sign, date, and indicate your title on the bottom of the first page of the report and return this report to this office no later than **September 27, 2017**.

Plan of Correction (POC)

Your POC must contain the following:

- What action you will take to correct the deficiency;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: and,
- How the corrective actions will be monitored so the deficient practice does not recur.
- The dates corrective action will be completed.

You may also request an informal review of all or part of the contents of the notice at any time prior to **September 27, 2017** by calling Suzanne Leavitt, RN, MS, Assistant Division Director, or Clayton Clark, Division Director at (802) 241-0480. If you are not satisfied with the outcome of the informal review with the Division, you may request a review by the Commissioner of Disabilities, Aging and Independent Living. To request a review with the Commissioner, call (802) 241-2401.

The Department is authorized to impose sanctions for failure to correct a deficiency and/or failure to provide proof of correction by the specified Correction Date. Depending on the nature of the violations, the following sanctions may be imposed: administrative penalties of up to $10.00 per resident or $100.00, whichever is greater, for each day the violation remains uncorrected; suspension, revocation or modification of an existing license; refusal to renew a license; suspension of admission or transfer of residents to an alternative placement; injunctive relief to enjoin any act or omission; and the appointment of a receiver for a facility. If you feel strict compliance with the law or regulations would impose a substantial hardship, you may apply to the Department for a variance as stated under Section III of the Residential Care Home Licensing Regulations. You must do so prior to **September 27, 2017**.

Appeals

As noted above, you may seek an informal review from Suzanne Leavitt, RN, MS, Assistant Division Director, or a Commissioner's review of this decision. In addition, you have a right to request a fair hearing with the Human Services Board. Decisions by the Department of Disabilities, Aging and Independent Living can be appealed to the Human Services Board pursuant to 3 V.S.A. §3091. The request for a fair hearing before the Human Services Board must be made within thirty (30) days of your receipt of the notice of this decision, and can be made by writing to the Board at 14-16 Baldwin Street, Montpelier, VT 05633-4302. You have a right to appear before the Board and to present witnesses and other evidence with regard to the case. You also have a right to be represented by an attorney at the Human Services Board fair hearing.

Please contact me at (802) 241-0480 if you have any questions.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING: _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(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 onsite follow-up survey to citations issued as a result of surveys on March 8, 2017 & May 25, 2017 was conducted by the Division of Licensing and Protection on August 28-30, 2017. A complaint investigation was also conducted at this time. The following regulatory deficiencies were identified as a result of this survey, which includes 8 deficiencies that remain uncorrected from the previous surveys:	R100		
R101 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.1. Eligibility 5.1.a The licensee shall not accept or retain as a resident any individual who meets level of care eligibility for nursing home admission, or who otherwise has care needs which exceed what the home is able to safely and appropriately provide. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to assure that no individual was accepted/retained who meets level of care eligibility for nursing home admission or who otherwise has care needs which exceed what the facility is able to provide. Findings include: Per interviews with the Memory Care Director (MCD) on 8/28/17, since March of 2017 s/he has not had the input of a Nurse for the pre-admission assessments of a number of residents, and in several instances was not aware of an admission until it happened. In an interview on 8/29/17 the Registered Nurse (RN), serving as the nurse oversight, confirmed that s/he had not been	R101		

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R101	Continued From page 1	R101		

involved in any admissions in the two weeks s/he has been serving in that capacity. In the month of August, 6 residents were admitted to the facility. At the time of the survey there is no evidence present that either the Licensed Practical Nurse (LPN) or the RN had done any type of admission screening at the time of admission for R #1,#2, #3 and #4. During the survey visit, an additional 2 residents were admitted without a nurse being involved in any pre-screening process.

During observations conducted during the survey, a large number of residents are noted to have significant cognitive impairment, which would qualify them as nursing home level of care. In an interview on 8/28/17 the MCD stated that during the pre-screening process s/he does not screen for the level of cognitive impairment but that if the Dementia is so severe that the resident is totally dependent for all aspects of care, the resident is refused admission.

Additionally in the record reviews, conducted during the survey, it was discovered that Resident # 4 has a Stage 4 pressure ulcer of the right toe. The Licensed Practical Nurse (LPN) on duty on 8/28/17 confirmed that the resident had a wound present on the toe when admitted to the facility. There is no variance request found for Resident #4.

R126 SS=E V. RESIDENT CARE AND HOME SERVICES — R126

5.5 General Care

5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's

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R126	Continued From page 2 personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: *Repeat Citation Based upon observations, record review, and interviews the facility failed to assure that necessary services were provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. *This is an uncorrected violation* Findings include: Per interviews with the Memory Care Director (MCD) on 8/28/17, since March of 2017 s/he has not had the input of a Nurse for the pre-admission assessments of a number of residents, and in several instances was not aware of an admission until it happened. In an interview on 8/29/17 the Registered Nurse (RN), serving as the nurse oversight, confirmed that s/he had not been involved in any admissions in the two weeks s/he has been serving in that capacity. In the month of August, 6 residents were admitted to the facility. During the survey visit, an additional 2 residents were admitted. In interviews with 2 of 3 families it was stated that they were told that there would be nursing care available for all residents as well as a staffing pattern of 1 staff to every 4 residents. During observations conducted during the survey, a large number of residents appear to have significant cognitive impairment, which may qualify them as nursing home level of care. In an interview on 8/28/17 the MCD stated that during the pre-screening process s/he does not screen for the level of cognitive impairment but that if the	R126		

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R126	Continued From page 3 Dementia is so severe that the resident is totally dependent for all aspects of care, the resident is refused admission. In a review of staff schedules there has been a significant decline in the number of nursing staff. Additionally, there is a graduate nurse on night shift duty who, though recently licensed in New York state, is not licensed in the state of Vermont. S/he has been practicing as an RN. Paperwork in the admission packet does state that there is nursing care for residents 24/7.	R126		
R134 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.7 Assessment 5.7.a An assessment shall be completed for each resident within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The resident's abilities regarding medication management shall be assessed within 24 hours and nursing delegation implemented, if necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to assure that an assessment was completed for 6 of 14 sampled residents (Residents # 1, 2, 3, 5, 6, & 7) within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency, and assessing the resident's abilities regarding medication management within 24 hours of admission. *This is an uncorrected violation*	R134		

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R134	Continued From page 4 Findings include: 1). Resident # 1 was admitted on 8/25/17. There was no initial nursing assessment; no Braden scale; no fall risk assessment; no medication self-administration assessment; no RN completion of the medication assessment within 24 hours and the Resident Assessment Information (RAI) form was not completed within 14 days of admission. 2). Resident #2 was admitted on 8/4/17 . There was a facility nursing assessment form completed by the LPN and no other facility forms completed and no RN completion of the medication assessment within 24 hours. The RAI was also not completed within 14 days of admission. 3). Resident #3 was admitted on 8/17/17. The facility assessment forms were completed by the LPN with no counter signature by the RN and no RN completion of the medication assessment on the RAI. 4). Resident #5 was admitted on 8/21/17. Though the facility admission forms were completed by an LPN there is no RN completion of the medication assessment within 24 hours on the RAI. 5). Resident #6 was admitted on 8/11/17. There were no facility nursing assessment forms completed and no RN completion of the medication assessment within 24 hours on the RAI. 6). Resident #7 was admitted 8/24/27. There was an initial nursing assessment completed by the LPN, a Braden scale, a fall risk assessment, and no RN completion of the medication assessment within 24 hours of admission on the RAI.	R134		

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R141 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9 Level of Care and Nursing Services 5.9.a Residents who require more than nursing overview or medication management shall not be retained in a residential care home unless the provisions of the following subsections (1)-(5) are all met: (1) The nursing services required are either: i. Provided fewer than three times per week; or ii. Provided for up to seven days a week for no more than 60 days and the resident's condition is improving during that time and the nursing service provided is limited in nature; or iii. Provided by a Medicare-certified Hospice program; and (2) The home has a registered nurse on staff, or a written agreement with a registered nurse or home health agency, to provide the necessary nursing services and to delegate related appropriate nursing care to qualified staff; and (3) The home is able to meet the resident's needs without detracting from services to other residents; and (4) The home has a written policy, explained to prospective residents before or at the time of admission, which explains what nursing care the home provides or arranges for, how it is paid for and under what circumstances the resident will be required to move to another level of care; and (5) Residents receiving such care are fully informed of their options and agree to such care	R141		

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R141	Continued From page 6 in the residential care home. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and observation he facility failed to assure that residents requiring more than nursing overview or medication management are not retained in a residential care home. *This is an uncorrected violation* Findings include: 1). Resident # 4 was admitted to the facility on 7/22/17 with a pressure ulcer on the right toe. A physician's note dated 8/16/17 described a right second toe ulcer with infection and exposed bone. On 8/28/17 at 2:45 PM, the unit nurse confirmed that the wound was a stage 4 pressure ulcer since at least 8/4/17. 2). During observations conducted during the survey, a large number of residents are noted to have significant cognitive impairment, which would qualify them as nursing home level of care (LOC). In an interview on 8/28/17 the MCD stated that during the pre-screening process s/he does not screen for the level of cognitive impairment but that if the Dementia is so severe that the resident is totally dependent for all aspects of care the resident is refused admission. The facility has two residents with an LOC variance and there are no pending variance requests found in the state agency files. During the survey it is noted that for 14 residents in a sample 6 residents did not have the required RN assessments completed either at all or in a timely fashion.	R141		
R142 SS=G	V. RESIDENT CARE AND HOME SERVICES	R142		

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R142	Continued From page 7 5.8 Level of Care and Nursing Services 5.9.b The following services are not permitted in a residential care home except under a variance granted by the licensing agency: intravenous therapy; ventilators or respirators; daily catheter irrigation; feeding tubes; care of stage III or IV decubitus; suctioning; sterile dressings. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to assure that a resident with a Stage 4 pressure ulcer was not retained/admitted to the facility. Findings include: 1). Resident # 4 was admitted to the facility on 7/22/17 with a pressure ulcer on the right toe. A physician's note dated 8/16/17 described a right second toe ulcer with infection and exposed bone. On 8/28/17 at 2:45 PM, the unit nurse confirmed that the wound was a stage 4 pressure ulcer since at least 8/4/17.	R142		
R144 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c.(1) Complete an assessment of the resident in accordance with section 5.7; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to complete an assessment of the resident in accordance with section 5.7. Findings include:	R144		

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R144	Continued From page 8 1). Resident # 1 was admitted on 8/25/17. There was no initial nursing assessment; no Braden scale; no fall risk assessment; no medication self-administration assessment; no RN completion of the medication assessment within 24 hours and the Resident Assessment Information (RAI) form was not completed within 14 days of admission. 2). Resident #2 was admitted on 8/4/17 . There was a facility nursing assessment form completed by the LPN and no other facility forms completed and no RN completion of the medication assessment within 24 hours. The RAI was also not completed within 14 days of admission. 3). Resident #3 was admitted on 8/17/17. The facility assessment forms were completed by the LPN with no counter signature by the RN and no RN completion of the medication assessment on the RAI. 4). Resident #5 was admitted on 8/21/17. Though the facility admission forms were completed by an LPN there is no RN completion of the medication assessment within 24 hours on the RAI. 5). Resident #6 was admitted on 8/11/17. There were no facility nursing assessment forms completed and no RN completion of the medication assessment within 24 hours on the RAI. 6). Resident #7 was admitted 8/24/27. There was an initial nursing assessment completed by the LPN, a Braden scale, a fall risk assessment, and no RN completion of the medication assessment within 24 hours of admission on the RAI.	R144		

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R144	Continued From page 9 This was confirmed by the unit nurse on 8/28/17 at 2:45 PM.	R144		
R145 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to assure that the RN oversees the development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment and which describes the care and services necessary to assist the resident to maintain independence and well-being for 6 residents (#1, #4, #10, #5, #8 and #9). *This is an uncorrected violation* Findings include: 1). Resident # 1 was admitted to the facility on 8/25/17 and has multiple medical issues requiring nursing oversight. There is no plan of care to address the resident's needs. 2). Resident # 4 was admitted to the facility on 7/22/17 and has multiple medical issues requiring nursing oversight, including a stage 4 pressure ulcer. There is no plan of care to address the	R145		

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R145	Continued From page 10	R145		

resident's needs.

3). Resident # 10 was admitted to the facility on 7/6/16 and has multiple medical issues requiring nursing oversight. The resident has had multiple falls at the facility and uses a room monitor and a mechanical lift for transfers. There is no mention of these interventions on the resident's care plan. Two care givers were interviewed on 8/28/17 and had no knowledge of the room monitor.

4). Resident # 5 was admitted to the facility on 8/21/17 and has multiple medical issues requiring nursing oversight. There is no plan of care to address the resident's needs.

5). Resident #8 was admitted to the facility on 1/11/17 and has multiple issues regarding nursing oversight. He has recently been placed on Hospice for the second time since admission. The resident fell on 8/4/17 and was transferred to the Emergency Room (ER). S/he was found to have an Intertrochanteric Fracture of the Left Femur which was not surgically repaired. The resident is not moved from the bed at this time for comfort reasons.
In a review of the care plan it states:
a). Ambulate as tolerated
b). Assist resident getting in and out of bed 1 assist
c). Transfer with limited assist using a gait belt and walker
d). Limited assist of 1 for ambulation and:
Though the resident is receiving an anticoagulant daily the care plan states that "5/13/16 anticoagulant tx DC'd" with no update to reflect the new order. There is also no Hospice/ End Of Life care plan in the record.

6). Resident #9 was admitted to the facility on

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R145	Continued From page 11 7/11/17. The record states that s/he has chronic pain and is at times aggressive, uncooperative, and refuses care. There is no care plan for addressing pain issues and no care plan addressing specific interventions for this resident in relation to the aggression, being uncooperative, and refusing care. The resident has also had a number of falls and though there is a falls care plan it does not address specific interventions which take into consideration her impaired cognitive status.	R145		
R146 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure that the RN provides instruction and supervision to all direct care personnel regarding each resident's health care needs for one resident with an infected Stage 4 pressure ulcer (R#4). Findings include: Nursing staff failed to provide adequate notification and instruction to caregivers for Resident # 4 who has an infected stage 4 pressure ulcer. Per a telephone call with a Nurse Practitioner (NP) and confirmed by a lab report, Resident # 4 has MRSA (methicillin resident staphylococcus aureus). MRSA requires staff to take infection control precautions while working	R146		

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R146	Continued From page 12 with the resident. The NP stated that h/she reported the MRSA to facility nursing staff on 8/17/17. In interviews 3 of 4 direct caregivers, stated that the nurses did not give them adequate information to care for a resident with MRSA including information regarding the contact precautions to use when caring for R#4. On 8/29/17 at 2:35 PM, the facility Registered Nurse (RN) confirmed that s/he received the report regarding MRSA and failed to adequately inform staff, write a nursing note and provide additional infection control instruction.	R146		
R150 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (7) Assure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure that symptoms or signs of illness was recorded at the time of occurrence, along with action taken for Resident #4. Findings include: Nursing staff failed to assure the presence of illness is recorded at time of occurrence, along with action taken for Resident # 4 who has an infected stage 4 pressure ulcer. Per a telephone call with a Nurse Practitioner (NP) and confirmed by a lab report, Resident # 4 has MRSA (methicillin resident staphylococcus aureus). MRSA requires staff to take infection control precautions while working with the resident. The	R150		

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R150	Continued From page 13 NP stated that h/she reported the MRSA to facility nursing staff on 8/17/17. On 8/29/17 at 2:35 PM, the facility Registered Nurse (RN) confirmed that h/she received the report regarding MRSA and failed to adequately inform staff, write a nursing note and provide additional infection control instruction.	R150		
R151 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (8) Ensure that the resident's record documents any changes in a resident's condition; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure that the resident's record documents any changes in a resident's condition for a resident with a pressure ulcer. Findings include: Nursing staff failed to document changes in Resident #4's condition, who has an infected stage 4 pressure ulcer. Per a telephone call with a Nurse Practitioner (NP) the NP stated that h/she reported the MRSA to facility nursing staff on 8/17/17. On 8/29/17 at 2:35 PM, the facility Registered Nurse (RN) confirmed that h/she received the report regarding MRSA and failed to adequately inform staff, write a nursing note and provide additional infection control instruction.	R151		
R162 SS=E	V. RESIDENT CARE AND HOME SERVICES	R162		

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R162	Continued From page 14 5.10 Medication Management 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure that staff does not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order. *This is an uncorrected violation* Findings include: 1). Per record review R#9 was receiving Tylenol 1000mg QID (four times a day) despite an MD order which had discontinued the medication. Additionally, in the month of August the resident was switched back and forth between Ferrous Sulfate 325mg and Ferrous Gluconate 324mg due to staff requests for a new order to match the available form of the medication.	R162		
R167 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific	R167		

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R167	Continued From page 15 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 medication use. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to assure that delegated staff did not administer as needed (PRN) psychoactive medications without 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; and documents the time of, reason for and specific results of the medication use for 5 of 6 residents with psychoactive medications who received those medications on an as needed basis. *This is an uncorrected violation* Findings include: Residents #3, 8, 11, 12, 13, 14 all are prescribed PRN psychoactive medications. None of the residents had a written care plan or behavioral plan to be utilized by unlicensed staff. Review of all medical administration records (MARs) showed that the residents had received the medications. This was confirmed by a facility Med Tech on 8/30/17 at 10:40 AM.	R167		
R173 SS=E	V. RESIDENT CARE AND HOME SERVICES	R173		

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R173	Continued From page 16 5.10 Medication Management 5.10.h. (1) Resident medications that the home manages must be stored in locked compartments under proper temperature controls. Only authorized personnel shall have access to the keys This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to assure that resident medications are stored in locked compartments under proper temperature controls and that only authorized personnel shall have access to the keys. Findings include: Per observation on 8/30/17, refrigerators on both Junction and Town units were not adequately monitored for proper temperatures. Both refrigerators contained temperature sensitive medications. The Junction refrigerator was last checked on 7/11/17 and no temperatures were recorded in August. The Town unit refrigerator was last checked on 3/31/17. Senior nursing staff indicated that they were unsure who was responsible for checking the temperatures. Additionally, there was an unlocked cabinet in the medication room containing multiple drugs, including antipsychotic medications. Staff were unable to locate a key to lock the cabinet. The Director of Nursing confirmed on 8/30/17 at 12:15 PM that non-delegated staff, including caregivers and housekeepers had keys to the medication room.	R173		

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5.11 Staff Services

5.11.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and interviews the facility failed to assure that a sufficient number of qualified personnel are available at all times to provide necessary care, maintain a safe environment, and assure prompt, appropriate action in cases of injury, illness, fire or other emergencies. Findings include:

1. Per record review staff interviews there is a Graduate Nurse working as an RN on the night shift. In a review of the personnel file there is no evidence of education or licensure as a Registered Nurse found. In an interview the Executive Director confirmed that there is no evidence that this staff member has actually attained licensure and that s/he told him/her that s/he had passed the boards and is now an RN. In a check of the State Board of Nursing the staff member is not listed as an active RN in the State of Vermont. In an interview on the morning of 8/29/17 the nurse stated that s/he attended nursing school in New York (NY) state and found out that s/he had passed the exam for NY licensure on 8/16/17 and informed the facility. S/he stated that the process for obtaining a Vermont license has begun but that it is still in process.

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R178	Continued From page 18 2. In interviews with 3 families, Family #1 stated that "Though I am very happy with the facility there just isn't enough staff especially at night." Family #2 states that in the past few weeks there has been a huge amount of staff turnover. In both nursing and the caregiver staff, many people have left. The work loads are huge and the residents are difficult to care for because of their Dementia. The main concern is that this facility is chronically understaffed. In the last 2 weeks there have been 5-6 new residents admitted and many staff have left. [Person's spouse] went without a shower for 7 days due to staffing issues. There is also a lot of overtime worked by the current staff. It is a concern that there is often one caregiver in the dining room and that person has to go to the kitchen to get the meals. There are residents who have choking concerns and there may not be staff in the room. Also a resident needed to use the bathroom and it took the family member a long time to find a staff member to help that person. In an interview on 8/28/17 the ED confirmed that the facility has lost several staff members in the past few weeks and that they are attempting to hire more nurses and caregivers.	R178		
R189 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b. (3) For residents requiring nursing care, including nursing overview or medication management, the record shall also contain: initial assessment; annual reassessment; significant change assessment; physician's admission statement	R189		

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	0653	A. BUILDING: _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

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R189	Continued From page 19	R189		

and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of physician visits, signed telephone orders and treatment documentation; and resident plan of care.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to assure that the record for each resident contains: initial assessment; annual reassessment; significant change assessment; physician's admission statement and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of physician visits, signed telephone orders and treatment documentation; and resident plan of care. Findings include:

1). Per record review Resident #4 was admitted to the facility on 7/22/17 with a pressure ulcer on the right toe. Though a physician's note dated 8/16/17 described a right second toe ulcer, with infection and exposed bone, there is no nursing description of the wound upon admission and as the wound continued. On 8/28/17 at 2:45 PM, the unit nurse confirmed that the wound was a stage 4 pressure ulcer since at least 8/4/17. There is no plan of care to address the resident's needs. Though the survey team was told that the resident has a wound on her toe which has MRSA, there was no information in the record about when the infection was identified as being positive for MRSA. Per a telephone call with a Nurse Practitioner (NP) and confirmed by a lab report, Resident # 4 has MRSA (methicillin resident staphylococcus aureus). MRSA requires staff to take infection control precautions while working with the resident. The NP stated that h/she reported the MRSA to facility nursing staff

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R189	Continued From page 20 on 8/17/17. On 8/29/17 at 2:35 PM, the facility Registered Nurse (RN) confirmed that s/he received the report regarding MRSA and failed to write a nursing note and provide additional infection control instruction in a plan of care.	R189		
R190 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: The facility failed to assure that the results of the criminal record and adult abuse registry checks for all staff were available for one staff member. Findings include: Per record review, for one employee whose personnel file was reviewed, there were no adult and child abuse registry forms found in that record. The absence of these forms was confirmed by the Executive Director on the afternoon of 8/28/17.	R190		
R206 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.a The licensee and staff shall report any case of suspected abuse, neglect or exploitation to the 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	R206		

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R206	Continued From page 21 made to APS within 48 hours of learning of the suspected, reported or alleged incident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure that the licensee and/or designated staff report any case of suspected neglect to the Adult Protective Services and Survey & Certification, the licensing agency, as required. *This is an uncorrected violation* Findings include: An anonymous complaint was made regarding an incident which occurred on 8/4/17. During this incident, a resident fell and responding staff could not locate a third staff member who they believed was a RN for help. There was a suspicion of neglect due the the belief that the third staff member had been sleeping on duty. The reported incident resulted in first responders and the Executive Director (ED) being called to the facility. There was no report of this incident made to the state agency. On 8/28/17 the ED confirmed that the incident had not been reported to the state agency.	R206		
R207 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.b The licensee and staff are required to report suspected or reported incidents of abuse, neglect or exploitation. It is not the licensee's or staff's responsibility to determine if the alleged incident did occur or not; that is the responsibility of the licensing agency. A home may, and should, conduct its own investigation. However, that must	R207		

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R207	Continued From page 22	R207		

not delay reporting of the alleged or suspected incident to Adult Protective Services.

This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff interviews the facility failed to assure that the licensee and staff report suspected or reported incidents of abuse, neglect or exploitation. The facility may, and should, conduct its own investigation, that does delay reporting of the suspected incident as required. Findings include:

An anonymous complaint was made regarding an incident which occurred on 8/4/17. During this incident a resident fell and responding staff could not locate a third staff member for help, who they believed was an RN. There was a suspicion of neglect due the the belief that the third staff member had been sleeping on duty. The reported incident resulted in first responders and the Executive Director (ED) being called to the facility. There was no report of this incident made to the state agency. On 8/28/17 the ED confirmed that the incident had not been reported to the state agency.

In addition, when asked to provide the incident investigation, the ED provided a single sheet with one paragraph, which contained an interview with the Alleged Perpetrator (AP) and the ED. This interview consisted of the AP's denial of having fallen asleep. In an interview on 8/28/17 the ED confirmed that there were no witness interviews (other staff and first responders), conclusions or other information conducted and included in the investigation. The ED also confirmed that the personnel file of the AP did not contain any professional qualification information or abuse background checks.

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R224 SS=G	VI. RESIDENTS' RIGHTS	R224		

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 record review and interview, the facility failed to assure that residents are free from neglect. Findings include:

Per review an anonymous complaint was made regarding an incident which occurred on 8/4/17. During this incident a resident fell and responding staff could not locate a third staff member for help. There was a suspicion of neglect due the the belief that the third staff member had been sleeping on duty. The reported incident resulted in first responders and the Executive Director (ED) being called to the facility. There was no report of this incident made to the state agency. On 8/28/17 the ED confirmed that the incident had not been reported to the state agency.

In addition, when asked to provide the incident investigation, the ED provided a single sheet with one paragraph, which contained an interview with the Alleged Perpetrator (AP) and the ED. This interview consisted of the AP's denial of having fallen asleep. In an interview on 8/28/17 the ED confirmed that there were no witness interviews (other staff and first responders), conclusions or other information conducted and included in the investigation. The ED also confirmed that the personnel file of the AP did not contain any professional qualification information or abuse

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R224	Continued From page 24 background checks.	R224		
R266 SS=G	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the home failed to provide a safe, and sanitary environment. Findings include: 1). Based on record review Resident #8 was placed on Q15Min (every 15 minute) safety checks after a fall with serious injury. Per observations there were no safety checks completed for a period of 45 minutes on 8/28/17 between 9:45 and 10:30 AM and for an hour and 15 minutes on 8/30/17 between 9 and 10:20 am. During the observation periods a surveyor sat in the resident's room. In a review of the flowsheets for the documentation of 15 minute checks the following is discovered: 7a-3p-for the period of 8/15-29 there is one sheet with no date, there are no dated sheets for 8/19 & 8/21, and for the remainder of the sheets there are 110 checks not initialed as completed. 3p-11p for the period of 8/15-28 there were no dated sheets for 8/18, 25, & 28, and for the remainder of the sheets there are 168 checks not initialed as completed.	R266		

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R266	Continued From page 25 11p-7a-for the period of 8/15-28 there are no dated sheets for 8/15, 16, 17, 18, 20, & 26, and for the remaining sheets 26 checks are not initialed as completed. 2). Per record review Resident #4 has a wound with MRSA. In observations there is no evidence of contact precautions or the need for care when with the resident. Per interviews the staff working with the resident were not informed of the MRSA or educated regarding the proper contact precautions to follow while caring for the resident or handling potentially contaminated linen or clothing, potentially putting all other residents at risk. This was confirmed by the unit nurse in an interview on 8/29/17.	R266		
R302 SS=B	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home 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	R302		

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R302	Continued From page 26 by: Based on record review and staff interviews the facility failed to assure that fire drills are conducted which rotate times of day among morning, afternoon, evening, and night. *This is an uncorrected violation* Findings include: Per review of facility fire drill records, there is no evidence that drills were carried out on the night shift as required. This was confirmed by the facility Executive Director on 8/28/17.	R302		
R999 SS=G	MISCELLANEOUS 4.13.b Whenever the authority is vested in the governing board of a firm, partnership, corporation, company, association or joint stock association, there shall be appointed a duly authorized qualified manager, however named, who will be in charge of the daily management and business affairs of the home, who shall be fully authorized and empowered to carry out the provisions of these regulations, and who shall be charged with the responsibility of doing so. The manager of the home shall be present in the home an average of 32 hours per week. The 32 hours shall include time providing services, such as transporting, or attendance at educational seminars. Vacations and sick time shall be taken into account for the 32-hour requirement. In the event of extended absences, an interim manager must be appointed. This REQUIREMENT is not met, as evidenced by: Based on observations, record reviews and interviews the governing board failed to ensure the Manager carries out all the provisions of the	R999		

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R999	Continued From page 27	R999		

regulations. Findings include:

1). The survey visit included a follow up of Plans of Correction for two previous visits with findings. In the 14 citations issued in the previous visits 8 of those citations remain out of compliance as found in this survey visit.

2). The facility failed to report suspected neglect to the state agency as required. There is no report, by the facility, regarding an incident which was reported through an anonymous source.

3). Per record review the facility failed to obtain verification of education and state licensure for a graduate nurse who practiced as an RN, on the night shift, without another nurse present, and who has not obtained RN licensure in the state of Vermont. There is no information in the file regarding where the staff member obtained a nursing degree or that the staff member passed any state board licensing examination.

4). Per record review the facility failed to conduct a thorough investigation after an incident of alleged neglect and continued to allow the staff member to work.

5). Per family interviews the facility has failed, at times, to have sufficient incontinence care supplies and family members have actually gone out to buy additional supplies for their family member and others.

6). Per interviews with the Memory Care Director (MCD) on 8/28/17, since March of 2017 s/he has not had the input of a Nurse for the pre-admission assessments of a number of residents, and in several instances was not aware of an admission until it happened. In an interview on 8/29/17 the

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R999	Continued From page 28 Registered Nurse (RN), serving as the nurse oversight, confirmed that s/he had not been involved in any admissions in the two weeks s/he has been serving in that capacity. In the month of August, 6 residents were admitted to the facility. At the time of the survey there is no evidence present that either the Licensed Practical Nurse (LPN) or the RN had done any type of admission screening at the time of admission for R #1,#2, #3 and #4. During the survey visit, an additional 2 residents were admitted without a nurse being involved in any pre-screening process.	R999		

VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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 Link: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

May 11, 2017

Ms. Emma Gonsalves, Manager
Spring Village At Essex
6 Freeman Woods
Essex, VT 05451

Dear Ms. Gonsalves:

Thank you for submitting materials for the Spring Village at Essex Residential Care Home in accordance with section 5.6 of the Residential Care Home regulations regarding the Memory Care services your entire facility provides. Since the building is secured and admission criteria includes memory impairment or diagnosis of dementia, this Division designates the whole facility as a Special Care Unit. Based on my review of the materials, **your Special Care Unit is approved.**

On future licensing applications, please circle "YES" to the question about the Special Care Unit and indicate all 56 beds.

Please note that per 5.6.c, a home that has received approval to operate a special care unit must comply with the specifications contained in the request for approval.

Please don't hesitate to call me with any questions.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

SPRING VILLAGE AT ESSEX
MEMORY CARE
DESCRIPTION OF SERVICES AND PROGRAMS

1. STATEMENT OUTLINING THE PHILOSOPHY, PURPOSE AND SCOPE OF SERVICES TO BE PROVIDED

Spring Village at Essex's first and highest priority is to provide memory care with respect, love and understanding.

The staff at Spring Village at Essex empowers all residents to make decisions and encourages each resident's independence. Residents can navigate freely throughout our entire community in a safe and secured setting, which includes beautiful outdoor courtyards and enclosed patios.

The community prides itself on their innovative enrichment programs. Our programs cater to the resident's individual interests, offering an active schedule, including local shopping trips, museums, movies, theater and dinners with their small peer groups. Music is always on the calendar, as well as the Walking Club, to mention a few of its varied activities.

Dementia is a progressive disease, so staff members are continuously reassessing residents to make certain that as each resident's needs and challenges change, Spring Village is ready to help the resident make the next transition in care. A resident care plan, which documents challenges and subsequent interventions provides the staff with a basis or a "road map" in the provision of resident care. As such, Spring Village is able to provide care from the beginning of one's memory care journey to the end.

Physicians, physical, occupational and speech therapies, hospice services, monthly support groups and psychological consults are some of the services offered at this community and serves to assist the staff in providing quality and comprehensive care to all of our residents.

Activities of Daily Living

This area provides some basic assistance with activities of daily living. This includes verbally instructing a resident with step by step instructions on activities of daily living; physical assistance with bathing and showering; assistance with the preparation of the tub bath or shower; physical assistance with dressing; clothing selection; physical assistance with grooming; including but not limited to hair and teeth brushing; shaving etc.; physical assistance with eating and/or meals that require mechanical alteration; and physical assistance with walking, wheelchair propelling and prescribed exercises.

Accommodations

Spring Village has both shared and private room accommodations. If the resident chooses not to furnish the suite with their own furniture, the community shall furnish the suite with a bed and dresser. The resident may furnish the suite with their own furniture, including minor electrical appliances and special equipment such as TV's and radios. This is provided that the Community's size restrictions and safety standards are met. Members of the Community's staff reserve the right to inspect and install all electrical appliances that the resident uses.

Common Areas

The resident and their guests may use the common areas of the Community. These are provided by the Community for the common use and enjoyment of all residents. Common areas include hallways, walkways, meeting rooms, activity rooms and open common spaces located within and under control of the Community.

Dining

Three (3) nutritious meals are plated and served daily in the Dining Rooms with snacks available 24 hours per day, (7) days per week.

Housekeeping

Daily light housekeeping services of the resident's suite is provided. This consists of making the bed and removal of trash. In addition, there is weekly housekeeping of the suite provided, consisting of vacuuming, dusting, cleared surfaces, cleaning bathroom and changing bed linens.

Laundry

Weekly personal laundry and linen service is provided, including pickup and delivery, but does not include dry cleaning services. Bed Linens, bedspreads, washcloths and towels are provided by and laundered in the Community.

Transportation

Transportation in the Community Bus is provided as scheduled by Spring Village at Essex for shopping and other community based services and for activities sponsored by the Community.

Five (5) free local medical transports for residents are provided monthly.

Activity Program

Regularly scheduled social, educational, religious and recreational programs are provided for the enjoyment of our residents. This includes outings in the Community, shopping and other social related activities. A monthly calendar of programs is located at the entrance of the Community.

Utilities

Utilities including heat, air conditioning, electric, water and sewage are included in the daily rate.

Emergency Call System

An emergency call system is located in every suite. A staff member is available at all times and can request emergency medical assistance from emergency services such as 911 and private ambulances located in the area.

Medication Assistance and Administration Program

The Medication Assistance and Administration Program is available to those residents who need or prefer that the Community assist the resident to administer medications. Medication assistance includes: reminding the resident to take the medication; opening the container if the resident is unable to do so; checking the medication to ensure that it is the correct medication dose; observing the resident taking the medication; documenting whether the resident had taken the medication and ordering additional medication. Medication administration may be delegated by the RN to qualified, unlicensed assistive personnel as per state regulation.

Community Life Program

Residents who reside in Spring Village at Essex will be provided with a Cognitive Therapy Program which involves daily mind stimulating exercises for residents with memory concerns. These exercises will help preserve the cognitive abilities the resident has so that they may retain their dignity. In addition, through use of an extensive Social History obtained prior to a resident's admission, programs are developed by the Spring Village team to accommodate the resident's interests, hobbies and preferences.

Wi-Fi, telephone and cable television

Wi-Fi access and cable TV are located in the community room and available free of charge. Staff will provide assistance as needed.

Resident Care Plan

A support plan will be developed based on the resident's assessment. A support plan is a written document that describes a resident's care, services or treatment needs; when those services, treatment or care needs will be provided and by whom.

Residents must supply their own personal hygiene items such as toothpaste, toothbrush, shampoo, deodorant, tissues, razors and shaving cream.

Beauty and Beauty Shop Services

Services for Barber and Beauty Shop Services may be arranged through the Community Concierge. A price list is available in the resident's admission packet or pricing may be obtained from the Concierge.

Enhanced Care

Based on the outcome of a resident's care plan, if services are needed beyond the basic assistance with ADL's to enable you to stay at Spring Village at Essex, the resident will receive enhanced care. This includes additional assistance with bathing, dressing, toileting, incontinence care, extraordinary housekeeping services and physical assistance for mobility. The resident and resident's designee will be notified of the need for enhanced care. If it has been determined that the resident needs enhanced care, the resident *will* be responsible for the enhanced care charge.

SERVICES NOT PROVIDED BY THE COMMUNITY

Services not provided by the community include: Optometrist, dental, podiatry, psychiatric consultation, physical therapy, speech therapy, occupational therapy, private duty caregivers, wheelchair, walkers and medications, (prescription and over the counter), dry cleaning, ambulance

transportation, laboratory and radiological services. In some cases, these services may be arranged through the community. Any such services and items will be billed to the resident by the third-party provider.

2. DEFINITION OF CATEGORIES OF RESIDENTS TO BE SERVED

Spring Village at Essex specializes in providing memory care to the residents who have been diagnosed with, but not limited to Alzheimer's Disease or other Dementia related diagnosis such as Lewy Bodies, Vascular Dementia, Parkinson's Disease, Frontotemporal Dementia, Creutzfeldt-Jakob Disease and Wernicke- Korsakoff Syndrome.

3. A DESCRIPTION OF THE ORGANIZATIONAL STRUCTURE OF THE UNIT CONSISTENT WITH THE UNIT'S PHILOSOPHY, PURPOSE AND SCOPE OF SERVICES

Refer to attached

4. A DESCRIPTION AND IDENTIFICATION OF THE PHYSICAL ENVIRONMENT

The Spring Village at Essex Community is carefully designed to make residents feel that they are in their own home. There is a host of design elements at Spring Village that are in place to ensure a resident's safety, foster independence and enhance environmental awareness.

- Short pile carpet makes it easier for a resident in a wheelchair or walker to maneuver and is less likely to create a tripping hazard.
- Grab bars - railings that are found in bathrooms, near toilets, bathtubs and showers.
- Specialty hand rails that are waist high with a wide ledge that residents can use for support as they walk around the community.
- Chairs always have arms to make it easier to get in and out.

Our Memory Care Unit is architecturally designed to promote independence and create opportunities for success. The Memory Care features are:

- Rounded corners
- Memory boxes outside the resident's door filled with items that reflect a resident's life story

- Solid, non-patterned carpeting encourages residents to walk freely throughout the community without being distracted
- Secured outdoor areas provide residents with a safe way to enjoy the outdoors.
- For residents who are "on the go" at mealtime, finger foods are available at every meal.
- Solid color china is used with contrasting linens so residents know where the plate ends and the table begins.

Spring Village at Essex will have 56 beds consisting of both shared and private rooms. The community is all on one floor and is comprised of 2 (A and B) neighborhoods. (Essex Junction and Essex Town). Each neighborhood consists of a community dining room, TV lounge, sunroom and enclosed courtyard. Office space, beauty parlor and concierge desk surrounds the entrance area to the community known as Town Square.

Refer to attached blueprint

S) THE CRITERIA FOR ADMISSION, CONTINUED STAY AND DISCHARGE

Admission Criteria and Continued Stay

Spring Village at Essex will serve only those residents whose needs can be met in this community. Before a resident is moved into our memory care community, a physician, physician assistant or certified resident nurse practitioner will complete a medical evaluation and document a diagnosis of Alzheimer's Disease or other Dementia or any other memory impaired diagnosis. The resident (if able) and the resident's designated person must agree to the resident's admission to our memory care community.

In addition, an assessment will be performed by a designated team member from Spring Village at Essex prior to a resident's admission and will include an evaluation of each resident's specific needs. The assessment covers areas such areas as mobility, skin care, eating habits, oral hygiene, continence, and cognition. Based on the outcome of the assessment, Spring Village at Essex will determine if a resident's needs can be accommodated in our Memory Care Community. If a prospective resident's needs cannot be met, the admission will be declined.

Following admission, an assessment will be completed on an annual basis or change of condition. The resident support plan will be reflective of these changes and interventions will be added to address those needs.

Spring Village at Essex will not admit an individual who has a history of problematic or dangerous behaviors i.e: criminal convictions, sex offenders, destructive behavior, refusal to follow home rules in other homes, suicide attempts or a history of abusive behaviors. Any exceptions to this policy and procedure will be at the discretion of the Administrator.

Discharge Criteria:

The only cause for discharge or transfer of a resident from Spring Village at Essex are for the following:

1) A resident is a danger to himself or to the welfare of others.
2) If the legal entity chooses to voluntarily close the home or a portion of the home.
3) If the resident care needs exceed those that Spring Village at Essex is licensed or approved through a variance.
4) Spring Village at Essex is unable to meet the resident's assessed needs.
5) The discharge or transfer is ordered by the Court.
6) The Resident has failed to pay for charges for room board and care in accordance with the Admission Agreement

6) A DESCRIPTION OF UNIT STAFFING TO INCLUDE:

Spring Village at Essex shall have a sufficient number of qualified team members in order to provide a safe and healthy environment, assure prompt appropriate action in cases of injury, illness, fire and other emergencies and to provide the necessary care and services as documented in each individual resident support plan. Please see attached schedule for staff numbers per shift and roles. *Please note that we are hiring staff as if we are at full capacity. Our current census as of 04.28.2017 is 26 individuals.*

i. Staff Qualifications:

Executive Director Qualifications:

- Completion of a Vermont approved certification course (or one of the following):
- At least an Associate's Degree in the area of Human Services, and two (2) years of Administrative experience in adult residential care; or
- Three (3) years of general experience in residential care, including one year in Management, supervisory or administrative capacity
- A current Vermont license as a nurse or nursing home administrator
- Other professional qualifications and experience related to the provision of healthcare services or management of healthcare facilities including but not limited to a licensed Social Worker.

Direct Care Staff qualifications:

- Be 18years of age or older
- Have a high school diploma, or GED diploma
- Be free from a medical condition, including drug or alcohol addiction that would limit Direct care staff persons from providing necessary personal care services with skill and Safety

  An individual who is 16 or 17 years of age may be a staff person in the home, but may not perform tasks relating to medication administration. A staff person who is 16 or 17 years of age may not perform tasks related to incontinence care, bathing or dressing.

Registered Nurse (Director of Nurse) qualifications:

- A Registered Nurse will have graduated from an accredited nursing program
- Will be licensed as a Registered Nurse by the State of Vermont and be in good standing.

Licensed Practical Nurse (Wellness Department) qualifications:

- Licensed Practical Nurse will have graduated from an accredited nursing program
- Will be licensed as a Practical Nurse by the State of Vermont and be in good standing

Ancillary Staff:

- Business Office Coordinator
- Memory Care Coordinator
- Dietary Services Coordinator
- Maintenance/Housekeeping/Laundry Coordinator
- Director of Marketing and Admissions
- Director of Activities

Ancillary Staff Qualifications:

For ancillary staff to perform their job successfully they must be able to implement each essential duty of their position satisfactorily. The requirements outlined throughout each ancillary staff job description are representative of the knowledge, skills and abilities that are required. At a minimum, each ancillary staff person shall have a high school diploma/GED, ability to handle multiple tasks, possess written and verbal skills for effective communication and demonstrate good judgement and problem solving skills.

ii. Orientation

Spring Village at Essex will ensure that all staff go through a 5-hour Memory Care orientation which is specific to giving them the knowledge and tools needed to effectively care for the residents of Spring Village. This training will consist of: Understanding Dementia, Different types of Dementia, Challenging Behaviors, Communication and direct care.

An additional 6 hours of orientation will also be done to educate on our culture, policies and procedures of facility, fire safety, nursing procedures, community life program, resident rights, and additional information that is needed before starting employment.

All new direct care staff will work in conjunction with a current staff member for orientation purposes before doing any unsupervised care for a resident. The length of this orientation process may vary but will never be less than 3 days. No staff will provide unassisted ADL's until proficiency is demonstrated for all skills needed. Additional training will be provided as needed.

Ancillary staff will receive a minimum of three (3) days of orientation relative to their individual departments. Orientation/job training may exceed 3 days, dependent on each newly hired team members' needs. Ancillary staff includes: Concierge, Admissions Director, Business Office Director, Laundry, Housekeeping, Maintenance and Food Service.

iii. In-Service Education and Specialized Training

Spring Village at Essex will shall provide at least twelve (12) hours of training each year for each staff person. This training will include:

1) Residents Rights
2) Fire Safety and Emergency Evacuations
3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police and ambulance contact, 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 handwashing, handling of linens, maintaining a clean environment, blood borne pathogens and universal precautions.
7) General supervision and care of residents
8) Falls and accident prevention
9) Gerontology
10) Nutrition and meal service

In addition to the 12 hours of annual training, each team member of Spring Village at Essex will receive 5 hours of annual training relating to dementia care and services. All 5 additional hours will be structured training related to dementia care and services. The 5 hours may not be on the job training.

Spring Village at Essex will educate team members relative to dementia care and services. This will assist the team member to understand the individualized needs of a resident with dementia. Staff members will be educated to recognize body language, verbal and nonverbal cues as well as specialized programs such as Reminiscence and Life Review. Education will be provided via verbal and visual presentations as well as role play.

Spring Village at Essex will maintain a record of education that will include documentation of the staff person trained, date, source, content and length of each individual training.

All training documentation will be kept together in the Business Office Coordinator's office and shall be made available to staff members and department heads.

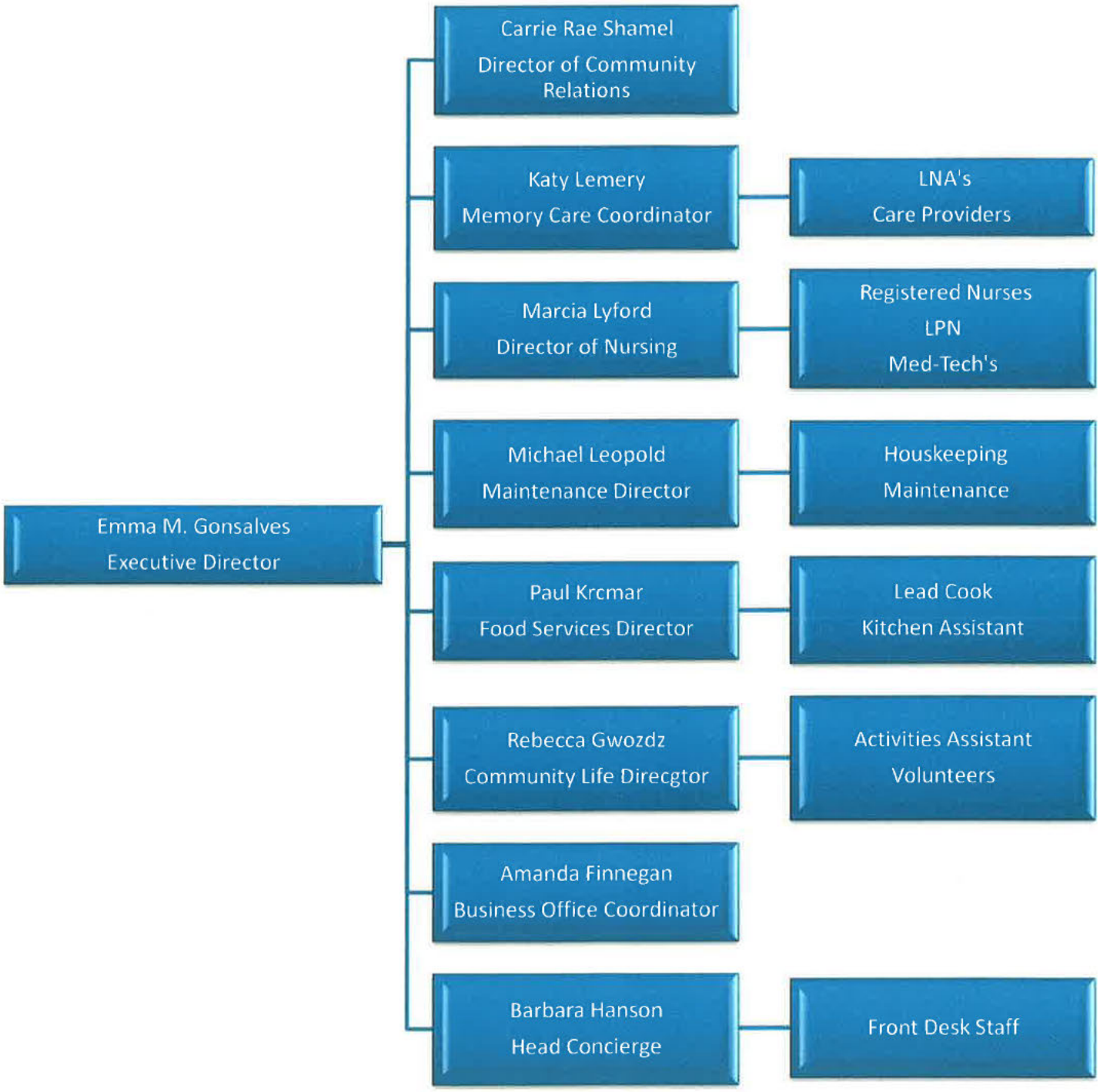
iv. Medical Management and Credentialing as Necessary

On admission to Spring Village at Essex, the wellness department will provide information pertaining to attending physicians and will be responsible for coordinating the physician's medical services. This will include scheduling medical appointments and arranging transportation. The resident/responsible party has the right to choose their own physician.

The medical care of each resident is supervised by an attending physician who has the responsibility of managing the residents overall medical condition and responding in person or via telephone relating to a resident's change in condition. When an attending physician is not available, it is his/her responsibility to provide coverage who will assume the responsibility in providing medical care for the resident.

Ref. 5.6.b

SPRING VILLAGE AT ESSEX ORGANIZATIONAL CHART



From: Wendy Rowe
To: Renner, Jamie; Sean Londergan
Subject: RE: [redacted]
Date: [redacted]

Hi Jamie,

[redacted]

I'm not sure if these numbers are current, but hopefully will work for you!

Wendy

Long term Care Ombudsman
Vermont Legal Aid, 264 N. Winooski Avenue, Burlington, VT 05401
Office 802-448-1690
Fax 802-863-7152

From: Renner, Jamie [mailto:Jamie.Renner@vermont.gov]
Sent: [redacted]
To: Sean Londergan <SLondergan@vtlegalaid.org>; Wendy Rowe <WRowe@vtlegalaid.org>
Subject: [redacted]

Sean & Wendy:
Could you possibly pass along [redacted] personal contact information? I'd like to follow up with them regarding Spring Village at Essex.
-Jamie

Jamie Renner
Assistant Attorney General
Office of the Vermont Attorney General
109 State Street, Montpelier, VT 05609
Dir: 802-828-5947

From: Renner, Jamie
To: [redacted]
Subject: RE: Spring Village at Essex
Date: [redacted]

Thank you.
-Jamie

From: [redacted]
Sent: [redacted]
To: Renner, Jamie <Jamie.Renner@vermont.gov>
Subject: Re: Spring Village at Essex
Attached is the letter from [redacted]. I will look for the other documents and send them early next week
Thank you,
[redacted]

> On [redacted], Renner, Jamie <Jamie.Renner@vermont.gov> wrote:
> That works for me. Thanks. What number can I reach you at?
>
> ---
>
> **From:** [redacted]>
> **Sent:** [redacted]
> **To:** Renner, Jamie <Jamie.Renner@vermont.gov>
> **Subject:** Re: Spring Village at Essex
> How about 9 am?
> [redacted]
>
> > [redacted], Renner, Jamie
> > <Jamie.Renner@vermont.gov> wrote:
> > [redacted]
> > What time on Friday morning could work for you?
> > Thanks,
> > Jamie
> >
> > ---
> >
> > **From:** [redacted]>
> > **Sent:** [redacted]
> > **To:** Renner, Jamie <Jamie.Renner@vermont.gov>
> > **Subject:** Re: Spring Village at Essex
> > Jamie,
> > I am so sorry for the slow response. I am in one of the busiest times of year work wise. I can perhaps carve out some time on Friday morning. Otherwise, I have work commitments next week that make it difficult to break away although I am generally free each day between 2 and 3 and perhaps connect with you then.
> > Thank you,
> > [redacted]
> >
> > > On [redacted], at 6:52 AM, Renner, Jamie
> > > <Jamie.Renner@vermont.gov> wrote:
> > > Thanks. Can we coordinate a time to chat for 20-30 mins? Is

there a day/time this week that works best for you?

[redacted] wrote:

> Jamie,
> I would be more than happy to speak to you. I can be reached via my home phone [redacted]
> Thank you,
> [redacted]
>
> > On [redacted], Renner, Jamie <Jamie.Renner@vermont.gov> wrote:
> >
> > [redacted] referred me to you. I'm an Assistant Attorney General at the VT Attorney General's Office. I work in our Office's Consumer Protection Division. My division's job, in short, is to help ensure that business' don't mislead Vermont consumers. I'm writing to follow up on certain complaints that have been publicly aired regarding Spring Village at Essex. [redacted] indicated that you might share the relevant concerns. For that reason, I'm interested to speak with you (by phone), if you're willing, to ask you a few questions about your family's experience with this facility. I'd be happy to explain more about our Office's role and interests when we speak.
> > Thanks,
> > Jamie
> > Jamie Renner
> > Assistant Attorney General
> > Office of the Vermont Attorney General
> > 109 State Street, Montpelier, VT

05609
Dir: 802-828-5947

From: [redacted]
To: Renner, Jamie
Subject: Re: Spring Village at Essex
Date: [redacted]
Attachments: SCN_0004.pdf

Attached is the letter from [redacted]. I will look for the other documents and send them early next week

Thank you,
[redacted]

On [redacted], Renner, Jamie <Jamie.Renner@vermont.gov> wrote:

That works for me. Thanks. What number can I reach you at?

From: [redacted]
To: Renner, Jamie <Jamie.Renner@vermont.gov>
Subject: Re: Spring Village at Essex
How about 9 am?
[redacted]

On [redacted], Renner, Jamie <Jamie.Renner@vermont.gov> wrote:

[redacted]
What time on Friday morning could work for you?
Thanks,
Jamie

From: [redacted]
To: Renner, Jamie <Jamie.Renner@vermont.gov>
Subject: Re: Spring Village at Essex
Jamie,
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Thank you,
[redacted]

On [redacted] Renner, Jamie <Jamie.Renner@vermont.gov> wrote:
Thanks. Can we coordinate a time to chat for 20-30 mins? Is there a day/time this week that works best for you?

On [redacted] wrote:

> Jamie,
> I would be more than happy to speak to you. I can be reached via my home phone [redacted]
> Thank you,
> [redacted]
>
> > On [redacted], Renner, Jamie <Jamie.Renner@vermont.gov> wrote:
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> > Thanks,
> > Jamie
> > Jamie Renner
> > Assistant Attorney General
> > Office of the Vermont Attorney General
> > 109 State Street, Montpelier, VT 05609
> > Dir: 802-828-5947

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 Link: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

[redacted]

Ms. Angela Pelletier, Manager
Spring Village At Essex
6 Freeman Woods
Essex, VT 05451

Dear Ms. Pelletier:

This letter is in response to a discharge appeal the Division of Licensing and Protection (DLP) received, appealing the discharge of [redacted] Thank you for the ongoing communication regarding this appeal and for providing materials as requested by this office. Please read this letter carefully.

Per my review of the notice of involuntary discharge, dated [redacted], you are discharging [redacted] due to the community being unable to meet the needs of the resident and the resident presenting a threat to herself, other residents and staff. Per review of the progress notes and information sent to this office, as well as a review of the resident assessment recently submitted to this office during a separate appeal, the resident is above the level of care you are licensed to provide as a Level 3 Residential Care Home, and is presenting a threat to her own health, and the safety of other residents and staff.

Therefore, DLP is allowing this discharge to proceed with the following change. The notice is dated [redacted] and you note a discharge date of [redacted], which is not 30 days as required by the regulations, due to the shortened February month. You may discharge on or after [redacted] Please proceed with discharge planning and orchestrate a safe and orderly discharge of this resident, if that is still your intention.

Please let me know if you have any questions.

Sincerely,
Pamela M Cota RN
Pamela M. Cota, RN, BS
Licensing Chief

From: [redacted]
To: Renner, Jamie
Subject: Re: Spring Village at Essex
Date: [redacted]
Attachments: SCN_0003.pdf

Attached are my notes from the meeting when they informed me of the discharge.

On [redacted] <Jamie.Renner@vermont.gov> wrote:

That works for me. Thanks. What number can I reach you at?

From: [redacted]>
Sent: [redacted]
To: Renner, Jamie <Jamie.Renner@vermont.gov>
Subject: Re: Spring Village at Essex

How about 9 am?

[redacted]

On [redacted], Renner, Jamie <Jamie.Renner@vermont.gov> wrote:

[redacted]

What time on Friday morning could work for you?
Thanks,
Jamie

From: [redacted]
Sent: [redacted]
To: Renner, Jamie <Jamie.Renner@vermont.gov>
Subject: Re: Spring Village at Essex

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Thank you,

[redacted]

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On [redacted] wrote:

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Thank you,
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> Thanks,
> Jamie
> Jamie Renner
> Assistant Attorney General
> Office of the Vermont Attorney General
> 109 State Street, Montpelier, VT 05609
> Dir: 802-828-5947

[redacted]

When asked what would be different for [redacted] @ Birchwood response: "[redacted] would no longer be her doctor."
In response to my concern about this statement:

No active listening. No sense that they were hearing any of my concerns at either meeting:
[redacted] meeting response were
"No pattern"
"Nothing helps"
"I haven't been here that long so I don't really know her"

[redacted] Any grievance, concern, dog + frustration was met with

"That's not what this meeting was for"

Dx Justification + blame.

Willing to me to pursue paying for a hospital bed when you knew she was leaving

Add [redacted] " fighting to keep her ~~[illegible]~~ for 30 days. Since the State came down on us for having her ~~[illegible]~~ here because we couldn't meet her needs".

If it was this concerning why didn't Andrea call

on several occasions She's good when you are here but then when you leave it escalate. ? equates with several excruciating pain that would cause screaming?

* Two concerning statements:

Who cares if she's addicted to Opiods?

[redacted] won't be her doctor.

From: [redacted]
To: Renner, Jamie
Subject: Re: Spring Village at Essex
Date: [redacted]
Attachments: First draft Spring Village Letter.pdf

Jamie,
Thank you for speaking with me. I have attached a copy of the first draft of the letter I sent contesting the discharge of [redacted] from Spring Village because it outlines the situation pretty clearly. But there is no signature line or conclusion so this must not have been the final draft of the letter actually sent to the state. I will
see if I can find the final version and send it to you but it does not appear to be on my computer so I will have to go through my files and find it. This may not happen until next week. Although I am sure it on file in Pam Cota's office somewhere too. In the meantime, I thought this might help clarify some of our conversation. I have the letter from Pam Cota which I will scan and send in a minute along with my handwritten notes from that final discharge meeting of what I thought we were discussing, you will see it is blank as we never discussed anything I was expecting. Apparently that was on February 22, not 14th. Sorry for the error. I also found my handwritten notes after that meeting in which I document some of my impressions and a few of the concerning statements made.

Hope this helps.

[redacted]

> On [redacted], Renner, Jamie <Jamie.Renner@vermont.gov> wrote:
>
> That works for me. Thanks. What number can I reach you at?
>
> **From:** [redacted]>
> **Sent:** [redacted]
> **To:** Renner, Jamie <Jamie.Renner@vermont.gov>
> **Subject:** Re: Spring Village at Essex
> How about 9 am?
> [redacted]
>
> > On [redacted], Renner, Jamie <Jamie.Renner@vermont.gov> wrote:
> >
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> > What time on Friday morning could work for you?
> > Thanks,
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role and interests when we speak.
Thanks,
Jamie
Jamie Renner
Assistant Attorney General
Office of the Vermont Attorney General
109 State Street, Montpelier, VT 05609
Dir: 802-828-5947

[redacted]

Andrea and Suzanne

This letter is meant to serve as official notice of my intention to contest your discharge of [redacted] from the Spring Village Facility in Essex Vermont. I have several concerns about the fairness of this decision and the lack of a clear communication to me of this intention that I would like to reflect upon.

My first concern is the nature in which this matter was handled. [redacted] has been a resident of Spring Village facility since [redacted] During this time, I have been frequent visitor to this facility. Prior to the meeting on February 14 I had received conflicting information from various members of the staff regarding my mother's status. In the final discharge meeting I was told that my mother had been screaming for hours for 4 months and yet the documentation in the chart does not reflect this according to [redacted] physician's chart review. I have outlined my perspective of the course of her care in a separate document which you may request for further information but which is lengthy so I have not included in this letter.

This included the phone call which was made to my home in order to set up this meeting. No one ever mentioned in our interactions or in our phone conversation to set up this meeting that Spring Village's intentions were to serve me with discharge papers. I arrived at the meeting thinking we were having we were having a follow up to the February 14th meeting in order to continue on a clear and careful plan to ameliorate my mother's behavior. Instead I was met with the Executive Director who I had never met and several staff members who had not been present at the previous care plan meeting and simply handed a letter of discharge.

If necessary, I have outlined the phone calls made to my home and cell number regarding the care of my mother including transcripts of the messages left since [redacted] regarding her care and I am happy to furnish those as well.

One of the main issues raised regarding the ability to care for my mother was my supposedly lack of response with regard to her regular medicines. The statement made in the meeting was "you never bring the medicine when we ask for it". However, I can easily outline the frequent last minute requests by the staff when they had run out of her medicine and were in urgent need in which I responded within hours of the request. I am happy to furnish an outline of this if needed.

I would maintain that the issues with communication between doctor, family and the facilty reflect issues on all sides and I hope that Spring Village staff would be willing to take responsibility for their role in this miscommunication.

I feel that we are also being unfairly punished for attempting to advocate for [redacted]. The staff had made several requests for heavy duty antipsychotics and painkillers, like Lorazepem and Fentayl citing uncontrollable pain as the cause for [redacted] behavior. When asked to elaborate on the patterns of behavior for me so that I could make an informed decision about the nature of her "pain" and her outbursts, where she was, what might have precipitated her outbursts like needing care and not being able to figure out how to get it, being lost and afraid in the back hallways of the building, sitting up for long periods of time without pressure relief, the staff responded with comments like "there is no pattern" or dismissed my concerns and continued to push for the medications. I will mainitn that because of [redacted] history of

[redacted], her tendency to use claims of pain as a response to negative situations which has existed for decades, I told the staff that I was concerned about use of such medications and would like to seek alternatives first and only using these medications as a last resort. In addition, [redacted] physician consulted with many professionals including a clinical psychiatrist, a clinical pharmacist and Dr Zail Berry of Birchwood Memory Care all of who urged her to avoid the use of Lorapem or Fentanyl with [redacted]

Since the beginning of the use of Rispiridone with [redacted] I have called the facilily daily and talked to multiple caregivers to get a report of her behavior. No caregiver has raised a concern to me about her safety or the safety of others in the facilty or their ability to meet her needs. I have been told when she has had episodes of yelling the staff has been able to easily redirect that she is taking her medications, allowing care, eating adequately, engaging with staff and residents.

The staff indicated that [redacted] would sometimes scream for 12 hours and that the state survey indicated a high concern for the facility to meet her needs. At no time during any of these 12 hours of screaming was I contacted to see if I might come and try to intervene with [redacted]. I was told that the facility had been advocating for a month for her to stay but never in that time was this communicated to me even at the care plan meeting held on February …..th I even specifically asked at the February 14th meeting and this was not commuicated to me. It was not until the discharge meeting, at which time when I raised this issue and my concerns, I was told “this is not what this meeting is for”. I have scheduled a meeting with Katie Lemry which could not be held until March 5th due to her vacation. I ask for the opportunity to reflect and evaluate the overall situation and how all parties may have contributed to the lack of commcuication, with Katie before a final decision about my mother’s discharge is made.

I strongly believe that [redacted] case and history are complex and therefore required a careful clinical team evaluation and approach. I believe that my decisions regarding [redacted] care were based on careful evaluation of what I and her doctors know of her history, and evaluation of the inconsistent information given to me about the nature of what was precitipating her behavior. The nature of the information provided to me by staff did not convince me that the requested heavy painkillers were necessary. I believe our choice of low dose rispirodone coupled with behavioural interventions, preventitive care and small amounts of oral tramadol have proven effective in improving the situation for my mother and her caregivers. In none of the phone calls since this medication was started, has anyone expressed to me the belief that [redacted] is in danger, or presents danger to others or that the staff is feeling they are unable to help her.

[redacted] has made several visits to the facilty, is willing to continue to work to improve the communication between her office and Spring Village facility in the future. [redacted] caregivers at Spring Village have been open and helpful and willing to attempt some interventions to help avoid the need for such strong medications now and in the future and I have attempted to make daily contact with the faciltiy to ensure continued flow of information regarding my mother’s care. All of these actions seem to be helping to allow us to adequately meet my mother’s needs at this time. Regular care plan meetings would also be helpful in maintaining an open flow information.

I believe that the critical issues that were cited for need to discharge my mother no longer exist and simply “not liking me or my doctor” are not sufficient grounds for discharge at this time.