

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

April 1, 2016

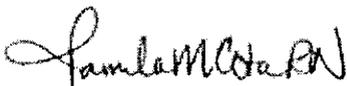
Ms. Elizabeth Pelletier, Manager
The Residence At Otter Creek
350 Lodge Road
Middlebury, VT 05753-4498

Dear Ms. Pelletier:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 3, 2016**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN
Licensing Chief



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2016
--	--	---	--

NAME OF PROVIDER OR SUPPLIER THE RESIDENCE AT OTTER CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 350 LODGE ROAD MIDDLEBURY, VT 05753
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

R100	Initial Comments: An unannounced on-site re-licensure survey was completed on 3/3/16 by the Vermont Division of Licensing and Protection. The following regulatory violations were found.	R100	Please see attached Plans of Correction.	
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 staff interview and record review, the Registered Nurse (RN) failed to assure that the written care plans for 2 of 7 residents in the total sample were revised to reflect their current identified needs. (Residents #3 and 4). Findings include: 1. Resident #3 had experienced an acute CVA (cerebral vascular accident) during June, 2015 that resulted in a significant decline in physical and functional status. Per review, the care plan was most recently updated on 10/21/15. The care plan to address transfers and safety stated the the resident required assist of 2 staff and a mechanical lift for all transfers. Per interview with the RN on 3/3/16, the resident has improved and no longer uses the mechanical lift; transfers are done using a 2 person stand lift now. Also, the nutrition care plan failed to include that the resident is at risk for aspiration while	R145		

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
Elizabeth Perrin, RN *3/25/16*
STATE FORM 6899 BS2511 If continuation sheet 1 of 11

R145 - R302 POC's accepted 3/31/16 mbohnruj/pmc

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2016
--	--	---	--

NAME OF PROVIDER OR SUPPLIER THE RESIDENCE AT OTTER CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 350 LODGE ROAD MIDDLEBURY, VT 05753
--	---

(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
R145	Continued From page 1 eating/drinking, as identified in the physician orders "Cut up all foods, chopped foods, aspiration risk". 2. Resident #4 has a diagnosis of obesity (since admission in 2014) and has experienced a weight gain since admission of 29.4 pounds. Per review, the nutrition care plan stated that the resident will be adequately hydrated and maintain baseline nutritional status....independent with eating.....alert the nurse if consumes less than 75% meals. There was no identification of the weight gain, nor any plan to address this need with the resident.	R145		
R160 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.a Each residential care home must have written policies and procedures describing the home's medication management practices. The policies must cover at least the following: (1) Level III homes must provide medication management under the supervision of a licensed nurse. Level IV homes must determine whether the home is capable of and willing to provide assistance with medications and/or administration of medications as provided under these regulations. Residents must be fully informed of the home's policy prior to admission. (2) Who provides the professional nursing delegation if the home administers medications to residents unable to self-administer and how the process of delegation is to be carried out in the home. (3) Qualifications of the staff who will be	R160		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2016
--	--	---	--

NAME OF PROVIDER OR SUPPLIER THE RESIDENCE AT OTTER CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 350 LODGE ROAD MIDDLEBURY, VT 05753
--	---

(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
--------------------	--	---------------	---	--------------------

R160	<p>Continued From page 2</p> <p>managing medications or administering medications and the home's process for nursing supervision of the staff.</p> <p>(4) How medications shall be obtained for residents including choices of pharmacies.</p> <p>(5) Procedures for documentation of medication administration.</p> <p>(6) Procedures for disposing of outdated or unused medication, including designation of a person or persons with responsibility for disposal.</p> <p>(7) Procedures for monitoring side effects of psychoactive medications.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the home failed to assure that there were written policies/procedures to direct staff in the process of monitoring residents using psychoactive medications for potential side effects. This practice affected 5 applicable residents in the sample. (Residents #1, 3, 4, 6 and 7). Findings include:</p> <p>Per review of the medical records for Residents #1, 3, 4, 6 and 7 on 3/2/16 and 3/3/16, each resident was prescribed a psychoactive medications for daily use by their physician/practitioner. Per review of the records, there was no written documentation of monitoring for evidence of adverse side effects for any of the residents. The lack of documentation of monitoring for side effects was confirmed during interview on the afternoon of 3/3/16 with the Unit RN and the Clinical Director. The Clinical Director also confirmed that there was no written policy/procedure to direct staff in this process.</p>	R160		
------	---	------	--	--

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2016
--	--	---	--

NAME OF PROVIDER OR SUPPLIER THE RESIDENCE AT OTTER CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 350 LODGE ROAD MIDDLEBURY, VT 05753
--	---

(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
R165 R165 SS=E	<p>Continued From page 3</p> <p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.10 Medication Management</p> <p>5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:</p> <p>(3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for:</p> <ul style="list-style-type: none"> i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects; ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications; iii. Assessing the resident's condition and the need for any changes in medications; and Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions. <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, the Registered Nurse (RN) failed to assure that maximum safe dose limits were obtained for 3 applicable residents who received medications both routinely and PRN (as needed). (Residents #3, 4 and 7). Findings include:</p> <p>Per review of the physician orders for Residents #3, 4 and 7 on 3/2/16 and 3/3/16, each of these residents had current orders for both routine Tylenol (acetaminophen) and PRN doses. The PRN doses are part of the facility's Standing</p>	R165 R165		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2016
--	--	---	--

NAME OF PROVIDER OR SUPPLIER THE RESIDENCE AT OTTER CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 350 LODGE ROAD MIDDLEBURY, VT 05753
--	---

(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
R165	<p>Continued From page 4</p> <p>Orders (SO), usually signed upon admission. The residents had current signed S.O. for Tylenol/acetaminophen, as well as the addition of the following routine Tylenol orders initiated at a later date.</p> <p>Resident #3 - acetaminophen, 1000 mg. PO 3 X daily for pain, dated 4/29/15.</p> <p>Resident #4 - acetaminophen 650 mg. PO 3 X daily for pain, dated 1/12/16.</p> <p>Resident #7 - acetaminophen 500 mg., 1 PO 2 X daily for pain, dated 8/28/15</p> <p>Residents #3, 4 and #7 also had current S.O. for acetaminophen, 650 mg. PO every 6 hours PRN pain or fever.</p> <p>During interview with the unit Charge RN and the Clinical Director on the afternoon of 3/3/16, they confirmed that there should be a maximum daily dosage included in the acetaminophen orders, routine and PRN, to assure that the resident does not get a higher than recommended safe daily dose, as a result of the 2 sets of current orders.</p>	R165		
R167 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.10 Medication Management</p> <p>5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:</p> <p>(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 behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the</p>	R167		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2016
--	--	---	--

NAME OF PROVIDER OR SUPPLIER THE RESIDENCE AT OTTER CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 350 LODGE ROAD MIDDLEBURY, VT 05753
--	---

(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
--------------------	--	---------------	---	--------------------

R167	<p>Continued From page 5</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that there was a written plan to direct unlicensed staff in the administration of a PRN psychoactive medication for 1 applicable resident in the sample. (Resident #7). Findings include:</p> <p>Per record review on 3/3/16, Resident #7 had physician orders for administration of "Ativan", (an anxiolytic medication), "0.5 mg. PO Every 8 hours PRN anxiety". During interview at 3:45 PM, on 3/3/16, the Unit RN confirmed that the resident had received the PRN dose of Ativan in the past month and that there was no PRN Care Plan to direct unlicensed staff in the use of this type of medication. Per licensing regulations, the PRN Psychoactive Care Plan must be written and include the following elements: a description of the behavior(s) the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates 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.</p>	R167		
R171 SS=E	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.10 Medication Management</p> <p>5.10.g Homes must establish procedures for</p>	R171		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2016
--	--	---	--

NAME OF PROVIDER OR SUPPLIER THE RESIDENCE AT OTTER CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 350 LODGE ROAD MIDDLEBURY, VT 05753
--	---

(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
--------------------	--	---------------	---	--------------------

R171	<p>Continued From page 6</p> <p>documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include:</p> <ul style="list-style-type: none"> (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, including the reason why and the actions taken by the home; (3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect; (4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and (5) For residents receiving psychoactive medications, a record of monitoring for side effects. (6) All incidents of medication errors. <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the home failed to assure that there was written documentation of monitoring for side effects for residents using psychoactive medications. This practice affected 4 of 7 residents in the total sample. (Residents #1, 3, 4, and 6). Findings include:</p> <p>Per review of the medical records for Residents #1, 3, 4 and 6 on 3/2/16 and 3/3/16, there was no evidence of written documentation of the RN's monitoring for potential side effects related to the use of the psychoactive medications for each of the residents stated. During interview on the afternoon of 3/3/16, the RN confirmed that s/he was not aware of the requirement and had not</p>	R171		
------	---	------	--	--

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2016
--	--	---	--

NAME OF PROVIDER OR SUPPLIER THE RESIDENCE AT OTTER CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 350 LODGE ROAD MIDDLEBURY, VT 05753
--	---

(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
R171	Continued From page 7 completed a record of monitoring for medication side effects.	R171		
R247 SS=E	<p>VII. NUTRITION AND FOOD SERVICES</p> <p>7.2 Food Safety and Sanitation</p> <p>7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure that all perishable foods stored under refrigeration were labeled and dated, in accordance with regulatory requirements. Findings include:</p> <p>During observations of the facility kitchen on 3/2/16 at 10:25 AM, the following perishable foods were stored unlabeled and/or undated in the walk-in refrigerator:</p> <ul style="list-style-type: none"> a. uncooked bacon, undated b. 6 individually wrapped meat portions, unlabeled and undated. c. dressing/sauce with mushrooms, unlabeled and undated. d. 2 containers of beans, unlabeled and undated. e. cooked rice, unlabeled and undated. <p>In addition, the following items were observed to have dates beyond the acceptable date range, per interview with the Food Service Director (FSD) on 3/2/16 at 11:45 AM: raw pork dated 2/24/16, and leftover cooked sweet potato dated</p>	R247		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2016
--	--	---	--

NAME OF PROVIDER OR SUPPLIER THE RESIDENCE AT OTTER CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 350 LODGE ROAD MIDDLEBURY, VT 05753
--	---

(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
R247	Continued From page 8 2/15/16.	R247		
R249 SS=E	<p>VII. NUTRITION AND FOOD SERVICES</p> <p>7.2 Food Safety and Sanitation</p> <p>7.2.d The home shall assure that food handling and storage techniques are consistent with safe food handling practices.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure that food storage techniques were consistent with safe food handling practices in all areas of the kitchen. Findings include:</p> <p>During a tour of the kitchen on 3/22/16 at 10:25 AM, a food storage rack was located less than 12 inches from the 3 bay pot sink, and the floor mop and broom were stored in the space between the 2 areas, with the handles in contact with the food storage shelving. Since these floor cleaning implements are not considered clean, this process violates safe food storage and handling practices. Soiled items, and cleaning implements, must not be stored immediately adjacent and in contact with food supplies. The improper food storage arrangement was confirmed during interview with the FSD during interview at 11:45 AM on 3/2/16.</p>	R249		
R253 SS=E	<p>VII. NUTRITION AND FOOD SERVICES</p> <p>7.3 Food Storage and Equipment</p>	R253		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2016
--	--	---	--

NAME OF PROVIDER OR SUPPLIER THE RESIDENCE AT OTTER CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 350 LODGE ROAD MIDDLEBURY, VT 05753
--	---

(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
R253	<p>Continued From page 9</p> <p>7.3.c All food service equipment shall be kept clean and maintained according to manufacturer's guidelines</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure that all food service equipment was maintained in a clean manner in all areas of the kitchen. Findings include:</p> <p>Per observation of the kitchen dish machine area on 3/2/16, the hand sink and wall behind the sink in the immediate dishwashing area were observed to be visibly soiled. The top of the automatic dish machine was also noted to be soiled with a build up of debris. The observations were confirmed with the FSD at 11:45 AM on 3/2/16.</p>	R253		
R302 SS=D	<p>IX. PHYSICAL PLANT</p> <p>9.11 Disaster and Emergency Preparedness</p> <p>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.</p>	R302		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2016
--	--	---	--

NAME OF PROVIDER OR SUPPLIER THE RESIDENCE AT OTTER CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 350 LODGE ROAD MIDDLEBURY, VT 05753
--	---

(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
--------------------	--	---------------	---	--------------------

R302	<p>Continued From page 10</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to assure that fire drills were conducted at the times and frequencies stated in the Vermont Residential Care Home Licensing Regulations, during the past 12 month period. Findings include:</p> <p>Per review of the fire drills conducted in the Assisted Living Licensed Units within the last 12 month period, there were no fire drills conducted during the evening shift hours (6 PM - 11:59 PM). Per licensing regulations, fire drills must be conducted at least quarterly and must include the following times: morning, afternoon, evening and night. The lack of evening fire drills was confirmed with the Director Of Maintenance on the afternoon of 3/2/16.</p>	R302		
------	--	------	--	--

R145

Deficiency #1

5.9.c (2) Oversee development of 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.

Deficiency: Based on staff interview and record review, the Registered Nurse (RN) failed to assure that the written care plans for 2 of 7 residents in the total sample were revised to reflect their current identified needs.

#1 Action to correct deficiency:

A review of all Assisted living residents current diagnosis list in the EMR will be reviewed and in accordance with state regulation. All resident care plans will be updated to describe the care and services necessary to assist the resident to maintain independence and well-being.

#2 Measures to assure this does not recur:

Registered Nurse will assure that the written care plans for all residents will be updated quarterly and upon change in condition to reflect current identified needs.

#3 How corrective action will be monitored:

This will be ongoing and reviewed during routine quarterly care-plan updates, annually and updated upon change in condition.

R160

Deficiency #2

5.10.a Each residential care home must have written policies and procedures describing the home's medication management practices. The policies must cover at least the following:

- (1) Level 3 homes must provide medication management under the supervision of a licensed nurse. Level 4 homes must determine whether the home is capable of and willing to provide assistance with medications and/or administration of medications as provided under these regulations. Residents must be fully informed of the home's policy prior to admission.
- (2) Who provides the professional nursing delegation if the home administers medications to residents unable to self-administer and how the process of delegation is to be carried out in the home.
- (3) Qualifications of the staff who will be managing or administering medications and the home's process for nursing supervision of the staff.
- (4) How medications shall be obtained for residents including choices of pharmacies.
- (5) Procedures for documentation of medication administration.
- (6) Procedures for disposing of outdated or unused medication, including designation of a person or persons with responsibility for disposal.

(7) Procedures for monitoring side effects of psychoactive medications.

Deficiency: Based on interview and record review, the home failed to assure that there were written policies/procedures to direct staff in the process of monitoring residents using psychoactive medications for potential side effects.

#1 Action to correct deficiency:

Policy and Procedure created by Resident Care Director and Reflections Director to monitor residents for side effects of administration of psychoactive medications (see attached policy and procedure).

#2 Measures to assure that this does not recur:

Registered Nurse will educate associates on 3/25/16 of the new policy for monitoring effects of psychoactive medications.

#3 How corrective action will be monitored:

Per policy and procedure during quarterly care plan updates and with any change in condition any resident who receives psychoactive medications will have a note placed in chart as well as update PCP if needed on ongoing effectiveness of medication administration.

R165

Deficiency #3

5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:

(3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for:

i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects;

ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications;

iii. Assessing the resident's condition and the need for any changes in medications; and Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions.

Deficiency: Based on staff interview and record review, the Registered Nurse (RN) failed to assure that maximum safe dose limits were obtained for 3 applicable residents who received medications both routinely and PRN (as needed).

#1 Action to correct deficiency:

All current residents residing in AL home had report run via electronic medical record specific to Tylenol. Registered nurse will seek clarification from primary care physicians to obtain maximum daily dose for all Tylenol orders that do not have maximum daily doses listed. Current standing orders do include maximum daily dose for Tylenol (see attached).

#2 Measures to assure that this does not recur:

During staff meeting on 3/25/16 education on maximum dose requirements for medications that are prescribed routinely and PRN reviewed.

#3 How corrective action will be monitored:

Registered nurse to review all orders for Tylenol upon admission to ensure that maximum daily dose is present.

R167

Deficiency #4

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 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 or, reason for, and specific results of the medication use.

Deficiency: Based on staff interview and record review, the facility failed to assure that there was a written plan to direct unlicensed staff in the administration of a PRN psychoactive medication for 1 applicable resident in the sample.

#1 Action to correct deficiency:

All Current residents receiving psychoactive medications will have a PRN care plan to direct unlicensed staff in the use of this type of medication. Care plan will include: specific behavior exhibited by resident that the medication is intended to correct or address; circumstances that indicate the administration of the medication; educates the staff about what desired effects or undesired effects the staff must monitor for and documents the time of; reason for and specific results of medication use (see attached).

#2 Measures to assure that this does not recur:

Reviewed changes in PRN psychoactive care plan during meeting 3/23/16.

#3 How corrective action will be monitored:

Refer to new policy and procedure for administration of psychoactive medications.

R171

Deficiency #5

5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician registered nurse certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum this should include:

- (1) Documentation that medications were administered as ordered;
- (2) All instances of refusals of medications including the reason why and the actions taken by the home;
- (3) All PRN medications administered including the date time reason for giving the medication and the effect;
- (4) A current list of who is administering medications to residents including staff to whom a nurse has delegated administration and
- (5) For residents receiving psychoactive medications a record of monitoring for side effects
- (6) All incidents of medication errors.

Deficiency: Based on interview and record review the home failed to assure that there was written documentation of monitoring for side effects for residents using psychoactive medications. This practice effected 4 of 7 residents in the total sample.

#1 Action to correct deficiency:

Policy and Procedure created by Resident Care Director and Reflections Director to monitor residents for side effects of administration of psychoactive medications (see attached policy and procedure).

#2 Measures to assure that this does not recur:

Registered Nurse will educate associates on 3/25/16 of the new policy for monitoring effects of psychoactive medications.

#3 How corrective action will be monitored:

Per policy and procedure during quarterly care plan updates any resident who receives psychoactive medications a note will be placed in chart as well as update PCP if needed.

The Residence at Otter Creek

Care Plan for the use of a PRN psychoactive medication

Resident Name: _____ Month & Year: _____

Medication Name: _____

Dosage Information: _____

Diagnosis for Prescription: _____

Side Effects of Medication: _____

The medication will be used to treat the following behaviors (select all that apply):

<input type="checkbox"/>	Behavior represents a danger to self
<input type="checkbox"/>	Behavior represents a danger to others
<input type="checkbox"/>	Behavior causes resident inconsolable or persistent distress
<input type="checkbox"/>	Behavior causes resident a major decline in function
<input type="checkbox"/>	Behavior causes resident substantial difficulty receiving needed care

Behaviors specifically exhibited by resident:

Prior to administering the medication, staff will attempt at least 1 of the following interventions and document them in the care record (check all that apply):

<input type="checkbox"/>	Change in environment/Take a walk with caregiver
<input type="checkbox"/>	Offer a snack or a drink
<input type="checkbox"/>	Try to engage resident in an activity or game
<input type="checkbox"/>	Companionship/Reminisce with resident
<input type="checkbox"/>	Therapeutic touch

Interventions that resident enjoys to reduce behaviors:

Desired Effects of Med: _____

IF THE INTERVENTION (S) DO NOT WORK, THEN THE MEDICATION MAY BE ADMINISTERED.

Plan written by: _____ Date: _____

The Residence at Otter Creek- ALF

BEHAVIOR MONTHLY FLOW SHEET , July 2015

Date Printed: 7/22/2015 12:05

Name: _____ Location: _____ Physician: _____

This form is to be used for the following medication classes: AA Antianxiety Agent AD Antidepressant AP Antipsychotic SH Sedative/Hypnotic

BEHAVIOR Codes		Intervention Codes		Outcome Codes
1	Afraid/panic	1	1 on 1	I Improved
2	Agitated	2	Activity	S Same
3	Angry	3	Adjust room temperature	W Worsened
4	Anxiety	4	Backrub	
5	Biting	5	Change position	
6	Compulsive	6	Give fluids	
7	Continuous crying	7	Give food	
8	Continuous pacing	8	Redirect	
9	Continuous screaming/yelling	9	Refer to nurse's notes	
10	Danger to others	10	Remove resident from environment	
11	Danger to self	11	Return to room	
12	Depressed withdrawn	12	Toilet	
13	Extreme fear	13	Other: _____	
14	False beliefs	14	Other: _____	
15	Fighting	15	Other: _____	
16	Finger pointing faces		Medication: use Drug/Dose Code on page 1	
17	Hallucinations/paranoid/delusion			
18	Head banging			
19	Insomnia			
20	Jittery or nervousness			
21	Kicking			
22	Mood changes			
23	Noisy			
24	Pinching			
25	Poor eye contact			
26	Pulling enteral feeding tube			
27	Pulling IV lines			
28	Pulling urinary catheter			
29	Restless			
30	Scratching			
31	Seeing, feeling or hearing things that are not there			
32	Slapping			
33	Spitting			
34	Striking out/hitting			
35	Suspiciousness			
36	Throwing objects			
37	Uncooperative			
38	Wandering			
39	Other: _____			
40	Other: _____			
41	Other: _____			