

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

January 31, 2012

Ms. Paula Patorti, Administrator
Our House Outback
196 Mussey Street
Rutland, VT 05701

Dear Ms. Patorti:

Enclosed is a copy of your acceptable plans of correction for the revisit survey conducted on **December 5, 2011**. 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, MS
Licensing Chief

PC:ne

Enclosure



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0593	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/06/2011
NAME OF PROVIDER OR SUPPLIER OUR HOUSE OUTBACK		STREET ADDRESS, CITY, STATE, ZIP CODE 196 MUSSEY STREET RUTLAND, VT 05701		
(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)	(X6) COMPLETE DATE
(R100)	Initial Comments: On 12/5/11 an unannounced on-site follow up survey was conducted by the Division of Licensing and Protection to determine compliance with the Residential Care Homes Licensing Regulations. The following deficiencies were found not to be corrected from the previous re-licensing survey completed on 6/2/11 and additional regulatory violations were identified.	(R100)		
(R128) SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RCH failed to ensure physician orders were carried out for 1 applicable resident and failed to assure that 3 residents' treatment is consistent with physician's orders. (Residents #1, #3, #4) Findings include: 1. Per record review on 12/5/11, a physician order for Resident #1 was received on 11/28/11 for the administration of Senna 1 tablet by mouth twice daily for constipation. Resident #1, who receives daily narcotics which creates the potential for and the resident has demonstrated, issues with bowel function, had not been administered Senna as prescribed from 12/1/11 through 12/4/11. Per interview on 12/5/11 at 11:00 AM the owner/manager of the RCH confirmed the physician order for the Senna was	(R128)	<i>R128</i> This was a transition month with our new pharmaceutical company - All M.A.R. and treatment sheets are now accurate and have been audited by the RN and House manager. Changes will be monitored as they occur by the House manager and RN. M.A.R. and treatment sheets will be audited by the RN Monthly.	<i>12/10/11</i>

Division of Licensing and Protection

Paula Galt

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

TITLE

Administrator

(X8) DATE

12/30/11

STATE FORM

8800

UUBG12

If continuation sheet 1 of 4

AMC

Division of Licensing and Protection

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(R128)	Continued From page 1 not written on the Medication Administration Record (MAR) for the month of December, as a result staff had not administered the medication. 2. During a tour of the facility on the afternoon of 12/5/11 with the owner/manager, it was confirmed staff utilized ¾ length side rails and bed alarm for Resident #1; and ¾ length mesh side rails are applied to the beds of Resident #3 and #4. Per record review, there was no indication for the purpose/use of the side rails. The nurse had not assessed whether the siderails are used as a means for restraining the resident, if there was a medical purpose for the use of the side rails or determined the resident utilized the railings for mobility. A physician order had not been obtained for the use of the devices which could constitute a mechanical restraint (potentially preventing a resident from exiting or entering their bed when siderails are raised).	(R128) R128	Medical Supply Company has agreed to replace all ¾ rails with ½ rails that will assure residents safety and assist them in getting in or out of bed. RN is adding instruction and reasoning to care plans for accuracy and compliance - New physician orders have been requested to specify need and intent for safety. House manager, RN and Administrator will monitor New equipment or changes to equipment for compliance. R128 POC accepted 1/30/12 PmetarN	1/15/12
(R167) SS=D	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 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	(R167) R167	New M.A.R/Behavior flow sheets are in place and accurate. Med Certified staff have been instructed in the importance of appropriate utilization and documentation. RN will monitor sheets weekly for compliance. R167 POC accepted 1/30/12 PmetarN	1/15/12

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(R167)	Continued From page 2 medication use. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the RCH failed to ensure indication for the use of PRN (as needed) psychoactive medications for 2 applicable residents. (Residents # 5, 6). Findings include: Per record review the MAR for Resident # 5 lists Risperdal 0.25 mg tablet by mouth daily as needed. There is was no indication why staff should administer this medication or identify specific behaviors the medication is intended to correct. The MAR for Resident #6 lists Ativan 0.5 mg tablet by mouth every 6 hours as needed without specifying indication for use or identifying specific behaviors the medication is intended to correct.	(R167)		
(R171) SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 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 shall include: (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	(R171) R171	M.A.R. was Corrected immediately, the survey uncovered a weak link in our system. Pharmacy + M.A.R. provider and NOT the same - problem was identified and resolved immediately - House manager will monitor changes in three steps to avoid a recurrence. RN will audit as changes occur or no less than monthly.	12/10/11

Division of Licensing and Protection
STATE FORM

0099

UUBG12

If continuation sheet 3 of 4

R171 POC accepted 11/30/12 Annetta RN

PRINTED: 12/19/2011
FORM APPROVED

Division of Licensing and Protection

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{R171}	Continued From page 3 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the RCH failed to ensure the correct medication dose was administered as physician ordered for 1 applicable resident. (Resident #2) Findings include: Per review of Physician orders for Resident #2 and the resident's MAR, a discrepancy was noted regarding the dose for the drug Midodrine (used to treat the resident's low blood pressure). A physician order dated 10/8/11 prescribed Midodrine 10 mg orally at 8:00 AM and noon. The resident's MAR also had the same dose; however per review of the resident's medication card, it noted the resident is receiving 7.5 mg of Midodrine twice daily. This was confirmed with the house manager on 12/5/11 at 4:55 PM. A "Medication List" in the resident's record also identified the resident's prescription to be Midodrine 5 mg and to take 1 and ½ tablets (7.5 mg) twice daily.	{R171}		