

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

December 2, 2011

Ms. Paula Patorti, Administrator
Our House Too Residential Care Home
69 1/2 Allen Street
Rutland, VT 05701

Dear Ms. Patorti:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 12, 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
Licensing Chief

PC:jl



NOV 14 2011

PRINTED: 10/31/2011
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0377	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 10/12/2011
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NAME OF PROVIDER OR SUPPLIER OUR HOUSE TOO RESIDENTIAL CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 69 1/2 ALLEN STREET RUTLAND, VT 05701
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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{R100} Initial Comments:
An unannounced follow-up survey was conducted by staff from the Vermont Division of Licensing & Protection for the survey completed on 6/21/11. The follow up survey was completed on 10/12/11 and the following deficiencies were not corrected.

{R126} V. RESIDENT CARE AND HOME SERVICES
SS=D

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 personal, psychosocial, nursing and medical care needs.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the home failed to provide services to meet the nursing and medical care needs for 1 applicable resident in the sample. (Resident # 1) Findings include:

1. Per record review on 10/12/11, Resident #1 has been receiving an antipsychotic medication daily since admission on 2/19/10 and there is no diagnosis nor recent documentation of behaviors justifying the use of this class of psychoactive medication and there has been no attempted reduction in dose since admission. The only documentation regarding behaviors in the medical record is from the Resident Assessment dated 3/3/11 and it stated "resists care less than daily, easily altered". During interview at 1:45 PM, the care giver stated that this resident was

{R100}

{R126}

Our philosophy has always been less is more when it comes to medication - we feel that the Doctors notes re: Review of her chart and "No Substantive Changes" state the Doctors instructions and expectations. IF this resident appears lethargic the med is held as stated on the M.A.R. IF we were holding more than occasionally the Doctor would be advised and he would instruct us as to any changes.

See Exhibit A

RE: No diagnosis, see admission documents and subsequent physicians statements.

See Exhibit B

N/A

N/A

R126
Cont'd

Division of Licensing and Protection

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

STATE FORM

Paula Park

TITLE

Owner/Administrator

(X6) DATE

11/11/11

6899

LZ7U12

If continuation sheet 1 of 5

Division of Licensing and Protection

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(R126) SS=D V. RESIDENT CARE AND HOME SERVICES

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(R126)

Addendum #1

Residents Care plan has been modified. RN spoke with family member, if the physician agrees to try a reduced dose she will approve, however, if agitation or behaviors increase she will expect it to be reinstated. Physician has been advised, we are awaiting his decision.

Addendum #2:
Per telephone call (TC) on 12/21/11 @ 2:20 pm with the Administrator, Administrator to monitor for compliance.

R126 PDC accepted with #1 + #2 addendums 12/21/11.
M Bolton RN / Pincot RN

12/1/11

Division of Licensing and Protection

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

Paula Galt

TITLE

owner/Administrator

(X6) DATE

11/21/11

Division of Licensing and Protection

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{R126}	Continued From page 1 'sometimes resistive to changing his/her brief'. These facts were confirmed during interview with the House Manager and the Registered Nurse (RN) on 10/12/11 at 5 PM.	{R126}	Addendum #1	
{R128} SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.5 General Care</p> <p>5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to assure that each resident's medications and treatments were consistent with physician orders for 2 applicable residents in the sample. (Residents #1 & #3) Findings include:</p> <p>1. Per review of the September Medication Administration Record (MAR) for Resident #1 on 10/12/11, 'Milk of Magnesia (MOM) 30 cc PRN no BM [bowel movement] X 3 days' was listed. Per review of physician orders, the MOM was listed on the Physician Standing Orders Sheet which had not been signed by the physician. This was confirmed during interview with the House Manager at 2:30 PM on 10/12/11.</p> <p>2. Per record review on 10/12/11, Resident #3 had physician orders to 'monitor body temp QD (every day) - record on back' and there were no temperatures recorded on the back of the October 2011 MAR. During interview, the care giver stated that they did not have any disposable sleeves left for use with the tympanic</p>	{R128}	<p>The house manager and the surveyor missed the signed standing orders in the M.A.R. (old order with ranges) New standing orders are now in place.</p> <p>MAR is now in order, this was an old order (for 72 hours) which omnicare had never removed (even after many requests). New MAR provider is anxious to assist us in achieving 100% accuracy and compliance. MAR audits continue monthly or as changes warrant.</p> <p>Addendum #2: Per TC with the Administrator on 12/2/11 @ 2:20 pm, The Administrator to monitor for compliance.</p> <p>R128 POC accepted with #1 + #2 addendums. 12/2/11 M Boltun / Pmetarn</p>	<p>10/20/11</p> <p>12/1/11</p>

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{R128}	Continued From page 2 thermometer used for residents. She stated that she had informed the manager 'about 2 weeks ago'. This was brought to the manager's attention during interview at 2:30 PM.	{R128}		
{R145} SS=D	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 RN failed to assure that the plans of care for 2 of 3 residents in the targeted sample addressed all of their identified needs regarding psycho-social issues and/or nutrition. (Residents #1 & 2) Findings include: 1. Per review on 10/12/11, the care plan for Resident #1 did not address the resident's use of a daily anti-psychotic medication and monitoring for effectiveness and appropriate indications for continued use. This was confirmed during interview with the House Manager and the RN on 10/12/11 at 5 PM. 2. Per record review on 10/12/11, Resident #2's care plan did not address the resident's recent weight loss, identified on the Resident Assessment dated 6/9/11. This was confirmed with the House Manager and the RN during interview at 5 PM the same day.	{R145}	<i>R145 1) See R128 New Care plan forms will incorporate behaviors and relative meds.</i> <i>R145 2) As with many of our residents the weight tracking shows the inconsistency of this resident's ability to be accurately weighed, a standing scale is inappropriate and the seat scale requires the resident to sit without using her/his arms and legs. This is a 96 year old - we do not believe her weight is an issue, moreover she visited her physician in Oct. and the method of obtaining</i>	<i>12/1/11</i> <i>N/A</i>

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{R128} Continued From page 2
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{R128}

{R145} V. RESIDENT CARE AND HOME SERVICES
SS=D

{R145}

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 RN failed to assure that the plans of care for 2 of 3 residents in the targeted sample addressed all of their identified needs regarding psycho-social issues and/or nutrition. (Residents #1 & 2)
Findings include:

1. Per review on 10/12/11, the care plan for Resident #1 did not address the resident's use of a daily anti-psychotic medication and monitoring for effectiveness and appropriate indications for continued use. This was confirmed during interview with the House Manager and the RN on 10/12/11 at 5 PM.

2. Per record review on 10/12/11, Resident #2's care plan did not address the resident's recent weight loss, identified on the Resident Assessment dated 6/9/11. This was confirmed with the House Manager and the RN during interview at 5 PM the same day.

Addendum #1:

1) Residents Care plan has been revised for compliance.

11/2/11

2) This resident regularly eats a large percentage of her meals and snacks; appetite is sometimes diminished -

A new Scale has been ordered to more accurately weigh all compromised residents.

11/11

Care plan has been updated Sons and physician feel she is maintaining.

Addendum #2:

Per TC with Administrator on 12/2/11 @ 2:20 pm, All care plans reviewed and current. Revised form. Administrator to monitor for compliance.

R145 POC accepted with #1 + #2 addendums 12/2/11.

MBolton RN / Administrator

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{R146} SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.9.c (3)</p> <p>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;</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the RN failed to provide specific instructions for staff who are delegated the responsibility to provide G-Tube feedings for 1 applicable resident in the sample. (Resident #3) Findings include:</p> <p>Per observation at 11 AM and confirmed by record review and staff interview on 10/12/11 at 12:30 PM, Resident #3's G-Tube feeding schedule was not consistent with physician orders and the RN failed to provide specific, separate written policies/procedures to address G-Tube feedings and medication administration via G-Tube. The RN also failed to determine the amount of free water necessary to maintain optimal hydration for this resident. The physician orders stated 'Flush 'mic tube' (a type of G-Tube) with 100 cc water in divided doses (50 cc) after Jevity feeding. Jevity 1 Cal 300 cc via G-Tube QID', with times listed as 7 A, 11 A, 3 P and 7 P. Per review of the combined policy and procedure (P/P) for G-Tube and Medication Administration, dated 6/21/11 and signed by the RN, the feedings were to be given in 150 cc increments, 8 x per day on a set schedule. The combining of P/P for both procedures resulted in methods that were not in accordance with Nursing standards of</p>	<p>Cont'd {R146}</p> <p>R146</p>	<p>her weight was discussed as he couldn't get her to stand on the scale. See Exhibit E</p> <p>See New Care plan details for this residents G-Tube Also See physicians orders to split Feedings and wait 1/2 hour in between to avoid vomiting. See physicians notes and RRMC discharge from then PCP. See Exhibits F, G</p>	<p>11/11</p>

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{R146}	Continued From page 4 practice for G-tube feedings and medication administration. As written, the directions do not instruct staff to flush with water before and after administration of medication, nor do they instruct staff to flush prior to giving formula when no medications are being given. Staff were not provided with clear procedures for both the administration of medications and feedings per review. Per observation of the G-Tube feeding by the care giver at 11:05 AM on 10/12/11, the care giver failed to flush the tube with water prior to administering the feeding and after checking for gastric residual. The resident had 1 medication due at 11 AM so the staff person instilled the dissolved medication via the tube after the 150 cc of Jevity was given, thus failing to flush after the feeding and prior to administering the medication. During interview with the RN at 12:30 PM, she confirmed that she had written the procedure for 8 feedings rather than 4 per physician orders and there was no evidence that the physician had been notified to update the orders. The RN also confirmed there were no specific orders for the total amount of free water to be administered daily to meet the resident's needs for hydration.	{R146}	<i>R146 Revised instructions have been written and reviewed with all staff certified for tube feed. Original orders were done under a different RN and have remained unchanged as splitting feedings is still necessary due to risk of vomiting. See exhibit F, G</i>	<i>10/11</i>

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{R146} Continued From page 4

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{R146}

R146

Addendum #2

Revised written instructions have been reviewed with all staff certified for tube feed.

original orders remain unchanged and have been reviewed with and approved by Physician as Split Feeding is still necessary due to risk of vomiting

Addendum #3

Per TC with Administrator on 12/2/11 @ 2:20 pm, the Administrator to monitor for compliance.

R146 POC accepted with #1, #2, #3 addendums 12/2/11.
M. Bolton RN | Pincot RN

10/11

CARE BEFORE EACH FEEDING:

Prior to each feeding the tube must be checked for (1) patency (being free to move/you should move the bolster each time), (2) the gastric contents measured and the (3) markings (cm) on the tube to make sure it hasn't moved.

Item (2) means that the contents of the stomach need to be withdrawn with a hand syringe to measure the residual to make sure the patient is absorbing the food properly. The doctor will tell you the level he feels is appropriate for each patient. But as a rule under 150 cc's is acceptable. Anything over, you withhold feeding until the level goes down.

CAUTION:

You must be certain to reinstall the withdrawn gastric (stomach fluid) contents to prevent loss of nutrients and electrolytes.

POSITION:

The patient should be fed in an upright position (at least 30 degrees) and remain in an upright position for 30 to 60 minutes following the feeding. This minimizes the possibility of aspiration (inhaling food into the lungs) and its inherent complications (pneumonia).

CAREGIVER:

Cleanliness: Thoroughly wash hands with soap and water before preparing formula/food and having contact with the patient.

Food Handling: Formula should be given at room temperature (too hot or cold would make patient uncomfortable). Unused formula and blenderized foods should be refrigerated. Refrigerated formula and blenderized food should be warmed to room temperature over a 30 minute period before feeding. **NEVER** heat the solution as this could increase the growth of bacteria.

Bolous Feeding: Never FORCE fluids through the tube, if bolous feeding (where the food is poured into the tube slowly verses by machine). Bolous feeding allows for rapid feeding of formula over a relatively short period of time. Formula may be instilled using a bulbed or piston syringe or through the use of gravity flow. The feeding usually consists of no more than 250 cc's to 500 cc's per feeding and is given to the patient every 4 to 6 hours.

Infuse the formula slowly and carefully to prevent abdominal cramping, nausea and vomiting, gastric distension (inflated stomach) or diarrhea. If the formula is not infused (poured) slowly, the patient is placed at a high risk for aspiration (fluid into the lungs) and the complications of pneumonia.

TUBE BLOCKAGE:

This is most often caused by the build up of formula residual in the lumen (internal space or opening that exists within the gastrostomy tube). Tube blockage may be prevented with the routine practice of flushing the tube after each use.

If blockage occurs the tube should be irrigated using a large bulbed syringe. Be careful to avoid excessive force while irrigating because the tube could rupture. Milking the tube may help dislodge the obstruction.

SUMMARY OF FEEDING:

The care of the tube and the feeding sound like a lot of work, but it really isn't. At first you swear you will never remember all of the steps necessary for each procedure!!

ORAL HYGIENE:

Good mouth care is imperative in preventing problems, especially with patients who are provided with total nutritional support through the tube.

Daily brushing of the patient's teeth, gums and tongue should be done. Mouthwash may be used with patients who retain a gag reflex.

The patient's lips should be moistened with water and, if necessary, lubricated with petroleum jelly to prevent cracking. (NOTE: Lips do dry out. If they begin cracking and bleeding rub petroleum jelly on them a couple of times a day.)

ASPIRATION:

To prevent the inadvertent inhalation of formula the patient should be fed in an erect or semi-erect position (at least 30 degrees) and remain in that position for 30-40 minutes after feeding.

Over distention (where the abdomen becomes super inflated) should be avoided by careful attention to the rate of feeding flow and the development of abdominal bloating. (NOTE: The doctor will recommend the measurement of feeding and the flow to be used.)

FOODS:

Commercial food: The formula comes commercially prepared or in powder form. Powdered form requires dilution with water. The physician will advise the patient/family on the type of food, methods of feeding, frequency/rates and administration/care of the tube. These can be ENSURE, JEVITY, etc. with or without fibers.

FEEDING TUBE INSTRUCTIONS

1. Flushing Tube:

Always make sure tube is flushed out with water after each feeding. To do this:

b. Using plunger, just insert outer plunger into feeding tube. Loosen tube from stomach by removing tape holding it in place. (This is only if you've taped the tube to the patient's stomach.)

c. Pour 60 cc water into plunger and work the fluid in downwards slowly towards the stomach until all excess fluids are down and tube is clean. Once water starts to go down you can insert the inner part of plunger and slowly plunge the fluid into stomach. **Do NOT force fluid down.**

d. Hold tube upwards until all fluid drains into stomach. Remove plunger and immediately put cap into tube to close it.