

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

May 10, 2012

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

Provider #: 0377

Dear Ms. Patorti:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **April 5, 2012**. 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: 0377	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/05/2012
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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
R100	Initial Comments: An unannounced onsite complaint investigation was conducted by the Division of Licensing and Protection on 3/26/12, and completed on 4/5/12. The following regulatory violations were identified.	R100	All addendums are per a telephone conversation with Paula Patorti on 5/3/12 at 12:25 pm.	
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 record review and staff interview, the home failed to assure that physician's orders for medication were followed for one resident (Resident #1). Findings include: Per record review on 3/26/12, Resident #1 had prescribed medications that were not administered in December 2011 due to them being unavailable at the home (see details under citation R165). Per interview on 3/26/12 and again on 4/5/12, the home manager confirmed that the staff did not alert the manager or the nurse that there were out of stock medications for this resident until 12/9/11, and that other medications were unavailable later in the month. On 4/5/12 at 12:45 PM, a telephone interview was conducted with the registered nurse and the home manager. They both confirmed at that time that the staff had not alerted them immediately of the unavailable medications, and that the physician was not notified in December 2011 that the medications were not being administered as	R128 R128	Weekly monitoring vs monthly has been implemented. RN reviews MAR one time weekly for accuracy and completion - -RN initials + Dates on MAR monthly - Manager monitors resident and House stock weekly or as necessary to assure all meds are in house, All back orders, missing orders must be documented and followed up immediately with RN and Administrator. All Med Certified staff attended an in-service and retraining on 1/30/12 - See Agenda Addendum: All residents of the home have the potential to be affected. The R.N. will review + initial the M.A.R. weekly. The R.N. and Administrator will be responsible for monitoring compliance.	2/2012 4/2012 2/2012 1/2012

Division of Licensing and Protection LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE STATE FORM	 6899	TITLE Administrator	(X6) DATE 4/29/12
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R165	<p>Continued From page 2</p> <p>Findings include:</p> <p>Based on record review, Resident #1 has diagnoses that include dementia and hypertension. In December 2011, the resident was prescribed to be taking several medications, including Aricept, Miralax, vitamin supplements, Labetolol, and Methocarbamol. Per review of the December 2012 Medication Administration Record (MAR), there were a number of days that the resident did not receive all of his/her medications, and on the back of the MAR sheet the reason written for it not being administered was "out of stock".</p> <p>The prescribed medication "Labetolol 100 mg. one tab PO BID", a blood pressure medication, was noted to have circled initials morning and evening for the entire month of December 2011. The reason listed on the back of the MAR was "out of stock". The prescribed medication "Methocarbamol 500 mg. PO BID", a muscle relaxant/pain relief medication, was noted to be initialed and circled also for the entire month of December 2011, with again the reason cited on the back of the MAR as "out of stock". The prescribed medication "Miralax Powder one capful PO with 8 oz. water daily" was documented as not given from 12/1/11 to 12/14/11, and then 12/17, 12/18, and 12/20. The reason again listed on the back of the MAR was "out of stock". "Aricept 5 mg PO daily", a drug used to promote cognitive function, was documented as not given on 12/14/11-12/31/11, reason again was "out of stock". The resident was prescribed vitamin supplements, "Multivitamin w/minerals one tab PO daily" which was documented as not administered on 12/1-12/5/11, 12/7-12/12/11, 12/14, 12/15, 12/24-12/26/11, and on 12/28/11, with the reason written as "out of stock". "Vitamin</p>	R165	<p>Med Competency observation and review will be starting in May 2012 -</p> <p>AT least one med Certified staff member will be observed one time weekly - (or as needed) observations will be reviewed with the staff member and the House manager -</p> <p>Addendum: The R.N. will complete the observations of all med-certified staff.</p> <p>(At April IN-service)</p> <p>All med certified staff were reminded of their roles and responsibilities -</p> <p>The importance of making sure that they have the supplies that they need at all times and who they need to contact in the event that something is out of stock or running low, and that that communication must be documented and followed up on if necessary.</p> <p>Addendum: The R.N. and Administrator are responsible for monitoring compliance.</p>	<p>5/2012</p> <p>4/10/12</p>

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R165	<p>Continued From page 3</p> <p>D3 1000 units one tab PO daily" was not administered on 12/20- 12/31/11, also "out of stock".</p> <p>Per interview on 3/26/12 at 1:30 PM, the medication trained staff person working in the home confirmed that when someone is running low or missing a medication, they are supposed to alert the home manager or the nurse. There was also no documentation in the record that the physician was notified of the missed doses of these medications.</p> <p>Per follow up telephone interview on 4/5/12 at 12:45 PM, the registered nurse and home manager spoke to the surveyor together via speaker phone from the home. The home manager stated that staff did not alert her to the missing medications Labetolol, Miralax, and Methocarbamol until 12/9/11, and then there were issues with the pharmacy and the resident's insurance information that delayed the availability of these medications. The missing Aricept later in the month was not relayed to them immediately either, and details were not clear as to the problems with the vitamins, but again the home manager confirmed that the staff were not communicating in a timely manner regarding low or missing items. The nurse also stated that the staff had not communicated incidents of the missed medications and vitamins in a timely manner. The nurse also confirmed that there was no evidence, and that they do not remember calling the physician in December 2011 to relay that the resident was not receiving the medications as prescribed.</p>	R165	↑	
R266 SS=D	IX. PHYSICAL PLANT	R266	↓	

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			 R216b Addendum: All residents have the potential to be affected. The home manager and Administrator will be responsible for monitoring compliance. R128, R165, R216b POC's accepted with addendums 5/3/12 Kcampos RNL @MCOAREN	