

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

July 9, 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 26, 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 04/26/2012
NAME OF PROVIDER OR SUPPLIER OUR HOUSE TOO RESIDENTIAL CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 89 1/2 ALLEN 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)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site complaint investigation was conducted from 4/25/12 - 4/26/12 to investigate allegations of failure to report resident abuse and inadequate staffing levels to provide care for resident needs. A situation of immediate and serious threat to resident safety and well being was determined to exist.	R100	Please see attached Plan of Correction.	
R126 SS=J	V. RESIDENT CARE AND HOME SERVICES 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 observations and staff interview, the facility failed to assure that necessary care and services were provided to 1 applicable resident to meet the resident's personal, psychosocial, nursing and medical needs. (Resident #1) Findings include: 1. Based on the results of an anonymous complaint alleging resident neglect and staffing shortages, an unannounced survey initiated on 4/25/12 found a situation resulting in the potential for significant harm to Resident #1 and other residents of the home, requiring immediate corrective action. The facility management and the Registered Nurse (RN) failed to assure that the Resident #1's needs were consistently met in an appropriate, timely manner by properly trained	R126		

Division of Licensing and Protection

Paula Oelt

TITLE

ADMINISTRATOR

(X8) DATE

5/27/12

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

STATE FORM

9899

QEFA11

If continuation sheet 1 of 25

PMC

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 04/26/2012
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		
(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	
R128	Continued From page 1 staff. The details are as follows. a. Per observation and confirmed by staff interview on 4/25/12, Resident #1, who had severe contractures to both upper and lower extremities and was weak and totally dependent on staff for mobility and transfers, was left unattended in a shower chair in the bathroom at 10 AM while the caregiver left to attend to another resident in another room. When the surveyor arrived at 10 AM, the care giver providing care to Resident #1 was in the living room and the other care giver was in a room with another resident. During interview, the care giver in the living room stated that S/he had to go back to the bathroom to attend to Resident #1. S/he confirmed the resident had been left alone in the shower chair in the bathroom. The resident was brought to their room and the other care giver arrived to assist with a transfer from the shower chair to the bed. During the observation of this transfer, the caregivers failed to lock both of the shower chair brakes and transferred the resident without utilizing the Hoyer lift, per the care plan. As the staff lifted the resident from the shower chair, the chair seat lifted up out of the seat frame and fell back askew, with the left side of the seat lifted out of the frame. Staff confirmed that the shower chair seat had been 'like that' (broken) for some time. During interview regarding staffing levels after this observation, the caregiver stated that a staff member had called in sick and that they had notified the scheduler at 7:15 AM and S/he said a replacement would be sent; however, as of 11 AM, there were only the 2 caregivers present. Staff explained that due to the extensive assistance of 2 staff needed for most care for Resident #1, having only 2 staff on duty left the	R128			

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 04/20/2012
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		
(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)	(X8) COMPLETE DATE	
R126	<p>Continued From page 2</p> <p>other nine residents unsupervised; sometimes for as long as an hour. This was observed to be the case during much of the observation of wound care and repositioning provided to Resident #1 after transfer to the bed. (The care provided lasted for approximately 1 hour.)</p> <p>b. Per observation of wound care for Resident #1 at 10:45 AM, staff were not adequately trained to provide the level of skilled nursing care required for the dressing changes and staff failed to adhere to clean technique during the wound care. The care giver stated that the resident had physician orders to do twice daily wound care and dressing changes to multiple wounds. The medical record showed that the resident had a significant pressure sore on the coccyx (sacrum) which was unstageable due to eschar and slough in the wound. The wound was observed to be deep and odorous and appeared to have tunneling at one edge that was approximately 3.75 - 4 cm in diameter, with redness surrounding the area to approximately 12 cm in diameter. There were 2 stage 2 pressure sores also noted to be on the lower right buttock area, away from the coccyx. There were 2 stasis ulcers on the right and left Achilles areas of the lower extremities and a stage 3 ulcer on the inner aspect of the left foot below the great toe (approximately 2.25 cm in diameter).</p> <p>During the observation of the wound care to the coccyx, the care giver failed to sanitize or wash hands each time when changing contaminated/soiled gloves. The caregiver touched items including the irrigation syringe, tweezers and other dressing supplies in the supply drawer with contaminated gloves. The care giver needed to be directed to change the stool soiled underpad during the dressing change</p>	R126			

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 04/26/2012
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		
(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	
R126	Continued From page 3 and needed to be asked to wash the wound perimeter prior to applying a Bard barrier wipe to the peri-wound area. During interview after the observation, the care giver was asked what training had been provided prior to that day and S/he replied that they had observed the RN from the VNA (Visiting Nurses' Association) on 1 occasion only. The caregiver stated that the VNA nurse came in and put a procedure in the MAR book and S/he had observed the nurse. No written procedure for them to follow regarding the wound care was seen in the medical record. The manager of the home had arrived (11:16 AM) and she was asked to provide evidence of the training of staff by the home's RN to perform this medically complex nursing procedure. The manager was not able to locate a copy of the wound/dressing protocol and received a copy from the RN via fax at 1332 on 4/25/12. Per review of the procedure, it was incomplete and did not include specific directions for non-nurse care givers to follow. The procedure failed to direct staff to change gloves and sanitize hands between dirty and clean actions during the dressing change and failed to instruct staff to wash the peri-wound area prior to applying the Bard barrier. The resident's wounds required skilled nursing care that was inappropriately delegated to unlicensed (non-nurse), untrained staff without regard for the consequences to the resident. The resident was first noted to have a stage 2 pressure sore on the "buttock folds" and had physician orders for a "Duoderm thin film to open area buttock folds". Per review of progress notes from 12/1/12 to the present, the wound has been present without healing and has deteriorated greatly since February, 2012. This was confirmed during interview with the	R128			

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 04/28/2012
NAME OF PROVIDER OR SUPPLIER OUR HOUSE TOO RESIDENTIAL CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 68 1/2 ALLEN 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)	(X5) COMPLETE DATE
R126	Continued From page 4 manager during the afternoon of 4/25/12 who stated that she requested physician orders for VNA services due to an overall decline including physical functioning and wound worsening. Although she said they did not get physician orders for the VNA services until 3/28/12, the RN notebook at the home had a copy of a referral signed by the physician and dated 2/27/12 which stated "OT/PT/SLP, Wound Nurse" (reviewed on 4/28/12). When the document was shown to the manager, she stated that 'they had been looking for that'. The manager stated that the physician never called the referral to the VNA, however, the home failed to follow up and get new orders until approximately 1 month late (3/26/12). By that time, the resident had declined precipitously and would likely have benefited from earlier intervention of more aggressive treatments. During interview on 4/25/12 at 6 PM, the RN confirmed that staff had been using the 'Duoderm' as the only treatment since December, 2012, and yet the wound had not improved and there was no change in the coccyx treatments ordered until after the VNA started services (4/2/12). Refer also to R146 3. The facility management also failed to assure that adequate staffing levels were maintained to provide the necessary care to all residents of the home. During interview, the manager stated that usual staffing pattern included 2 staff from 8 AM - 2 PM, and 1 staff member from 7 AM - 3 PM for day shift, and 2 staff from 2 PM -10 PM and 1 staff from 4:30 PM - 8:30 PM for evening shift, and 2 staff from 10 PM - 6 AM for night shift. Per review of the staffing records for the period of 1/28/12 - 4/20/12, the day shift had 2 staff only on the following dates: 1/29/12, 1/31/12, 2/6/12, 2/8/12, 2/11/12, 2/28/12, 3/4/12, 3/13/12, 3/24/12, 4/1/12, 4/16/12, 4/18/12 and 4/20/12. The	R126		

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 04/26/2012
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		
(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
R126	Continued From page 5 evening shift had only 2 staff on the following dates: 1/28/12, 1/29/12, 1/30/12, 1/31/12, 2/2/12, 2/4/12, 2/5/12, 2/6/12, 2/11/12, 2/26/12, 2/27/12, 3/2/12, 3/3/12, 3/4/12, 3/17/12, 3/24/12, 3/25/12, 3/31/12, 4/1/12, 4/2/12, 4/7/12, 4/8/12, 4/19/12 and 4/20,12. Refer also to R178. 4. Per observations on 4/25/12 and 4/28/12, Resident #1 was not repositioned every 2 hours, as directed by the care plan. On 4/25/12, the resident was observed sitting in the recliner in the sunroom from 2:05 PM until 4:30 PM, when he was transferred back to bed. In addition, the resident was observed at 4:10 PM with a significant amount of a yellow food substance oozing out of his mouth. Although staff were walking about in the area, they failed to notice this. The resident's right foot/lower leg was also observed to be resting directly on the recliner footrest on the area of the Achilles tendon, where there was a large stasis ulcer. After the surveyor brought these concerns to a caregiver, they cleaned the mouth, repositioned the foot and prepared to transfer the resident back to bed. The resident was Hoyer lifted back to bed at 4:40 PM, per observation. 5. On 4/26/12 at 12:50 PM, the resident was transferred from the bed to the wheelchair and staff failed to lock the wheelchair legs until reminded by the surveyor prior to placement in the chair. Staff also were preparing to take the resident to the dining room when they were stopped and asked to clean the resident's mouth. There was a yellow substance oozing out of the mouth. The care giver cleaned the outer mouth and failed to clean the inside areas of the mouth until asked to do so by the surveyor. The resident clearly had visible residue inside of the mouth that	R126		

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 04/26/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER OUR HOUSE TOO RESIDENTIAL CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 89 1/2 ALLEN 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)	(X5) COMPLETE DATE
R126	<p>Continued From page 6</p> <p>required additional cleaning. Due to his declining condition, the resident was not swallowing well during the 2 days of survey.</p> <p>6. The home failed to maintain the resident's wheelchair in a safe manner. On 4/26/12 at 12:30 PM, the resident was observed during a Hoyer transfer from the bed to the wheelchair by 2 caregivers. The wheelchair arms were noted to have sharp, rough plastic inner edges that could cause skin tears. One arm of the wheelchair was covered with a soiled towel, attached to the chair with tape. Staff removed the soiled towel and were preparing to transfer the resident without covering the arm to protect the resident's skin. Staff said the wheel chair arms had been like that for a while. Per review of progress notes dated 2/5/12, the resident "has skin tear on R (right arm). Put dressing on, also bacitracin". Another note dated 3/13/12 stated "I put washcloths around arms on his wheelchair so it is no longer a danger to him".</p>	R126		
R136 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.7. Assessment</p> <p>5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, the RN failed to reassess 1 applicable resident in the targeted sample after a significant change in medical condition. (Resident #1)</p>	R136		

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 04/26/2012
--	--	--	---

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
---	---

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

R136 Continued From page 7

Findings include:

Per review (4/25/12) of the most recent annual assessment in the record dated 8/23/11, the resident was coded as having no open areas as of the assessment date. Per review of the medical record on 4/25/12 and confirmed during interviews with the manager and per observations of wounds, the resident has experienced a significant impairment of skin integrity with multiple pressure and stasis ulcers. The resident also had been observed to verbalize pain during a Hoyer transfer lift procedure. Issues with difficulty swallowing were also observed during the afternoon of 4/25/12 and after the noon meal on 4/26/12. There had been no new resident assessment completed by the RN since August, 2011. This was confirmed during interview with the manager on 4/25/12 at 5 PM.

R136

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 observation, interview and record review, the nurse failed to assure the written plan of care was updated to reflect specific care needs and monitoring of health conditions for 2 of 4 applicable residents. (Residents #1 and #2)

Findings include:

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 04/26/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER OUR HOUSE TOO RESIDENTIAL CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 88 1/2 ALLEN 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)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

R145	Continued From page 8 1. Per record reviews on 4/25/12 and 4/26/12, the care plan for Resident #1 inaccurately stated that the resident was on a therapeutic diet when S/he was on a regular diet with pureed foods. The care plan failed to include the physician orders for use of thickened liquids. The care plan also failed to identify pain/pain assessments related to contractures and severe pressure sores. The resident was observed to voice pain during a Hoyer transfer on 4/26/12 at 3:25 PM and was observed to wince /grimace during 2 observations of dressing changes (4/25/12 and 4/26/12). The care plan also lacked any interventions to address the decline in mood symptoms. The care plan omissions were confirmed with the manager on 4/25/12 at 5 PM. 2. Per record review on 4/26/12, Resident #2 developed, on 4/1/12, swelling and redness to their penis and scrotum requiring treatment with ice and creams as directed by the RN. Per a "Resident Care Service Note" the nurse documented on 4/10/12 Resident #2's "...buttocks red and excoriated" instructing staff to provide specific skin care. Further documentation notes a decline in the resident's skin including 2 open wounds on the resident's sacrum. The RN failed to update the care plan to reflect changes in the resident's skin condition and the ongoing treatments being provided.	R145		
R146 SS=G	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	R146		

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 04/26/2012
NAME OF PROVIDER OR SUPPLIER OUR HOUSE TOO RESIDENTIAL CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 88 1/2 ALLEN 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)	(X5) COMPLETE DATE
R148	<p>Continued From page 9</p> <p>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 adequate instruction and supervision to care givers regarding dressing changes to pressure ulcers and failed to delegate nursing tasks appropriately for 1 of 9 residents in the sample. (Resident #1) Findings include:</p> <p>Per observation of wound care for Resident #1 at 10:45 AM on 4/25/12, staff were not adequately trained to provide the level of skilled nursing care required for the dressing changes and staff failed to adhere to clean technique during the wound care. The care giver stated that the resident had physician orders to do twice daily wound care and dressing changes to multiple wounds. The medical record showed that the resident had a significant pressure sore on the coccyx (sacrum) which was unstageable due to eschar and slough in the wound. The wound was observed to be deep and odorous and appeared to have tunneling at one edge that was approximately 3.75 - 4 cm in diameter, with redness surrounding the area to approximately 12 cm in diameter. There were 2 stage 2 pressure sores also noted to be on the lower right buttock area, away from the coccyx. There were 2 stasis ulcers on the right and left Achilles areas of the lower extremities and a stage 3 ulcer on the inner aspect of the left foot below the great toe (approximately 2.25 cm in diameter).</p> <p>During the observation of the wound care to the coccyx, the care giver failed to sanitize or wash hands each time when changing contaminated/soiled gloves. The caregiver</p>	R148		

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 04/26/2012
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		
(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
R146	Continued From page 10 touched items including the irrigation syringe, tweezers and other dressing supplies in the supply drawer with contaminated gloves. The care giver needed to be directed to change the stool soiled underpad during the dressing change and needed to be asked (by the surveyor) to wash the peri-wound area prior to applying a Bard barrier wipe to this area. During interview after the observation, the care giver was asked what training had been provided prior to that day and S/he replied that they had observed the RN from the VNA (Visiting Nurses' Association) on 1 occasion only. The caregiver stated that the VNA nurse came in and put a procedure in the MAR book. The manager of the home had arrived (11:16 AM) and she was asked to provide evidence of the training of staff by the home's RN to perform this medically complex nursing procedure. The manager was not able to locate a copy of the wound/dressing protocol and received a copy from the home's RN via fax at 1:32 PM on 4/26/12. Per review of the procedure, it was incomplete and did not include specific directions for unlicensed care givers (non-nurses) to follow. The procedure failed to direct staff to change gloves and sanitize hands between dirty and clean actions during the dressing change and failed to instruct staff to wash the peri-wound area prior to applying the Bard barrier. The resident's wounds required skilled nursing care that was inappropriately delegated to unlicensed, untrained staff without regard for the consequences to the resident. The resident was first noted to have a stage 2 pressure sore on the 'buttock folds and had physician orders dated 12/1/11 for a "Duoderm thin film to open area buttock folds". Per review of progress notes from 12/1/12 to the present, the wound has been present without healing and has	R146		

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 04/26/2012
--	--	--	---

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
---	---

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

R146	<p>Continued From page 11</p> <p>deteriorated greatly since February, 2012. This was confirmed during interview with the manager during the afternoon of 4/25/12 when she stated that she requested physician orders for VNA services due to an overall decline, including physical functioning and wound worsening.</p> <p>Although she said they did not get physician orders for the VNA services until 3/26/12, the RN notebook at the home had a copy of a referral signed by the physician and dated 2/27/12 which stated "OT/PT/SLP, Wound Nurse". This document was found in the nurse's notebook on 4/26/12 at 11:265 AM. When the document was shown to the manager, she stated that 'they had been looking for that'. The manager stated that the physician never called the referral to the VNA, however, the home failed to follow up and get new orders until approximately 1 month later (3/26/12). By that time, the resident had declined precipitously and would likely have benefited from earlier intervention of more aggressive treatments by the VNA nurses.</p> <p>During interview on 4/25/12 at 5 PM, the RN confirmed that staff had been using the 'Duoderm' as the only treatment since December, 2012, and yet the wound had not improved and there was no change in the treatments ordered until after a significant deterioration in the wound and resident's overall condition. The resident's treatment was changed after the VNA wound nurse visit on 4/4/12. A physician telephone order dated 3/22/12 for "Meplex dressing to coccyx", stated "we faxed 4/2/12" in the upper right corner and was signed by the MD on 4/4/12.</p> <p>The RN also could not provide any documentation of formal instruction (in-servicing) to all care givers for providing resident wound</p>	R146		
------	--	------	--	--

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0577	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/26/2012
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		
(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
R146	Continued From page 12 care for extensive pressure/stasis ulcers. During interview at 5:55 PM on 4/26/12, the RN confirmed that there was no evidence of appropriate training, nor care giver demonstration of competence for providing the wound care for Resident #1. The lack of a complete procedure for the dressing change was also confirmed at that time. Refer also to R148	R146		
R149 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (6) Maintain a current list of all treatments for each resident that shall include: the name, date treatment ordered, treatment and frequency prescribed and documentation to reflect that treatment was carried out; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RN failed to assure that all physician orders were complete regarding a dietary treatment order for a change in consistency for Resident #1. Findings include: Per review of the physician orders for Resident #1 on 4/25/12, a telephone order (T.O.) dated 3/19/12 written by the manager, stated "thick lt to liquids". The order failed to include specific information to direct staff on the proper consistency for the resident's needs (for example, nectar, pudding etc). Although the RN co-signed the T.O. on 4/1/12, she failed to take action and get clarification from the physician on the consistency for the thickened liquids. The was confirmed with the manager on 4/25/12 at 6 PM.	R149		

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 04/28/2012
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		
(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	
R178	Continued From page 13	R178			
R178 SS=G	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.11 Staff Services</p> <p>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 observation, staff interview and record review the facility management failed to assure that sufficient number of properly trained staff were available at all times to consistently meet the needs of all residents in a timely manner. Findings include:</p> <p>1. Per review of work schedules for the period from 1/28/12 - 4/20/12, medical records and confirmed during interviews with staff, the facility management failed to assure that adequate staffing levels were maintained to provide the necessary care to all residents of the home on multiple days from the period. Per information received via an anonymous complaint to the State Agency, during part of this time period, the home had 2 residents (Residents #1 & #2) requiring transfer with a mechanical lift and requiring frequent repositioning due to pressure sores and a decline in mobility. Staff stated that during the days with only 2 staff on duty, there were times when the 2 staff were not able to adequately monitor and care for other resident's needs in a timely manner. During interview on 4/26/12 at 12 noon, the owner/licensee and manager stated that the usual staffing pattern included 2 staff from 8 AM - 2 PM, and 1 staff</p>	R178			

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 04/28/2012
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		
(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
R178	<p>Continued From page 14</p> <p>member from 7 AM - 3 PM for day shift, and 2 staff from 2 PM -10 PM and 1 staff from 4:30 PM - 8:30 PM for evening shift, and 2 staff from 10 PM - 6 AM for night shift. On 4/28/12 another anonymous staff person stated that they had previously voiced concerns over a lack of adequate staffing to the owner/licensee and the scheduler.</p> <p>Per review of the staffing records for the period of 1/28/12 - 4/20/12, the day shift had 2 staff only on the following dates: 1/28/12, 1/31/12, 2/6/12, 2/8/12, 2/11/12, 2/28/12, 3/4/12, 3/13/12, 3/24/12, 4/1/12, 4/15/12, 4/18/12 and 4/20/12. The evening shift had only 2 staff on the following dates: 1/28/12, 1/29/12, 1/30/12, 1/31/12, 2/2/12, 2/4/12, 2/5/12, 2/6/12, 2/11/12, 2/28/12, 2/27/12, 3/2/12, 3/3/12, 3/4/12, 3/17/12, 3/24/12, 3/25/12, 3/31/12, 4/1/12, 4/2/12, 4/7/12, 4/8/12, 4/19/12 and 4/20/12.</p> <p>On the day of arrival for the complaint survey (4/25/12), staff stated that another employee was scheduled to work that day but had called in sick. They stated that the scheduler told them at 7:15 AM that S/he would find a replacement; however, upon arrival at 10 AM, there were still only 2 staff working at the home. Staff indicated that at times, the scheduler, who was to find replacements, would not answer the calls.</p> <p>Per review of documentation called " Employee in-service "on 4/26/12, it stated "this meeting is to review the "our House RCH" policies. The following policies are in place for a reason. They help us deliver the best care for our residents...". " These policies will be mandatory and take effect on February 25, 2011". On page 2 "Calling Out... Coverage will be the sole responsibility of the person calling out. At NO time will the managers or other co-workers be responsible for</p>	R178		

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 04/26/2012
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		
(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	
R178	<p>Continued From page 15</p> <p>locating proper coverage...if an employee cannot find coverage he/she will be required to come in and fulfill their shift responsibility...Managers should not be asked or expected to work an employee's shift".</p> <p>Staff interviewed during the survey confirmed that they have been told to find their own replacements, regardless of reason for absence. (This was also one of the anonymous allegations in the complaint to the State Agency). When the owner was asked about this policy, s/he stated that of course if they (staff) could not find someone, they (the scheduler) would help; however this fact was not corroborated by staff who were interviewed.</p> <p>2. During the observation of personal care and a dressing change to Resident #1 (10:40 AM to 11:30 AM), one of the care givers had to leave the room in response to other resident 'voices, louder sounds' from the living room and dining room areas. Another resident also wandered into Resident #1's room during the personal care observation and had to be escorted out by a care giver, who then returned to help with the care. Staff confirmed that these issues were hard to manage with only 2 staff present in the home. The scheduler called at 11:05 AM on 4/25/12 to tell staff that another care giver would be coming in shortly (was due in at 7 AM).</p> <p>3. Per review of the Resident Assessment completed on 3/30/12, Resident #2 was totally dependent on staff for all of his/her activities of daily living (ADLs). The resident was a 2 person physical assist for transfers from bed to wheelchair, requiring a Hoyer mechanical lift. The resident also required turning every 2 hours and had special skin needs and treatments requiring attention and time from staff. Staff confirmed via</p>	R178			

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 04/26/2012
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		
(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
R178	Continued From page 16 Interviews on 4/25/12 and 4/26/12 that during the period when both Residents #1 & #2 were living in the home, it was very hard to provide adequate care to all of the residents when only 2 staff were working. Staff said that they had expressed this fact to the management/owner.	R178		
R188 SS=D	V. RESIDENT CARE AND HOME SERVICES 6.12.b.(2) A record for each resident which includes: resident's name; emergency notification numbers; name, address and telephone number of any legal representative or, if there is none, the next of kin; physician's name, address and telephone number; instructions in case of resident's death; the resident's assessment(s); progress notes regarding any accident or incident and subsequent follow-up; list of allergies; a signed admission agreement; a recent photograph of the resident, unless the resident objects; a copy of the resident's advance directives, if any completed; and a copy of the document giving legal authority to another, if any. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that documentation regarding incidents/follow up including resident neglect and development of greater than stage 2 pressure sores was documented in the medical record to include subsequent follow up including notification of the family/legally responsible party and the physician for 1 applicable resident in the sample. (Resident #1) Findings include:	R188		

Division of Licensing and Protection
STATE FORM

0000

QEFA11

If continuation sheet 17 of 25

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 04/26/2012
NAME OF PROVIDER OR SUPPLIER OUR HOUSE TOO RESIDENTIAL CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 68 1/2 ALLEN 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)	(X5) COMPLETE DATE
R188	Continued From page 17 Per record review on 4/25/12, Resident #1 developed a significant pressure sore on the coccyx and left foot area. The stage 2 coccyx area was first noted on 12/1/12 and continued to be open until the present time, worsening greatly after early February, 2012. There was no documented evidence in the medical record that staff had informed the family in a timely manner of either of these wounds. The resident also sustained skin tears/other open wounds on 2/5/12, 4/8/12, 4/21/12 (new wound on left inner arm), 4/23/12 (new open area R Achilles). There was no documentation that the family had been notified of these changes in condition. These issues were confirmed during interview with the manager on 4/25/12 at 5 PM.	R188		
R194 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.14 Restraints 5.14.a Mechanical restraints may be used only in an emergency to prevent injury to a resident or others and shall not be used as an on-going form of treatment. The use of a mechanical restraint shall constitute nursing care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the home failed to assure mechanical restraints are not used as an ongoing treatment on a non-emergency basis for 3 of 10 applicable residents in the sample. (Residents #1, 2 and 3) Findings include: 1. Per observation at 9:15 AM on 4/26/12, Resident #3 was observed laying in bed awake with one side of the bed positioned against the	R194		

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 04/26/2012
NAME OF PROVIDER OR SUPPLIER OUR HOUSE TOO RESIDENTIAL CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 09 1/2 ALLEN 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)	(X5) COMPLETE DATE
R184	Continued From page 18 wall and the other side of the bed with a full mesh side rail in use. The most recent Resident Assessment completed on 11/28/11 states the resident requires limited assistance with bed mobility and is not considered bed bound. Per review of "Comment Sheets" notes staff documented on 3/13/12, Resident #3 "Sat up in bed and pulled on side rail, fell out of bed and landed on...butt"; on 4/1/12 "Staff report resident pushed bedrail off of bed and sld self off bed onto floor...". Per interview on 4/26/12 at 6:00 PM, the home's owner/manager confirmed the side rail is being used as a restraint to prevent Resident #3 from getting out of bed and has created safety concerns for the ongoing use of the mechanical restraint. 2. Per closed record review of "Comment Sheets" dated 3/24/12, staff documented Resident #2 "Fell out of bed x 2" and on 3/25/12 documented "A little restless...was kicking bed rail off". This resident's side rail was used for 'safety' per documentation and the resident is no longer at the home. However, there was no reason to have a side rail that was clearly restrictive (i.e., resident kicking bed rail off) and posed a risk of entrapment on the bed. 3. Per observation on 4/25/12 at 10:40 AM, Resident #1 was transferred back to bed and staff raised the 1/2 side rails which had been attached to the middle of the bed frame on either side, thus restricting resident movement. Although the resident was in a weakened state at the time and no longer independantly mobile, there was no reason to place the side rails in the middle of the bed frame. The care plan stated that the resident utilized the side rails to help with repositioning in bed. The same benefit could have been achieved with simple U bars attached to the	R194		

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 04/26/2012
NAME OF PROVIDER OR SUPPLIER OUR HOUSE TOO RESIDENTIAL CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 89 1/2 ALLEN 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)	(X5) COMPLETE DATE
R194	Continued From page 19 bed, rather than side rails. The licensee had been previously advised during another survey that restrictive side rails (mechanical restraints) were not allowed in a residential care home except under emergency conditions and they are not to be used as a form of on-going treatment. This regulatory violation was again confirmed with the owner on 4/28/12, as stated above in example #1.	R194		
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 1-800-384-1812. Reports must be 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 staff interview, the licensee failed to report an allegation of suspected resident abuse (neglect) to Adult Protective Services (APS) as required by Vermont Statute within 48 hours of learning of the alleged abuse to 1 applicable resident of the home. (Resident #1) Findings include: Based on an anonymous complaint received by the Licensing Agency regarding alleged resident neglect, an unannounced on-site investigation was initiated on 4/25/12. Per interviews with care	R206		

Division of Licensing and Protection
STATE FORM

6899

QEFA11

If continuation sheet 20 of 25

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 04/26/2012
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		
(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
R206	<p>Continued From page 20</p> <p>givers and the manager and the licensee throughout the day of 4/25/12, staff on the 10 PM to 6 AM shift on the night of 4/4/12 failed to conduct rounds to provide necessary care to dependent residents of the home. Per interview with the manager and licensee during the afternoon, they each confirmed that Resident #1 was found in the same position as S/he had been left in during the evening, on the following morning. The manager stated that she viewed video footage of the living room and saw staff using personal phones and sitting around and not providing care to residents. The manager left a note for all staff to review stating that she was upset at the lack of care provision to Resident #1, who was dependent on assist of 2 staff for all care. The resident was very debilitated and had severe wounds including multiple pressure and stasis ulcers. Progress notes indicate that the resident's wounds have worsened since February, 2012. The care plan required staff to change the resident's position at least every 2 hours and use special pressure relieving techniques for positioning in bed. The resident was also to be given sips of fluids on nights and incontinence and indwelling urinary catheter care. The manager stated that she watched over 4 hours of the video and the 2 staff never left the living room long enough to provide any care to Resident #1.</p> <p>Further review of the memo that the manager of the home posted for all staff to read and sign revealed that another dependent resident (#2), who required repositioning every 2 hours (per care plan) had developed a stage 2 pressure sore on the buttocks and he had been in the home for less than 1 month (was admitted on 3/23/12).</p> <p>During interview with the licensee on the</p>	R206		

Division of Licensing and Protection
STATE FORM

6889

QEFA11

If continuation sheet 21 of 25

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 04/26/2012
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		
(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
R206	Continued From page 21 afternoon of 4/26/12; she stated that she had not finished her investigation into the incident and had not reported it yet. She stated that APS investigators had come to the home on 4/11/12 and that she thought she was not required to report because 'they were aware of the allegation' (through an anonymous complaint). The licensee also allowed the alleged perpetrators to work on the night shift after learning of the allegations of neglect (and confirming neglect had occurred). One of the staff worked on 4/6/12, 4/7/12, 4/8/12, 4/9/12 and 4/10/12. Both staff were scheduled to work together on 4/11/12 however, that is the day that investigators from Adult Protective Services (APS) arrived to do an on-site investigation. The licensee confirmed that the 2 staff were not suspended until 4/11/12 (the date of the APS investigation). Both the licensee and the manager failed to protect the residents from the known perpetrators of neglect by allowing them to continue to work at night. Both the manager and the licensee clearly knew that these 2 residents did not receive necessary care for at least 4 hours (per video) on the night of 4/4/12 and neither one reported this neglect until the surveyor informed them of the requirement to do so on 4/25/12. It was not reported to APS until 4/26/12 after it was again brought to their attention by the surveyor. Refer also to R 224	R206		
R213 SS=D	VI. RESIDENTS' RIGHTS 6.1 Every resident shall be treated with consideration, respect and full recognition of the resident's dignity, individuality, and privacy. A home may not ask a resident to waive the resident's rights.	R213		

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 04/26/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OUR HOUSE TOO RESIDENTIAL CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 89 1/2 ALLEN 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)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

R213	<p>Continued From page 22</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, staff failed to assure that 1 of 9 applicable residents in the sample received care in a manner that respected each resident's dignity and privacy. (Resident #1) Findings include:</p> <p>Per observations of 2 transfers (4/25/12 at 10:40 AM and 4/26/12 at 12:40 PM), staff failed to provide care respectful of the resident's dignity and privacy regarding the lack of cover to perianth areas during transfers. During incontinence care and a dressing change at 10:46 AM on 4/25/12, staff failed to provide cover to the other uncovered areas of the body. During observation at 4:10 PM on 4/25/12, the resident was observed with yellow food matter oozing out of both sides of the mouth while seated in the sunroom. Staff in the area failed to notice until the surveyor brought this to their attention. Again on 4/26/12 at 12:40 PM, the resident had yellow food stuff oozing out of the mouth and staff started to bring the resident out of the room when the surveyor stopped them and asked that they clean the resident's mouth. Staff wiped the mouth but the yellow matter was still visible in the mouth and the surveyor also asked staff to clean the inside of the resident's mouth.</p>	R213		
R224 SS=G	<p>VI. RESIDENTS' RIGHTS</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced</p>	R224		

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 04/28/2012
NAME OF PROVIDER OR SUPPLIER OUR HOUSE TOO RESIDENTIAL CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 88 1/2 ALLEN 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)	(X5) COMPLETE DATE
R224	Continued From page 23 by: Based on staff interviews and record reviews, the licensee and manager of the home each failed to assure that 2 applicable residents in the home from 4/5/12 - 4/10/12 were free from potential staff neglect/abuse. (Residents #1 and #2) Findings include: Per review of documentation of a manager's Memo to staff on 4/25/12, the manager stated that 2 residents clearly did not receive care for a period of at least 4 hours on the evening and night of 4/4/12. S/he asked staff to read and sign the memo which stated that each of these dependent residents had impaired skin integrity, including 2 new severe blisters on Resident #1, and a pressure sore for Resident #2 (developed since admission on 3/23/12). Although the manager and licensee were aware of the neglect of the residents, they failed to report it timely to APS, and failed to take steps to assure that the alleged staff perpetrators were removed from providing direct care to residents during the days immediately following the incident. Per review of the work schedules and confirmed during interview with the manager on 4/25/12 at 12 noon, the staff worked the 10 PM - 6 AM night shifts (although not together) on 5 additional shifts (on 4/6/12, 4/7/12, 4/8/12 4/9/12 and 4/10/12). This was also confirmed during interview with the licensee on the afternoon of 4/25/12. Refer also to R 194	R224		
R291 SS=E	IX. PHYSICAL PLANT 9.6 Plumbing 9.6.d Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas.	R291		

Division of Licensing and Protection
STATE FORM

6888

QEFA11

If continuation sheet 24 of 25

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 04/28/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER OUR HOUSE TOO RESIDENTIAL CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 89 1/2 ALLEN 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)	(X5) COMPLETE DATE
R281	<p>Continued From page 24</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the home failed to assure that hot water temperatures did not exceed 120 degrees Fahrenheit (F) on 1 day of the survey. Findings include:</p> <p>Per observation of the temperature readings of the hot water in 2 resident bathrooms (the shower room and the bathroom off of the dining room) temperatures were in excess of 120 degrees F. The temperature in the shower room at 9:35 AM was recorded as 123.7 degrees F. and the temperature in the bathroom off the dining room was 122.3 degrees F. at 9:40 AM. The excessively hot water temperatures were confirmed with the owner/licensee, who had them adjusted (to less than 120 degrees F.) later the same day.</p>	R281		



5/24/12
Revised 7/5/12

Department of Licensing & Protection
VIA Facsimile # 802 871 3318

Plan of Correction

RE: "Statement of Deficiencies and Imposition of Sanctions effective immediately"
Our House Too R.C.H.

R 126

Provider disagrees with this characterization.

The LNA attending to the resident when the surveyor called her out of the bathroom has been reoriented and retrained and this has been documented. Completed 5/16/12

Both LNA's have demonstrated proper and safe techniques in resident transfers with the Manager and such has been documented. 5/2/12

Understanding and following a plan of care and the importance of writing an accurate plan of care, including documentation of alternative methods when appropriate has been reviewed and revised with caregivers and RN's. 5/11/12

Caregivers have all been reminded of the wheelchair shower chairs proper seat positioning as the latches must be engaged. A new wheelchair shower chair was purchased, received and is in use. 5/10/12

Relief caregiver arrived at 11:15 a.m. — third caregiver was expected at 7:00 a.m. but due to a family emergency, did not notify the scheduling Manager until 7:15 at which time she went to the house to inform the staff and started looking for coverage. The Manager had been working with the overnight staff leaving at 4:30 a.m., she did not know that the third caregiver had not

arrived; the caregivers had everything under control or they would have called for assistance. We have revised our protocol as follows:

When a scheduled caregiver does not show up, within 15 minutes of their expected time of arrival they must;

- Attempt to call the caregiver for an estimated time of arrival.
- If no results immediately, call the scheduler and the manager.
- Scheduler will arrange coverage as soon as possible, and/or scheduler or manager will cover as necessary for compliance.

During reorientation and retraining the LNA was reminded of the importance of appropriate planning and protocol for all resident care and the importance of exercising only care within her scope of practice at all times.

Wound care for this resident was under the direction of RAVNAH RN's and ET Nurse Kate Lawrence; dressing changes were being done by RAVNAH RN and/or Our House RN's.

New written wound care protocol:

Document has been established and initiated to be used for any and all wound care.

RN trains caregiver

Caregiver executes proper demonstration to RN

RN and Caregiver document approved protocol

Document will be present in the MAR and employee record

RN to monitor for accuracy and compliance per incident at least 5 times weekly.

At a mandatory in-service on 5/15/12 all caregivers were reminded of executing safety at all times when any resident is "out of sight" – That the house is designed for safety in floor plan and size and the planning of even a 2 to 3 minute interval in taking eyes off of the common area must be appropriately planned. That all equipment should be in good repair and that any need for repair should be reported to the appropriate Manager immediately. That all equipment must be used appropriately at all times. **Continued monitoring by all Our House employees is expected 24/7. Manager is expected to report equipment in need of repair to the Administrator.**

In addition to reorientation and retraining the LNA was counseled for integrity and confidence when working under pressure. Though she has proven to be a competent caregiver, she has also performed poorly in the past while under observation. Continued monitoring of this LNA's performance will be ongoing. **See orientation checklist and training outline as requested. Manager will monitor, weekly for one month to assure performance standards remain intact.**
5/16/12 – 6/16/12

A written protocol and training has been established for APS and DLP visits to assure compliance and assist all caregivers in overcoming anxiety that may result in poor performance or inappropriate decision making. **See Protocol as requested**

New written wound care protocol will provide training when wound care is delegated by an Our House RN. Our House RN will monitor as needed. Documentation of training, delegation and demonstration will eliminate any uncertainty as to individual caregivers' expectations, training and abilities. **RN will monitor for compliance and accuracy as needed.**

All physicians' orders and referrals must be monitored per incident, daily, for timeliness and accuracy. **RN will monitor for compliance.**

This resident was under the combined care of RAVNAH, Our House RN's and the physician for comfort, as is often our routine for residents close to the end of life. Family meetings had been conducted and expectations communicated with the visiting nurses, the physician, the administrator and the RN. **Continued communication with families is expected by all applicable entities as well as the RN, Manager and Administrator of Our House.**

There is no denying that staffing is challenging- The scheduling dates mentioned included much time when census was down to 7- 9 residents with two caregivers, the Manager is present at least 40 hours weekly (often 50) and the RN makes rounds at minimum, five days a week and is on call 24/7 as well as the administrator is on call 24/7.

R126 POC accepted 7/6/12 PmcotaRN

R 136

Provider disagrees with this characterization.

RN will assure to complete reassessment promptly when significant status change occurs.
Backup RN will verify assessment needs or status changes with House RN and House Manager
Monthly. 6/12

R136 POC accepted 7/6/12 PmcotaRN

R 145

Provider disagrees with this characterization.

These residents were under the combined care of RAVNAH, Our House RN's and the physician's for comfort, as is often our routine for residents close to the end of life. Family meetings had been conducted and expectations communicated with the administrator and RN.

Understanding and following a plan of care and the importance of writing an accurate plan of care, including documentation of alternative methods when appropriate has been reviewed and

revised with caregivers and RN's. All care plans have been audited for accuracy and compliance. Alternate RN will review with House RN and House Manager as needed or at least monthly. 5/11/12

R145 POC accepted 7/6/12 PmcotaRN

R 146

Provider disagrees with characterization.

New written wound care protocol will prove training when wound care is delegated by an Our House RN. Our House RN will monitor as needed. Documentation of training, delegation and demonstration will eliminate any uncertainty as to individual caregivers' expectations, training and abilities. RN will monitor for compliance and accuracy as needed.

During reorientation and retraining including universal precautions, the LNA was reminded of the importance of appropriate planning and protocol for all resident care, use of equipment, and the importance of exercising only care within her scope of practice at all times.

Mandatory May In-service to all caregivers completed: Safety, Resident Safety, Equipment, APS mandatory reporting. 5/12

Wound care for this resident was under the direction of the RN, the Manager requested a referral for RAVNAH RN's and ET Nurse Kate Lawrence; dressing changes were being done by RAVNAH RN and/or Our House RN's.

R146 POC accepted 7/6/12 PmcotaRN

R 149

Provider disagrees with this characterization.

RN's, Administrator and Manager have agreed to assure that physician's orders are always worded appropriately. Orders will state detailed expectations.

RN and Manager will monitor for accuracy and compliance per incident. 5/12

R149 POC accepted 7/6/12

R 178

Provider disagrees with this characterization.

The scheduling dates mentioned included much time when census was down to 7- 9 residents with two caregivers, the Manager is present at least 40 hours weekly (often 50) and the RN makes rounds at minimum, five days a week and is on call 24/7 as well as the administrator is on call 24/7.

When a scheduled caregiver does not show up, within 15 minutes of their expected time of arrival the staff on duty must;

- Attempt to call the caregiver for an estimated time of arrival.
- If no results immediately, call the scheduler and the manager.
- Scheduler will arrange coverage as soon as possible, and/or scheduler or manager will cover as necessary for compliance. 5/12

At a mandatory in-service on 5/15/12 all caregivers were reminded of executing safety at all times when any resident is "out of sight" – That the house is designed for safety in floor plan and size and the planning of even a 2 to 3 minute interval in taking eyes off of the common area must be appropriately planned. That staff calling in and being covered needs to be reported at the time, not after the fact. That staff has a responsibility to Our House residents and coworkers when scheduled for a shift, that they should do their best to request time off in advance, to switch shifts with coworkers when possible and to call the scheduler as soon as possible in an emergency. Scheduler is expected to cover shift as soon as possible. Scheduler or Manager will assist caregivers until coverage can be arranged when necessary. **Manager will notify Administrator with concerns immediately, staffing changes and/or concerns will continue to be reported to the Administrator at the weekly Managers meeting for monitoring and compliance.**

R178 POC accepted 7/6/12 PmcotaRN

R 188

Provider disagrees with this characterization.

This resident lived with us for nearly six years and his wife and daughter visited frequently as most of our families do: This resident was under the combined care of RAVNAH, Our House RN's and the physician for comfort, as is often our routine for residents close to the end of life. Family meetings had been conducted and expectations communicated with the visiting nurses, the physician, the administrator and RN's.

2/12, 3/12, 4/12, 5/12

In the future these meetings will be documented in the residents chart. 5/12

R188 POC accepted 7/6/12 PmcotaRN

R 194

Provider disagrees with this characterization.

Regulations prohibit restraints; our residents have dementia and any bed rail would only be appropriate when safety is a factor and the physician and family have agreed to details of and reason for use and detailed intended use. Detailed physician's orders in writing are required,

when appropriate for a resident with a level of care variance for compliance. Our House doesn't believe in restraints of any kind, but safety for people with dementia.

Manager will monitor for compliance. 5/12

R194 POC accepted 7/6/12 PmcotaRN

R 206

Provider disagrees with this characterization.

The Manager reacted immediately to protect this and all residents by informing staff by urgent memo of what must be done to assure proper care, as a result of her suspicions – Our internal investigation was started within the 48 hours but evidence wasn't obtained until outside the 48 hours.

The caregivers in question had a positive performance record with us for more than one year and the other more than two years. Each caregiver did work three more shifts after the night in question but schedules were changed so they did not work together.

The Administrator, RN's and Managers have all been reminded that APS must be advised within 48 hours with no exceptions, this will not be repeated. It is understood that any and all concerns or suspicions must be reported to APS as required. Internal investigations must start immediately, findings will be documented, and staff will be suspended or terminated immediately. 4/26/12

The Administrator, Manager, RN Crystal and all staff (less 6 absent) have completed an in-service on mandated reporting and the role and importance of APS and the pride that we all have in working in a state that is good at advocating for our elders. The APS' raising awareness handbook' was reviewed in detail and a new copy is in the house. 5/15/12 (A laminated sign regarding reporting of abuse, neglect and exploitation, has been and still is, posted in the home.) **All staff has been advised of their role as mandated reporters at a mandatory in-service in May 2012**, continued education is ongoing. Orientation for new staff includes APS reporting. **Manager, RN and Administrator will monitor.**

R206 POC accepted 7/6/12 PmcotaRN

R 213

Provider disagrees with this characterization.

At a mandatory in-service 5/15 all staff reviewed the resident's rights and our responsibility in executing them at all times, especially dignity, even when working under pressure. Continued monitoring of all caregivers is expected at all times by all caregivers, managers and visitors 24/7. **Manager and Administrator will monitor for compliance, at least weekly.**

A written protocol and training has been established for APS and DLP visits to assure compliance and assist all caregivers in overcoming anxiety that may result in poor performance or inappropriate decision making. See Protocol as requested

R213 POC accepted 7/6/12 PmcotARN

R 224

Provider disagrees with this characterization.

The Manager reacted immediately to protect this and all residents by informing staff by urgent memo of what must be done to assure proper care, as a result of her suspicions – Our internal investigation was started within the 48 hours but evidence wasn't obtained until outside the 48 hours.

The caregivers in question had a positive performance record with us for more than one year and the other more than two years. Each caregiver did work three more shifts after the night in question but schedules were changed so they did not work together. Their behavior was monitored closely during these shifts.

The Administrator, RN's and Managers have all been reminded that APS must be advised within 48 hours with no exceptions, this will not be repeated. It is understood that any and all concerns or suspicions must be reported to APS as required. Internal investigations must also start immediately, findings will be documented, surveillance video may be reviewed or recorded, and staff will be suspended or terminated immediately. 4/26/12

Manager, RN and Administrator to monitor daily as needed to assure compliance.

R224 POC accepted 7/6/12 PmcotARN

R 291

Provider disagrees with this characterization.

Water temperature is monitored and recorded monthly at each water faucet, April read was recorded never above 117 degrees, after the surveyor stated her findings the co-owner measured it again witnessed by the owner and manager and it never went above 110 degrees, he then went to FW Webb and purchased a new thermometer with the same results. Licensed plumber was called in where he measured it with a laser thermometer never reaching 120 degrees; hot water heater has a regulator that is set at 119 degrees. Temperatures are taken, and documented during the first week of each month. Ongoing monthly Co-owner and Plumber.

R291 POC accepted 7/6/12 PmcotARN

OHT 11 manager ~~Went to work~~ (OK) → leave after state visit HTCO
 April, 2012
 total time: 1.5 hrs
Our House Orientation

Orientation checklist is intended to be used as a tool internally to document training and completion of training for house duties and some personal care procedures. Staff training is not limited to this outline; additional training should always be documented and can be done on this paper. Just handwrite it in.

EMPLOYEE NAME MIA MORGAN

TASK	TRAINER	EMPLOYEE SIGNATURE	DATE
Dusting/Vacuuming, Dishes Organization	(BR)	<i>[Signature]</i> (MLO)	5/16/12
Changing Beds/with and Without resident in iv Dry & Wet		MLO	5/16/12
Feeding a resident/proper Procedure: blended, puree Thickened etc..		MLO	5/16/12
Laundry (loading, soap use, Folding & put away		MLO	5/16/12
Activities/Approaching Residents		MLO	5/16/12
Answering phone & HIPPA		MLO	5/16/12
Garbage, mopping, Cleaning bathrooms, kitchen, etc		MLO	5/16/12
Regular wash ups / showers (never less than 2 washcloths)		MLO	5/16/12
Bedbath/brushing teeth/ Razor use, combing hair etc		MLO	5/16/12
Transferring a resident (to and from bed, chair, toilet etc)		MLO	5/16/12
→ Taking a resident To the bathroom <i>stay</i>		MLO	5/14/12
Nail care/ getting resident Dressed & undressed		MLO	5/16/12
Cooking/Meal prep & plan (proper units for meals & desserts)		MLO	5/16/12
Medication (ordering, counting, di etc) / <i>Low supply contact manager</i>		MLO	5/16/12
Stocking/Restocking Supplies (bathroom, kitchen, Bedrooms)		MLO	5/16/12
All charting, shopping lists Timesheets, schedule, filing		MLO	5/16/12
Call-in policies, being on Time, proper conversation With residents, coworkers		MLO	5/16/12
Changing Bandages/dressing		MLO	5/16/12
Flower lift		MLO	5/16/12
Feeding tube		MLO	5/16/12
Catheterization / <i>Forley</i>		MLO	5/16/12
Urinal, bed pan, bedside		MLO	5/16/12
Commode (use and cleaning)		MLO	5/16/12
Abuse / Neglect		MLO	5/16/12
MUSIC/TV		MLO	5/16/12
Mandatory Reporter		MLO	5/16/12
Nurses Notes/book		MLO	5/16/12
cell phone		MLO	} 5/16/12
smoking		MLO	

SPECIAL CARE PROCEDURES

THIS DOCUMENT CONFIRMS THAT THE TRAINER (MANAGER, NURSE or DELEGATED INDIVIDUAL) AND TRAINEE (EMPLOYEE) APPROVE WHAT IS BEING TRAINED, DEMONSTRATED, RE-TRAINED, OR ORIENTED ON (ANYTHING CAN BE LISTED). A FOLLOW UP DEMONSTRATION MAY BE REQUIRED AND OR NEEDED AT THE DISCRETION OF THE TRAINER.

DATE	TRAINER	TRAINER SIGNATURE	TRAINEE	TRAINEE SIGNATURE	SKILL TRAINED (DESCRIBE IN DETAIL)	TOTAL TIME TRAINED
5/16	BP	Beth Ren	MANAGER	<i>[Signature]</i>	Orientation	1 1/2 hours
6/14	BP	Beth Ren	MANAGER KAREN P	<i>[Signature]</i>	Abuse, Neglect, Terri Communication	

Our House R.C.H.'s

Emergency Care Guidelines Policies and Procedures - Quiz

5/2012

Print Name XXXXXXXXXXXXXXXXXXXX Date _____

Use the manual at any of the care homes, **DO NOT TAKE THE MANUAL OUT OF THE HOUSE!**
Please complete and return this to the office or your manager no later than 5/29/12...

1) If a resident falls but has no apparent signs of distress the first thing I should do is?

- Call the RN on call
- Call the Manager
- Call the Family

page 35

2) Who can legally take vital signs?

- RN only
- Med Certified Staff only
- Anyone

page 6

3) When reading results for blood pressure, what is the top number called?

systolic

page 9

4) If a resident who has Alzheimer's disease is agitated what would be the best thing to do to try and relax them?

- Insist that they stop immediately
- Try to redirect their thought process
- Call 911

5) If a resident falls and is bleeding, what is the first thing you do before approaching.

- Call 911
- Call the RN
- Put on Gloves

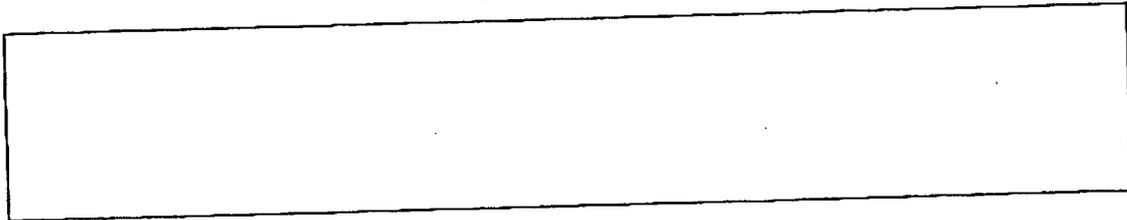
page 24



5/28/12

URGENT MEMO

ALL HOUSES – ALL OUR HOUSE STAFF
MUST READ AND INITIAL



**PROTOCOL FOR VISITS FROM LICENSING AND PROTECTION RN NURSE SURVEYORS
AND/OR ADULT PROTECTIVE SERVICES INVESTIGATORS**

EFFECTIVE IMMEDIATELY

When a surveyor or investigator arrives:

Greet them, ask them to have a seat and you will be right with them, tell them you must get a Manager:

- If the Manager is in the House, get them and they will assist the surveyor/investigator.
- If the Manager is not in the House, call them and the Administrator at once.
- If the surveyor/investigator must wait, we will give you instructions on what they may need or want.
- Any observations will be done with a Manager or the Administrator to accompany the surveyor and caregiver(s).

The Orange survey binder may be appropriate for a surveyor, since they will most likely be doing a survey and the information in the binder will help get them started. Know where it is!

Also know where your policy and procedures manual is! Remember you are good caregivers, try to relax and always be aware of appropriate care-giving.



Adopted
5/28/12

**PROTOCOL FOR VISITS FROM LICENSING AND PROTECTION RN NURSE SURVEYORS
AND/OR ADULT PROTECTIVE SERVICES INVESTIGATORS**

EFFECTIVE IMMEDIATELY

When a surveyor or investigator arrives:

Greet them, ask them to have a seat and you will be right with them, tell them you must get a Manager:

- If the Manager is in the House, get them and they will assist the surveyor/investigator.
- If the Manager is not in the House, call them and the Administrator at once.
- If the surveyor/investigator must wait, we will give you instructions on what they may need or want.
- Any observations will be done with a Manager or the Administrator to accompany the surveyor and caregiver(s).

The Orange survey binder may be appropriate for a surveyor, since they will most likely be doing a survey and the information in the binder will help get them started. Know where it is!

Also know where your policy and procedures manual is! Remember you are good caregivers, try to relax and always be aware of appropriate care-giving.