

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 20, 2011

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 **November 9, 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:ne

Enclosure



Division of Licensing and Protection

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 11/09/2011
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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 complaint survey to assess compliance with Vermont Residential Care Home Licensing Regulations was conducted on 11/9/11 by the Division of Licensing and Protection. The following are regulatory violations.	R100		
R145 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.9.c (2)</p> <p>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;</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the Residential Care Home (RCH) nurse failed to develop a care plan to address behaviors and interventions for 1 applicable resident. (Resident #1) Findings include:</p> <p>Per record review, Resident #1 (age 75 with a diagnosis of Alzheimer's dementia) was admitted to the RCH on 10/14/11 after being hospitalized for agitation and altered mental status. Prior to admission, the resident was demonstrating accelerating behaviors in the home setting, subsequently preventing family to safely maintain and care for Resident #1 at home. Shortly after admission to the RCH, Resident #1 became increasingly agitated resulting in several episodes of physical and/or verbal encounters with both staff and other residents. As a result of this behavior, Resident #1 was seen by a psychiatrist</p>	R145	<p>Care plans are now accurate, current and ON New forms.</p> <p>Care plans will be kept accurate and changes will be made by the RN as warranted. monthly resident assessment note will alert us to changes necessary for care plans and assessments.</p> <p>RN is responsible for care plans accuracy - Administrator will monitor for completion as changes occur, new residents are admitted OR NOT less than quarterly for compliance.</p>	12/15/11

Division of Licensing and Protection

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

Paula Zolt

TITLE

Owner/Administrator

(X6) DATE

12/19/11

Division of Licensing and Protection

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R145	Continued From page 1 on 10/31/11 who made changes in the resident's medications. As a result, the resident has slowly improved and is more easily redirected. However, per review of the resident's care plan, behaviors with interventions to assist staff in the management and/or prevention of further disruptive behaviors had not been addressed on the plan of care. The RN (Registered Nurse) on 11/9/11 at 5:00 PM confirmed s/he had failed to develop a behavioral plan into Resident #1's plan of care.	R145	This resident was discharged 12/8/11 - OP. R145 POC accepted 10/16/11 Fmedintsh RN / Pincot RN	
R167 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for, and documents the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RCH failed to assure that staff other than a nurse administered PRN psychoactive medications in accordance with a specific plan that included all of the required elements as specified in 5.10.d for	R167	No ranges will be accepted - Physicians orders will be specific instructions to comply with the stated expectations. orders RN will monitor for accuracy, house manager will monitor med appt. forms and Drs orders for compliance. R167 POC accepted 12/16/11 Fmedintsh RN / Pincot RN	11/1/12

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R167	Continued From page 2 1 applicable resident in the sample. (Resident #1) Findings include: Per record review on 11/9/11, Resident #1 had physician orders for PRN (as needed) Lorazepam 1 mg daily for "moderate agitation" or Lorazepam 2 mg for "severe agitation". Per review of the PRN Medication Administration Record (MAR), there was no plan that described the specific behaviors for the use of the Lorazepam medication or education for staff regarding desired effects or undesired side effects that staff must monitor. This was confirmed with the RN on 11/9/11 at 5:05 PM.	R167		
R266 SS=D	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the Residential Care Home failed to ensure all furniture used by the residents was safe, functional and comfortable. Findings include: Per observation on 11/9/11 at 2:15 PM, 2 dining room chairs used by residents during meal time were missing part of the back support, creating an uncomfortable and limited support. The chair legs were also noted to be loose allowing the chairs to sway when moved. The observation of the unsafe and hazardous chairs was confirmed with the house manager, who removed the chairs upon surveyor's request.	R266	<i>Kwaku Furniture was ordered in October, arrival is scheduled for 12/13 ^{OR} 12/14 -</i> <i>Interim chairs were brought in immediately. manager is expected to report needs as they occur.</i> <i>Rabb POC accepted 12/16/11 Friedtosh RN / Amcarn</i>	<i>11/9/11</i>

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