

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

June 25, 2013

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 complaint investigation conducted on March 20, 2013 and concluded on **March 25, 2013**. 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

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 03/25/2013
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 1 nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the Registered Nurse failed to direct care providers regarding 1 applicable resident's health care needs and tasks. (Resident #1) Findings include: 1. Resident #1 has history of COPD (chronic obstructive pulmonary disease), asthma, hypertension and dementia. Per record review on 03/20/13 of the progress notes and staff statements dated 03/08/13, Resident #1 was having difficulty breathing, shortness of breath, wheezing, tired, difficulty walking and was warm. The staff notes also state family members expressed concern "about how the way [resident] was acting" and "[family] was crying and demanding we call 911". Per interview on 03/20/13 at 11:04 A.M., the Registered Nurse (RN) stated that the evening before, the resident was wheezing and thought that perhaps [s/he] might have pneumonia so staff were to call the physician's office in the morning. "The next morning staff called saying that the resident was more wheezy and that the [family] wanted to transfer [resident] to the hospital. I told the [family] that I could not come to assess the resident now but the family could call if they wanted to, they didn't want to wait and hung the phone up on me". The RN stated that the resident was a DNR and "to me the DNR was not to do anything". When asked what other assessments or information was gathered to determine the course of action for this resident, the RN acknowledged s/he did not direct staff to take an oxygen saturation measurement, nor basic vital signs	R146	<i>R146</i> RN and manager have attended training on DNR and Advance Directives, all staff has also attended training - families are working on COLST forms to create a more accurate and consistent method of interpreting resident wishes and Code Status. RN and manager will monitor resident records for regulatory compliance and accuracy. <i>R146 POC accepted 6/20/13 SEMMONS RN/ PMR</i>	5/1/13

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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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R228	Continued From page 3	R228		
R228 SS=D	VI. RESIDENTS' RIGHTS 6.16 Residents have the right to formulate advance directives as provided by state law and to have the home follow the residents' wishes This REQUIREMENT is not met as evidenced by: Based on record review and interview the home failed to clearly identify the resuscitation / advance directive wishes of 1 applicable resident (Resident #1). Findings include: 1. Per record review on 03/20/13 at 9:30 A.M., Resident #1's medical record indicated the resident was a Do Not Resuscitate (DNR) regarding code status. However, there are no signed orders for the DNR. The resident does have a valid Advanced Directive (A.D.) which expressed "I do not want to be kept alive if I become unconscious or unaware and not regain consciousness." And "if it is possible that I might recover with treatment and more time is needed to determine if I can get better, I wish my medical team to start the necessary treatment to keep me alive, if over time these treatments do not improve my condition I wish to have life-sustaining treatment stopped". Per interview, the RN at 11:00 A.M. stated "[the resident] is a DNR, to me the DNR was not to do anything". The RN was unable to find the signed DNR orders and confirmed that the current physician list and MAR (medication administration record) both state 'Full Code'. The RN confirmed "confusion" over the A.D. and DNR status. Per interview at 3:35 P.M. the House Manager and Human Resource person confirmed the home failed to clearly and correctly identify the wishes	R228 R228	All Charts have been reviewed for Code Status accuracy - All residents legal representatives have been urged to complete and file a COLST form. House manager will monitor charts for accuracy. R228 POC accepted 6/20/13 SEMMONS R/J PMLL	3/13/13 3/22/13

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R228	Continued From page 4 of the resident. Also see R144	R228		