Division of Licensing and Protection
103 South Main Street
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

April 30, 2015

Mr. Timothy Ryan, Administrator
The Residence At Otter Creek
350 Lodge Road
Middlebury, VT 05753-4498

Dear Mr. Ryan:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 7, 2015.** 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

PRINTED: 04/14/2015
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0596	A. BUILDING: _____ B. WING _____	C 04/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT OTTER CREEK	350 LODGE ROAD MIDDLEBURY, VT 05753

(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 on 4/6 and 4/7/15 by the Division of Licensing and Protection. There were regulatory findings with this investigation.	R100	Please see attached plans of correction.	
R126 SS=D	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 staff interview and record review, the facility failed to insure that the nursing services and medical care needs were met for 3 of 3 residents, Resident #1, #2 and #3, in the survey sample. Findings include: 1. Based on record review for Resident #1 on 4/6/15, there is a care service plan that indicates the resident is on every 2 hour safety checks. Review of the record does not provide evidence that the safety checks were conducted except on the night shift. Interview with the manager presented that the residents are only checked on during the night shift to insure safety. S/he confirmed at 1:34 PM on 4/6/15 that the service plan does state to do 'every 2 hour safety check, not intended to wake resident if sleeping. Ensure resident is safe' and that it is only being done on the night shift and not every 2 hours. S/he further	R126		

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Timothy Ryan RN TITLE Resident Care Director (X6) DATE 4/22/15

R126 - R302 POC accepted 4/28/15 BBartell RN/PMC

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R126	Continued From page 1 stated that the safety checks are only intended for the night shift, but did confirm that the way it is documented indicates to be done all the time. 2. Based on record review for Resident #2 on 4/7/15, there is a care service plan that indicates the resident in on every 2 hour safety checks. Review of the record does not provide evidence that the safety checks were conducted except on the night shift. Interview with the manager presented that the residents are only checked on during the night shift to insure safety. S/he confirmed at 9:15 AM on 4/7/15 that the service plan does state to do 'every 2 hour safety check, not intended to wake resident if sleeping. Ensure resident is safe' and that it is only being done on the night shift and not every 2 hours. S/he further stated that the safety checks are only intended for the night shift, but did confirm that the way it is documented indicates to be done all the time. 3. Based on record review for Resident #3 on 4/7/15, there is a care service plan that indicates the resident in on every 2 hour safety checks. Review of the record does not provide evidence that the safety checks were conducted except on the night shift. Interview with the manager presented that the residents are only checked on during the night shift to insure safety. S/he confirmed at 10:20 AM on 4/7/15 that the service plan does state to do 'every 2 hour safety check, not intended to wake resident if sleeping. Ensure resident is safe' and that it is only being done on the night shift and not every 2 hours. S/he further stated that the safety checks are only intended for the night shift, but did confirm that the way it is documented indicates to be done all the time.	R126		

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R136	Continued From page 2	R136		
R136 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 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. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assess changes in the resident's physical or mental condition for 2 of 3 residents in the survey sample, Resident #1 and #2. Findings include: 1. During record review for Resident #1 on 4/6/15, diagnoses present that s/he had Dementia and Memory loss. A nurse progress note dated 10/27/14 states that the resident had an abrasion on left forehead approximately 6cm x 9cm and the area is red and with mild swelling noted. There also was an area on top of head, approximately 0.5cm with a superficial skin opening noted. The resident stated that he grabbed something above him and it fell on his head. The progress note was written by a Licensed Practical Nurse (LPN) with no evidence that the resident was assessed by a Registered Nurse (RN) following the incident. Per confirmation with the RN, house manager, on 4/6/15 at 3:32 PM, s/he signed off on the incident report that s/he had reviewed the information surrounding the incident, but had not assessed the resident.	R136		

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R136	Continued From page 3 2. Per record review for Resident #1 on 4/6/15 a skin assessment dated 9/30/14 was completed by an LPN that indicated the resident had a Stage 3 wound at "other site". Another skin assessment completed on 12/7/14 presented that the resident had an unstageable wound at "other site". There was no documentation in the record to present that the resident had wounds. Per manager at 3:32 PM on 4/6/15, the "other site" for 9/30/14 and 12/7/14 were not wounds, but were secondary to removal of squamous cell carcinomas. S/he confirmed that the assessment was completed by the LPN and that s/he had not assessed the areas. 3. Per record review for Resident #2 on 4/7/15 at 8:15 AM the nurse progress notes present that on 11/29/14 the on-call nurse, a Licensed Practical Nurse (LPN) was notified at 4:40 AM that the resident fell and hurt his back left side. Staff reports no bruising noted and the resident did report that his side did hurt. Advised by the LPN to administer Tylenol for pain and continue to monitor till the LPN arrives. The LPN made a note on 11/29/14 at 9:39 AM that s/he saw the resident for a follow up to fall. Resident was in bed and there was no bruising noted to area on left lower backside. No swelling noted but area is tender to the touch and with certain movements. Reports feels dizzy before and after falls. Follow up note written 11/30/14 by LPN indicates that resident was up and sitting in chair and reports that left back side feels the same. Tenderness noted to the area. No redness or bruising noted. Resident reports that still has pain to that area with certain movements and was encouraged to use Ibuprofen and use pendant to call for assistance. There is no evidence that the resident was assessed by a Registered Nurse (RN) in relation to this fall. Confirmed in an	R136		

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R136	Continued From page 4 Interview with the RN on 4/7/15 at 9:45 AM that s/he had signed off on the incident report, but had not actually assessed the resident. 4. Per record review for Resident #2 on 4/7/15 at 8:15 AM the nurse progress notes present that on 2/17/15 the LPN was asked to see the resident because of complaints of right side pain after having a fall at Project Independence the day before. Further notes dated 3/8/15 and written by the LPN, presents that resident had a fall and "bumped" his head and complained of achiness just above right eye and on right side of torso. A nurse progress note written 3/23/15 by the LPN states that the resident was seen by him/her due to coughing due to cold symptoms for the past few days. Noted that resident has some rales noted to the right lower base and right mid lobe. History of emphysema which would be exacerbated with any type of upper respiratory symptoms. Resident has productive cough at times. Noted to have dry hoarse cough when "assessing" resident. There is no evidence of the resident being seen by the RN. During interview with the RN on 4/7/15 at 9:45 AM that s/he had not assessed the resident's medical condition for these incidents.	R136		
R188 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.12.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	R188		

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R188	Continued From page 5 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 in insure that instructions in case of resident's death was included in the medical record for 3 of 3 residents, Resident #1, 2 and 3, in the survey sample. Findings include: 1. During record review on 4/6/15 at 12:25 PM, there is no evidence of documentation in regards to instructions in case of resident's death and the manager confirmed at this time that there is no documentation for any of the residents that reside in the home. 2. Record review for Resident #2 on 4/6/15 at 2:53, presented with no evidence in regards to instruction in case of resident's death and the manager confirmed at this time that there is no system to gather the information and record it in the medical record for the residents that reside in the home. 3. Record review for Resident #3 on 4/7/15 at 10:00 AM, has no evidence of documentation in regards to instructions in case of resident's death and the manager confirmed at this time that there is no documentation or information in regards to what to do in the event of death of the resident.	R188		

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R191	Continued From page 6	R191		
R191 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12 Records/Reports 5.12.c A home must file the following reports with the licensing agency: 5.12.c.(1) When a fire occurs in the home, regardless of size or damage, the licensing agency and the Department of Labor and Industry must be notified within twenty-four (24) hours. A written report must be submitted to both departments within seventy-two (72) hours. A copy of the report shall be kept on file. 5.12.c.(2) A written report of any accident or illness shall be placed in the resident's record. Any untimely deaths shall be reported and a record kept on file. 5.12.c. (3) A report of any unexplained absence of a resident from a home for more than 12 hours shall be reported to the police, legal representative and family, if any. The incident shall be reported to the licensing agency within twenty-four (24) hours of disappearance followed by a written report within seventy-two (72) hours, a copy of which shall be maintained. 5.12.c.(4) A written report of any breakdown or cessation to the home's physical plant's major services (plumbing, heat, water supply, etc.) or supplied service, which disrupts the normal course of operation. The licensee shall notify the licensing agency immediately whenever such an incident occurs. A copy of the report shall be sent to the licensing agency within seventy-two (72) hours.	R191		

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R191	Continued From page 7 5.12.c. (5) A written report of any reports or incidents of abuse, neglect or exploitation reported to the licensing agency. 5.12.c. (6) A written report of resident injury or death following the use of mechanical or chemical restraint. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to file a report with the Division of Fire Safety and Department of Public Safety, which involved a fire at the facility with injury occurring to Resident #1. Findings include: During interview with the Residential Care Home Manager on 4/6/15 at 11:10 AM, regarding a fire that occurred at the facility on 3/19/15, I was referred to the Maintenance Director when I asked if the fire had been reported to the Division of Fire Safety and Public Health. At 12:46 PM, the Maintenance Director stated that there had been no report made to the Fire Safety Division of the State of Vermont per requirement as s/he was unaware of the need to do so.	R191		
R266 SS=E	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:	R266		

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R266	Continued From page 8 Based on staff interview and record review, the facility failed to insure that a safe environment was maintained for 3 residents, Resident #1, 2 and 3, in the survey sample. Findings include: 1. During review of medical record for Resident #1, on 4/6/15, s/he presented with a diagnosis of Dementia, which the Registered Nurse (RN) Residential Care Home (RCH) manager confirmed at 11:10 AM. Resident #1 resided in a studio apartment at the facility that is equipped with a kitchenette, that includes a working electric stove. S/he also stated that the breakers are supposed to be turned off and there is no system in place to insure that the breakers are not turned on by the family or the resident. Per interview with the Maintenance Director at 12:46 PM, the stove in the apartment was plugged in and the breaker was turned on at the time of incident that involved a fire, resulting in burns that covered 15% of the body of Resident #1. S/he further confirmed that the stoves for Resident #2 and 3, were also functional. Confirmation was made by the RN manager that the stove in the apartment was operational and that the resident did have dementia at 1:34 PM. S/he he also confirmed at this time that Resident #2 and 3 have a diagnosis of Dementia and should not use the stoves. 2. During review of Fire Safety Policy, on 4/7/15, it stated that the facility maintained "DEFEND IN PLACE" instead of doing evacuations drills for the residents. The Maintenance Director confirmed on 4/7/15 at 9:46 AM, that there is no contract with the Fire Department in regards to "DEFEND IN PLACE". The "DEFEND IN PLACE"policy states, 'The building construction, sprinkler system, and fire doors separating sections of each corridor provide protection from most fires. Based on that protection, we are able to use	R266		

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R266	Continued From page 9 "DEFEND IN PLACE" as a principle means of protecting residents who are unable to egress in case of fire.' Per interview with the Maintenance Director on 4/6/15 at 12:46 PM, s/he stated that the fire was small and s/he was able to extinguish before the Fire Department arrived, but the residents from that section of the building needed to be evacuated because of "smoke rolling into the hall". 3. During record review on 4/6/15 at 12:46 pm, the records showed that fire drills were conducted on 2/9/14 at 2 PM; 9/5/14 at 4:30 PM and 11/12 at 11:15 AM. Per interview with the Maintenance Director at this time, s/he confirmed that fire drills are done every 2 to 3 months in various sections of the facility (which houses Independent Living and Assisted Living Residence), but are not routinely done specifically for the Residential Care Home. S/he stated at this time that they do not practice evacuation but "DEFEND IN PLACE".	R266		
R302 SS=E	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be	R302		

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R302	Continued From page 10 documented. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to conduct fire drills on a quarterly basis that rotated times of day to include evening and night. Findings include: During record review on 4/6/15 at 12:46 pm, the records showed that fire drills were conducted on 2/9/14 at 2 PM; 9/5/14 at 4:30 PM and 11/12 at 11:15 AM. Per interview with the Maintenance Director at this time, s/he confirmed that fire drills are done every 2 to 3 months in various sections of the facility (which houses Independent Living and Assisted Living Residence), but are not routinely done specifically for the Residential Care Home. S/he stated at this time that they do not practice evacuation but "DEFEND IN PLACE".	R302		

The Residence at Otter Creek Plan of Correction-RC

R126

Deficiency #1

5.5 General Care: 5.5A Upon admission to a residential care home, necessary services shall be provided or arranged to meet the residents personal, psychosocial, nursing and medical care needs.

Deficiency: Based on staff interview and record review, the facility failed to ensure that necessary services for nursing and medical needs were not met for 3 of 3 residents, resident #1, #2 and #3 in the survey sample.

#1 Action to correct deficiency:

Resident Care Director updated each care plan to reflect every 2 hours safety checked be conducted on the night shift.

#2 Measures to assure this does not recur:

During care-plan updates and annually this will be monitored as it is part of the care-plan. This was changed in electronic medical record on the administration level to ensure each care plan with that intervention is the same.

#3 How corrective action will be monitored:

During routine care-plan updated and annually this intervention will be reviewed.

R 136

Deficiency #2

5.7 Assessment: 5.7.c: Each resident shall be reassessed annually and at any point in which there is a change in the resident's physical or mental condition.

Deficiency: Based on staff interview and record review, the facility failed to assess changes in the resident's physical or mental condition for 2 of the 3 residents in the survey sample, resident #1 and #2.

#1: Action to correct deficiency:

Licensed Practical Nurses to report to Registered Nurses any follow up incidents in a timely manner. Reporting to Registered Nurses will be communicated via email when a RN is not present in the building. LPNs were educated on what constitutes an assessment by a RN on 4/27/2015 (see attached) at nurse's meeting, as well as the way to communicate that a follow up is needed.

#2: Measures to assure this does not recur:

Registered Nurses to read 24- 72 hour communication report which contains all nurse's notes, to monitor for incidents requiring a registered nurse follow up. Registered Nurses will continue to read incident reports and sign off as previously required, however, a follow up note to be completed by Registered Nurse with an assessment.

#3: How corrective action will be monitored:

A 24 or 72 hour communication report from our electronic medical record will be printed by Registered Nurses, with completion of follow up assessment and nurse's note, the registered nurse will be required to initial next to each resident assessed. One week's worth of 24 or 72 hour communication reports will be kept in a binder in Resident Care Director's office.

R 188

Deficiency #2

5 Resident Care and Home services: 5.12.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 residents 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 advanced directives, if any completed; and a copy of the document giving legal authority to another, if any.

Deficiency: Based on staff interview and record review, the facility failed in insure that instructions in case of resident's death was included in the medical record for one resident, Resident #1.

#1: Action to correct deficiency:

By 6/1/2015, a letter will be composed and distributed to all residents or power of attorney requesting instructions in the event of a resident's death.

#2: Measures to assure this does not recur:

Going forward, any new admissions will be required to have a funeral home listed. This will be placed on the application for residency which is reviewed upon admission. From the application for residency, the information will be placed in the individual resident's electronic medical record.

#3: How corrective action will be monitored:

Upon admission this will be reviewed while creating individual resident's chart. This will be monitored by Reflections Director, Resident Care Director, or designee.

R191

Deficiency #3

5.12 Records/Reports 5.12.C

5.12.C(1) When a fire occurs in a home, regardless of size or damage, the licensing agency and the Department of Labor and Industry must be notified within 24 hours. A written report must be submitted to both departments within 72 hours. A copy of the report shall be kept on file.

5.12.C(2) A written report of any accident or illness shall be placed in the resident's record. Any untimely death shall be reported and a record kept on file.

5.12.C(3) A report of any unexplained absence of a resident from a home for more than 12 hours shall be reported to the police, legal representative and family, if any. The incident shall be reported to the

licensing agency within 24 hours of disappearance followed by a written report within 72 hours, a copy of which shall be maintained.

5.12.C(4) A written report of any breakdown or cessation to the homes physical plants major services (plumbing, heat, water supply, etc.) or supplied service, which disrupts the normal course of operation. The licensee shall notify the licensing agency immediately when such an incident occurs. A copy of the report shall be sent to the licensing agency within 72 hours.

5.12.C(5) A written report of any reports or incidents of abuse, neglect or exploitation reported to the licensing agency.

5.12.C(6) A written report of resident injury or death following the use of a mechanical or chemical restraint.

Deficiency: Based on staff interview and record review, the facility failed to file a report to Fire Safety & Department of Public Safety, which involved a fire at the facility with injury occurring to Resident #1.

#1: Action to correct deficiency:
State surveyor stated that report would be tendered by her to Fire Safety & Department of Public Safety.
#2: Measures to assure this does not recur:
Management team made aware (on 4/29/2015) of process in the event of a fire and reporting requirements. Policy created regarding Fire emergency plan (see attached)
#3: How corrective action will be monitored:
Will be monitored per Policy.

R266

Deficiency #4

XI. Physical Plant

9.1 Environment

9.1.A The home must provide and maintain a safe, functional, sanitary, home-like and comfortable environment.

Deficiency: Based on staff interviews and record review, the facility failed to insure that a safe environment was maintained for three residents, Resident #1, 2 and 3 in the survey sample.

#1: Action to correct deficiency:
Stove cords have been removed for stoves in RCH, with the exception of a resident who has requested the stove be one and has completed a mini mental exam done by a registered nurse, showing no cognitive impairment.

#2: Measures to assure this does not recur:
Stove cords to remain in a secure location, not assessable to residents and/or family members.

#3: How corrective action will be monitored:

Annual checks of all apartments in RCH to insure stove cords are not in place (except in approved apartments) to be completed by maintenance. (see attached sign off). Completed annual check offs to be kept in Business/Executive Office.

R302

Deficiency #5

XI Physical Plant

9.1.1 Disaster and Emergency Preparedness

9.1.1(C) Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of a fire and for the evacuation of the building if necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented.

#1: Action to correct deficiency:

Going forward, fire drills will be done in accordance with regulation beginning on 5/1/2015. Fire drill log will be maintained per regulation.

#2: Measures to assure this does not recur:

Quarterly fire drills that will rotate between shifts to insure all staff participation and to maintain compliance. Maintenance Director and Executive Director met with Chief Dad Shaw of the Middlebury Volunteer Fire Department to discuss the composition of a contract. He stated that there are no such contracts in the town of Middlebury. He has reached out to fellow Fire Chiefs in the state and has determined no one has this type of contract for The Residence at Otter Creek as an evacuation time of under thirteen minutes is an impossibility for this facility. The Fire Chief does approve the community to defend in place unless otherwise instructed by Community associates or emergency responders.

#3: How corrective action will be monitored:

Fire drill log will be maintained per regulation.

Agenda for Nurse's meeting 4/27/2015

- New resident issues
- Equipment and Environmental concerns
- Staff Concerns
- Incidents that require RN follow up and no assessing by LPNs

ANNUAL SIGN OFF OF RCH STOVE CORDS

YEAR 2015	Resident Name	Mini-Mental?	Stove Off or On?
101			
102			
103			
104			
105			
106			
107			
108			
201			
202			
203			
204			
205			
206			
207			
208			
209			
210			
211			
212			
213			
214			

Fire Safety Plan

Policy/Procedures

THE RESIDENCE AT OTTER CREEK FIRE SAFETY PLAN

I. INTRODUCTION

A. Purpose

The Residence at Otter Creek Fire Safety Plan's purpose is to define potential emergency policy and procedures. This policy is the framework for emergency response procedures, training and oversight for The Residence at Otter Creek Associates.

II. POLICIES

The Residence at Otter Creek policies are designed to guide and direct all emergency response and disaster activity. The following policies are applicable to all staff and will guide emergency procedures and responses. The purpose of this policy is to insure the safety of residents and protect property to the extent possible. This is a **DEFEND IN PLACE** model and has been reviewed with Chief David Shaw, Middlebury Fire.

A. First, resident safety and health are always the highest priority in any and all planning and emergency response. Therefore, The Residence at Otter Creek operations are oriented first to supporting that policy, protecting the safety of residents, Associates and visitors, and then, the facility.

B. The Residence at Otter Creek's policy of emergency response includes specific planning and preparation to meet natural and man-made emergencies and disasters identified as a threat to The Residence at Otter Creek or its residents. This Emergency Preparedness & Disaster Plan is organized and structured to meet those risks through the application of specific program direction, emergency response procedures and information that is readily available to responders.

C. The Residence at Otter Creek emergency planning will be supported by an active training program that includes: orientation for all new employees to potential emergencies and to this plan; periodic in-service training for employees regarding emergency planning; and drills and tests of this plan.

III. PROCEDURES

A. General

Fire creates a range of hazards including fire, heat, smoke and debris, all of which can injure or kill. Any fire must be considered very dangerous because of the size and complexity of each building, and because of the special needs of residents.

The building construction, sprinkler system, and fire doors separating sections of each corridor provides protection from most fires. Based on that protection, we use **"DEFEND IN PLACE"** as a principle means of protecting residents in case of fire. Defend in place includes an expectation that in case of fire, residents who may be threatened immediately by the fire will be moved at least past a fire door away from a fire.

In addition to the preventive measures provided by design and construction, such as sprinklers, fire doors and alarms, this section provides emergency response activities for the facility.

1. When a fire alarm sounds, staff should first go to the fire panel to determine the location of the alarm.

2. Staff shall call 911 to report the fire to the fire department (the will automatically report this to omega electric, but staff should report the fire directly to the fire department as a cautionary measure). Inform the fire department of the location of the alarm and a summary of the situation.

3. If possible, a staff member should be available at the front door when the fire department arrives to brief the emergency personnel of the situation (e.g., location of the fire, nature or cause of the fire if know, number of residents still in the building, etc.).

4. If the situation involves smoke or fire, first assure the safety of any resident or other individual who might be in immediate danger by assisting them from the area of the fire to an area behind fire doors.

5. Use the nearest fire extinguisher(s) to control any flames or smoke if this can be done safely. Upon arrival at the point of activation, feel the door (if closed) with the back of the hand to determine if hot. If the door is hot, DO NOT ENTER. If it is not hot, open the door a crack to determine if smoke is coming from the apartment/room. If the area is smoky, close the door. DO NOT ENTER! In such a case, wait for the fire department to arrive. If a small and confined fire is discovered, try to extinguish the fire with fire extinguisher(s).

6. DEFEND IN PLACE

7. In the event that fire or water threatens essential records and safety will not be threatened, collect and store the following in a secure area:
    - Any cash, checks, or ledgers
    - Resident valuables
    - Personnel and resident records
    - Any other necessary documents

8. Once the fire has been extinguished, open any windows in the immediate area and/or use any means possible to clear the air of smoke. Staff and residents must stay away from the fire area until the smoke has cleared.

9. Reset the fire alarm system.

10. Begin Cleaning up any affected area as soon as it is safe to do so. Affected residents must be relocated to another area until the clean-up has been completed.

11. When a fire occurs, regardless of size or damage, the division of licensing and protection and the division of fire safety must be notified within 24 hours. A written report must be submitted to both departments within 72 hours. A copy of the report shall be kept on file.

12. Investigate the cause of the fire and take any needed follow-up so the situation does not re-occur.

4. **GENERAL PROGRAM**

(1) Situation Control and Chain of Command

a. The Residence at Otter Creek uses a top down chain of command to direct emergency -response efforts with specific responses made by the person most appropriate to the situation. The Residence at Otter Creek plan depends on managers initiating responses and assembling further resources as necessary to the situation.

b. The Residence at Otter Creek Emergency Response Chain of Command and their associated emergency response duties is noted below. Since we may at times have limited staffing, especially at night and on weekends, this chain of command depends upon staff availability.

c. In all cases where police, fire or other community emergency responders have arrived at The Residence at Otter Creek in response to an emergency, those officials will direct emergency response activities and The Residence at Otter Creek staff will assist them as requested.

d. Managers have emergency response responsibilities as noted below.

Chain of Command

1. Executive Director
2. Resident Care Director
3. Maintenance Director
4. Marketing & Sales Director
5. Activities Director
6. Business Office Director
7. Reflections Program Director
8. Executive Chef

Emergency Situation Responsibilities (POSTS) Chart

Post #1 *(Executive Director)*	Overall direction of the Emergency Plan. Directs emergency response activity. Meets emergency responders.
Post #2 *(Resident Care Director)*	Coordinates emergency responses with MOD in the absence of Executive Director. Directs internal emergency communications. Directs Health Services Staff.
Post #3 *(Maintenance Director)*	Responds to location of facility emergencies. Coordinates emergency communications. Determines requirements for emergency vendor assistance. Directs Housekeeping and Maintenance staff.
Post #4 *(Marketing & Sales Director)*	Coordinates communications with resident families and media, if required. Directs Concierge Staff.

Post #5 *(Activities Director)*	Monitors / directs evacuation of 3rd floor (IL) if ordered. Monitors / directs evacuation of 4th floor (IL) if ordered. Directs evacuation of 1st floor (IL) if ordered. Monitors / directs evacuation of 2nd floor (IL) if ordered
Post #6 *(Business Office Director)*	Monitors / directs evacuation of the 2nd floor Shores if ordered. Monitors / directs evacuation 3rd floor Shores if ordered.
Post #7 *(Reflections Manager)*	Monitors / directs evacuation of Haven if ordered. If all previous POSTS are present, assist individual department managers with their POSTS.
Post #8 *(Executive Chef)*	Provides emergency meal services if required. Provides potable water in emergency. Directs Dining Services staff.

Depending on who is present at the time of the Emergency, whoever is the highest ranking on the Chain of Command takes the first POST, and then down the list. Some POSTS may not get covered, depending on staffing. Care Staff should ALWAYS stay with their assigned Residents.

(2) Command Center(s)

a. Primary Command Center
The Front Desk / Transportation Office will serve as the prime command center in organizing for and responding to emergencies.

b. Alternate Command Center
If the prime command center cannot be used, alternate locations include the Employee Lounge on the 1st Floor, or the Shores Nurses Station on the 2nd Floor, depending on the type of emergency.

c. Equipment
The primary command center will always have:
1. A cellular telephone (kept at the front desk during off-hours.),
2. 2-way radios (all depts., plus an extra one kept at the front desk),
3. Flashlights (kept in lower left cabinets behind the desk),
in addition to the regular telephone and security computer.

If the alternate command center is activated, the emergency equipment (except the computer) will be taken to the back-up location.

d. Notification
If the alternate command center is activated, emergency responders will be notified of the new location and the reason.

(3) Communications

The Residence at Otter Creek employs a combination of communications capabilities for use in emergencies. These include emergency pull cords, emergency pendants, smoke detectors in

resident rooms and smoke and fire detectors in common areas, and fire alarms in common areas, a central telephone system, 2-way radios, and cellular telephones.

a. 2-Way Radios
Managers will utilize 2-way radios for emergency communications. Radios are used by the health services, housekeeping, and maintenance staff, as well as at the front desk.

(4) Resident Status Information

While not strictly a management element of emergency response, accurate information regarding The Residence at Otter Creek residents will be crucial in emergency response situations.

Specifically, the following is essential information:

a. In/Out Log
The Concierge staff will maintain an up-to-date log of resident's departures if they are overnight. That log is kept at the front desk and will be available to emergency responders.

b. Visitors Sign In/Out Log Book
All visitors are required to sign in and out of the building, including private aides. This log will be moved to the command center during an emergency and will be available to emergency responders.

c. Daily Accountability
Daily accountability of all Residents will be maintained by a combination of methods including: meal check-off, in/out log, Avalon resident check-in report, and daily census report in the Shores and the Haven.

d. Resident Status
The Resident Care Director or designee will maintain a current list of residents who have conditions, which may impair their ability to respond to an emergency.

Such impairments could include hearing, sight, ambulatory capability or cognitive capabilities. These lists will be maintained in the Emergency Information Binder kept at the Front Desk. These lists will be updated monthly or as changes occur.

5. Training
Training is the fundamental building block in preparing employees to recognize threats to health and safety, and in preparing employees to respond to emergencies. All training will be coordinated by the Business Office Director and Resident Care Director..

Training will include:

a. Orientation training
Provided to all new employees at the beginning of employment. This training will include general safety guidance, fire prevention and protection, emergency response assignments, hazard recognition and protection, infection responses. The orientation training will be conducted by the department head and appropriate other managers. A record of the training will be noted in the employee's personnel file.

b. Drills and Exercises
Employees will participate in regular drills& exercises to practice this plan.

Critical actions in all emergency response to fires include:

RACE

Rescue
The first priority is always to protect the safety of people- residents, employees and visitors.

Alarm
Notify other staff members and the fire department immediately.

There are 3 stages of alarm:

1. Shouting out for assistance from other staff. Be sure that other staff members are aware that there is a fire and that is why you are calling out for assistance.
2. Pulling the nearest fire alarm.
3. Calling the fire department.

Contain
Close all doors and windows to contain the fire and limit its expansion as much as possible.
Use fire doors to help protect residents, staff and visitors.

Extinguish

- Use an extinguisher on a fire only after all residents are safe and the alarm has been sounded.
- Never leave to get a fire extinguisher if the resident is still in the room of fire origin.
- Never let the fire extinguisher get between you and the door.
- Never use a fire extinguisher unless you have been properly trained, the fire is extremely small, and you are sure that you can put it out.

All residents in the area of a fire should be moved horizontally away from a fire at least past one set of fire doors, and residents in apartments on floors above the location of the fire will be evacuated past a set of fire doors from their apartment.

Do not attempt to extinguish a fire unless it is small and confined such as in a trash can. In addition, never allow a fire (or other hazard) to be between you and an exit- don't get trapped!

B. Fire Extinguishers

The facility has portable fire extinguishers located throughout the facility. All extinguishers are multi-purpose "ABC" variety appropriate for all types of fires.

Fire extinguishers should only be used under the following conditions:

a. All notification measures have been made.
b. Necessary immediate evacuations have been accomplished.
c. The fire is small and confined to a small area and is not spreading quickly.
d. The person using the fire extinguisher has an unobstructed escape route from which he/she will not be blocked if the fire grows, and
e. The person is trained in the use of the extinguisher.

Use of fire extinguishers follows the PASS system:

Pull the pin, unlocking the control lever.

Aim low, Point the nozzle or hose at base of the fire.

Squeeze the level which starts discharge.

Sweep from side to side, continuing this motion until flames disappear.

If efforts to extinguish with a fire extinguisher are unsuccessful, leave the area and report further on the status of the fire.

C. Fire Drills

The Maintenance Director manages and directs the fire drill program, determining when to hold drills. Drills will be conducted on a random, unannounced basis at least quarterly and each shift will have at least one drill annually, including weekends. Drills may include resident participation or their involvement may be simulated at the direction of the Executive Director.

Drills will be used to determine if staff reacts in accordance with the procedures of this plan and in a safe manner. Results of fire drills will be recorded on the Fire Drill Report by the Environmental Services Director and results will be reported to the Executive Director. Records of fire drills will be maintained for at least one year from the date of the drill. The results of fire drills will be the basis for further training and changes to procedures.

Fire alarms will also be tested annually. Tests will be conducted by the contractor responsible for the fire alarm system with reports of each test given to the Executive Director.

D. Responsibilities

Staff should follow the POSTS Chart and Chain of Command listed on pages 4 and 5 of this manual when responding to a Fire Emergency.

E. Procedures In Response To Discovering A Fire

The following procedures and steps will be followed in response to discovering a fire.

1. Immediately pull the nearest fire alarm.

2. Remove anyone from immediate danger from the fire. Remove residents in vicinity of fire at least beyond first fire door. Do not use elevators. Residents should use stairways if they must evacuate a floor.

3. Contact the Concierge to:
   a. Confirm a fire has started.

b. Where the fire is located?:
c. What is burning?
d. How large it appears.
e. Is anyone in immediate danger.

4. If the fire can be contained, smother the fire or pour running water on it. If the fire is in a trash can or other container, Do Not pick the container up and run with it. This will only fan the fire and cause it to burn more rapidly.
5. If necessary get the nearest fire extinguisher for use.
6. Be sure that the fire is extinguished.
7. Assure residents or personnel who have smelled the smoke that everything is under control and that the fire has been extinguished.
8. Report the incident to the Concierge. Tell what happened and that the fire has been extinguished.
9. Return to the fire area to assure that the fire has been extinguished. (Note: The room or area in which the fire was discovered must also be inspected to assure that it is safe to enter.)
10. Close all doors in the fire area.
11. After leaving a room where a fire has occurred place a wet blanket under the room entrance door to prevent smoke from entering the rest of the building.

F. Procedures if a General Fire Alarm is Activated

The following actions will be taken in response to a fire alarm signal.

1. Concierge checks fire alarm panel in the Lobby to ascertain where the alarm was triggered, (or records call from person who discovered fire) note location and any other information available.
2. Concierge calls Middlebury Fire Department (911) to inform of fire.
   a. Confirm fire alarm
   b. Location of fire as indicated by the panel
   c. Address of facility
3. Concierge contacts all personnel to notify of the fire alarm activation and the location.
4. Managers and go to Lobby first and communicate with Concierge where they are headed, then to assigned Posts, taking 2-way radios with them.
5. Staff go to assigned stations or the lobby.
6. Maintenance Director and personnel will check fire location and status.
   a. Always use stairways to respond to fire.
   b. Determine if it is safe to enter a corridor - is the corridor threatened

by smoke, fire or heat? Never enter a corridor that is unsafe.

c. Never allow a fire (or other hazard) to be between you and an exit.
d. Determine if fire is small and can be contained and reports to Concierge.
e. Determine safety of anyone in area, moving anyone in area at least past a fire door.
f. Only move residents who are in immediate danger and only if they can be moved without danger from fire or smoke.
g. If fire can be contained **safely** attempt to contain and extinguish fire using fire extinguisher if necessary.

7. Executive Director or next in command meets and briefs fire department on status. Provides list of residents with impairments and location of oxygen.

8. **Fire Department determines if evacuation is necessary.**

Always use stairways to respond to fire.

I. Night\Weekend Fire Response

A fire or report of a fire at night or on the weekend puts a premium on immediate action to request emergency response. The most important part of any employee's action is to request that emergency response. The following actions will be taken in response to a fire alarm in the evening or on weekends:

1. Concierge/Security calls 911 to confirm alarm or report smoke alarm at the facility.

a. Confirm fire alarm
b. Location of fire as indicated by the panel
c. Address of facility

2. Concierge/Security calls:

a. MOD to notify of alarm.
b. Any staff on duty by radio and phone to notify of alarm.

3. Concierge/Security should stay in the Lobby and wait for the First Responders from the Fire Department and give them the information they have about the fire.

EVACUATION

A. Background

A number of emergencies may lead to an evacuation of the building. There are two kinds of evacuations— the first is when there is warning and time to prepare. The second is an emergency evacuation that must happen immediately. Evacuations are the most complicated emergency event that the facility will face. Age and capability of residents, presence of privately hired nurses, residents of second floor and third floor units, accountability for residents, and the stress associated with the emergency conspire to make an evacuation extremely risky.
In all evacuations, Local Emergency Services will be notified ASAP, asked to respond and upon arrival will be in charge of the evacuation. Associates will assist as requested.

1. Accurate available information regarding resident capabilities which may affect their ability to evacuate.

2. Where time permits, residents will be encouraged to use family and friends as a location to which they will be evacuated;

3. Local Emergency Services will assist in evacuations.

4. Staff have pre-designated responsibilities in evacuation and will assist residents.

5. Stairways will be used in most emergency evacuations, and always used in case of fire. Unless blocked or it is unsafe to do so, residents will be evacuated using stairways on each corridor.

Staff should follow the Responsibility Listing in the POSTS Chart and Chain of Command found in this Emergency Plan.

B. Procedures For A Planned Internal Evacuation To The Common Areas And Dining Room

1. Executive Director or designee orders preparation for evacuation.

2. Maintenance does a communications check and distributes flashlights (if needed).

3. Concierge controls away log and visitor sign-in/out log.

4. Concierge calls:
   a. Department Managers and Supervisors,
   b. LCB,
   c. Local Emergency Services (911) to warn of pending evacuation of residents to living areas and dining room.

5. Food Services turns off all kitchen equipment.

6. Staff go to assigned corridors (with keys) to begin evacuating residents to stairways.

   a. Assure that each apartment is cleared and door closed.
   b. Mark each door with reflective tape or reflective door handle hanger as apartment is cleared.
   c. Check common and laundry rooms in assigned corridor to assure all are evacuated, mark these doors as well.
   d. As an area is cleared Supervisor contacts Concierge when area is cleared.
   e. Supervisor is last person to exit assigned area.

7. Food services, Housekeeping, and Administrative staff assist in calming residents upon arrival in living commons and dining room or "safe area".

8. Resident Services/Activities conduct head count of residents upon arrival in living areas and dining room.

9. Executive Director will notify local Emergency Services of relocation and status of emergency.

C. Procedures for Planned Evacuation to Off-Site Location

1. Executive Director or designee orders preparation for evacuation – almost always only under the direction of the Local Emergency Services.

2. Maintenance Director does a communications check and provides managers with 2-Way Radios and flashlights (if needed).

3. Concierge calls:
   a. Local Emergency Services/Fire Department (911) to warn of evacuation to off-site location (if they are not already on site),
   b. All Department Managers and Supervisors,
   c. LCB

4. Executive Director or designee will call potential receiving facility(ies) to coordinate the transfers.

5. Resident Care Director will:

(1) Assemble medical records for relocation.
(2) Charge nurse(s) assign staff to assist residents.
(3) Assemble necessary medications to go with residents.

6. Food/Culinary Services turns off all kitchen equipment.

7. Housekeeping staff turns off all equipment and clears cleaning equipment from hallways.

8. All available staff will report to the Command Center for instructions.

9. Maintenance staff check all evacuation exits and stairwells to assure access and report to Concierge.

10. Concierge collects emergency preparedness plan, resident emergency medical information binders, resident away log, and visitor sign-in/out log.

13. Concierge informs Executive Director when all supervisors have reported in from clearing floors.

16. Activities Director conducts head count of residents and staff upon arrival at off-site location.

17. Upon arrival at off-site location, Marketing Director, Business Office Director and Executive Director begin to contact families and friends to notify of evacuation and request pickup if appropriate for the resident.