Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

March 6, 2018

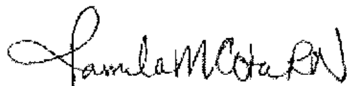
Ms.. Paula Pelkey, Manager
The Residence At Otter Creek
350 Lodge Road
Middlebury, VT 05753-4498

Dear Ms.. Pelkey:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 24, 2018.** 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1008	A. BUILDING: ______ B. WING	C 01/24/2018

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 onsite re-licensing survey and an investigation of complaints and self- reported incidents were conducted by the Division of Licensing and Protection from 1/22 to 1/24/18. The following regulatory deficiencies were identified.	R100	**R100 Initial comments:** The submission of this plan of correction does not imply agreement with the existence of a deficiency. It is submitted in the spirit of cooperation, to demonstrate The Residence at Otter Creek's commitment to continued improvement in the quality of our resident's care.	
R167 SS=E	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 observation, record review and confirmed by staff interview, the facility staff failed to ensure that for 3 of 7 sampled residents, who have received psychoactive and anti-anxiety medications, staff document the time of administration, the reason for administration and specific results of the medication given (Resident #1, #2 and # 4). The findings include the	R167	**R167 # 1,2,3 Action to Prevent Recurrence:** The current PRN medication policy as well as requirements listed in 5.10.d will be reviewed with nursing and med tech staff, to include that all PRN's need to be documented in the MAR and Progress note including time given, reason, effectiveness, and non-pharmacological approaches attempted prior to utilizing medication. Nursing and Med Tech staff will also be provided re-education on following PRN indication parameters. The RCD or designated nurse will be responsible for monitoring and ensuring staff follow through with random chart and eMar audits. Completion Date : 3/30/18 - RCD	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature], Executive Director		2/16/2018

R167 - R302 POCs accepted 3/1/18 KCampos RN/PMC

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following:

1. The Medication Administration Record (MAR) for the month of December 2017 for Resident #1, identifies a physician order for Haldol 0.5 milligrams (mg.) by mouth (po) as needed (PRN) for agitation. A progress note dated 12/11/17 identifies that the medication was administered at 12:25 PM. The MAR for January 2018 identifies Haldol 1 mg po every 6 hours PRN for agitation. The medication is documented as given on 1/1/18 at 1:42 AM.
Psychoactive medication is used to change brain function and results in alterations in perception, mood and behavior. The Director of Nurses (DNS) confirms on 1/22/18 at approximately 2 PM that there is no documentation identifying why the medication was administered, what non-pharmacological interventions were attempted prior to the administration of the medication (as care plan identifies) and the results of the medication.

2. MAR for the month of September 2017 for Resident #4, identifies a physician order for Haldol 0.5 millimeters (ml) po liquid for extreme agitation or anxiety, may repeat in 30 minutes if no effect. Resident may have only 2 doses in 8 hours PRN for agitation/anxiety. The MAR identifies that 0.5 ml. of Haldol was administered three different times on 9/2 and 9/27/17, once on 9/4, 9/11, 9/12, 9/19, 9/21, 9/23/17 and twice on 9/15/17. The January 2018 MAR for Resident #4, identifies administration of Haldol 0.5 ml po twice on 1/1/18 and once on 1/6, 1/9, 1/15, 1/16, 1/17, 1/19 and 1/20/18. The Director of Nurses (DNS) confirms on 1/22/18 at approximately 4:30 PM that there is no documentation identifying why the medication was administered, what non-pharmacological interventions were

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R167	Continued From page 2 attempted prior to the administration (as care plan identifies) and the results of the medication. 3. MAR for the month of January 2018 for Resident #2, identifies Ativan 0.25 mg po PRN for, increased agitation and aggressiveness. The MAR identifies that the medication was administered on 1/3/18 at approximately 6 PM. Ativan is a sedative medication used to treat anxiety. The Director of Nurses (DNS) confirms on 1/23/18 at approximately 11:30 AM that there is no documentation identifying why the medication was administered, what non-pharmacological interventions were attempted prior to the administration (as care plan identifies) and the results of the medication. Per facility policy titled "Guidelines for Medication Assistance", identifies that medications should not be used to address behavioral issues unless other approaches have been tried first. Documentation of all approaches tried, along with, the corresponding results should be documented in the resident's Service Notes.	R167		
R291 ss F	IX. PHYSICAL PLANT 9.6 Plumbing 9.6.d Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas. This REQUIREMENT is not met as evidenced by Based on observation and confirmed by the Executive Director (ED) and the Maintenance Director, water temperatures in resident bathrooms, through out the facility, were identified	R291	**R291 Action taken to correct Deficiency :** The high water temp discovered during survey was found to be due to a faulty valve. This valve has since been replaced. **Action to prevent recurrence:** Per Community policy and requirements listed in 9.6.d the Maintenance director will complete water temp checks in 10 apartments weekly. These temps will be recorded in a log maintained by the Maintenance Director. Completed 1/24/17 - Maintenance Director and Executive Director	

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R291	Continued From page 3	R291		

to exceed 120 degrees Fahrenheit (F). The findings include the following:

On 1/24/18 at8:45 AM, with the use of a pocket thermometer, the Registered Nurse Surveyor identified 12 of 16 resident rooms in the secure Memory Care Community to have hot water temperatures that registered above 120 degrees F, 5 of the 12 rooms registered above 130 degrees F. Eleven (11) of the residents are independent and can access the sink independently.

Surveyor #2 conducted a tour checking temperatures on all other units and floors between 8:50 AM and 9:30 AM, and found temperatures consistently between 132 and 135 Degrees F. in all areas. Some of these rooms checked are occupied by residents who have memory problems, but use the sinks independently. This was confirmed by the Resident Care Director and the nurse on duty at the time of the observations.

On 1/24/18 at 9:45 AM the temperatures were confirmed by the ED and the Maintenance Director. The temperatures were checked using the facility digital pocket thermometer and identified the temperatures 2-4 degrees higher then the temperatures obtained by the surveyor. The mixing valves were immediately adjusted and at 12:45 PM the temperatures of the hot water, in the Memory Care Community were all below 120 degrees F.

Maintenance Director confirms at approximately 10 AM on 1/24/18, that temperature logs for December 2017 identified one (1) room with a water temperature of 121 degrees F and in January 2018 identified eight (8) rooms

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R291	Continued From page 4 registering 121-122 degrees F. · A contingency plan has been put in place by administration to ensure that water temperature do not exceed 120 degrees F.	R291		
R302 SS=F.	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 documented. This REQUIREMENT is not met as evidenced by: Based on review of fire drill logs and confirmed by interviews with the Executive Director and the Maintenance Director, the facility failed to conduct, fire drills quarterly and at various times of the day. The facility also failed to document the date and time of each drill and the names of participating staff members. The findings include the following: Review of the fire drill logs for 2017, fire drills were conducted on 2/16/17 at 3:50 PM, 2/23/17	R302	**R302 Action to correct deficiency :** All Fire Drill needed to comply with community policy and requirements listed in 9.11.c will be completed and the log updated accordingly. **Steps to prevent recurrence:** The Maintenance Director will perform fire drill per community policy and requirements listed in 9.11.c. The Executive Director will be responsible to ensure follow through with quarterly audits of the fire drill logs. Completion Date – 3/30/18 Maintenance Director and Executive Director	

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at 1130 AM, 10/12/17 at 11 AM, 11/13/17 at 6:30 PM and 12/14/17 at 10 AM.

The Executive Director and the Maintenance Director both confirm on 1/22/18 at approximately 3 PM, that the remaining fire drill logs can not be located and that the only evidence of drill are as noted above. The drills do not meet the requirements of rotating times of day among morning, afternoon, evening, and night Facility policy identifies that the record will evidence the type of drill conducted, the location and type of situation used, the alarm device, the response and time response of the staff who attended and and analysis of the drill. Two of five drills do not follow facility policy.