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

April 27, 2018

Ms. Paula Pelkey, Administrator
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 **March 14, 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

Division of Licensina and Protection

STATEMENT OF DEFICIENCIES AND PLA N OF CORRECT IO N	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1008	A. BUILDING:_____ SWING _ _ _ _ _ _ _ _ _ _	C 03/14/2018

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)	(XS) COMPLETE DATE
R100	Initial Comments: An unannounced on-site complaint survey was completed on 3/14/18 by the Vermont Division of licensing and Protection. The purpose of the survey was to investigate 2 complaints and a mandated facility self -report. The following regulatory violations are related to these ivestigations.	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.	
R160 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.a Each residential care home must have written policies and procedures describing the home's medication management practices. The policies must cover at least the following: (1) Level III homes must provide medication management under the supervision of a licensed nurse. Level IV homes must determine whether the home is capable of and willing to provide assistance with medications and/or administration of medications as provided under these regulations. Residents must be fully informed of the home's policy prior to admission. (2) Who provides the professional nursing delegation if the home administers medications to residents unable to self-administer and how the process of delegation is to be carried out in the home. (3) Qualifications of the staff who will be managing medications or administering medications and the home's process for nursing supervision of the staff. (4) How medications shall be obtained for residents including choices of pharmacies. (5) Procedures for documentation of medication administration.	R160	**R160 # 1 Actions to Prevent Recurrence** The current community medication policies as well as requirements listed in 5.10 will be reviewed and re-education will be provided to all community nurses and med techs, to include policies and procedures for narcotic count, documentation, pre-pouring and labeling medication, and reporting errors. The RCD will ensure follow through with these policies through bi-weekly random community narcotic counts for 3 months and then monthly for 3 months then quarterly on-going. The RCD will perform bi-weekly random audits of the narcotic count log for 3 months, then monthly for 3 months and then quarterly on-going. Completion date: 5/1 /2018 RCD R160 POC accepted 4/19/18 M. Bolton, RN / S. Perry, RN	

D1v1s1on of Licen sin g and P ro tection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Melanie Munn, Executive Director — 4/18/2018

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R160	Continued From page 1	R160		

(6) Procedures for disposing of outdated or unused medication, including designation of a person or persons with responsibility for disposal.
(7) Procedures for monitoring side effects of psychoactive medications.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and record review, nursing staff failed to manage controlled medication accountability in accordance with the facility's policies and procedures. This failure had the potential to affect 1 resident in the targeted sample and other residents receiving narcotic medications. (Resident# 1). Findings include:

Based on information reviewed subsequent to a facility mandated self-report regarding missing narcotic medications, it was determined that Medication Technicians (MTs) and Licensed Practical Nurses (LPNs) were not following the facility's policy/procedures "1.11 Narcotic Count" and "1.14 Assisting with Controlled Medication" and "1.13 (Vermont) Medication Pre-Pour" policy.

1. This investigation revealed a problem with staff not doing the narcotic count process per the facility's policy. The facility did not have the forms described in the policy for use in this facility. The form in use by the home included insufficient information to include on each line, the amount of medication on hand, the amount given, and the amount remaining. Per review of controlled count sheets, issues identified included the following practices: staff made errors and drew lines through recorded medication administrations with no written explanation of why (Resident ##3): staff skipped lines on count sheets and started counts on new sheets before the current sheet was filled up; nurses who were pre-drawing up

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R160	Continued From page 2	R160		

liquid morphine used different processes; some continued the count of morphine left in the bottle until count sheets were full (correct process); others started a new sheet each time they drew up more morphine. For Resident #4, who was admitted in early January, 2018, staff completed 2 Controlled Drug Records, one for 7 tabs of oxycodone, and one sheet for 109 tabs of oxycodone; there was no explanation of why the medications were recorded on 2 separate sheets. The medications were brought into the facility upon admission to the home. There was no explanantion on either sheet of what the numbers represented, the total amount the resident had upon admission, and the process failed to clearly show how the controlled medication was being accounted for on a daily basis.

During interview on 3/12/18 at 11:30 AM, one LPN (#1)° co nfirm ed thats/he documented on 2/11/18 that they had drawn up liquid morphine into 5 mg. doses per syringe for oral administration for Resident #1. According to the count sheet, there were 15 doses remaining at 1615 hr. on 2/11/18. Sometime on 2/11/18, the LPN stated that s/he was told by a MT that were only 5 syringes left and more were needed. S/he verified that they never looked at the narcotic count sheets, S/he just started drawing up more doses of morphine at the desk at the Meadows unit. S/he stated that s/he and the MT couldn't find the count sheet for the bottle of morphine, which is kept in a locked box in the med cart lock box. S/he started a new sheet and didn't write how much morphine was left in the bottle at that time. S/he said s/he drew up 34 syringes and there was only a little morphine left in the bottle so s/he wasted it by adding hot water to it and pouring it down the drain, witnessed by the MT on

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R160	Continued From page 3	R160		

duty. When she wrote the amount drawn up on the new controlled sheet, she wrote "2/11/18, 17 50 hr., dose 5 mg/ml, 12 under 'remaining'. There was no documentation of adding the 34 syringes to the count anywhere. The number 12 did not match any other syringe co unt sheet, the LPN did not know how they came by this number, but believed it was in error.

The morphine bottle was missing from the locked box where it was stored because the nurse stated that after wasting the remaining small amount, s/he threw the bottle into the trash. The missing morphine count sheet was later found and the last date of a count had been 2/8/18 by LPN #2 and stated 'drew up 35 (doses), 14 ML left' (in the bottle).

Additionally, per observation of plastic bags containing the pre-drawn morphin e medication on 3/ 12/18, not all bags were labeled in accordance with the facility procedure "1.13 (Vermont) Medication Pre-Pour" , which stated at #4: the nurse shall label the unit dose container with the resident name, name of medication, dose of medication, medication, and reason/indication for the medication. One bag of pre-drawn morphine syringes was not labeled as stated in the procedure per observation duri ng a count with a MT on duty on the morning of 3/12/18.

During interview with LPN #2 on afternoon of 3/18/18, the LPN confirmed that on 2/12/18 at 6 PM when s/he wasted 11 syringes with a MT , s/he just asked the MT to get them out of the locked boxes from the med cart and bring them to h/her, however, they did not watch or validate the number of syringes being pulled, s/he "trusted h/her". LPN #1 stated that after drawing up the 34 syringes on 2/11/18, s/he handed the syringes, with the count sheet wrapped around them to the

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R160	Continued From page 4 MT and asked h/her to lock them up and put the new sheet into the binder; the LPN did not personally observe this process, counter to facility procedure: "Narcoti c count", Daily Narcotic count, #1. Both med techs will visualize the actual count....against the individual narcotic record and against the index for the narcotic record.....#4. Both med te chs will visualize and confirm the presence of an intact lock on the narcotic back up box....." . The failure of nursing staff to adhere to the facility's policy/procedures for daily counting of narcotic medications and ensuring that all narcotic records show an accurate accounting of the amounts on hand verses the amounts administered to specific residents was confirmed during interview with the RN Resident Director on 3/13/18 at 2 PM.	R160		
R162 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Managem ent 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, facility nursing staff administered medication to a resident after the physician had.discontinued the medication due to a failure to note orders and transcribe the orders timely onto the MAR (Medication Administration Record). The practice	R162	**R162 Actions to prevent recurrence** The current community policies and requirements listed in 5.10c will be reviewed and reeducation with be provided to all community nurses to include policies regarding medication order transcription , procedures for discontinuing medications, and process for reporting errors. The RCD will ensure follow through with bi-weekly random audits of the medication administration records for 3 months. Completion Date : 5/1/2018 RCD R-162 POC accepted 4/19/18 M. Bolton, RN / S. Levy, RD	

Division of Licensing and Protection

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R162	Continued From page 5 affected 1 applicable resident in the sample. (Resident #2). Findings include: Per record review, Resident #2, who had pre-existing routine (daily) orders for the anti-psychotic medication Haldol upon re-admission to Hospice Services on 1/26/18, had a change in medications ordered by the physician after a care conference on the afternoon of 1/26/18. Per staff interviews on the afternoon of 3/13/18, after the care conference had ended on 1/26/18, the physician met with members of the resident's family and wrote new orders for medications. The order dated 1/26/18 stated: Admit to Hospice. See Standing Orders. The order also discontinued 8 routine (daily) orders, including Haldol, 0.5 mg. PO twice daily, diagnosis, anxiety/agitation. Per interview with the LPN on duty on the afternoon/evening of 1/26/18, s/he had started to note and transcribe the new orders to the MAR (medication administration record) and was interrupted from that process . The nurse verified that s/he did not go back to the orders to finish up transcribing them that day and s/he later administered a dose of the D/C'd Haldol at 1826. The following day, the nurse on duty did not transcribe the new orders and on 1/28/18, when the Hospice RN arrived, it was discovered that there had been orders to discontinue the Haldol /26/18. Due to lack of timely transcription of the new physician order, the resident received a total of 4 doses of the Haldol in error over a 3 day period. The error was confirmed during interview with the LPN on 3/14/18 at 2:15 PM	R162		
R165 SS=D	V. RESIDENT CARE AND HOME SERVICES	R165	**R165 Actions to prevents recurrence** Current Community policy and requirements listed in 5.10 will be reviewed with all Med Techs. To ensure follow through and evaluate med tech competence the RCD will randomly audit the medication administration record as well as the Narcotic log. All Med Techs will receive a supervised medication pass at minimum one time yearly. (see next page)	

Completion Date : 5/1/ 2018 RCD

R 165 POC accepted
5/19/18 M. Bolton, RN/
S. Remy RN

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R165	Continued From page 6 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for: i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects; ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications; iii. Assessing the resident's condition and the need for any changes in medications; and Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RN (Registered Nurse) failed to develop a process to monitor and evaluate staff performance in carrying out the nurse's instructions related to procedures for accounting for controlled medication per facility policy. This practice had the potential to affect residents receiving controlled medications. Findings include: Based on a facility mandatory report to the licensing agency on 2/21/18 at 1557, the facility was missing controlled narcotic medication, morphine sulfate, dose ordered as 5 mg./0.25 ML	R165		

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R165	Continued From page 7 (milliliters) liquid medication. During an investigation regarding missing controlled medications on 3/12/18, the missing morphine was discovered on 2/14/18 at 1:15 PM when the LPN asked the Med. Tech. (MT) to 'pull the narcotic box from the Meadows unit medication cart' so s/he could draw up additional doses of the medication for Resident #1. The LPN found that the box containing the morphine had no numbered red zip tag lock (provided by the pharmacy per policy) and was unlocked in the medication cart lock box. The LPN could not account for a missing bottle of morphine that should have contained 14 ml. of morphine, per review of the morphine amounts count sheet. The count was confirmed with the RN (registered nurse) RCD (Resident Care Director). Per review of the narcotic medication count sheets used by the facility for this resident and interviews with 2 LPNs who had drawn up 5 mg. dose syringes for MTs to administer to Resident #2, there had been missing count sheets and the count for morphine could not be verified as to the exact amount of morphine that was missing. It was discovered during the investigation that MTs and LPNs were not following the facility's policy/procedures for "Narcotic Count" and "Assisting with Controlled Medications" and the "Vermont Medication Pre-Pour P/P." During interview with the RN RCD on 3/13/18 at 2 PM, staff failures to follow the facility's narcotic count P/P was confirmed; the RN also confirmed that they had not performed any random audits of the narcotic count process with MTs to assure that staff were properly accounting for all controlled medications, including narcotic medications.	R165		

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R189 SS=D	Continued From page 8 R189V. RESIDENT CARE AND HOME SERVICES 5.12.b. (3) For residents requiring nursing care, including nursing overview or medication management, the record shall also contain: initial assessment; annual reassessment; significant change assessment; physician's admission statement and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of physician visits, signed telephone orders and treatment documentation; and resident plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, a facility nurse failed to document the reason for administration of a PRN antipsychotic medication for 1 applicable resident in the sample receiving Hospice services, in accordance with the facility's policy. (Resident #2). Findings include: Per review of the MAR (medication administration record) on 3/14/18, Resident #2 had Hospice physician orders done on 1/28/18 for Haldol, 0.5 mg. (milligrams) by mouth every one hour as needed PRN agitation. Per review of the MAR for February, 2018, on 2/1/18 at 1333 HR. the resident received 0.5 mg of Haldol. The PRN medication note (for the reason for administration of the Haldol) did not state that the resident was experiencing any symptoms of agitation. The note stated: "resident slowing down... respirations.....were 54... now down to 43." During interview on the afternoon of 3/14/18, the licensed nurse who wrote the note stated the the resident was moaning and moving around as if	R189	**R189 Steps to prevent recurrence** Community polices as well as requirements listed in 5.12.b will be reviewed with all community nurses and med techs. Reeducation on documenting PRN medication notes will be provided. The RCD will ensure follow through with random audits of at least 3 different resident progress notes and the medication administration records bi-weekly for 3 months and then monthly for 3 months and then quarterly on-going. Completion date: 5/1/2018 RCD R 189 POC accepted 5/19/18 M. Bolton, RN/ S. Leary RN	

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R189	Continued From page 9 agitated at that time and that is why s/he administered the Haldol. S/he verified that they failed to include the reason/ indication for use (per physician orders) of the medication in the PRN medication note.	R189		

VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
NOB 2 South, 280 State Drive
Waterbury VT 05671-2060 http://www.dlp.vermont.gov
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To Report Adult Abuse: (800) 564-1612

March 29, 2018

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

Dear Ms. Pelkey:

The Division of Licensing and Protection completed a complaint investigation at your facility on **March 14, 2018.** The purpose of the survey was to determine if your facility was in compliance with Vermont Assisted Living Residence Regulations. The survey statement is enclosed. This survey found the most serious deficiency in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy. You must submit a plan of correction. Please write/type the Plan of CoLTection in the space provided to the right. A completion date for each plan of correction must be indicated in the far right hand column. Attach additional pages if necessary.

Please sign, date, and indicate your title on the bottom of the first page of the report and return this report to this office no later than **April 11, 2018.**

Plan of Correction (POC)

Your POC must contain the following:

- What action you will take to correct the deficiency;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective actions will be monitored so the deficient practice does not recur.
- The dates corrective action will be completed.

You may also request an informal review of all or part of the co ntents of the notice at any tim e prior to **April 11, 2018** by calling Suzanne Leavitt, RN , MS, Assistant D ivi s io n Directo r, or Clayton Clark, Divis io n Director at (802) 241-0480. If you are not satisfied with the o utco me of the informal revie w with the Division, you may request a review by the Commissioner of Disa bilities , Aging and Independent Living. To request a review with the Co mm iss io ne r, call (802) 241-2401.

The Department is authori zed to impose sanctions for failure to correct a deficiency and /or failure to provide proof of correction by the specified Correction Date. Depending on the natur e of the viola tions, the following sanctions may be im po s ed: administrative pena lties of up to $10.00 per res ident or$ 1 00 .00 , whichever is greater, for each day the violation remain s. unco rrected; suspens io n, revocation or modification of an existing licen se; refusal to rene w a license; suspension of admiss ion or transfe r of residents to an alternative placement; injun ct ive re li ef to enjoin any act or omission ; and the appointment of a receiver for a facility. If you feel strict compliance with the law or reg ulation s would impose a substantia l hardship, you may apply to the Department for a variance as stated under Section III of the Residential Care Home Licensing Regulations. You must do so prior to **April 11, 2018.**

A ppeal s

As noted above, you may seek an informal review from Suzanne Leavitt, RN, MS, Ass is tant Division Directo r, or a Commiss ion er's review of this decision. In add it ion , you have a right to request a fair hearing with the Human Services Board. Decisions by the Department of Disa bili ties, Aging and Independent Living can be appealed to the Human Services Board pursua nt to 3 V.S.A. §3091. The request for a fair hea ring before the Human Services Board must be made within thirty (30) days of your receipt of the notice of this decision, and can be made by writing to the Board at 14-16 Baldwin Street, Montpelier , VT 05633-2536. You have a right to appear before the Board and to prese nt witness es and other evidence with regard to the case. You also have a rig ht to be represe nted by an attorney at the Human Services Board fair hea ring.

Plea se contac t_ me at (802) 241-0480 if you have any question s .

Sincerely,

PMCota

Pamela M. Cota, RN
Lice ns in g Chief