VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

December 18, 2023

Ms. Shana Lee, Manager
Our House Residential Care Home
196 Mussey Street
Rutland, VT 05701-4551

Dear Ms. Lee:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 15, 2023.** 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.

If you have any questions, please feel free to contact me at (802) 585-0995.

Sincerely,

Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

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
	0360	A. BUILDING: _____ B. WING _____	08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE RESIDENTIAL CARE HOME	196 MUSSEY STREET RUTLAND, VT 05701

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R100	Initial Comments: On 8/15/23 the Division of Licensing and Protection conducted an unannounced on-site relicensure survey and investigation of one complaint. There were no regulatory deficiencies identified related to the complaint investigation. The following regulatory deficiencies were identified during the relicensure survey :	R100	Plan of Correction accepted by Jo A Evans RN on 12/17/23, please see attached for accepted plans of correction for individual tags.	
R136 SS=D	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 there was a failure to complete an annual assessment for one applicable resident (Resident #1). Findings include: Per record review Resident #1's annual reassessment for 2023 dated 1/13/23 was not signed as complete by the Registered Nurse (RN). The Resident Assessment form also lacked the signature of the person who completed the form and a completion date. At 2:59 PM on 8/15/23 the Owner of the home confirmed Resident #1's annual assessment for 2023 was not signed as complete by the RN.	R136		

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R189	Continued From page 1	R189		
R189 SS=F	V. 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 there was a failure to maintain and keep on file progress notes for all residents of the home. Findings include: Per record review 3 out of 3 sampled resident's charts did not contain Progress Notes. While information typically documented in progress notes appeared in other designated sections of the resident's records; Progress Notes, defined by Taber's Medical Dictionary as "An ongoing record of a patient's [resident's] treatment...concerning the progress or lack of progress made by the patient [resident] between the time of the previous note and the most recent note", were not maintained in the resident's charts. At 3:15 PM on 8/15/23 the Owner confirmed the facility did not have written policies and procedures related to staff noting, and indicated 3 months of ADL tracking sheets are maintained in	R189		

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R189	Continued From page 2 all resident charts to document individual progress. Additional methods of documentation including Staff to Nurse Notes, Doctor's Notes, and Incident Reports were identified in the charts by the Owner. At 3:45 PM the Manager confirmed individual progress notes are not maintained in the resident records for all residents of the home; stated the facility was previously instructed to remove documentation of progress notes from resident record; and confirmed there are no facility policies and procedures related to maintaining individual progress notes in resident records.	R189		
R222 SS=F	VI. RESIDENTS' RIGHTS 6.10 The resident's right to privacy extends to all records and personal information. Personal information about a resident shall not be discussed with anyone not directly involved in the resident's care. Release of any record, excerpts from or information contained in such records shall be subject to the resident's written approval, except as requested by representatives of the licensing agency to carry out its responsibilities or as otherwise provided by law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure the right to privacy for all residents of the home extends to all records and personal information. Findings include: During the course of the facility tour commencing	R222		

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R222	Continued From page 3 at 11:12 AM on 8/15/23 individual binders containing medical and service records were observed to be stored in an unlocked closet in the dining room of the home where they were accessible to residents and visitors. The facility fax machine, which is used to communicate with providers, and transmit and receive resident's personal information, was observed to be in use in the living room of the home. During the facility tour commencing at 11:12 AM on 8/15/23 the Manager of the home confirmed records and personal information for all residents are unsecured and accessible in the dining room and living room of the home.	R222		
R234 SS=C	VII. NUTRITION AND FOOD SERVICES 7.1.a.(3) The current week's regular and therapeutic menu shall be posted in a public place for residents and other interested parties. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure weekly menus are posted in a public place in the home. Findings include: During the course of the survey on 8/15/23 a current weekly menu was observed to be missing from the public areas of the home. At 2:48 PM on 8/15/23 the Owner of the home confirmed the weekly menu was not posted in a public place in the home.	R234		
R246 SS=F	VII. NUTRITION AND FOOD SERVICES	R246		

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R246	Continued From page 4 7.2 Food Safety and Sanitation 7.2.a Each home must procure food from sources that comply with all laws relating to food and food labeling. Food must be safe for human consumption, free of spoilage, filth or other contamination. All milk products served and used in food preparation must be pasteurized. Cans with dents, swelling or leaks shall be rejected and kept separate until returned to the supplier. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure timely discarding of opened food items to prevent food spoilage. Findings include: During the kitchen tour commencing at 11:37 AM on 8/15/23 the following opened perishable foods were observed to be stored in the refrigerator: *a bottle of prune juice opened 21 days before the survey date on 7/25/23, fruit juice is typically labeled to be discarded in 7-10 days after opening * a quart of liquid scrambled egg mix opened 14 days before the survey on 8/1/23 with instructions on the label to discard three days after opening During the tour of the kitchen on 8/15/23 the Manager confirmed opened perishable food was stored in the home's refrigerator after opening for a period of time longer than recommended.	R246		
R247 SS=E	VII. NUTRITION AND FOOD SERVICES	R247		

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R247	Continued From page 5 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure all perishable foods and drinks were labeled, dated, and stored at or below 40 degrees Fahrenheit. Findings include: During the tour of the facility kitchen commencing at 11:37 AM on 8/15/23 opened perishable foods were observed to be without dates in the refrigerator including whipped cream, Cool Whip, BBQ sauce, Italian dressing, a jar of strawberry jelly and a small unlabeled plastic tub containing jelly, heavy cream and milk, sliced pepperoni and ham, and a large bag of shredded mozzarella cheese which had solidified on the bottom. In the freezer opened unlabeled and undated ice cream, waffles, ravioli, and breaded chicken were observed. Ice crystals were observed inside opened packaging and coating the breaded chicken and ravioli. A thermometer indicated the temperature inside the fridge was 46 degrees Fahrenheit, with a recheck of the fridge temperature at approximately 5:05 PM on 8/15/23 indicating the fridge temp was 48 degrees Fahrenheit. The Manager confirmed opened perishable food and drink were stored without labels and dates in the facility refrigerator freezer, and the 46 degree Fahrenheit thermometer reading during the tour	R247		

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R247	Continued From page 6 of the kitchen commencing at 11:37 AM on 8/15/23. The Manager also confirmed the subsequent fridge temp reading of 48 degrees Fahrenheit at approximately 5:05 PM on 8/15/23.	R247		
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: Based on observation and staff interview there was a failure to ensure care in a safe and functional environment. Findings include: 1. During the facility tour commencing a 11:12 AM on 8/15/23 there was a missing screen in Resident #4's room, the crank utilized to open a window in Resident #5's room was missing; and there was only a partial screen in the window in Resident #2's room. Ripped window screens were observed in a hallway adjacent to the living room and in the living room; and the screened door in the dining room was also ripped. These findings were confirmed by the Manager during the facility tour on 8/15/23. 2. During the facility tour on the morning of 8/15/23 1 bed rail was observed to be unstable and 2 stand assist rails were observed to be unsecured. In Resident #5's room a bed not currently in use was observed with a stand assist rail which was not secured with a strap around	R266		

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R266	Continued From page 7 the box springs, and the mattress was observed to slide off the bed with ease when the rail was pulled. The Manager removed the rail to prevent use. Resident #5's bed was observed with a half rail which was unstable and moved in a downward motion towards the floor with ease when pulled up and clicked into place. Minimal pressure on the rail towards the head of the bed caused the rail to descend towards the floor in the direction the pressure was applied. In Resident #6's room a second lift assist rail was observed without a strap securing the device to the box springs causing the mattress to slide when pressure is applied as described above. During the facility tour on the morning of 8/15/23 the Manager confirmed the unstable bed rail and unsecured lift assist rails in Resident #5's and #6's rooms. The Manager also confirmed there were no physician's orders on file for the bed rails and lift assist bars in use at the home to include the aforementioned devices in Resident #5's and #6's rooms and an addition side rail in Resident #1's room which was not observed to be unstable or unsecured. 3. During the facility tour commencing at 11:12 AM on 8/15/23 hazardous chemicals were observed to be stored in unlocked areas of the home including Cascade dishwashing powder and a box of ant baits stored in the unlocked cabinet under the kitchen sink; and hydrogen peroxide and laundry detergent in an unlocked closet in laundry room.	R266		
R281 SS=D	IX. PHYSICAL PLANT 9.3 Toilet, Bathing and Lavatory Facilities	R281		

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R281	Continued From page 8 9.3.e Resident lavatories and toilets shall not be used as utility rooms. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure one bathroom in the home was not used as a utility room. Findings include: During the facility tour commencing at 11:12 AM on 8/15/23 a resident bathroom in the home located down the hall from the laundry area was observed with bedside commodes stored in the bathtub stacked on top of plastic buckets and tubs in the bath tub; and a mop head was draped over the shower curtain rod. During the facility tour the Manager confirmed utility items were stored in the bath tub.	R281		

Plan of Correction for Survey at Our House RCH 162 Jackson Ave. Rutland, VT 8/15/23

Prepared by: [redacted] with [redacted] and [redacted] and reviewed by RN [redacted]
Internal Compliance Monitor

12/13/23

Names removed by DLP 12/18/23

R136

RN signed this assessment the evening of this survey to correct oversight. 8/15/23

RN will leave assessments, new, re-assessments, and significant change assessments in the Managers bin for approval before filing in the resident chart to ensure the deficient practice does not reoccur.

RN and Manager are aware of the systematic change and will monitor for compliance at monthly briefing. 9/01/23

R136 Plan of Correction accepted by Jo A Evans RN on 12/17/23

R189 – ***Provider does not agree with interpretation of regulation.***

As stated by the surveyor our documentation does provide every facet of progress or decline – as also stated previous checklist "progress notes" were discontinued by other surveyors pointing out a duplication of efforts thus leaving room for possible errors or inconsistency when unlicensed staff create a narrative, therefore current methods have proven most accurate.

Referenced here is Tabers Medical Dictionary's definition of progress notes, it does not use "resident" and only references;" Physicians, Nurses, Consultants and Therapists" not including unlicensed staff, nor does it state a routine or time frame other than "between time of the previous note and the most recent note" therefore it seems that the most accurate documentation of progress or decline are provided via medical professionals. Further the regulation 5.12 b(2) states "progress notes regarding any accident or incident and subsequent follow-up" as is documented on the accident/incident report form and when necessary further detailed on the care services notes by a PCP, RN or Manager.

As for written policies and procedures related to "staff noting" we refer to the RCH regulations for compliance.

PCP's, RN's or Managers will create periodic progress notes when applicable using the care service note form no later than 01/01/2024.

R189 Plan of Correction accepted by Jo A Evans RN on 12/17/23

R222

A keypad lock has been ordered and will be installed once delivered. 9/15/23

The fax machine has been relocated to avoid exposure and achieve compliance- action taken is stated above, staff is aware of the lock being added to the closet and will honor this systematic change by continuing to store charts in the closet when not in use. All staff will monitor for compliance throughout each shift. Manager will monitor for compliance as needed.

R222 Plan of Correction accepted by Jo A Evans RN on 12/17/23

R234

Menus are provided monthly and a copy is now placed on a bulletin board located in a public area of the home. Manager will be sure to continue placement each month as new menus are printed.

R234 Plan of Correction accepted by Jo A Evans RN on 12/17/23 9/08/23

R246

This should not happen the overnight staff is charged with maintaining safe practices with food being discarded-Action taken is a written weekly report to the Manager evidencing the task has been done accurately and in a timely manner – this report will be prepared no later than Saturday mornings every week – the Manager will verify the systematic change for safety and compliance no less than weekly. 9/16/23

R246 Plan of Correction accepted by Jo A Evans RN on 12/17/23

R247

All staff have been reminded that labelling of all open goods is required. This task is expected by anyone who opens any container-action to assure compliance will be added to the overnight staffs weekly written report to the Manager to assure the task is being regularly monitored for compliance. 9/16/23

Temperatures are routinely documented on the overnight shift when the doors are kept closed for longer periods of time, these two checks were right at meal times or meal prep times when the doors had been opened and closed several times. Thermometers have been routinely checked to assure they are working properly and that temps are within safe practice as has been evidenced by continued daily documented temp checks. Continued monitoring and documentation will assure compliance. Manager or designated staff will monitor daily.

8/16/23

R247 Plan of Correction accepted by Jo A Evans RN on 12/17/23

R266

1)Missing screen was put back up on 8/16/23 and was checked for quality in resident #5, The screen in resident #2's room is factory designed to move up or down depending on what part of the window is opened. Torn screens were removed and taken to Countryside glass for repair, they will be done the week of 9/11/23 and will be put back on these windows. A new screen door was installed on 9/9/23. 9/15/23

2)Provider does not agree with interpretation of regulation.

The bed rail on resident #5's bed was removed and discarded. We have ordered an anchor strap for resident #6 out of bed assist rail and will apply it when it arrives. (by 9/20/23) We continue to use our bed rail evaluation and outcome forms – there is no indication found anywhere that a physicians order is required for OOBA, however resident #1 has a physicians order through hospice for a hospital bed with a half rail. 9/20/23

3) Kitchen half door has an added keypad lock and staff is aware that the door must be closed and locked whenever the area is unsupervised. A keypad lock has been added to the laundry room closet and staff has been reminded that this closet must be locked when not in use. 10/13/23

R266 Plan of Correction accepted by Jo A Evans RN on 12/17/23

R281

This was the result of one caregiver taking shortcuts – all staff have been reminded that these items must be stored appropriately and signs to remind them have been added to this bathroom. 8/23/23

Manager will monitor daily for compliance. All inappropriate items were removed this day. 8/15/23

R281 Plan of Care accepted by Jo A Evans RN on 12/17/23