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

January 19, 2023

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 **December 15, 2022.** 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

Pamela M. Cota, RN
Licensing Chief

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
	1008	A. BUILDING: ____ B. WING ____	C 12/15/2022

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 12/15/22 by the Division of Licensing and Protection. The following regulatory violations were identified:	R100	This plan of correction is not an admission to and does not constitute an agreement with alleged deficiencies herein. To remain in compliance with the Division of Licensing and Protection regulations, The Residence at Otter Creek has taken and/or will take the actions set forth in this plan of correction.	
R213 SS=D	VI. RESIDENTS' RIGHTS 6.1 Every resident shall be treated with consideration, respect and full recognition of the resident's dignity, individuality, and privacy. A home may not ask a resident to waive the resident's rights. This REQUIREMENT is not met as evidenced by: Based on observation and resident, family and staff interview, the ALR failed to ensure a resident was treated with consideration, respect, individuality and privacy. (Resident #1) Findings include: Resident #1 is visually impaired and requires assistance from staff with some of the activities of daily living. Per interview with Resident #1 on 12/15/22 at 10:45 AM it was confirmed s/he dislikes the lack of privacy resulting from not having a door to his/her bathroom. Resident #1 acknowledged there was a recommendation made in the past by an individual from an association for the visually impaired who suggested the door to Resident #1's bathroom should be removed. However, Resident #1 dislikes this lack of privacy and stated s/he wanted a bathroom door re-installed. Per interview with a family member on 12/14/22 at 4:45 PM confirmed Resident #1 disliked the lack of personal privacy and had also discussed	R213	R213 Resident private apartment bathroom door was re-installed 1/16/2022. Resident Rights education was provided to care department associates in 8/2022. As part of this plan of correction Stacie, Jaquish, Executive Director will ensure that all Otter Creek and contracted associates are retrained on Resident Rights. Completion Date: 2/17/2023 and then ongoing.	

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paula Pelkey RN
TITLE: Senior Resident Care Director
(X6) DATE: 1/17/2023

R213 - A607 POC's accepted 1/18/23 FMcIntosh RN/pm

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R213	Continued From page 1 having the door re-installed with the Administration at the ALR. Observation noted Resident #1 has a studio apartment with a kitchenette and bedroom area. The bathroom is opposite the kitchenette, near the front door of the apartment and was without a door. If the resident was using the bathroom for personal needs or showering, anyone visiting Resident #1 would find the resident in full view lacking the protection of privacy. Per interview on 12/15/22 at 2:00 PM, the ALR Executive Director stated it was his/her understanding a recommendation/agreement was made regarding removing the bathroom door. Noting when Resident #1 transferred from Independent Living on campus to the ALR, it was necessary for safety purposes and per recommendation from an individual familiar with vision impaired deficits. However, any evidence of this decision and/or contract related to the decision to remove the bathroom door was unavailable. At this time, Resident #1 has requested a door for the bathroom be installed.	R213		
R220 SS=D	VI. RESIDENTS' RIGHTS 6.8 A resident may complain or voice a grievance without interference, coercion or reprisal. Each home shall establish a written grievance procedure for resolving residents' concerns or complaints that is explained to residents at the time of admission. The grievance procedure shall include at a minimum, time frames, a process for responding to residents in writing, and a method by which each resident filing a complaint will be made aware of the Office of the Long Term Care Ombudsman and Vermont Protection and	R220		

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R220	Continued From page 2 Advocacy as an alternative or in addition to the home's grievance mechanism. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, there was a failure of the ALR to establish a Grievance Procedure which included time frames and process for responding to residents in writing and a failure to provide a prompt and equitable solution to ongoing reported concerns. Findings include: Per review of the ALR 1.69 Grievance Procedure, noted there is a lack of time frames for resolving a resident and/or family concerns when presented to the Executive Director. When a family member of Resident #1 brought concerns to the attention of the facility staff and Executive Director regarding the locking of Resident #1's door (as per request of the resident); delivery of food to Resident #1's room; access to the menu (providing assistance with menu choices as read to the resident by staff); and the lack of consistent housekeeping. Per review on the afternoon of 12/15/22 of ALR grievances noted the specific concerns raised by Resident #1's relative could not be found in the documented grievances provided to the surveyor. This was confirmed by the Excutive Director on the afternoon of 12/15/22.	R220	R220 See POC for R213 The community's grievance process was immediately reviewed, and a formal grievance form was developed. The first level of review (Supervisor) shall respond to the grievance in writing within ten workdays after the receipt of the formal grievance. All grievance forms will be reviewed at the communities At Risk Meetings. Associate education regrading updated grievance process began 1/8/2023 and is ongoing. Stacie Jaquish, Executive Director and/or Paula Pelkey, Resident Care Director will ensure each Department Head is trained on the updated process. Department Heads will be responsible for the education for associates within their specific department. The updated grievance process will be part of each new associates new hire orientation on-going. Completion Date: Stacie Jaquish, Executive Director will ensure training for all associates completed no later than 2/17/2023 and then on-going.	
R266 SS=D	IX. PHYSICAL PLANT 9.1 Environment	R266		

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R266	Continued From page 3 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, resident and family interview, there was a failure of the ALR to provide an environment which was homelike and comfortable for 1 applicable resident. (Resident #1) Findings include: Resident #1 is visually impaired and requires assistance from staff with some of the activities of daily living. Per interview with Resident #1 on 12/15/22 at 10:45 AM it was confirmed s/he dislikes the lack of privacy resulting from not having a door to his/her bathroom. Resident #1 acknowledged there was a recommendation made in the past by an individual from an association for the visually impaired who suggested the door to Resident #1's bathroom should be removed. However, Resident #1 dislikes this lack of privacy and stated s/he wanted a bathroom door installed. Per interview with a family member on 12/14/22 at 4:45 PM confirmed Resident #1 disliked the lack of personal privacy and had also discussed having the door re installed with the Administration at the ALR. Observation noted Resident #1 has a studio apartment with a kitchenette and bedroom area. The bathroom is opposite the kitchenette, near the front door of the apartment and was without a door. If the resident was using the bathroom for personal needs or showering, anyone visiting Resident #1 would find the resident in full view lacking the protection of privacy. The absences of a bathroom door created a lack of a home-like environment and caused the resident discomfort	R266	R266 See POC R213	

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R266	Continued From page 4 when using the bathroom due to the lack of privacy. Per interview on 12/15/22 at 2:00 PM, the ALR Executive Director stated it was his/her understanding a recommendation/agreement was made regarding removing the bathroom door. Noting when Resident #1 transferred from Independent Living on campus to the ALR, it was necessary for safety purposes and per recommendation from an individual familiar with vision impaired deficits. However, any evidence of this decision and or contract related to the decision to remove the bathroom door was unavailable.	R266		
A 607 SS=D	VI Resident Care and Services 6.7 Care Plans The licensee, the resident and/or the resident's legal representative shall work together to develop and maintain a written resident care plan for those residents who require or receive care. The care plan shall describe the assessed needs and choices of the resident and shall support the resident's dignity, privacy, choice, individuality, and independence. The licensee shall review the plan at least annually, and whenever the resident's condition or circumstances warrant a review, including whenever a resident's decision, behavior or action places the resident or others at risk of harm or the resident is incapable of engaging in a negotiated risk agreement. This Statute is not met as evidenced by: Based on staff interview and record review, there was a failure within the Service Plan to include	A 607		

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A 607	Continued From page 5 specific goals/actions for securing the resident's room and a specific process for the delivery of food to Resident #1's room. Findings include: Per review of Progress Notes dated 2/14/22 @ 2:57 PM states "Resident stating that someone came into her/his room. Resident referred it to being a resident next door & upset about other resident entering room." Per interview on 12/15/22 at 10:45 AM Resident #1 stated how upset s/he was when a resident who was "out of her/his mind...out of control" entered the resident's room..."and tried to drag me out of my bed, and pulled my hair..". The resident further stated "my door is supposed to be locked." However, during the onsite Resident #1's door was found to be unlocked and partially ajar during the late morning and at 2:00 PM on 12/15/22. The resident's Service Plan dated 9/28/22 failed to identify the necessity of keeping Resident #1's door locked at all times, especially important due to the resident being sight impaired and lacking awareness when unwanted intruders enter his/her apartment. In addition, the Service Plan failed to establish a specific process for managing the resident's food delivery to his/her room. Resident #1's relative confirmed on 12/14/22 at 4:45 PM during a recent visit and in the past has found the resident's food sitting on a table located approximately 25 feet from the resident's room. Per observation at 11:40 AM on 12/15/22, a dietary staff member was observed delivering the noon meal in takeout containers. The staff member knocked on Resident #1's door. After no acknowledgement, the container was placed on the table. At this point, Resident Care Aides (RCA) are responsible for delivering the food to the resident and setting up the meal. RCAs are alerted via radio contact	A 607	A607 Resident's care plan was reviewed and updated with resident specific requests including process for resident's food deliveries. Updated process includes resident to alert care staff when she is ready to eat, care staff will review menu and daily specials with resident. Resident will place meal order with care staff. Care staff will deliver resident order to dining and when meal is done dining will radio care staff to pick up meal. Care staff will pick up meal and deliver meal directly to resident. Resident wishes to have apartment door locked was updated in resident plan of care. Paula Pelkey, Senior Resident Care Director initiated education on resident care plan updates on 1/12/2023 and education is ongoing. Paula Pelkey, RN Senior Resident Care Director and nurses will audit care plan for all current residents to ensure accuracy. Date of Completion: 2/17/2023 and then ongoing. Jeff Trump, Director of Restaurant Operations will provide food services team education of resident delivery preferences and restructured process of resident food delivery process. Date of Completion: 2/17/2023	

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A 607	Continued From page 6 the meal containers have been brought to the unit where this resident resides. Unfortunately, Resident #1's hearing is impaired and was evident during the observation, Resident #1 did not hear the knock on the his/her door. Eventually the food was brought to the resident's room which was confirmed by the LPN assigned to the location where Resident #1's resides. The Service Plan fails to identify and develop a specific delivery process for the resident's meals. Due to sight impairment and hearing loss, Resident #1 can not venture into the hallway in an attempt to locate his/her meals. As a result, meal tray delivery can be delayed if RCA's are completing other tasks. It was acknowledged staff would reheat food if necessary and per resident's request.	A 607		