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

March 1, 2018

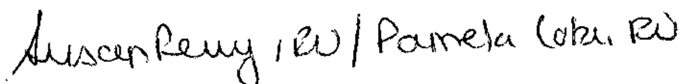
Ms. Randi Cohn, Administrator
The Gables At East Mountain
1 Gables Place
Rutland, VT 05701-8868

Dear Ms. Cohn:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 12, 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 Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	592	A. BUILDING: ______ B. WING ______	C 02/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GABLES AT EAST MOUNTAIN	1 GABLES PLACE RUTLAND, VT 05701

(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 survey was completed on 2/12/18 by the Vermont division of Licensing and Protection. The following regulatory violations were identified.	R100	**R179 Corrective Action Plan** All current contracted staff will have a full employee orientation to ensure they receive the seven necessary trainings. All future contracted staff will receive a full Gables employee orientation before they are allowed to work with residents. All contracted employees will also participate in annual training to ensure compliance with this regulation. All contracted employees will have a training checklist maintained in a file located in the facility. Three of these employees will be randomly audited every month for six months. If a contracted employee file is found to be lacking, all of the files will be checked. Training will be completed as needed to gain compliance. This plan will be implemented by March 15, 2018. R179 POC accepted 3/1/18 Mary Bolton RN S. Perry RN	
R179 SS=C	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on staff interview an record review, the	R179		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Candi Cohn — TITLE: Program Administrator — (X6) DATE: 2/25/18

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R179	Continued From page 1 facility failed to assure that all staff demonstrated competency in the skills they are expected to perform as required by the 7 mandated trainings prior to providing care to residents. This practice had the potential to affect multiple residents of the home. Findings include: Per review of trainings completed for contracted staff who work and interact with residents of the home on a routine basis on 2/12/18, contracted Dietary staff had not completed the 7 Vermont required trainings prior to actually working with residents of the home. During interview with a recent hire whose job requirements include dining room service to residents of the home, the staff person stated that they had been working at the home for approximately 2 months and had not received formal training regarding Resident Rights and Abuse Protocols. During interview at 11:45 AM, the Food Service Director confirmed that these required trainings had not been provided upon hire as a practice of this department. The Administrator was not aware that the contracted company had not provided the trainings as part of their hiring and orientation process.	R179		
R181 SS=C	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the	R181		

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R181	Continued From page 2 public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that staff working in the facility, including contracted service staff, had required background checks completed related to Vermont Adult and Child Abuse Registry screenings. This practice had the potential to affect multiple residents of the home. Findings include: Per review of the records regarding new employee background checks, it was found that contracted staff working in the facility had not undergone the required Adult Protective Services (APS) Vermont Adult and Child Abuse Registry checks prior to working at the facility. A sample of background checks conducted for 4 employees of the contracted company revealed that none of the 4 had screening conducted for the Adult and Child Abuse Registries, as required. The failure to complete these background checks was confirmed during interview with the Administrator and the Food Services Director on 2/12/18 at 11:45 AM.	R181	**R181 Corrective Action Plan** All contracted staff will have the required background checks completed. All future contracted staff will have the required background checks completed by Gables staff prior to working on premises. These background checks will be maintained at the facility. A monthly audit will be conducted for three months to ensure all contracted employees have the required background checks completed. If any issues are found, they will be corrected immediately. If the findings from the monthly audit are satisfactory it will be changed to quarterly after three months for a year. This plan will be implemented by 3/15/18. R181 POC accepted 3/1/18 M. Bolton, RN / S Perry RN	

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R247	Continued From page 3	R247		
R247 SS=E	VII. NUTRITION AND FOOD SERVICES 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 observations in the kitchen on 2/12/18 at 10:10 AM, the facility failed to assure that all perishable foods were labeled and dated in accordance with safe food handling practice. Finding include: 1. During a tour of the kitchen on 2/12/18 at 10:10 AM, the small reach-in cooler had a bag of white substance identified as non-dairy whipped topping, with no label and no date the purchased bag was opened, nor when it should be discarded. A stainless steel container labeled as "Roux" and dated as 1/24/18 was observed under the steam table; the area had various other non food items on the shelf. The Roux, which was loosely covered in plastic wrap and made from butter and flour, should have been stored in the refrigerator. Per interview with the FSD, the whipped topping should have been labeled and dated according to policy and the Roux was outdated and should have been discarded. Per review of the "FOOD DATING POLICY" provided, "Date all foods when received, pulled, cooked or opened. Check date before using. If it is beyond the list time frame, dispose of and inform (names)."	R247	**R247 Corrective Action** All items found to be out of compliance during the inspection have been discarded or stored properly. All Food Service Staff will receive education on the Food Dating Policy and ensure the policy is followed. The Administrator, or designee, will conduct weekly review of all food storage to ensure compliance with both the policy and regulations. Any identified issues will be remedied. This plan will be implemented before 3/15/18. R247 POC accepted 3/11/18 M.Bolton RN/S.Perry RN	

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R247	Continued From page 4	R247		

The list of foods is incomplete and does not provide dietary staff direction to assure all perishable foods/types are included and the timing of dates to discard for all food items used at the facility.

2. During a tour of the walk-in cooler, the following observations regarding safe food handling practices were made:

a. raw meat (beef) was seen stored directly on the shelf above the bottom shelf, in original cardboard cartons, which were piled on top of each other and collapsing under the weights; there was no impervious tray under the raw meat; the meat was stored over a shelf that had raw pork, and raw chicken and cooked meatballs and cooked lobster meat.

The FSD confirmed on 2/12/18 at 2 PM that raw meat should have an impervious barrier under the packaging and that raw foods should not be stored over or next to any cooked foods.

R248 SS=E — VII. NUTRITION AND FOOD SERVICES — R248

7.2 Food Safety and Sanitation

7.2.c. All work surfaces are cleaned and sanitized after each use. Equipment and utensils are cleaned and sanitized after each use and stored properly.

This REQUIREMENT is not met as evidenced by:
Based on observations, the facility failed to assure that all work surfaces were cleaned after use and failed to assure that equipment and utensils were clean and stored properly. Findings include:

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R248	Continued From page 5 Per observations of the dining room beverage service areas (hot and cold beverages) the following areas were observed to be visibly soiled with dust and crumbs: a. the area under the table skirt for the hot beverages station was soiled with food crumbs and dust; containers storing clean table cloths were visibly soiled inside (not covered) and had ripped, sharp surfaces where the bins were split; b. 2 cream pumps on the table were visibly soiled, one was in use and the other was not being used that day, per the FSD; c. the counter under the juice and ice machine was soiled with visible dust; d. the table top toaster had a build up of visible grease near the top of the toaster. When the cleaning schedule for the area was requested, the FSD confirmed that there was no cleaning schedule for that area of the dining room. Observations in the kitchen area revealed the following areas needing cleaning: a. the shelf containing washed coffee pots had pots that still had coffee remains in the pots (dark evaporated stains); the pots were also generally stained and there was no system to routinely clean the stains; b. the back kitchen door was heavily soiled and the floor/mats were soiled with soiled water under the mats; c. the interior of the storage cabinets in the kitchen near the 3 bay sink were soiled on bottom shelf.	R248	**R248 Corrective Action** All items identified as deficient during the inspection have been cleaned and brought into compliance. The Food Service Supervisor will develop a cleaning schedule that will include the items identified, and other items, to ensure future compliance. Staff will be educated on the schedule and procedure. All issues identified during the inspection will be reviewed weekly by the administrator or designee to ensure continued compliance. Any item identified as deficient will be remedied. This plan will be implemented before 3/15/18. R248 POC accepted 3/1/18 mBolton RN/ SPerry RN	
R266 SS=E	IX. PHYSICAL PLANT	R266		

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R266	Continued From page 6 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, the facility failed to assure and maintain a safe environment in all areas of the facility. Findings include: Per observations of the facility main dining room on 2/12/18 at 10 AM, a power cord, with multiple electronic equipment plugged into it was observed hanging freely and not resting on the floor surface, under the hot beverage tables. The FSD who was present for the tour confirmed s/he was not aware of the hanging electric power strip located in that area. This posed a potential safety hazard.	R266	**R266 Corrective Action** The surge strip that was identified during the inspection has been replaced. The new one does not hang as the previous one. An inspection will be made throughout the facility to see if there are any other surge strips, or extension cords, found to be out of compliance. Any item identified as non-compliant will be fixed. Staff will receive training to identify any non-compliant surge protector or cord. If staff identify any issue, they will notify Maintenance to remedy the issue. Quarterly inspections by the Administrator or designee will be used to ensure compliance. This plan will be implemented by 3/15/18. R-266 POC accepted 3/1/18 m.Bolton, RN Sferrup	