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

June 30, 2023

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 **May 22, 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.

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
	1008	A. BUILDING: _____ B. WING _____	C 05/22/2023

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: On 5/22/23 the Division of Licensing and Protection conducted and unannounced on-site relicensure survey, and investigation of 2 entity reported incidents and 5 complaints. The following regulatory deficiencies 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.	
R144 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c.(1) Complete an assessment of the resident in accordance with section 5.7; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure completion of resident assessment in accordance with section 5.7 for 2 applicable residents (Resident #1 and #2). Findings include: 1. Per record review the annual reassessments Resident #1's Resident Assessment form dated 1/14/22 did not include the date the Registered Nurse signed the document as complete; and the Resident Assessment form for Resident #1 dated 1/12/21 indicated it was signed as complete by the Registered Nurse on 1/10/2020. These findings were acknowledged by the Manager of the ALR at approximately 6:00 PM on 5/22/23. 2. The Manager of the ALR was unable to provide documentation of a significant change assessment completed for Resident #2 when s/he was admitted to hospice in February of 2022. Please refer to tag 192.	R144	R144 Resident Care Director and/or designee will audit assessments for RN signature and date 2 times per month x 3 months. and then monthly x 6 months. Quarterly thereafter and as needed ongoing. R144 Residents with significant changes that require a significant change assessment will be discussed at Weekly Resident Tracking meeting. The Resident Care Director and/or designee will be responsible for ensuring significant change assessment are scheduled and completed. Completion Date: Ongoing	Complete and ongoing Complete and ongoing

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paula Pillsbury | TITLE: Senior Resident Care Director | (X6) DATE: 6/15/2023

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 05/22/2023

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
R144	Continued From page 1 These findings were acknowledged by the Manager of the ALR at approximately 6:00 PM on 5/22/23.	R144	R144 5.9.c.1 correction is accepted by Carolyn Scott, LTcM	
R179 SS=D	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 and record review, the Assisted Living Residence (ALR) manager failed	R179	R179 Each department will be responsible for ensuring the associates in their department have completed the required 12 hours of training each year. R179 5.11.b correction is accepted by Carolyn Scott, LTCM	Due 07/01/23

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 05/22/2023

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
R179	Continued From page 2 to ensure all staff received the required 12 hours of training each year. Findings include: Per record review of staff trainings records, 1 out of 5 staff did not demonstrate completion of the required annual trainings. The staff record record of trainings indicated s/he had not completed trainings related to Resident Rights, Fire Safety, Respectful Effective Communication, and Infection control. Per interview with the Registered Nurse (RN) on the afternoon of 5/22/23 the RN confirmed the record does not demonstrate completion of all the required annual training for the 1 out of 5 staff.	R179	R179 Business Office Director and/or designee will audit all current associate files for compliance. Business Director and/or designee will create a tracking system moving forward utilizing outlook calendar invites to department heads with due dates of required trainings. All associates will be in compliance with scheduled trainings by 7/31/2023 and ongoing thereafter.	Audit due: 07/31/23 Tracker Due: 07/31/23 07/31/23
R190 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on record review the Assisted Living Residence failed to ensure adult abuse registry checks were completed for all staff. Findings include: Per staff record review, 1 out of 5 staff of the applicable sample did not have an abuse registry check completed upon hire. Per interview on 5/22/23 at 6:08 PM the Registered Nurse (RN) confirmed the record demonstrated a failure to complete the abuse registry check upon hire for 1 out of 5 staff.	R190	R190 Missing abuse registry check was for an associate in 2017. (Prior to current BOD) Current Business Office Director and/or designee since has used a new hire checklist for each associate file upon hire. Business Office Director and/or Designee will audit all associate files to ensure new hire checklist are completed. Completion date: 7/31/2023 R190 5.12.b.4 correction is accepted by Carolyn Scott , LTCM	Due: 07/01/23 Due: 07/31/23

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 05/22/2023

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
R192 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12 Records/Reports 5.12.d Reports and records shall be filed and stored in an orderly manner so that they are readily available for reference. Resident records shall be kept on file at least seven (7) years after the date of either the discharge or death of the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure records for one applicable resident (Resident #2) were kept on file and available for review for at least seven years following the death or discharge of the resident. Findings include: During the course of the survey and investigations on 5/22/23 the Manager was requested to provide documents for Resident #2 including a copy of his/her Medication Administration Record for May of 2022, signed medication orders on file at his/her time of death on 5/5/22, documentation of admission to hospice in February of 2022, and copies of Resident Assessments completed after his/her annual reassessment on 1/11/22. On the afternoon of 5/22/23 the Manager stated the requested documents were not available for review due to a change in the Electronic Health Record (EHR) used by the facility. Lack of access to documents stored in the previous EHR affects all resident's who were provided care during the period of time no longer accessible to the facility.	R192	R192 The medical record filing system has been relocated and is being reorganized for a better filing system. The Resident Care Coordinator and/or designee will systematically do ongoing resident chart audits and file as needed any medical records in ordinance with R192 5.12 Records/Reports Completion Date: July 13, 2023 and then ongoing. R192 5.12.d correction is accepted by Carolyn Scott , LTCM	Due: 07/13/23
R230 SS=F	VI. RESIDENTS' RIGHTS	R230		

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 05/22/2023

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
R230	Continued From page 4 6.18 The enumeration of residents' rights shall not be construed to limit, modify, abridge or reduce in any way any rights that a resident otherwise enjoys as a human being or citizen. A summary of the obligations of the residential care home to its residents shall be written in clear language, large print, given to residents on admission, and posted conspicuously in a public place in the home. Such notice shall also summarize the home's grievance procedure and directions for contacting the Ombudsman Program and Vermont Protection and Advocacy, Inc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure a summary of the home's grievance policy was posted in a public place. Findings include: During the facility tour commencing at 10:00 AM on 5/22/23 the Business Office Manager confirmed the posted information related to resident grievances did not include a summary of the home's grievance policy.	R230	R230 6.18 Otter Creek's grievance policy is now posted in a common area within Otter Creek community. Completed: 6/13/2023 R230 6.18 correction is accepted by Carolyn Scott , LTCM	COMPLETE
R234 SS=F	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	R234	R234 Director of Restaurant Operations and/or designee will audit posted menu daily. Implemented: 5/23/2023	Compete and Ongoing

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 05/22/2023

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
R234	Continued From page 5 was a failure to ensure the weekly menu was posted in a public place for review by residents and other interested parties. Findings include: During the facility tour commencing at 10:00 AM on 5/22/23 the Culinary Director confirmed the menu posted for review by residents and other interested parties was limited to the dinner menu for the previous week,	R234	R234 7.1.3 correction is accepted by Carolyn Scott , LTCM	
R247 SS=F	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 observation and staff interview there was a failure to ensure all perishable food items were labeled and dated. Findings include: Perishable food items were observed to be unlabeled and undated in the kitchen and second floor kitchenette as follows: 1. In the kitchen unlabeled and undated items included tubs of prepared items in the sandwich and salad prep units, and the low reach in fridge included pancake batter, french toast batter, and opened unsealed bags of battered chicken and fish, as well as other bags of prepared foods. In the reach in refrigerator there were undated	R247	R247: Dry food items in bags will remain in original packaging to ensure that expiration dates are visible. Re-training with servers, chefs and department heads was initiated immediately and will continue ongoing make sure that these practices are followed. Audits will occur daily and will be documented x 1 month, followed by weekly x 1 month, and then every other week x1 month, followed by monthly ongoing thereafter. Re-education will be completed as needed. As part of this plan of correction in addition to Restaurant Operations Director, the Executive Director will maintain documentation of the completed audits. Implemented: 5/23/2023 and ongoing	Complete and ongoing

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 05/22/2023

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
R247	Continued From page 6 opened items such as containers of milk and juice, a bottle of malt vinegar without a top that was warm to the touch, containers of whipped cream without tops with dried whipped cream visible on the dispenser and sides, a container of boiled eggs without a lid or cover, dessert toppings such as chocolate sauce and caramel sauce, and large containers of sour cream and Greek yogurt. In the walk in fridge opened undated pesto and a container of sour cream were observed; and in the freezer opened unsealed bags of chicken, fries, meatballs, and fish were observed. Unlabeled and undated perishables in the kitchen area were confirmed by the Culinary Director at 10:34 AM on 5/22/23. In the kitchenette on the third floor there were unlabeled and undated containers of Chinese food; and undated opened salad dressing, condiments, dairy products, and beverages. In the kitchenette freezer there were opened undated containers of ice cream. There findings were confirmed by the Business Office Manager at 11:41 AM on 5/22/23.	R247	R247 7.2.b correction is accepted by Carolyn Scott , LTCM	
R258 SS=D	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.h All garbage shall be collected and stored to prevent the transmission of contagious diseases, creation of a nuisance, or the breeding of insects and rodents, and shall be disposed of at least weekly. Garbage or trash in the kitchen area must be placed in lined containers with covers.	R258	R258 Trash can lids have been purchased and implemented for all kitchen trash and disposal containers. Implemented:	Complete and implemented

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 05/22/2023

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
R258	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure garbage cans were covered with lids. Findings include: During the facility tour commencing at 10:05 AM on 5/22/23 the Culinary Director confirmed a kitchen garbage can and compost bucket were observed to be uncovered and confirmed by staff to routinely be without lids; and the garbage can in the second floor kitchenette was confirmed by the Business Office Manager to be without a lid at 11:41 AM on 5/22/23.	R258	R258 7.3.h correction is accepted by Carolyn Scott , LTCM	
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, functional, sanitary, homelike and comfortable environment. Findings include: The following environmental concerns were observed during the facility tour commencing at 10 AM on 5/22/23: 1. A fire extinguisher was observed on the kitchen floor behind the door to the dining area where it was confirmed by the Chef to be routinely stored	R266	R266 Cleaning protocols were reviewed and enhanced to meet regulation R22 "home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment" As part of the policy revision a daily cleaning checklist was implemented. Retraining of associates was initiated immediately regarding proper cleaning procedures, food storage and labeling of food. Director of Restaurant Operations and/or designee will audit completion of checklist daily for 30 days, then weekly x30 days, monthly x3 months and ongoing. Implemented: 5/23/2023	Complete and implemented.

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 05/22/2023

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
R266	Continued From page 8 at 10:05 AM. Kitchen surfaces were observed to be in need of cleaning including white streaking of mineral deposits on the ice machine; grease and food crumbs on both grill surfaces, and pieces of chopped vegetables remaining on the prep surface of the salad prep unit when not in use. Trays of baked potatoes were observed in the oven from dinner the previous night and confirmed by the Culinary Director to have remained in the over overnight. Bags of thawing shrimp overflowing from the sides of a stainless steel pan were observed placed on a shelf in the walk in refrigerator above a box of tomatoes and other produce items, which is a risk for food borne illness. Utensils were left inside food containers in three refrigerated units including inside a tub of pancake mix, in tubs of prepared salad items in a prep unit, and in a tub of mayonnaise in a second prep unit. In the second prep unit the mayonnaise, egg salad, and chicken salad appeared discolored and the tubs of the prepared foods were not labeled and dated. Unlabeled, undated, and uncovered/unsealed perishable foods were observed in the refrigerators and freezer. Please refer to tag 247. All kitchen findings were confirmed by the Culinary Director at 10:34 AM on 5/22/23. 2. During a tour of the rooms and common areas of the Assisted Living Residence (ALR) the second floor laundry room door was labeled with a sign stating the door was to remain closed at all times, however the floor was propped open with a box leaving cleaning chemicals including bleach	R266		

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 05/22/2023

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
R266	Continued From page 9 spray and white board spray accessible to residents. Antifungal powder, wound spray, and Clorox spray were stored in an unlocked cabinet under the sink in bathroom accessible to residents on the second floor of the ALR. In the common areas of the third floor of the ALR there were missing screens in the living room, the laundry room door was left ajar leaving hazardous chemicals including urine remover, isopropyl alcohol, Microkill brand disinfectant, and Ecolab all purpose cleaner accessible to residents. The Housekeeping closet and garbage bins within this utility room were in need of cleaning, and a strong unpleasant odor was observed in and around this utility room. Findings in the second and third floor common areas and rooms were confirmed by the Business Office Manager at 11:41 AM on 5/22/23.	R266	R266 (continued) New screens have been ordered and will be installed when received from the vendor. All chemicals were removed immediately. Retraining on proper storage of chemicals and medications (including over the counter powders, first aid supplies) was initiated with associates and will continue ongoing and as needed. Garbage bins were cleaned. Garbage is taken out to dumpster twice a day. Implemented: 5/23/2023 R266 9.1.a correction is accepted by Carolyn Scott , LTCM	ON order still waiting Complete and implemented.