

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

October 22, 2012

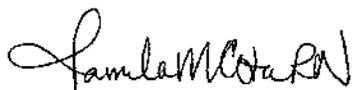
Mr. James Thomsen, Administrator
Lodge At Otter Creek
350 Lodge Road
Middlebury, VT 05753-4498

Dear Mr. Thomsen:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 12, 2012**. 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

PC:jl



PRINTED: 09/27/2012
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/12/2012
NAME OF PROVIDER OR SUPPLIER LODGE AT OTTER CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 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 survey was conducted by the Division of Licensing and Protection on 9/12/12 & 9/13/12. The following regulatory deficiencies were identified during the survey.	R100		
R126 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to assure the necessary services were provided to meet the nursing and medical needs of two residents in the sample of three (Resident #1 and #3). Findings include: 1). Per interview, Resident #3 was identified as having a wound and requiring wound care by the facility Health Services Director (HSD) on 9/12/12. On the afternoon of 9/12/12 at 1:47 PM an observation of wound care and culture was conducted. The wound care was provided by the HSD (a Registered Nurse) and included wound assessment, cleansing, culture, and dressing change. During the observation there were identified infection control issues including: a). A failure to establish a clean field for	R126		

Division of Licensing and Protection

[Signature]
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
HEALTH SERVICES

(X6) DATE

10/18/12

STATE FORM

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04TR11

If continuation sheet 1 of 6

[Handwritten mark]

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/12/2012
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R126	Continued From page 1 supplies b). Placing a bottle of spray wound cleanser on the floor c). Failure to sanitize hands when changing from soiled to clean gloves d). Failure to change gloves after removing the soiled dressing and before using clean supplies to cleanse the wound. e). Failure to place soiled materials in a separate closed bag after dressing change. During the wound care it was noted that the wound was not measured. In an interview on 9/13/12 during the late morning, the HSD confirmed that the wound was not measured and that it was not facility practice to do wound measurements as a part of wound assessments. It is the facility practice for nurses to "judge" the size of the wound by observation. This is not consistent with accepted standards of practice regarding nursing wound assessment**. S/he also stated that there is no facility policy/procedure regarding wound care or assessments. 2). Per record review for Resident #1 (R#1), the resident was identified as having a Stage II pressure ulcer of his/her Left Buttocks on 10/31/11. In the next two days the area became hard and reddened and when the resident was seen by the MD on 11/4/11 the area was determined to be an abscess. The area was incised and drained in the physician's office. According to notes the area continued to open and drain at frequent intervals until the time the resident left the facility on 6/16/12. There are no wound assessments in the record which describe the wound measurements, the wound parameters, drainage (amount, color, and odor if any), surrounding skin, and skin	R126		

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R126	Continued From page 2 temperature. In an interview on 9/13/12 during the late morning, the HSD confirmed that the wound was not measured and that it was not facility practice to do wound measurements as a part of wound assessments. It is the facility practice for nurses to "judge" the size of the wound by observation. S/he stated that there is no facility policy/ procedure regarding wound care or assessments. **Reference: S. Baranoski, E. Ayello. Wound Care Essentials Practice Principles. Second Edition, pgs 79-91.	R126		
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 record review and staff interview the facility failed to assure that the resident was assessed at any point there is a change in resident condition for 1 applicable resident in the sample. (Resident #3) Findings include: 1). Resident #3 (R#3) was admitted to Porter Medical center (PMC) and returned to the facility on 8/19/12. According the interview with the Health Services Director (HSD) on 9/12/12 the resident required a one to two person transfer and no longer was using his/her motorized	R136		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1DD8	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/12/2012
NAME OF PROVIDER OR SUPPLIER LODGE AT OTTER CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 350 LODGE ROAD MIDDLEBURY, VT 05753		
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R136	Continued From page 3 wheelchair. Additionally the resident needed assistance to bathe and dress his/her lower body. The resident also has a wound of his/her Left Shin (Lower leg) which s/he obtained by bumping his leg on the bed. The HSD stated that R#3 was seen by the MD on 9/12/12 and that the MD and HSD had discussed the possibility of Hospice for this resident in light of his/her deterioration. The last assessment conducted for this resident was conducted on 6/5/12 and coded the resident as independent in transfers and personal care. There was no more recent assessment in the record. In interview the HSD confirmed that no Significant Change assessment of the resident had been conducted upon his/her return from the hospital.	R136		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure that the Plan of Care for two residents in the sample (Residents #1 & #3) described the care and services necessary to assist the resident in maintaining independence and well-being. Findings include: 1). The Plan of Care and Kardex (used by direct care staff) for Resident #1 did not reflect the	R145		

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R145	Continued From page 4 resident's Actual Impaired Skin Integrity and the care and treatments provided for an ongoing wound in the period from 10/31/11 until the resident left the facility on 6/16/12. It also did not reflect the resident's Congestive Heart Failure (CHF) and the measures in place to monitor the resident's condition (daily weights, monitoring edema of the lower extremities, TED stockings, NAS (No added sodium) diet, diuretic medications, encourage fluid intake) noted in the nurses notes, MD orders, and MARs (Medication Administration Records). The HSD confirmed that the resident's Plan of Care had not been updated with these problems/ interventions in an interview on 9/12/12 at 3:45 PM. 2). The Plan of Care and Kardex for Resident #3 did not reflect the resident's Functional level for Dressing Lower Body, Hygiene, and Bathing Lower Body and the necessary interventions. The Care Plan also did not reflect the resident's Impaired Physical Mobility and the level of transfer assistance, use of gait belt, and Physical Therapy services which had been put in place. The Care Plan for Impaired Skin Integrity did not reflect the wound of the Left Shin requiring wound culture, dressing changes, and wound assessment and cleansing. The wound was causing pain which was impairing mobility. There was no pain control care plan in place.	R145		
R200 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request.	R200		

Division of Licensing and Protection

STATE FORM

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94TR11

If continuation sheet 5 of 8

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/12/2012
NAME OF PROVIDER OR SUPPLIER LODGE AT OTTER CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 350 LODGE ROAD MIDDLEBURY, VT 05753		
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R2DD	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on staff interview the facility failed to assure that policies and procedures for all services provided by the home were available upon request. Findings include: Per interview on 9/13/12 at 2:54 PM the Health Services Director (HSD) stated that there were no facility policies and procedures for assessments, wound assessments, wound care, and isolation/contact precautions. Assessments are required for all residents and wound care and assessments are currently required for Resident #3.	R200		

Plan of correction for The Lodge at Otter Creek;**Survey conducted 09/12/2012 & 09/13/2012****R126****5.5 General care**

5.5a Upon a residents admission to a residential care home, necessary services shall be provided or arranged to meet the residents personal, and psychosocial, nursing and medical care needs.

This requirement is not met as evidenced by:

Based on an observation and staff interview the facility failed to assure the necessary services were provided to meet the nursing and medical needs of two residents in a sample of three residents (residents #1 and #3). Findings include;

1.) Per interview, Resident # 3 was identified as having a wound and requiring wound care by Health Services Director(HSD) on 09/12/2012. On the afternoon on 09/12/2012 at 1:47pm an observation of wound care and culture was conducted. The wound care was provided by the HSD (a Registered Nurse) and included wound assessment cleansing, culture and dressing change. During the observation there were identified infection control issues, including;

- a.) Failure to establish a clean field for supplies.
- b.) Placing a bottle of spray wound cleanser on the floor.
- c.) Failure to sanitize hands when changing from soiled to clean gloves.
- d.) Failure to change gloves after removing soiled dressing before using clean supplies to clean the wound.
- e.) Failure to place soiled materials in a separate closed bag after dressing change.

During wound care it was noted that the wound was not measured. In an interview on 09/13/2012 during the late morning, the HSD confirmed that it was not facility practice to do wound measurements as a part of wound assessments. It is the facility practice to "judge" the size of the wound by observation. This is not consistent with accepted standards of practicing regarding nursing wound assessment. S/he also stated that there is no facility policy/procedure regarding wound care or assessments.

2.) Per record review for Resident #1 (R#1), the resident was identified as having a stage II pressure ulcer of his/her left buttocks on 10/31/2011. In the next two days the area became hard and reddened and when the resident was seen by MD on 11/4/2011, the area was determined to be an abscess. The area was incised and drained in the physicians office. According to no notes the area continued to open, and drain at frequent intervals until the time the resident left the facility on 06/15/2012.

There are no wound assessments in the record which describes the wound measurements, the wound parameters, drainage,(amount of color, and odor if any) surrounding skin and skin temperature. In an interview on 09/13/2012 during the late morning, the HSD confirmed that the wound was not measured and that it was not facilities practice to do wound measurement as a part of wound assessments. It is facility practice for nurses to "judge" the size of the wound by observation. S/he stated that there is not facility policy/procedure regarding wound care or assessments.

1. Action To Correct Deficiency

A policy was identified that is addressed "Wound Documentation" dated 05/19/2009 (copy attached #1). This policy requires the use of a wound assessment tool which includes the measurement of the wound. (copy attached #2). This policy had been written and enforced by the previous HSD. On 10/18/12, this policy was reviewed with all nursing staff and updated. It is agreed, by current Lodge nursing staff, that measuring wounds is a required part of accepted standards of nursing care as this relates to wound assessments. An updated policy is attached, (#3). Wound care, wound assessments and wound documentation was reviewed at the nurses meeting on 10/18/2012. A policy for non-sterile dressing change was also reviewed and is attached (#4).

2. Measures To Assure That This Does Not Recur:

As part of The Lodges updated wound care and assessment policy, all nurses will be required to complete the Bates-Jensen wound assessment tool and fax to physician. This will be completed for wound first reported, for any deterioration in wound condition and on a weekly basis while the wound is being treated. All Bates-Jensen wound assessments sent to the physician will also be copied to the Health Services Director and the Senior Director of Health Services for monitoring of wounds and staff education needs.

3. How Corrective Action Will Be Monitored;

A.) HSD and SDHS will monitor all completed Bates-Jensen wound assessment tools and monitor for education needs.

B.) HSD will see all wounds weekly

C.) Observation and audits of wound care will be carried out by HSD and SDHS quarterly.

R136 POC accepted 10/22/12 M.Higgins RN/PMC

R136**5.7 Assessment**

5.7c Each Resident shall also be reassured annually and at any point in which there is a change in residents physical or mental condition.

This requirement is not met as evidenced by:

Based on record review and staff interview the facility failed to assure that the resident was assessed at any point that there is a change in resident condition for 1 applicable resident in the sample. (Resident #3) findings include;

1.) Resident #3(R#3) was admitted to Porter Medical Center (PMC) and returned to the facility on 08/19/2012, the resident required a one to two person transfer and was no longer using his/her motorized wheel chair; additionally the resident needed assistance to bathe and dress his/her lower body. The resident also has wound of his/her left shin (lower leg) which s/he obtained by bumping his/her leg on the bed. The HSD stated that the R#3 was seen by the MD on 09/13/2012 and that the MD and the HSD had discussed the possibility of Hospice for this resident in light of his/her deterioration. The last medical assessment conducted for this resident was conducted on 06/05/1212 and coded the resident as independent in transfers and personal care. There was no more recent assessment in the record. In interview the HSD confirmed that no significant change assessment of the resident had been conducted upon his/her return from the hospital.

1. Action To Correct Deficiency

- a.) Regulation 5.7c reviewed with all lodge nursing staff at 10/18/2012 nursing meeting.
- b.) All care plans will be reviewed and updated by primary nurses- with all assessment care plans updated and completed by 10/26/2012.

2. Measure To Assure That This Does Not Reoccur:

A.) HSD will be required to review assessment and care plans of all residents returning to The Lodge community following a medical stay away.

3. How Corrective Action Will Be Monitored

A.) SDHS will do monthly care plan and assessment audits.

R136 POC accepted 10/22/12

R 145

5.9c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and wellbeing.

This requirement was not met as evidenced by;

Based on record review and staff interview the facility failed to assure that the plan of care for two residents in the sample (Resident #1 and #3) described the care and services necessary to assist the resident in maintaining independence and wellbeing. Findings include;

1.) The plan of care and kardex (used by direct care staff) for resident #1 did not reflect the residents actual impaired skin integrity and the care and the treatments provided for an on going wound in the period from 10/31/2011 until the resident left the facility on 06/06/12. It also did not reflect the residents congestive heart failure (CHF) and the measure in place to monitor the residents condition daily. (daily weights monitoring edema of the lower extremities, TEDs stockings, NAS (no added salt diet) diuretic medication, encourage fluids in-take) noted in the nurses notes and MD orders, and on MAR'S (medication administration records). The HSD confirmed the residents plan of care had not been updated with these problems/interventions in an interview on 09/12/2012 at 3:34pm.

2.) The plan of care and kardex for resident #3 did not reflect the residents' functional level for dressing lower body, hygiene and bathing lower body and the necessary interventions. The care plan also did not reflect the residents physical impaired mobility and the level of transfer assistance, use of gait belt, and physical therapy services which had been put in place. The care plan for impaired skin integrity did not reflect the wound of the left shin requiring a wound culture, dressing changes and wound assessment and cleansing. The wound was causing pain which was impairing mobility. There was no pain care plan in place.

1. Action To Correct Deficiency;

All nurses are asked to review plans of care as they relate to each resident. Nurses are reminded to consider results of completed, up to date assessment, when reviewing care plans. Nurses are asked to consider nursing measurements often put into place for symptom/condition management and asked to include this in care planning. Nurses are reminded to care plan for pain management. All care plans are to be reviewed and up dated with these considerations by 10/26/2012.

2. Measures to Assure This Will Not Recur;

A.) HSD will review all care plan updates.

B.) SDHS will conduct monthly audits.

3. How Corrective Action Will Be Monitored;

SDHS will conduct monthly care plan audits.

R145 POC accepted 10/22/12 M Higgins RN/PMC

R200

5.15 Policies and Procedures

Each home must have written policies and procedure that governs all services provided by the home. A copy shall be available at the home for review upon request.

This requirement is not met by ;

Based on staff interview the facility failed to assure that the policies and procedures for all services provided by the home were available upon request. findings include;

Per interview with HSD on 09/13/2012 at 2:45pm the (HSD stated that there were not facility policy and procedure for assessments, wound assessments, wound care, and isolation/contact precaution assessments are required for all residents and wound care assessment due for resident #3.

1. Action To Correct Deficiency:

It has been confirmed that a policy and procedure manual is available in the Health Services Directors office. This manual has been updated to include the revised wound care policies. It was determined that a wound care management policy did exist for this community, however the policy was NOT located in the policy manual. Effective 10/18/12 this has been corrected.

It was also determined that a policy on assessments was also available in the Policy and procedure manual, a copy of that policy, as well as the infection control policies are attached for your review.

2. Measures to Assure This Will Not Recur:

A policy process committee will be established to write policies as needed, to update policies and to review policies on an annual basis.

3. Measure to assure this does not recur.

The above mention committee and resulting review process.

R200 POC accepted 10/22/12 MTH/qms RN | AMW