

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

November 12, 2013

Ms. Emma Burke, Administrator
Lenny Burke's Farm, Inc.
PO Box 1837-A
Rutland, VT 05701

Provider #: 0061

Dear Ms. Burke:

Enclosed is a copy of your acceptable plans of correction for the unannounced onsite re-licensing survey conducted on **October 14, 2013**. 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:ne

Enclosure

NOV 04 2013

PRINTED: 10/21/2013
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/14/2013
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NAME OF PROVIDER OR SUPPLIER LENNY BURKE'S FARM, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 1837-A RUTLAND, VT 05701
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(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 Re-Licensing survey was conducted on 10/14/13 by the Division of Licensing and Protection. The following are Residential Care Home violations.	R100		
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 staff interview and record review, the facility failed to ensure that a Registered Nurse (RN) oversees the development of a written care plan and/or a plan of care was developed for care and services for 2 of 3 applicable residents (Residents #1 & 2). *This is a repeat deficiency. Findings include: 1. Per record review on 10/14/13, there is no evidence that an RN had overseen the development of the care plan for Resident #1. The Resident has a diagnosis of traumatic brain injury and has multiple progress notes for behaviors. Additionally, the resident is taking a variety of psychotropic medications. Neither the behaviors nor the use of the psychotropic medications have been care planned. Per interview on 10/16/13 at 2:30 PM the manager confirmed that there were no care plans to help direct staff for the use of psychotropic	R145	<i>See pg. 1 of 7 attached</i>	

Division of Licensing and Protection ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Emma J Burke, Co-Director of LRP</i>	TITLE	(X6) DATE 11-2-13
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Division of Licensing and Protection

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R145	Continued From page 1 medications nor the resident's behaviors. 2. Per record review, Resident #2 has a diagnosis of traumatic brain injury and has documented behavior of elopement. On October 8, 2013 the progress notes reflect the resident leaving the facility without staff knowledge. The care plan does not reflect a behavior/safety care plan relating to elopement risk. Per interview with the manager at 2:30 PM h/she confirmed that the facility did not develop a care plan for elopement risk.	R145		
R148 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (5) Assure that residents' medications are reviewed periodically and that all resident medications have either a supporting medical diagnosis or problem; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure that each resident's medications are reviewed by the physician periodically and that all resident medications have either a supporting medical diagnosis or problem for 2 of 3 sampled residents. (Resident #1 and Resident #2) Findings include: Per record review and review of the MAR [medication administration record] there is no list of medical diagnoses and/or problems to support all medications administered for both Residents #1 or #2. During an interview on 10/14/13 at 4:30 PM the facility's Administrator confirmed that there is no documentation of a list of medications	R148	See pg. 2 of 7 attached	

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R148	Continued From page 2 and/or diagnoses available in the records.	R148		
R180 SS=C	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.c All training to meet the requirements of 5.11.b shall be documented. Training in direct care skills by a home's nurse may meet this requirement, provided the nurse documents the content and amount of training This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to assure that the staff education hours were documented for 5 of 5 staff reviewed. Findings include: Per record review on 10/14/13, the RCH's Manager and Administrator was able to provide documentation of only a few hours of training material used for staff education. Based on the lack of documentation, the Manager and Administrator could not assure that staff education for five of five applicable staff met the 12 hours per year, as well as the required subject matter as listed in the regulation for three newly hired staff. The information was not available for review at the time of survey. Per interview on 10/14/13 at 4:20 PM, the Administrator confirmed that the education provided to staff was not documented as required.	R180	<i>See page 2 of 7 attached</i>	
R188 SS=A	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(2)	R188	<i>See pg. 3 of 7 attached</i>	

Division of Licensing and Protection
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If continuation sheet 3 of 11

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0081	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/14/2013
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R188	<p>Continued From page 3</p> <p>A record for each resident which includes: resident's name; emergency notification numbers; name, address and telephone number of any legal representative or, if there is none, the next of kin; physician's name, address and telephone number; instructions in case of resident's death; the resident's assessment(s); progress notes regarding any accident or incident and subsequent follow-up; list of allergies; a signed admission agreement; a recent photograph of the resident, unless the resident objects; a copy of the resident's advance directives, if any completed; and a copy of the document giving legal authority to another, if any.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to assure that 2 of 4 resident records included all of the required information. (Resident #1) Findings include:</p> <p>Per record review on 10/14/13, there were no photograph for Resident #1 observed to be present in the medical record nor in the MAR (Medication Administration Record). Resident #1 was admitted on 12/11/12 with traumatic brain injury. Per interview at 5:00 PM, the Administrator confirmed that they did not have a photograph of the resident in any of the medical records as required by the regulation.</p>	R188		
R232 SS=C	<p>VII. NUTRITION AND FOOD SERVICES</p> <p>7.1.a.(1) Menus for regular and therapeutic diets shall be planned and written at least one (1) week</p>	R232	See pg. 3 of 7 attached	

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R232	Continued From page 4 in advance. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide menus for regular and therapeutic diets planning and failed to assure they are written at least one (1) week in advance. During tour of facility it was observed that there was menu postings for only the supper meals and none for the breakfast or lunch per regulatory requirements. This was confirmed by the manager at 10:10 AM on October 14, 2013.	R232		
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, the facility failed to maintain that all perishable food and drink be labeled, dated and held at proper temperatures: At or below 40 degrees Fahrenheit. *This is a repeat deficiency. On 10/14/13 at 10:00 AM, during the tour of the facility's refrigerator and freezer storage, it was observed that there was no temperature logs for the freezer or refrigerator and some of the celery	R247	See pg 4 of 7 attached	

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R247 Continued From page 5
stored on the shelf of the refrigerator was frozen and mushy. Per manager at this time, h/she confirmed that they do not record the temperatures in the freezers or refrigerators and h/she did not know how the facility could assure that perishables were being stored at the proper temperatures.

R247

R248 VII. NUTRITION AND FOOD SERVICES
SS=F

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 observation of the facility's kitchen area at 10:00 AM on October 14, 2013 the facility failed to assure that all work surfaces were cleaned and sanitized after each use, and failed to assure equipment and utensils are cleaned and sanitized after each use and stored properly.

1. During the tour, a staff member was swatting flies and the flies landed on the counter top and the staff member did not clean the top after the flies landed on the counter.
2. There was a build up of spaghetti sauce on the microwave oven's plate base, walls and top on the interior of the microwave.
3. The oven was rusted and dirty with built up grease on the interior door.

See pg. 5 of 7 attached

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R248	<p>Continued From page 6</p> <p>4. A frying pan was on the floor in the pantry.</p> <p>5. There was a dead fly in the sugar container and fruit flies flying in the cupboards and some were found frozen in the refrigerator.</p> <p>6. The over head hood of the range had grease build up and dead fruit and house flies located right over the cooking area of the stove.</p> <p>The manager confirmed these findings at the time they were discovered.</p>	R248		
R249 SS=E	<p>VII. NUTRITION AND FOOD SERVICES</p> <p>7.2 Food Safety and Sanitation</p> <p>7.2.d The home shall assure that food handling and storage techniques are consistent with safe food handling practices.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation of the facility's kitchen area at 10:00 AM on October 14, 2013 the facility failed to assure that handling and storage techniques were consistent with safe food handling practices.</p> <p>During the tour of the facility's food storage area on 10/14/13 at 10:00 AM it was discovered that there were potatoes and onions stored on the floor of the pantry. This was confirmed at the time of the discovery by the manager.</p>	R249	<p><i>See pg. 5 of 7 attached</i></p>	
R266 SS=E	<p>IX. PHYSICAL PLANT</p>	R266	<p><i>See pg. 5 of 7 attached</i></p>	

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R266	Continued From page 7 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 maintain a safe environment. *This is a repeat deficiency. Findings include: Per observation during a facility tour on 10/14/13 at 9:45 AM, an unlocked closet, which served as the laundry room located near the main living room, contained germicidal bleach and other cleaning supplies, creating a potential accident hazard. Per interview with the manager, there are residents in the facility that are confused and ambulate in the area. The administrator confirmed the observation at the time of the observation and stated that the closet should be locked at all times when not in use by staff.	R266		
R296 SS=C	IX. PHYSICAL PLANT 9.8 Heating 9.8.b The minimum temperature shall be maintained at an ambient temperature of 70 degrees Fahrenheit in all areas of the home utilized by residents and staff during all weather conditions. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview the facility failed to maintain the	R296	<i>See pg. 6 of 7 attached</i>	

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R296	<p>Continued From page 8</p> <p>minimum temperature at an ambient temperature of 70 degrees Fahrenheit in all areas of the home utilized by residents and staff during all weather conditions.</p> <p>October 14, 2013 at 9:45 AM a facility tour was conducted and during the tour the temperatures were randomly checked. In a hallway that has stairs that lead to the back side of the upstairs, where there are resident rooms, the temperature was 62.5 degrees and on the stairs near the top it was 63 degrees. The room at the top of the stairs was 62.5 and the resident residing in this room stated that it was chilly in his room. The common living area registered at 67 degrees and the common bathroom was 63.5 degrees. Per interview with manager at 10:17 AM, h/she said that they commonly keep the temperature lower and do not maintain the 70 degrees. H/she also stated that it is difficult to maintain the proper temperatures for all the resident's as some like it cooler and others like it warmer.</p>	R296		
R302 SS=C	<p>IX. PHYSICAL PLANT</p> <p>9.11 Disaster and Emergency Preparedness</p> <p>9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be</p>	R302	<p><i>See pg. 6 of 7 attached</i></p>	

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R302	Continued From page 9 documented. This REQUIREMENT is not met as evidenced by: Based on review of fire drill records and interview, the facility failed to ensure that fire drills were conducted at varying times of the day, including morning, afternoon, evening and nights. This has the potential to affect all Residents in the current census. Findings include: Review of the fire drill records on 10/14/13 shows the fire drills held from January 2013 to present day were held quarterly, however no evening nor night fire drills were conducted. Per interview at 10:15 AM, the Manager confirmed that the fire drills were not rotated among all times of day.	R302		
R999 SS=C	MISCELLANEOUS 4.14.f The home shall make written reports resulting from inspections readily available to residents and to the public in a place readily accessible to resident where individuals wishing to examine the results do not have to ask to see them. The home must post a notice of the availability of such written reports. If a copy is requested and the home does not have a copy machine, the home must inform the resident or member of the public that they may request a copy from the licensing agency and provide the address and telephone number of the licensing agency. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the	R999	<i>See pg. 7 of 7 attached</i>	

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R999	<p>Continued From page 10</p> <p>Residential Care Home (RCH) did not have the latest licensing agency inspection report readily accessible for residents or the public. Findings include:</p> <p>1. Per observation during the initial tour on 10/14/13 at 09:30 AM, a copy of the most recent survey was not found or posted, readily accessible for residents or the public. Per interview at that time, the Manager stated "I think it might be in the [main] office." However, confirmed that no surveys or written report were posted readily accessible for residents or the public without asking to see them.</p>	R999		

EMMA P BURKE
LENNY BURKE'S FARM
PO BOX 1837-A
RUTLAND, VT 05701

October 30, 2013

Pamela M. Cota, RN, Licensing Chief
103 Main Street, Ladd Hall
Waterbury, VT 05671-2306

Dear Pamela,

I have received your letter of Licensing and Protection dated October 21, 2013 and will answer for the facility as follows:

R145 V. RESIDENT CARE AND HOME SERVICES

5.9c(2) Admission

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 for each resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being;

Resident #1:

Action to correct the deficiency: Resident #1 will have an updated plan of care signed by Kathleen Paulin, RN that describes the care and services necessary to assist Resident #1 to maintain independence and well being. In addition RRMCM Behavioral Health monitors and overviews psychotropic medications and provides counseling for Resident #1.

Measures to take place to ensure that deficient practice does not recur: Our RN will be asked by the Manager to look for documentation and complete the plan of care for resident #1.

How corrective actions will be monitored: At Managers' Meetings (held at the LBF office) a co-director will review the compliance of the Manager and RN as outlined above to assure completion by the deadline given below.

Date the corrective action will be completed: December 15, 2013. RRMCM Behavioral Health monitoring is on-going.

Resident #2:

Action to correct deficiency: Staff has developed a plan for elopement challenges with Guardian of Resident #2. The Guardian has sent a letter outlining this plan it is attached to Resident #2's plan of care. Staff has been trained on observation and de-escalating behaviors.

Measures to take place to ensure that deficient practice does not recur: Manager and staff will monitor the whereabouts of Resident #2 at all times.

How corrective actions will be monitored: Reviewed and discussed at each weekly Managers' Meeting.

Date the action will be completed: The RN will sign the revised plan of care prior to November 15, 2013.

R148V SS=E RESIDENT CARE AND HOME SERVICES

5.9c (5)

Assure medications are reviewed periodically and that all resident medications have either a supporting medical diagnosis or problem

As to Resident #1 and Resident #2:

Action to correct deficiency: Rutland Pharmacy supplies all medications and interaction information. All this data has been placed in a binder, with Medication Administration Record. A diagnosis has been added to this information. The MAR is a list that goes with every resident to every appointment for information to the physician and is signed by the physician at the end of the appointment.

Measures to take place to ensure that deficient practice does not recur: Review regularly necessary at weekly managers' meetings.

Date the action will be completed: October 30, 2013

R180 V SS=C RESIDENT CARE AND HOME SERVICES

5.11 Staff Services

5.11c All training to meet the requirements of 511.b will be documented. Training in direct care skills bt a home's nurse may meet this requirement, Provided the nurse documents the content and amount of training.

5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing direct care to residents. There shall be at least (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's rights*
- (2) Fire safety and emergency evacuation*

- (3) Resident emergency response procedure, 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, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions, and
- (7) General supervision and care of residents.

Action to correct deficiency: In addition to our established training protocols, we have added a specific modular program addressing the above listed items separately. Co-ordination for training with the RN will be established and reviewed by managers and co-directors.

How corrective actions will be monitored: To be reviewed by managers and co-directors at the weekly managers' meetings.

Measures to take place to ensure that deficient practice does not recur: All training materials will be kept current and reviewed monthly (first managers' meeting of each month).

Date the action will be completed: December 3, 2013

R188 V SS=A- RESIDENT CARE AND HOME SERVICES
5.12 b (1) (2)

A record of each resident which includes resident's name, address and telephone, number, of any legal representative or, if there is none, the next of kin; physician's name, address and telephone number; instructions in case of death; the resident's assessments; progress notes regarding any accident or incident and subsequent follow-up; list of allergies; assigned admission agreement; a recent photograph of the resident, unless the resident objects; a copy of the resident's advance directives, if any completed; and a copy of the document giving legal authority to another, if any.

Action to correct deficiency: Our emergency fact sheet will be updated to include information required and a photograph of each resident. Resident #1 has a photograph added as of 10/15/13.

How corrective actions will be monitored: House Managers will report any changes needed in the future and this information will be incorporated in the fact sheet immediately.

Measures to take place to ensure that deficient practice does not recur: This practice will be reviewed at the first monthly managers' meeting to be sure all records are being maintained properly.

The date the action will be completed: December 3, 2013

R232 SS=C V11. NUTRITION AND FOOD SERVICES

7.1a (1) Menu's for regular and therapeutic diets shall be planned and written at least one (1) week in advance

Action to correct deficiency: Menus have been reviewed and revised to include breakfast, lunch of choice menus and dinner for three weeks in advance. These changes will be on-going to meet requirements for therapeutic and regular diets.

How corrective actions will be monitored: Staff person responsible for the menus will report regularly to the manager and/or co-director.

Measures to take place to ensure that deficient practice does not recur: To be reviewed at regular managers' meetings.

The date the action will be completed: October 30, 2013

R247 SS=F

V11. NUTRITION AND FOOD SERVICES

7.2 Food Safety and Sanitation

7.2b All perishable food and drink shall be labeled, dated and held at proper temperatures; (1) At below 40 degrees Fahrenheit (2) At or above 140 degrees Fahrenheit when served or heated prior to service.

Action to correct deficiency: We will follow all the appropriate instructions for perishable food and drink as they will be labeled, dated, and held at proper temperatures (at or below 40 degrees Fahrenheit for refrigeration; at or above 140 degrees Fahrenheit when served or heated prior to serving. Temperature logs have been created and thermometers properly placed to monitor all perishable food and drink.

Measures to take place to ensure that deficient practice does not recur: Temperature logs will be completed daily. Monitoring of these logs will assure compliance.

How corrective actions will be monitored: This will be reported, logged, and discussed at our weekly meetings.

The date the action will be completed: October 30, 2013

R248 SS=F V11. NUTRITION AND FOOD SERVICES

7.2 Food Safety and Sanitation

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

Action to correct deficiency: Staff who prepare meals and clean the kitchen have been retrained. Emphasis has been given to sanitation of all work surfaces, equipment and utensils and their proper storage after each use. Deep cleaning is a high priority and will be monitored closely. The oven completely cleaned 10/15/13, with no signs of rust thereafter. A new oven will be budgeted for 2014. Old utensils have been discarded. All food has been stored properly.

Measures to take place to ensure that deficient practice does not recur: Vermont Pest Control is contracted to address pest control (most recently on 9-16 and 9-29 and are scheduled to come again on 10-31). Staff will be trained to report any influx of pests so appointments can be made as needed. Staff will work together in teams to ensure that deficient practice does not recur.

How corrective actions will be monitored: At weekly managers' meetings.

The date the action will be completed: October 15, 2013 (and on going)

R249 SS=F V11. NUTRITION AND FOOD SERVICE

7.2 Food Safety and sanitation

7.2.d. The home shall assure that food handling and storage techniques are consistent with safe food handling practices.

Action to correct deficiency : Corrected immediately upon inspection. Potatoes and onions now on shelf in pantry.

Measures to take place to ensure that deficient practice does not recur: In addition to improved staff awareness of these requirements, inspections will take place weekly for a period time and monthly thereafter.

How corrective actions will be monitored: Review at weekly managers' meetings.

The date the action will be completed: October 30, 2013 and on going.

R266 SS=E 1X PHYSICAL PLANT

9.1 Environment

9.1a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment.

Action to correct deficiency: A lock has been in place. Staff has now been retrained to LOCK this closet at ALL TIMES. In addition, a sign has also been placed to provide visual cues.

Measures to take place to ensure that deficient practice does not recur: Monitoring and observation by LBF staff and manager will be done daily.

How corrective actions will be monitored: Review at weekly managers' meetings. an additional meeting has been scheduled with the manager and assistant at the facility to review and enlighten them in greater detail concerning all of the requirements of the regulations, and the issues brought up in this survey.

The date the action will be completed: October 15, 2013 the above mentioned re-training was complete and the lock was secure, with a reminder note. The meeting with the manager and assistant to address this specific item will be complete by November 15, 2013.

R296 SS=C 1X PHYSICAL PLANT

9.8 Heating

9.8b The minimum temperature shall be maintained at an ambient temperature of 70 degrees Fahrenheit in all areas of the home utilized by residents and staff during all weather conditions.

Action to correct deficiency: A licensed plumber was hired to install digital thermostats in all areas in order to maintain a minimum temperature at an ambient 70 degrees Fahrenheit in all areas of the home utilized by residents and staff during all weather conditions.

Measures to take place to ensure that deficient practice does not recur: Manager and all staff will closely observe the temperature in all areas of the home, at various times of the day. A daily log will be kept of the temperature readings.

How corrective actions will be monitored: At weekly managers' meetings, all daily temperature logs will be reviewed.

The date the action will be completed: October 15, 2013

R302SS=C 1X PHYSICAL PLANT

9.11 Disaster and Emergency Preparedness

9.11c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted

on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented.

Action to correct deficiency: Fire drills will be conducted on a quarterly basis and will rotate at varying times of day, including morning, afternoon, evening and night. The date and time of each drill and the names of the staff conducting the drill shall be documented.

Measures to take place to ensure that deficient practice does not recur: Manager will assign a time and date, and train staff for each drill rotated among morning, afternoon, evening and night.

How corrective actions will be monitored : Reported and discussed at weekly managers' meetings.

The date the action will be completed: November 15, 2013

R999ss=c MISCELLANEOUS

4.14f The home shall make written reports resulting from inspections readily available to residents and to the public in a place readily accessible to resident where individuals wishing to examine the results do not have to ask to see them. The home must post a notice of the availability of such written reports. If a copy is requested and the home does not have a copy machine, the home must inform the resident or member of the public that they may request a copy from the licensing agency and provide the address and telephone number of the licensing agency.

Action to correct deficiency: The most recent written reports resulting from inspections (survey) will be readily available to residents or the public at the Residential Care Home (RCH). Several notices will be clearly posted in the home of the report's availability.

Measures to take place to ensure that deficient practice does not recur: All staff will be aware of the whereabouts of the latest survey, located in its own binder, readily available for review.

How corrective actions will be monitored: Reported and discussed at weekly managers meetings.

The date the action will be completed: November 15, 2013

Please let me know of your questions or suggestions. Please reach me at my home office: 802-773-0503. Thank you.



Emma P. Burke, Co-Director
Lenny Burke's Farm, Inc.

(original documents mailed 11/2/13)