VERMONT
AGENCY OF HUMAN SERVICES
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

September 11, 2012

Ms. Paula Patorti, Administrator
Our House Outback
196 Mussey Street
Rutland, VT 05701

Dear Ms. Patorti:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 16, 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

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0593	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 07/16/2012
NAME OF PROVIDER OR SUPPLIER OUR HOUSE OUTBACK	STREET ADDRESS, CITY, STATE, ZIP CODE 196 MUSSEY STREET 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 investigation was completed on 7/16/12 by the Division of Licensing and Protection. The following are regulatory violations:	R100	See attached Plans of Correction.	
R126 SS=G	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 staff interview and record review, the facility failed to assure that 2 of 3 applicable residents in the sample received care to meet their nursing and medical needs. (Residents #3 & #1) Findings include: 1. Per observation around 11:50 AM on 7/16/12, Resident #1 has an open sore on the coccyx/buttocks area with no dressing applied to the wound. Per record review, Resident #1 has a history of open sores in the buttocks/coccyx region. On June 1, 2012, staff documented that the duoderm (dressing applied to open sore) fell off of the resident's bottom and that the House Manager instructed for staff to use Crisco on the wound. Per interview with the Manager on 7/16/12 at 2:55 PM, she indicated that staff may not have told her the wound was open when she instructed the use of Crisco, and that Crisco is a	R126	R126, R134, R145, R146, R149, R150, R176, R230, R234, + R247 P.O.C.'s accepted 9/10/12 PMcotaRN	

PMC

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R126	Continued From page 1	R126		

home remedy they use. There was no evidence this was in policy anywhere or in standing orders for use. Per interview at 4:30 PM, the RN confirmed staff use Crisco on residents' skin when the skin is still intact and that it is "cheaper" than other skin barrier options, but that she was unaware Crisco was used on Resident #1's open sore on 6/1/12. On 6/6/12, staff documented that the resident's "bottom was bleeding" and a dressing was placed at that time. An assessment by the RN on 6/7/12 indicated Resident #1 had 2 open areas on the buttocks. There was no documentation after 6/7/12 that indicated staff ever changed the duoderm.

Per record review, the open areas were healed as of 6/28/12. However, on 7/10/12, staff requested that the RN check Resident #1's bottom due to an open sore. An note by the RN on 7/11/12 indicates the resident had an open sore and that a duoderm was applied to the area. While the note from the RN indicates the duoderm is to be changed in 2 days, there is no evidence that dressing changes were completed by staff or the RN, and as stated above, the resident was observed by the surveyor with an open, uncovered wound on the coccyx/buttocks area on 7/16/12. The 2 staff assisting the resident during the observation also did not place a duoderm on the open sore.

There was no clear direction to staff as to how to treat this wound. During staff interviews, staff had differing opinions on when to use a duoderm and when to use the ordered Calazime treatment "as needed". There is an order, dated 6/4/12 for "Calazime lotion to buttock as needed", but no indication as to when it is to be applied. One staff member reported using the lotion on open areas, and one staff member reported it should only be

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R126	Continued From page 2 used on intact skin. In addition, Resident #1's care plan indicates use of a "seat cushion" for preventative skin integrity care. Per interview with the RN, the seat cushion indicated on the care plan was a pressure relieving cushion called an "EHOB" cushion. Per observation on 7/16/12, the Resident spent most of the morning (9:15 AM to 12:00 noon) in a wheelchair. The wheelchair did not have any seat cushion in place and this was confirmed by the direct care staff as well as the House Manager during the morning. At 1:30 PM, Resident #1 was transferred with staff assistance to a recliner chair. There was no additional cushion on that chair, where the resident remained for at least 2 hours, per observation. Per interview and observation with direct care staff after the 11:50 AM observation, there was no seat cushion available for use in Resident #1's room. Per interview with the RN, she stated the cushion had "popped" in the recent past (unable to give length of time) and that the facility had not replaced the broken cushion. During this interview, the RN also indicated that the EHOB cushion that was on the resident's bed had also popped and not been replaced. 2. Per record review on 7/16/12 of Resident #3's chart, a "Resident Care Service Note" dated 1/24/12, 2:10 PM stated "--- has a lot of bruising on her body...right side of body, wrist, biceps, lower stomach and two thighs...on her left side are located on her breast and large clusters of bruises on her side." Although the RN wrote a note on 1/25/12 stating that she had been informed of the bruising, there was no evidence of any follow up assessment or interviews to try to determine the reason for the bruising. When the manager of the home was interviewed at 2:20 PM	R126		

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R126	Continued From page 3 on 7/16/12 about this documentation, she stated that she had not been notified of the bruising and that this was the first time she had been made aware of it. She confirmed that no incident report had been completed, per the facility's policy/procedure "Accident/Incident/Injury Report". The policy states that "Anytime an ...injury of a resident occurs, the RN, Administrator and Manager need to know about it" and "Report anytime a resident ...has an ..accident, incident or injury." 3. Per record review on 7/16/12, Resident #3 experienced 2 falls from bed during the night shift on 6/15/12 and caregivers failed document monitoring of the resident post fall per the RN's instructions and per the facility's "Falls and Injuries Procedures". The procedure states under #2 "Do not move the resident...call for assistance...#3 take the resident's Blood Pressure, Temperature, Respirations and document the results on the Accident/Incident/Injury Report From" and "recheck the resident every few minutes and then in one hour." Per review of the incident report completed by the 2 caregivers on duty on 6/15/12, they failed to completely document the resident's vital signs (none were listed) and documented that they helped the resident up at 11:50 PM and did Range of Motion (ROM) Exercises, then 'called nurse'. The resident fell again at 2:15 AM, staff documented a 'bump on head', helped her up and called the nurse. After the second fall, the RN documented that she instructed staff via telephone call to apply ice to head and give Tylenol for discomfort and to monitor behavior. Caregivers documented one entry after the 2 falls stating "Seemed OK, went back to bed around 3:30". There were no other notes/evidence from caregivers (on the Incident	R126		

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	Report or the caregiver comment sheets forms) that they provided further monitoring of the resident until a day shift caregiver wrote "--- brought to hospital around 8:30 this morning...leg wouldn't move". The failure to show evidence of monitoring per the RN's directions after the falls and staff's movement of the resident prior to notification to the RN were confirmed during interview with the RN at 4:30 PM on 7/16/12.			
	*This is a repeat citation.			
R134 SS=D	V. RESIDENT CARE AND HOME SERVICES	R134		
	5.7 Assessment			
	5.7.a An assessment shall be completed for each resident within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The resident's abilities regarding medication management shall be assessed within 24 hours and nursing delegation implemented, if necessary.			
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the home failed to assure assessments accurately reflect each resident's condition for 2 applicable residents (Residents #1 and #2). Findings include:			
	1. Per record review, Resident #1's assessment, dated 5/8/12, indicates that Resident #1 has a pressure relieving device for his/her bed. Resident #1 has a history of open areas on the buttocks/coccyx areas in June and July 2012. Per observation on 7/16/12, Resident #1's bed is			

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R134	Continued From page 5	R134		
	a standard mattress with no pressure relieving device in place. Per interview with the Registered Nurse (RN) on 7/16/12 at 4:30 PM, Resident #1's pressure relieving devices for his/her bed and chair popped and were not replaced by the home. Per observation on 7/16/12 at about 11:50 AM, Resident #1 has a current open sore in the coccyx region.			
	2. Per record review, Resident #2's assessment, dated 5/29/12, does not indicate any use of bed siderails. Per observation throughout the day on 7/16/12, Resident #2's bed is against the wall and there is a metal half siderail on the open side of the bed that the resident uses for bed mobility. Under the physical functioning section of the assessment, bed rails were not indicated on the assessment for being used for mobility or transfer, and instead, "none of the above" was indicated. Per record review, the physician was contacted in January 2012 regarding use of the siderail and the physician signed the order for use of the siderail on 1/23/12.			
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES	R145		
	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 observation, interview and record review, the RN failed to develop a written plan of			

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R145	Continued From page 6	R145		

care for each resident that describes the care and services necessary to assist the resident to maintain well-being for 3 applicable residents in the sample (Resident #1, #2 and #3). Findings include:

1. Per observation on 7/16/12, Resident #1 has an open sore on his/her coccyx area. Per record review, the written care plan for Resident #1 does not include any measures for treating the current open sore. While the care plan states for staff to monitor coccyx and folds under the skin integrity section, there is no evidence of the open sore that was present in June 2012 nor the currently observed open sore, and does not indicate any needs for wound care. The open sore that was observed on 7/16/12 has been present since 7/10/12 and the RN was alerted on that day to the open sore. Per interview on 7/16/12 at 4:30 PM, the RN verified that the written care plan did not include any indications of a need for wound treatment.

2. Per record review, Resident #1's assessment, dated 5/8/12 indicates that Resident #1 has debris in mouth prior to going to bed and has broken, loose or carious teeth. Per a progress note of 6/30/12, Resident #1 had a choking episode during lunch, unable to clear his/her airway, cyanosis occurred (turned blue) and that staff had to perform back percussions for the airway to be cleared. Per record review, there was no follow up regarding this incident to evaluate whether Resident #1 needed to be evaluated for swallowing difficulty or that the physician was contacted regarding this incident. Per review of the care plan, although the care plan indicates poor dentition and that the resident does better with soft foods, there is no indication of this choking episode on the written care plan

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R145	Continued From page 7	R145		

so that staff would be aware of this potential complication. Per interview on 7/16/12 at 4:30 PM, the RN stated that during this time s/he was on vacation and was not aware of any follow up notification to staff or the physician, also verified that the written care plan did not indicate any indication of the choking episode nor a need for increased supervision by staff of the resident's swallowing abilities.

3. Per record review, Resident #2 had falls on 4/27/12 and 4/29/12. Per review of the written plan of care, there were no fall prevention strategies documented on the care plan to reduce the chance of further falls and/or injuries. Per interview on 7/16/12 at 4:30 PM, the RN verified Resident #2's care plan did not include any fall prevention strategies. At the time of interview, the RN was under the impression that Resident #2 had a chair alarm in place when up in the wheelchair (primary mode of locomotion). Per observation, no chair alarm was in place at any time on 7/16/12 and staff informed the RN that Resident #2 uses a bed alarm, not a chair alarm. The RN then verified that the bed alarm was not indicated as being used on the written care plan.

4. Per record review on 7/16/12, Resident #3 had a history of bruising easily and was receiving daily medication with potential blood thinning properties (Aspirin and Naproxen Sodium). During interview on 7/16/12 at 4:27 PM, the RN confirmed there was no care plan to address this identified need.

*This is a repeat citation.

R146 SS=G	V. RESIDENT CARE AND HOME SERVICES	R146		

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R146	Continued From page 8 5.9.c (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the RN failed to provide instruction and supervision to all direct care personnel regarding each resident's health care needs for 1 applicable resident in the sample (Resident #1). Findings include: Per observation around 11:50 AM on 7/16/12, Resident #1 has an open sore on the coccyx/buttocks area with no dressing applied to the wound. Per record review, Resident #1 has a history of open sores in the buttocks/coccyx region since August 2011. On June 1, 2012, staff documented that the duoderm (dressing applied to open sore) fell off of the resident's bottom and that the House Manager instructed for staff to use Crisco on the wound. Per interview with the Manager on 7/16/12 at 2:55 PM, she indicated that staff may not have told her the wound was open when she instructed the use of Crisco, and that Crisco is a home remedy they use. There was no evidence this was in policy anywhere or in standing orders for use. Per interview at 4:30 PM, the RN confirmed staff use Crisco on residents' skin when the skin is still intact and that it is "cheaper" than other skin barrier options, but that she was unaware Crisco was used on Resident #1's open sore on 6/1/12. On 6/6/12, staff documented that the resident's "bottom was bleeding" and a dressing was placed at that time. An assessment by the RN on 6/7/12 indicated	R146		

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R146	Continued From page 9	R146		

Resident #1 had 2 open areas on the buttocks. There was no documentation after 6/7/12 that indicated staff ever changed the duoderm.

Per record review, the open areas were healed as of 6/28/12. However, on 7/10/12, staff requested that the RN check Resident #1's bottom due to an open sore. An note by the RN on 7/11/12 indicates the resident had an open sore and that a duoderm was applied to the area. While the note from the RN indicates the duoderm is to be changed in 2 days, there is no evidence that dressing changes were completed by staff or the RN, and as stated above, the resident was observed by the surveyor with an open, uncovered wound on the coccyx/buttocks area on 7/16/12. The 2 staff assisting the resident during the observation also did not place a duoderm on the open sore.

There was no clear direction to staff as to how to treat this wound. During staff interviews, staff had differing opinions on when to use a duoderm and when to use the ordered Calazime treatment "as needed". There is an order, dated 6/4/12 for "Calazime lotion to buttock as needed", but no indication as to when it is to be applied. One staff member reported using the lotion on open areas, and one staff member reported it should only be used on intact skin.

In addition, Resident #1's care plan indicates use of a "seat cushion" for preventative skin integrity care. Per interview with the RN, the seat cushion indicated on the care plan was a pressure relieving cushion called an "EHOB" cushion. Per observation on 7/16/12, the Resident spent most of the morning (9:15 AM to 12:00 noon) in a wheelchair. The wheelchair did not have any seat cushion in place and this was confirmed by

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R146	Continued From page 10	R146		
	the direct care staff as well as the House Manager during the morning. At 1:30 PM, Resident #1 was transferred with staff assistance to a recliner chair. There was no additional cushion on that chair, where the resident remained for at least 2 hours, per observation. Per interview and observation with direct care staff after the 11:50 AM observation, there was no seat cushion available for use in Resident #1's room. Per interview with the RN, she stated the cushion had "popped" in the recent past (unable to give length of time) and that the facility had not replaced the broken cushion.			
R149 SS=G	V. RESIDENT CARE AND HOME SERVICES	R149		
	5.9.c (6)			
	Maintain a current list of all treatments for each resident that shall include: the name, date treatment ordered, treatment and frequency prescribed and documentation to reflect that treatment was carried out;			
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the RN failed to maintain a current list of all treatments for each resident to include the appropriate treatment and frequency prescribed and failed to ensure documentation was completed to reflect that treatment was carried out for 1 applicable resident (Resident #1). Findings include:			
	Per observation around 11:50 AM on 7/16/12, Resident #1 has an open sore on the coccyx/buttocks area with no dressing applied to the wound. Per record review, Resident #1 has a			

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R149	Continued From page 11	R149		

history of open sores in the buttocks/coccyx region since August 2011. On June 1, 2012, staff documented that the duoderm (dressing applied to open sore) fell off of the resident's bottom and that the House Manager instructed for staff to use Crisco on the wound. Per interview with the Manager on 7/16/12 at 2:55 PM, she indicated that staff may not have told her the wound was open when she instructed the use of Crisco, and that Crisco is a home remedy they use. There was no evidence this was in policy anywhere or in standing orders for use. Per interview at 4:30 PM, the RN confirmed staff use Crisco on residents' skin when the skin is still intact and that it is "cheaper" than other skin barrier options, but that she was unaware Crisco was used on Resident #1's open sore on 6/1/12. On 6/6/12, staff documented that the resident's "bottom was bleeding" and a dressing was placed at that time. An assessment by the RN on 6/7/12 indicated Resident #1 had 2 open areas on the buttocks. There was no documentation after 6/7/12 that indicated staff ever changed the duoderm.

Per record review, the open areas were healed as of 6/28/12. However, on 7/10/12, staff requested that the RN check Resident #1's bottom due to an open sore. An note by the RN on 7/11/12 indicates the resident had an open sore and that a duoderm was applied to the area. While the note from the RN indicates the duoderm is to be changed in 2 days, there is no evidence that dressing changes were completed by staff or the RN, and as stated above, the resident was observed by the surveyor with an open, uncovered wound on the coccyx/buttocks area on 7/16/12. There was no documentation on the Medication or Treatment record that any changes of the duoderm had occurred. The 2 staff assisting the resident during the observation

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R149	Continued From page 12	R149		
	also did not place a duoderm on the open sore. There was no clear direction to staff as to how to treat this wound. During staff interviews, staff had differing opinions on when to use a duoderm and when to use the ordered Calazime treatment "as needed". There is an order, dated 6/4/12 for "Calazime lotion to buttock as needed", but no indication as to when it is to be applied. One staff member reported using the lotion on open areas, and one staff member reported it should only be used on intact skin. In addition, Resident #1's care plan indicates use of a "seat cushion" for preventative skin integrity care. Per interview with the RN, the seat cushion indicated on the care plan was a pressure relieving cushion called an "EHOB" cushion. Per observation on 7/16/12, the Resident spent most of the morning (9:15 AM to 12:00 noon) in a wheelchair. The wheelchair did not have any seat cushion in place and this was confirmed by the direct care staff as well as the House Manager during the morning. At 1:30 PM, Resident #1 was transferred with staff assistance to a recliner chair. There was no additional cushion on that chair, where the resident remained for at least 2 hours, per observation. Per interview and observation with direct care staff after the 11:50 AM observation, there was no seat cushion available for use in Resident #1's room. Per interview with the RN, she stated the cushion had "popped" in the recent past (unable to give length of time) and that the facility had not replaced the broken cushion. There was no documentation of when the seat cushion popped to reflect discontinuation of this intervention.			
R150 SS=D	V. RESIDENT CARE AND HOME SERVICES	R150		

Division of Licensing and Protection

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NAME OF PROVIDER OR SUPPLIER OUR HOUSE OUTBACK	STREET ADDRESS, CITY, STATE, ZIP CODE 196 MUSSEY STREET RUTLAND, VT 05701		

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R150	Continued From page 13	R150		

5.9.c (7)

Assure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken;

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the RN failed to assure that resident symptoms and accidents were documented at the time of occurrence and included actions taken by staff for 1 of 3 residents in the applicable sample. (Resident #3) Findings include:

1. Per record review on 7/16/12, Resident #3 was found with multiple bruises on her body on 1/24/12 at 2:10 PM. Per review of a progress note dated 1/25/12, the RN acknowledged that staff had informed her of the bruising but there was no evidence of any follow up documentation to assess the possible reasons for the bruising nor to state when they resolved. There was no documentation that the family had been notified.

2. Per record review on 7/16/12, Resident #3 experienced 2 falls from bed during the night shift on 6/15/12. Per the facility's "Falls and Injuries Procedures", #2 states "Do not move the resident...call for assistance...#3 take the resident's Blood Pressure, Temperature, Respirations and document the results on the Accident/Incident/Injury Report From" and "recheck the resident every few minutes and then in one hour." Per review of the incident report completed by the 2 staff on duty on 6/15/12, they failed to completely document the resident's vital signs (none were listed) and documented that they helped the resident up at 11:50 PM and did

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R150	Continued From page 14	R150		
	Range of Motion (ROM) Exercises...'called nurse'. The resident fell again at 2:15 AM, 'bump on head' , helped her up and called nurse.' After the second fall, the RN documented that she instructed staff via telephone call to apply ice to head and give Tylenol for discomfort and to monitor behavior. Staff caregivers documented one entry after the 2 falls stating "Seemed OK, went back to bed around 3:30". There were no other notes/evidence from caregivers (on the Incident Report or the caregiver comment sheets forms) that they provided further monitoring of the resident until a day shift caregiver wrote "--- brought to hospital around 8:30 this morning...'leg wouldn't move". The failure to show evidence of monitoring per the RN's directions after the falls and staff's movement of the resident prior to notification to the RN were confirmed during interview with the RN at 4:30 PM on 7/16/12.			
R176 SS=D	V. RESIDENT CARE AND HOME SERVICES	R176		
	5.10 Medication Management			
	5.10.h (4)			
	Medications left after the death or discharge of a resident, or outdated medications, shall be promptly disposed of in accordance with the home's policy and applicable standards of practice.			
	This REQUIREMENT is not met as evidenced by: Per interview and record review, the home failed to dispose of medications in accordance with the home's policy for 1 applicable discharged resident (Resident #4). Findings include:			

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R176	Continued From page 15	R176		
	Per review of the home's policy directs staff to document when medications are destroyed and have a family member sign the Medication Administration Record if the medication are sent with a family member and to also have staff sign that the medications have been taken by the family. Per record review, there was nothing in Resident #4's record to indicate what was done with the medications upon discharge. Upon the State Medicaid office contacting the resident's family, the family stated that when they went to pick up the resident's medications, they were not in the facility. In speaking with the nurse, the nurse indicated that the medications had been sent back to the pharmacy. Per the pharmacy, they never received any medications back for Resident #4. The State Medicaid office is alleging theft of the 2 medications, Zyprexa and Exelon. Per interview with the House Manager on 7/16/12 at 2:55 PM, she indicated that they don't document where medications are sent upon discharge of a resident.			
R230 SS=C	VI. RESIDENTS' RIGHTS	R230		
	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.			

Division of Licensing and Protection

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R230	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the home failed to assure a summary of the obligations of the RCH to its residents in terms of resident's rights are posted conspicuously in a public place in the home and failed to ensure the notice also summarizes the home's grievance procedure and directions for contacting the Ombudsman Program and Vermont Protection and Advocacy (currently named "Disability Rights Vermont"). Findings include: Per observation, a listing of resident's rights was located, in small print, behind a half door in the staff medication area/medical records area out of sight from the hallway beyond the half door. It did not contain the home's grievance procedure or the information for contacting Disability Rights Vermont. Per interview with the House Manager at 2:55 PM, it was verified that this information was not in a public place where residents and/or family members/legal representatives could view.	R230		
R234 SS=C	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: Per observation, the current week's regular menu was not posted in a public place for residents and other interested parties. Findings include: Per observation with the House Manager on 7/16/12 during the initial tour, the menu for the day was posted in the dining room area.	R234		

Division of Licensing and Protection

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R234	Continued From page 17 However, the menu for the week was not posted in a public place, but rather was located on the side of the refrigerator with other papers on top of it, behind a half door.	R234		
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 observation, staff interview and record review, the facility failed to assure that all perishable food and drink was held at proper temperatures regarding refrigerator/freezer storage: (1) at or below 40 degrees Fahrenheit. Findings include: Per observation of the refrigeration temperature monitoring logs on 7/16/12 at 11:20 AM, the last entry recording the refrigerator/freezer temperatures was on 6/25/12. A sign posted on the kitchen cabinet directed staff to check refrigerator/freezer temperatures daily and record weekly temperatures on the logs. Per observation, the temperature of the refrigerator was noted to be 50 degrees Fahrenheit and the freezer thermometer read 8 degrees. The failure to assure safe food storage temperatures for perishable foods was confirmed during interview with the manager at the time of the tour. *This is a repeat citation.	R247		

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8/12/12

Edited 9/3/12 per P.C.

Plan of Correction:

"Statement of Deficiencies and Enforcement Action Effective Immediately"

Our House Outback

Survey 7/16/12

R126

Provider disagrees with this characterization.

1) WOC/ET Nursing agreement with RRMC has been added to the ET nursing services through RAVNA. WOC/ET nursing team will assist the Our House RN with urgent cases as needed, with in service training to staff and with documentation on a case by case basis in combination with Our House RN.

Our House RN will continue to maintain and monitor progress and document such on flow sheet provided by ET Nurses as necessary for compliance or on a mutually agreed upon MAR or treatment sheet, RN or authorized staff will document such per incident of care/observation.

ET Nurses, OH RN and Administrator will provide written protocol for existing daily preventive procedures for all residents. 9/15/12

Only med certified staff or other staff authorized by the house RN (in writing) would be expected to do dressing changes and only when, instructed by, trained by and demonstrated to the RN.

As all of our residents have dementia and therefore often pick, and remove dressings, bandages, clothing etc., Staff has been advised that we must document these events and not just report them during rounds at shift change.

Med certified staff is trained by the RN when any new product or procedure is necessary, instructions are on the M.A.R.

RN and Med Certified staff have been reminded to document dressing changes on MAR or ET Nurse flow sheet when appropriate.

8/27/12

Care Plan has been updated, new type of cushion was ordered by the ET nurses and the PCP and are in place to be used while in the wheelchair and the IRIS overlay on his bed. Staff is reminded to encourage the resident to use and to replace it asap when he does remove it. 7/17/12

2) Staff note to RN was an observation; RN note was response to findings. RN and senior caregiver (R.A.) discussed verbally the residents history of bruising but nothing more was documented and there was no more conversation about the bruising. In the future there will be more detailed documentation of such conversations and in addition to the drug side effect sheets; the RN will add "susceptibility to bruising" caused by meds or body type to the plan of care when appropriate. Any bruising of unknown origin will be investigated and the outcome documented. House Manager will monitor for compliance weekly.

8/17/12

Quoted "policy" was adopted in March 2012 prior to the January incident as is stated on the cover.

Resolved 3/2012

The staff members involved have been reminded of proper procedures and have demonstrated verbally their understanding of the importance of following procedures.

RN and Caregivers have been reminded to document on the incident report form as well as several other notes done during this time, the incident report was not complete. This has been readdressed by memo and will be reiterated at our September in service. RN and relief RN will monitor for compliance.
9/18/12

R134

Provider does not agree with this characterization.

Care Plan has been updated, new type of cushion was ordered by the ET nurses and the PCP and are in place to be used while in the wheelchair and the IRIS overlay on his bed. Staff is reminded to encourage the resident to use and to replace it asap when he does remove it. 7/17/12

Care plan did include info re: side rail, Assessment did not but has since been corrected. Monthly monitoring of assessments will continue, RN and the House Manager will review monthly for accuracy and compliance, or when new assessments or changes occur. 8/20/12

R145

Provider does not agree with this characterization.

New wound care flow sheets will be added to the plan of care file when necessary – RN and Manager will monitor and sign together to assure accuracy. 8/20/12

This was an isolated incident – Legal rep does not want any tests and that has been discussed with the Administrator and the Physician. The plan of care states soft diet and small pieces are expected. The RN on call documented staffs report and her assessment this day – she instructed staff to contact her with

changes or if additional choking occurred. The event was also documented in the daily comment log, and the residents ADL's. Nothing further was necessary.

All Residents care plans have been reviewed for accuracy; Manager has been reminded that the RN must be advised when any change occurs so that the plan of care and the assessment may be accurately updated. RN and Manager will review and monitor at least monthly or as changes occur; for accuracy, and regulatory compliance.

8/20/12

R146

Provider does not agree with this characterization.

WOC/ET Nursing agreement with RRMC has been added to the ET nursing services through RAVNA. WOC/ET nursing team will assist the Our House RN with urgent cases as needed, with in service training to staff and with documentation on a case by case basis in combination with Our House RN.

Our House RN will continue to maintain and monitor progress and document such on flow sheet provided by ET Nurses as necessary for compliance or on a mutually agreed upon MAR or treatment sheet, RN or authorized staff will document such per incident of care/observation.

ET Nurses will provide written protocol for existing daily preventive procedures in writing as agreed upon with RN for all residents. Written protocol will clearly state preventive measures for all residents. Staff training on new written protocol will be complete at our September in service. 9/21/12

Only med certified staff or other staff authorized by the house RN (in writing) would be expected to do dressing changes and only when, instructed by, trained by and demonstrated to the RN.

RN will monitor wounds and preventive care on a weekly or daily basis as needed, per occurrence, per resident and will document observations.

House Manager will advise RN of any new concerns, daily, in writing, as well as verbally. RN and Manager will review skills with delegated staff on a monthly basis or as needed to assure they are following training and plan of care expectations to assure compliance. 7/30/12

As all of our residents have dementia and therefore often pick, and remove dressings, bandages, clothing etc., Staff has been advised that we must document these events and not just report them during rounds at shift change.

Med certified staff is trained by the RN when any new product or procedure is necessary, instructions are on the M.A.R.

RN and Med Certified staff have been reminded to document dressing changes on MAR or ET Nurse flow sheet when appropriate.

8/27/12

Care Plan has been updated, new type of cushion was ordered by the ET nurses and the PCP and are in place to be used while in the wheelchair and the IRIS overlay on his bed. Staff is reminded to encourage the resident to use and to replace it asap when he does remove it. 7/17/12

R149

Provider does not agree with this characterization.

WOC/ET Nursing agreement with RRMC has been added to the ET nursing services through RAVNA. WOC/ET nursing team will assist the Our House RN with urgent cases as needed, with in service training to staff and with documentation on a case by case basis in combination with Our House RN.

Our House RN will continue to maintain and monitor progress and document such on flow sheet provided by ET Nurses as necessary for compliance or on a mutually agreed upon MAR or treatment sheet, RN or authorized staff will document such per incident of care/observation.

ET Nurses will provide written protocol for existing daily preventive procedures for all residents i.e. use of Crisco as a recommended barrier to reduce sheering; lotion vs. soap for night time wash ups to maintain skins natural moisture barriers, etc. as they have instructed us always and we practice daily.

Only med certified staff or other staff authorized by the house RN (in writing) would be expected to do dressing changes and only when, instructed by, trained by and demonstrated to the RN.

RN and House Manager will monitor staff performance and skill sets based on training, as needed or at least monthly. All will be noted on the skills training sheet for compliance. 9/12

As all of our residents have dementia and therefore often pick, and remove dressings, bandages, clothing etc., Staff has been advised that we must document these events and not just report them during rounds at shift change.

Med certified staff is trained by the RN when any new product or procedure is necessary, instructions are on the M.A.R.

RN and Med Certified staff have been reminded to document dressing changes on MAR or ET Nurse flow sheet when appropriate.

8/27/12

Care Plan has been updated, new type of cushion was ordered by the ET nurses and the PCP and are in place to be used while in the wheelchair and the IRIS overlay on his bed. Staff is reminded to encourage the resident to use and to replace it asap when he does remove it. 7/17/12

R150

Provider does not agree with this characterization.

The staff members involved have been reminded of proper procedures and have demonstrated verbally their understanding of the importance of following procedures.

All falls will be reported to families, unless families have written expectations on when they don't want to be notified. Manager and Administrator will monitor resident records for compliance daily. 7/12

RN and Caregivers have been reminded to document on the incident report form as well as several other notes done during this time, an incident report was not completed. This has been readdressed by memo and will be reiterated at our September in service. RN and relief RN will monitor for compliance. 9/18/12

Any bruising of unknown origin will be investigated and the outcome documented. House Manager will monitor for compliance weekly. 7/12

R176

Provider does not agree with this characterization.

New tracking form has been developed by Health Direct for Our House use when sending meds to them for credit or destruction. Manager will complete form and keep a copy in the residents chart (M.A.R.). RN will sign as well. All other procedures remain in place as we have always had legal reps or family sign the M.A.R. when sending meds out of the carehome. 9/1/12

R230

Provider does not agree with this characterization.

We framed and hung the Resident Rights poster which includes the grievance procedures as well as the contact information for the Ombudsman.. as well as each legal rep being presented with their own copy of our "grievance policy and procedure" document with each admission which does include the Ombudsman's contact info as well, since we have been operating. Even though # 13 states:

"When a resident is adjudicated mentally disabled such powers as have been delegated by the probate or family court to the residents Guardian shall devolve to the Guardian pursuant to applicable law."

Therefore giving a copy to each resident's legal representative (since they all have some kind of dementia) prior to admission should suffice. Disability rights Vermont poster hangs in our entryway (6/12). All legal reps are also given a copy of our policy and procedure on filing a grievance or complaint.

No action needed 7/18/12

R234

Provider does not agree with this characterization.

Daily menu board will be maintained. New framed monthly menu has been added to the common area in large print. Manager will change monthly to assure compliance. 7/23/12

R247

Provider does not agree with this characterization.

RNNS checked temps during meal prep for lunch and clean up from late breakfasts – at exit interview administrator asked if she had checked it since, RNNS said no but I can, but didn't recheck.

Staff has been reminded to log temperatures at least weekly and view them daily in all fridges and freezers – Manager will monitor weekly for compliance. 8/20/12