

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

August 23, 2011

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

Provider ID#: 0596

Dear Mr. McWilliam:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation **conducted on July 11, 2011 and completed on July 13, 2011**. 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



8/19/11
*error in
 Facility Properties
 Report JB*

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 Division of
 AUG 12 11

PRINTED: 08/02/2011
 FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596 0595	(X2) MULTIPLE CONSTRUCTION Licensing and Protection A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/13/2011
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NAME OF PROVIDER OR SUPPLIER THE LODGE AT OTTER CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 350 LODGE ROAD MIDDLEBURY, VT 05753
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R100	Initial Comments: An unannounced on-site licensing survey was completed by the Vermont Division of Licensing & Protection on 7/11/11. The following regulatory violations were found.	R100		
R112 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.2 Admission 5.2.d On admission each resident shall be accompanied by a physician's statement, which shall include: medical diagnosis, including psychiatric diagnosis if applicable. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the home failed to acquire a physician statement for 1 applicable resident in the survey sample (Resident #2) at the time of admission. Findings include: 1. Per record review on 7/11/11, there was no admitting physician statement for Resident #2 (admitted 1/3/11) in the resident record. During interview at 3:20 PM, the Health Services Director confirmed that the physician statement, including all applicable medical and psychiatric diagnosis had not been completed for this resident.	R112	<i>R112 POC accepted per addendum 8/18/11 Maggie Ketchum, RN</i>	
R128 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders.	R128		

Division of Licensing and Protection

Rose Cleveland RN
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

ROSE CLEVELAND RN

TITLE
 SENIOR DIRECTOR OF

(X6) DATE

STATE FORM

6899

9GC311

Health SERVICES

If continuation sheet 1 of 15

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R128	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RN failed to assure that physician orders for 2 of 4 applicable residents in the sample were carried out as ordered. (Residents #3 & #4) Findings include: 1. Per record review on 7/11/11, a physician's visit note dated 4/13/11 instructed staff to arrange a "follow up appointment for a new mouth splint -mouth guard doesn't fit" for Resident #3. Per interview that day, the Staff Nurse stated that the receptionist makes the appointments after nursing notifies the receptionist. Per interview on 07/12/11 at 8:10 AM the receptionist stated and confirmed that notification for the appointment was "not brought to my attention" and therefore the appointment was not made. 2. Per record review on 7/11/11, physician orders for Resident #4, dated 5/17/11 on the MAR (Medication Administration Record) stated "Tylenol #3, 1-2 tabs as needed (PRN) for Carpal Tunnel Syndrome". Per review of the MAR, staff had documented administration of Tylenol #3 on 7/02/11 for neck and shoulder pain and on 7/03/11 for toe pain. During interview on 7/11/11 at 12:38 PM, the Health Services Director confirmed that there was 'a med error because they were giving the medication for other uses' than the prescribed use, Carpal Tunnel Syndrome.	R128		
R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment	R136		

*R128 POC accepted per address on 8/18/11
Mig Botte, RN*

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R136	Continued From page 2 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 staff interview and record review, the home failed to complete a timely annual re-assessment for 1 of 4 applicable residents in the survey sample (Resident #3). Findings include: 1. Per record review on 7/11/11, the last recorded annual assessments for Resident #3 were completed during February, 2010 and next on 6/16/11. Per interview and confirmed by the manager on 7/11/11 the annual assessment completed on 06/16/11 for Resident #3 was greater than 4 months overdue for completion.	R136		
R137 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.8 Physician Services 5.8.a All residents shall be under the continuing general supervision of a physician of their choosing, and shall receive assistance, if needed, in scheduling medical appointments. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to assure that 1 applicable resident in the survey sample (Resident #2) was under the continuing supervision of a physician. Additionally, the home failed to provide	R137	<i>R136 PAC accepted per addendum 8/18/11 Mary Beth, RN</i>	

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R137	Continued From page 3 assistance in scheduling a medical appointment for 1 applicable resident in the targeted sample (Resident #3). Findings include: 1. Per record review on 7/11/11, Resident #2 was admitted on 1/3/11 with hospital discharge orders signed by a hospital physician. Staff progress notes indicated that there was no ongoing physician coverage for this resident until a Nurse Practitioner became the provider of record on 1/28/11. During interview on the afternoon of 7/11/11, the Health Services Director confirmed that the resident was admitted to the home without a Primary Care Provider to direct care and medication and that this continued for more than 3 weeks. 2. Per record review on 7/11/11, a progress note dated 6/24/11, 4:46 PM for Resident # 3's medical record stated that the resident requested the nurse contact the doctor "to see if my Mamo [mammogram] was due, concerned it was overdue" and that the nurse "will follow up with the doctor and let her know". Per interview, the Staff Nurse stated that the receptionist makes the appointments after nursing notifies the receptionist. Per interview on 7/12/11 at 8:10 AM the receptionist confirmed that notification for this appointment was "not brought to my attention" and "the appointment was not made."	R137	<i>R 137 POC accepted per addendum 8/18/11 Mey Boethy, RSW</i>	
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.	R145		

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R145	<p>Continued From page 4</p> <p>necessary to assist the resident to maintain independence and well-being;</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RN (Registered Nurse) failed to develop a plan of care reflecting all identified needs of 1 applicable resident in the survey sample (Resident #2). Findings include:</p> <p>1. Per record review on 7/11/11, Resident #2 was newly diagnosed with COPD (Chronic Obstructive Pulmonary Disease) on 1/23/11. The resident's problem list did not include this new diagnosis, nor was a service plan developed to address the resident's specific needs related to this diagnosis. During interview at 3:05 PM, a staff nurse confirmed that there was no service plan for the resident's care needs related to COPD.</p>	R145	<p><i>R145 PIC accepted per addendum 8/15/11 Maggie Butler RN</i></p>	
R165 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.10 Medication Management</p> <p>5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:</p> <p>(3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for:</p> <p>i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects;</p> <p>ii. Establishing a process for routine</p>	R165		

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R165	Continued From page 5 communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications; iii. Assessing the resident's condition and the need for any changes in medications; and Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the Registered Nurse (RN) failed to assure that 1 of 4 applicable residents in the total sample was assessed for a need to change medications after a trial of a new medication. (Resident #1) Findings include: 1. Per record review on 7/11/11, Resident #1's physician ordered a trial of loratadine 10 mg (milligrams) by mouth daily for one week on 5/24/11, to treat the resident's allergic symptoms. Review of the May 2011 Medication Administration Record (MAR), revealed that the resident did receive this medication for the full 7 days. There was no documentation of a new order and it was not included on the June, 2011 MAR. There was no documented evidence that the RN assessed the efficacy of the medication to treat the resident's symptoms, nor subsequent notification to the physician to update him/her with the resident's response to the treatment. This lack of follow up regarding the trial of this medication was confirmed during interview with the unit nurse on 7/11/11 at 3:25 PM.	R165		
R171 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management	R171		

*R 165 POC accepted per addendum 8/18/11
Maggie [signature]*

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R171	<p>Continued From page 6</p> <p>5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include:</p> <ul style="list-style-type: none"> (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, including the reason why and the actions taken by the home; (3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect; (4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and (5) For residents receiving psychoactive medications, a record of monitoring for side effects. (6) All incidents of medication errors. <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the Registered Nurse (RN) failed to assure that there was a current list of RN delegated staff who administer medications. Findings include:</p> <p>Per record review on 7/12/11, the list of medication delegated staff was incomplete and contained illegible entries. During interview at 2:30 PM, the Health Services Director confirmed that the delegation list contained some illegible entries and stated that it was not current as some employees on the delegation list are no longer working with the company and that some new employees who have been delegated to administer medications had not been added to</p>	R171		

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R171	Continued From page 7 the list.	R171	<i>R171 POE accepted per addendum 8/18/11 Mey Bothe, MD</i>	
R178 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.11 Staff Services</p> <p>5.11.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to assure that sufficient numbers of staff were available at all times to provide necessary care regarding medication administration to residents of 2 separately licensed entities owned by the company. Findings include:</p> <p>1. Per interview with a medication technician (Med Tech) on 7/11/11 at 1:40 PM, regarding adequacy of staffing patterns, the Med Tech stated that s/he was sometimes assigned to administer medications to residents in the licensed Residential Care Home (RCH) and the Assisted Living Residence (ALR) during the same shift, on the same day. S/he stated that it was difficult to administer medications to both entity's residents during the same shift due to the high numbers of medications involved. Review of the staffing schedule for 7/10/11 revealed that there was no name assigned to work as Med Tech on the RCH. The Med Tech stated that when there is no Med Tech assigned to either the ALR or the RCH, the Med Tech scheduled for either one was required to administer medications to the</p>	R178		

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R178	Continued From page 8 residents of both entities for that shift. This staffing process was confirmed during interview with the RN for both entities at 5:15 PM on 7/11/11. 2. Per interview with a Med Tech on 7/12/11 at 1:20 PM, regarding staffing of the RCH (Meadows) unit, s/he covered both the assigned RCH licensed portion of the home for the entire day shift the prior weekend and also covered the medication needs of the Assisted Living Residence portion of the home from noon until end of shift. The Med Tech stated that s/he was aware of the need for separation of staffing, noted that to the scheduler, but was told that the need for the shift would be to cover both sections for the afternoon portion as there was no one else available to pass medications for the Assisted Living Residence. 3. Per record review on 7/13/11, the staff schedule indicated that there was no Med Tech scheduled for the Meadows (RCH) on 7/12/11 and 7/13/11. During interview at 9:40 AM, the Administrative Assistant confirmed that there were no changes to the previously posted night shift schedule of 7/12/11 and that there was no Med Tech scheduled to work that shift on the night of 7/13/11. During interview at 10:15 that morning, the HSD (Health Services Director) confirmed that a single Med Tech was scheduled for the prior shift of 7/12/11 and a single Med Tech is scheduled for the night shift of 7/13/11. This Med Tech was / is expected to cover both the ALR and RCH sections of the home due to a lack of available trained Med Techs.	R178		
R179 SS=E	V. RESIDENT CARE AND HOME SERVICES	R179		

*R178 POC accepted per addendum 8/15/11
Ming Bath, RN*

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R179	Continued From page 9 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to assure that all employees received all required annual trainings. Findings include: 1. Per record review on 7/12/11, 5 of 8 employee records lacked evidence of training within the past year regarding infection control. During interview that afternoon, the Health Services Director confirmed that the records did not indicate that training in this topic had occurred for these 5 employees.	R179	<i>R 179 POC accepted per addendum 5/16/11 May Kalth, RN</i>	

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R181 R181 SS=E	Continued From page 10 V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to provide evidence that child registry checks had been completed for 7 of 8 employees. Findings include: 1. Per record review on 7/12/11, 7 of 8 employees had no child abuse registry check results. During interview at 12:20 PM, the Business Office Manager confirmed that there were no child abuse registry results for these 7 currently employed staff members.	R181 R181		

*R181 POC accepted per all denials 8/18/11
May Bolte, RN*

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R249 R249 SS=E	Continued From page 11 VII. NUTRITION AND FOOD SERVICES 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. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the home failed to assure that food handling and storage areas were maintained in a sanitary manner in accordance with accepted safe food handling practices. Findings include: During a tour of the home's kitchen and food storage areas on the morning of 07/11/11 the following concerns were noted: 1. The convection ovens had a build up of grease, crumbs and old blackened material throughout both oven interiors. 2. The 3 compartment sink was noted to have pots soaking in light colored water. When asked to check the sanitizer solution level by the nurse surveyor, staff were unable to locate the reagent strips. In addition, staff stated "they empty the sinks about twice a day and and they check the solutions about 2 times a week with the strips". 3. The hood vents had a build up of dust and the back splash around the main burner stove had thick grease splatter. Staff stated that "clean up of the stoves is suppose to be cleaned once a week but there was there is no official schedule". 4. The Dishwasher temperature were not being recorded daily and the most current list was dated 11/06/10. Staff were unable to locate a current temperature log.	R249 R249		

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R249	Continued From page 12 5. Outdated tuna salad and macaroni salad containers in the salad bar as well as undated tomato and mozzarella plates were observed in the reach in cooler. Staff removed these items after the nurse surveyor pointed this out. Per interview on 7/12/11 at 10:15 AM, the Food Service Supervisor confirmed the above findings are not acceptable food handling practices.	R249	<i>R249 PIC accepted per addendum 5/18/11 - May Bath, RN</i>	
R266 SS=E	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the home failed to provide a safe resident environment at all times. Findings include: 1. Per observation on 7/12/11 at 8:36 AM, the door to the Maintenance Department room was unlocked and ajar. The room contained a wide variety of hand and electrical tools, chemicals, and paint materials and was unattended by any staff member. A housekeeper adjacent to the room confirmed that the room was unlocked, that it was unattended and that there were materials that should not be available for resident access. The housekeeper locked the door at surveyor request when maintenance staff indicated an inability to immediately respond. 2. Per observation on 7/12/11, a cleaning cart containing a liquid all purpose cleanser, a cream	R266		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0595	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/13/2011
NAME OF PROVIDER OR SUPPLIER THE 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
R266	Continued From page 13 cleanser, Windex, liquid disinfectant, toilet bowl cleaner and Lysol Disinfectant spray was observed outside a 3rd floor resident room from 1:25 PM to 1:55 PM unattended. During interview with a housekeeper at the conclusion of this observation, s/he stated that these items were left unattended in a resident accessible area and that it is the usual practice to leave the cart in the hall while finishing a units cleaning / vacuuming. 3. Per observation on the Residential Care Unit on 7/12/11 at 1:00 PM, a housekeeping cart was unattended in the hallway outside a resident room. The cart contained Windex, toilet bowl cleaner, liquid disinfectant, and a liquid all purpose cleanser. During interview immediately following the observation, the housekeeper confirmed that the cart outside the closed resident unit door contained the listed chemicals and stated that this is the usual practice while vacuuming each unit.	R266	<i>R 266 POC accepted per addendum 8/11/11 May Balthus RN</i>	
R302 SS=F	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 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 documented.	R302		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0595	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/13/2011
NAME OF PROVIDER OR SUPPLIER THE 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
R302	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the home failed to conduct fire drills following the required frequency and times. Findings include: 1. Per record review on 7/12/11, there were 6 fire drills completed during the prior year with 4 of 6 drills without a time of drill indicated, 2 drills had no staff signatures to indicate that staff participated in the drill. During interview at 11:40 AM, the Maintenance Director confirmed that the documented fire drills did not indicate, in every instance, the time of day the drill occurred and the names of each participating member of the Residential Care Home staff.	R302	<i>R302 POC accepted per addendum 8/15/11 Meg Balthus</i>	

Plan of Correction for The Lodge at Otter Creek:

R112

5.2.d On admission each resident shall be accompanied by a physician's statement which shall include: medical diagnosis, including psychiatric diagnosis if applicable.

This requirement was not met as evidenced by:

Based on interview and record review the home failed to acquire a physician statement for 1 applicable resident in the survey sample (resident #2) at the time of admission.

1. Per record review on 7/11/11, there was no admitting physician statement for resident #2 (admitted 1/3/11) in the resident record. During interview at 3:20pm, the Health Services Director confirmed that the physician's statement, including all applicable medical and psychiatric diagnosis had not been completed for this resident.

1. Action to correct deficiency:

Per The Lodge at Otter Creek's policy, "Prior to, or at the time of admission each resident's physician must provide a statement that includes their current medical diagnosis, including psychiatric diagnosis if applicable."

- This policy will be amended to read: "Twenty four hours prior to admission, each resident's physician must provide a statement that includes their current medical diagnosis, including psychiatric diagnosis if applicable. **NO** resident will be accepted for admission in the absence of this document."
- Residents current provider has agreed to provide a current physician's statement.

Expected completion date August 8th, 2011.

2. Measures to assure that this does not recur:

- No resident will be permitted to take occupancy of a new apartment unless the Health Services Director has approved physician's statement twenty four hours prior to resident's planned admission. Any resident seeking to move in with out this approved document will be refused by the Health Services Director until such time completed document is made available.
- This policy update was reviewed by all staff nurses on 8/8/11 nurses meeting. All current nurses were asked to read and sign updated policy indicating understanding. Additionally, on 8/10/11 this policy update was reviewed with the Marketing department by the company Owner, Gregg Beldock, who insists the Marketing department adheres to this policy.

3. How will corrective action will be monitored:

- Health Services Director will inspect all completed physician's statements for completion twenty four hours prior to admission.
- Senior Director of Health Services will be required to review all paperwork prior to admission

*POC R112 accepted 5/18/11
May Balle, RN*

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R128 - 1

5.5. c Each residents medication, treatment and dietary services shall be consistent with the physician's order.

1. "Based on staff interview and record review, the RN failed to assure that the physician orders for two of the four applicable residents in the sample were carried out as ordered. (Residents #3 and #4) . . ."a physician's order dated 4/13/11 instructed staff to arrange a "follow up appointment for a new mouth splint - mouth guard doesn't fit" for resident #3"

2. "Per record review 7/11/11 physician orders for Resident #4, dated 5/17/11 on the MAR (medication administration record) stated Tylenol #3, 1-2 tabs as needed (PRN) for Carpal Tunnel Syndrome". Per review of the MAR, staff had documented administration of Tylenol #3 on 7/02/11 for neck and shoulder pain and on 7/03/11 for toe pain."

1. Action to correct deficiency:

Per the lodge at Otter Creek policy, "Each resident's medication, treatment, and dietary services shall be consistent to the physician's order."

1. There is a process in place which allows all physician orders which come to the Lodge at Otter Creek to be double checked by nurses. In April 2011 the Lodge at Otter Creek suffered from a near complete change in nursing staff. During this transition several temporary nurses came to the facility to provide support. It was during the initial days of this transition that the mouth guard follow up (for resident #3) was missed. Follow up was completed with this resident to correct this issue. Resident #3 has been scheduled to see her dentist for a cleaning and to be evaluated for a new mouth guard. At a nurses meeting on 8/8/11 Nursing staff was reeducated on the importance of following an MD orders and following through with the scheduling of all requested follow up appointments by physicians. Additionally Nursing staff was asked to include this in the second check process for all orders.

2. A meeting is scheduled with all Lodge at Otter Creek Med Techs for Monday August 15th. Med Techs will be reeducated at the Med Tech Meeting regarding PRN use and

documentation. Meanwhile individual meetings with med techs have been taking place to remind med techs that PRN medications must be used specifically per order,(PRN for headache my be used ONLY for headache, not fever). Med Techs are reminded a nurse is always available, in the building or on call, if there are ANY questions about this. If a resident has a PRN medication need with no medication available, med techs are reminded to work with nursing so that correct PRN orders can be obtained. Reminders are placed in the med tech daily information note book and this will be addressed, in detail, at the August 15th, 2011 Med Tech Meeting.

Expected date of completion: August 15th, 2011

2. Measures to ensure that this does not recur:

Nursing will carry out daily monitoring of PRN usage via a form Med Tech must complete each time a PRN is used. Thus form prompts the Med Tech to report why the PRN was ordered and why they are administering. Nursing will immediately follow up with Med techs who are making errors provide education and corrective action as needed.

Nursing will F/U with resident and physicians to obtain new orders as needed.

3. How corrective action will be monitored:

Senior Director of Health Services will perform weekly audits in these area. Evidence of improvement will be measured by the absence of missed follow up appointments and PRN Medication errors.

*PO2 R 128 accepted 8/18/11
May Balth, RN*

R136

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.

" . . . the last recorded annual assessments for resident #3 were completed during February 2010, and next on 6/16/11 . . ."

1. Action to correct deficiency:

Assessment reminders have been added to all nurses calendars to allow for timely completion of annual assessments. All assessment were brought up to date.

Expected Date of completion August 8th, 2011.

2. Measures to ensure that this will not recur:

1. Monthly reminders will be automatically provided to nursing to remind them of assessment due.
2. Nurses are reeducated on the importance of timely completion of Assessments and how these assessments direct nursing care in a nurses meeting held on August 8, 2011

3. How corrective actions will be monitored:

Senior Health Services Director will conduct ongoing monthly audits of assessments due. Nurses will be required to send email notification to SDHS when assessments are completed. Improvement will be measured via the absence of overdue assessments.

*POC R136 accepted 8/18/11
May Balth, RN*

R137

5.8.a All residents shall be under the continuing general supervision of a physician of their choosing, and shall receive assistance, if needed in scheduling medical appointments.

"...the home failed to assure that 1 applicable resident in the survey sample (resident #2) was under the continuing supervision of a physician. Additionally the home failed to provide assistance in scheduling a medical appointment for 1 applicable resident in the targeted sample (Resident #3).

1. Action to correct deficiency:

- a.) In a nurses meeting on 8/8/11, nurses were reeducated on this regulation. **No** resident may be accepted for admission without a physician, of the resident's choice, that will agree to provide ongoing care. Additionally this was reviewed with the marketing department by the Lodge Owner, Gregg Beldock on 8/10/11.
- b.) In a nurses meeting on 8/8/11, nurses were reeducated on this regulation as it relates to receiving assistance with scheduling of appointments. Nurses were told that while the transportation department may schedule appointments, it remains the Nurses responsibility to F/U to be sure the appointment is scheduled, make progress note and record appointment outcome.
- c.) Physician statement was sent to current provider who agreed to complete and return.

Expected Date of completion August 8th, 2011.

2. How Corrective action will be monitored:

a.) NO resident will be permitted to move into the Lodge at Otter Creek without evidence of a physician who is willing to provide ongoing care.

b.) Nurses will send appointment/ transportation request to the front desk. The front desk will respond to the nurses request, once appointment is made, via email. If there is no email response in 24 hours, it is nursing responsibility to f/u. Appointment / transportation requests will be kept in the "pending folders" which is reviewed daily. Any appointment request left unscheduled will require f/u by the nurse on duty on that day.

3. How Corrective action will be monitored:

a.) Director of Health Services will review all admission paperwork PRIOR to admission. No resident will be permitted to move in until the Health Services Director approves all admission paperwork including evidence of personal physician coverage. Any resident with out evidence of physician coverage will not be permitted to move into the Lodge. Residents who have the physician's statement completed by a facility physician, will be required to show evidence of a personal physician willing to provide ongoing care.

b.) Appointment requests will be monitored and followed up on daily by Nursing. Director of Health Services will monitor weekly for outstanding appointments and follow up with nursing and transportation.

*POC R 137 accepted 8/18/11
May Buelter, RN*

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.

"Resident #2 was newly diagnosed with COPD on 1/23/11. The resident's problem list did not include this new diagnosis, nor was a service plan developed to address the resident's specific needs related to this diagnosis."

1. Action to correct the deficiency:

Care plan focus for COPD added to the residents' #2's care plan. Health Services Director and nursing staff, reviewed problem lists to be sure all new dx were showing. All care plans for community are being reviewed with attention given to each resident's problem list. Care plan focus related to diagnosis, added where needed.

Request to be sent to physician's with quarterly med review, for an updated problem list.

Expected date of Completion: 8/22/11

2. Measures to assure that it does not recur:

Senior Director of Health Services is working with Nurses in the process of reeducation as this relates to care plan development and the importance of addressing problem list dx within care plan, in an effort to assist Lodge residents in maintaining independence and well being. Nurses education will be completed in nurses meeting August 15th 2011.

3. How corrective actions will be monitored:

Director of Health services will monitor problem list and will periodically review care plans to see that care plan focuses r/t diagnosis are added in a timely manner.

Senior Director of Health Services will conduct monthly audits on a resident sample and provide results to nursing staff.

*POC R145 accepted 8/18/11
May Balth, RN*

R165

5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: . . .

This requirement was not met as evidenced by:

Based on staff interview and record review the Registered Nurse (RN) failed to assure that 1 of 4 applicable residents in the total sample was assessed for a need to change medications after the trial of a new medication (Resident #1).

". . .physician ordered loratadine 10mg by mouth daily for one week on 5/24/11 to treat the resident's allergic symptoms."

"There was no documented evidence that the RN assessed the efficacy of the medication to treat the residents symptoms, nor notification to the physician to update him/her with the residents response . . ."

1. Action to correct the deficiency:

Nursing saw resident approx two weeks following the trial, but did not document.

Nurse indicated f/u with resident who reported that she had good results with the medication but preferred not to have another daily medication. The option for PRN was discussed and resident indicated she would f/u with nurse if interested. The Nurse did indicate to this writer that she "missed" that documentation. A late entry was made to this resident's record and an "FYI" sent to ordering physician.

Expected date of completion: August 11, 2011 .

2. Measures to assure that it does not recur:

Nurses were reminded of the expectation of reading daily notes EVERY day at the beginning of their shifts and to use the nurse communication board to communicate specific follow up that may need to occur on days when they are not in the community. Additionally, counseling with the nurse who did not follow through with documentation took place on 8/11/2011

3. How corrective action will be monitored:

Health Services Director will read daily notes and prompt nursing F/U as needed. A monthly audit will be conducted of MARS, this will be completed by the Senior director of Health Services.

*POC R165 accepted 8/18/11
May Bultz, RN*

R171

5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. "... list of medication delegated staff was incomplete, contained illegible entries ..."

1. Action to correct deficiency:

List was recreated. Med Techs who were no longer employed at the Lodge or no longer employed as med techs were removed from the list. The newly created list has all current Med Tech Only and has name printed or typed along with signature and initials of Med Tech indicated. This list will be completed by August 15th and will be maintained by the Health Services Director.

Expected date of completion: August 15th 2011.

2. Measures to assure that it does not recur:

The RN responsible for medication administration education will be responsible for updating this list with the printed name of any new Med Tech who has successfully completed Med Tech training and obtaining the Med Techs signature.

Senior Director of Health Services will also be responsible for removing any Med Tech from the list who no longer works in the Med Tech role

3. How corrective actions will be monitored:

Senior Health Services Director will audit this process monthly

*POC R171 accepted 8/18/11
Mey Baltus, RN*

R178

5.11.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies.

"... the home failed to assure that sufficient numbers of staff were available at all times to provide necessary care regarding medication administration to residents of 2 separately licensed entities owned by the company."

1. Action to correct deficiency:

Additional Med Techs have been trained for all shifts allowing for a Med Tech to be assigned to each licensed area, each program, Shores, Haven and Meadows. If a Med Tech is unavailable to cover a licensed area, a nurse will pass medication in that area.

Scheduler instructed that there must always be separate Med Techs for each licensed area, and a med tech for each program (Shores, Haven, Meadows).

Expected date of completion: August 11th 2011.

2. Measures to assure that it does not recur:

On going hiring and training of care staff with an eye toward those individuals who excel as care givers and demonstrate competency to be invited to train as Med Techs. Nurses are also available to pass medications in any licensed program.

3. How corrective actions will be monitored:

Health Services Director will meet with the Scheduler weekly to review scheduling needs and to ensure each licensed area has a separate Med Tech assigned for the Med Pass for each shift.

*POC R178 accepted 8/18/11
Mey Baltus, RN*

R179

5.11.b The home must ensure the staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at

least twelve (12) hours of training each year for each staff person providing direct care to residents.

“... record review ... 5 of 8 employee’s lacked evidence of training within the last year regarding infection control.”

1. Action to correct the deficiency:

All employees, regardless of date of hired have been required to complete all training for this year via self studies provided by the Lodge. The self studies ay be completed during time made available to the new employee during orientation period. Each self study requires approx. one hour to complete. It will be expected that all training due on hire, is completed within the first 90 days of employment. Scheduler / administrative assistant will monitor this monthly and remove employees from the schedule who become non compliant in this area.

Expected date of completion: August 25th 2011.

2. Measures to assure that it does not recur:

Senior Director of Health services oversees all education. Yearly Education Summary Sheets have been developed to provide a quick view of all employees training requirement status. Employees are encouraged to review this sheet and to remain current in trainings. Each January training days will be offered and employee will be required to attend and complete all required trainings for the year. Monthly, training will continue, to build on the information completed in the self studies and to present additional interesting educational topics.

3. How corrective actions will be monitor:

Health Services Director and Scheduler will review this weekly, removing those employees from the schedule, who are not meeting this regulation.

*DOC R179 accepted 8/18/11
May Koth, RN*

R181

5.11.d The results of the criminal record and adult abuse registry checks for all staff. “Based on staff interview and record review, the home failed to provide evidence that child registry checks have been completed for 7 of 8 employees.”

1. Action to correct the deficiency

Per The Lodge at Otter Creek Policy, “we will conduct personal reference checks, adult abuse registry, child registry and criminal conviction investigation checks on all employees making application for employment with this facility.”

Child registry checks are performed in conjunction with the adult registry checks. Prior to April 18, 2011 documentation needed as proof of the Child registry check was not retained. The results were reviewed but not kept on file. All documentation for Child registry checks performed after April 18, 2011 are already on file.

All employees that were hired prior to 4/18/11 and therefore did not have documentation of child registry check received recheck paperwork with their paychecks on 8/5/11. Rechecks are currently being performed. All current employee rechecks will be completed by the end of August.

Expected completion date: August 12, 2011

2. Measures to assure that it does not recur

Documentation supporting checks of the adult abuse registry, child registry and criminal conviction investigation will be maintained in hard copy or electronically or both. Executive Director will not conduct final interview for employment without first seeing the completed background checks.

3. How corrective actions will be monitored

Background check completion has been added to the new hire paperwork. Employees will be given new hire paperwork until the Business Office Manager has signed off that all background checks have been done properly documented.

*POC R181 accepted 8/18/11
May Balth, RN*

R249

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

"... (1.) The convection ovens had a build up of grease and old blackened material throughout both oven interiors. (2) The 3 compartment sink was noted to have pots soaking in light colored water . . . Staff were unable to locate reagent strips . . ." (3) The hood vents had a build up of dust and the back splash around the main burner stove had thick grease splatter . . ." (4) The dishwasher temperatures were not being recorded daily and the most current list was dated 11/06/10. (5) out dated tuna salad and macaroni salad containers in the salad bar as well as undated tomato and mozzarella plates were observed . . ."

1. Action to correct the deficiency:

1. Interior scraping vacuuming and cleaning of the connection oven was completed and is now scheduled weekly, on Thursday.

2. The sanitizer compartment sink is filled and drained ^{3x} ~~twice~~ per day or more often as necessary. Fresh fill water is at approximately 75 degrees and tested twice daily with hydriion

POC R. Cleveland 8/18/11 @ 3:50 PM / May Balth, RN

ph test paper to test at 200-300 ppm, a brownish green on test paper. A daily log is now kept to record these tests.

3. Hood filters were removed and cleaned. This will continue every two weeks on Wednesdays. Likewise, the stovetop char grill, griddle and fryer were cleaned and will continue to be cleaned on a scheduled basis, once per week on Thursdays.

4. A daily temperature log was created and is now kept for dishwasher wash and rinse temperatures 3 times per day.

5. Prepared food items are disposed of after 72 hours of being prepared. Undated foods are disposed of immediately. Reach in coolers that contain prepared foods or salads are checked twice daily by manager or shift leader.

Expected completion date: August 12, 2011

2. Measures to assure that it does not recur

Expectations, with regard to kitchen cleanliness, has been reviewed with Kitchen Staff. Ongoing days for cleaning have been established with staff. Logs have been provided to record temps and Staff has been told to be vigilant in discarding out dated food or undated food.

3. How corrective actions will be monitored

The manager and or shift leader will monitor daily and enforce cleaning as needed.

*POC R249 accepted per T.C. Rose Cleveland 8/18/11 at 3:50 PM
Man. Balto, RN
6*

R266

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

(1) ". . . the home failed to provide a safe resident environment at all times. . . the door to the maintenance Department was unlocked and ajar . . ." (2) ". . . a cleaning cart containing a liquid all purpose cleanser, a cream cleanser, Windex, liquid disinfectant, toilet bowl cleaner and Lysol disinfectant spray was observed outside a 3rd floor resident room from 1:25 to 1:55 unattended . . ." (3) a housekeeping cart was unattended in the hallway outside a resident's room . . ."

1. Action to correct the deficiency:

Effective immediately both housekeeping and maintenance office doors are to be locked at all times regardless if rooms are occupied.

All cleaning solutions are kept in a caddy on the housekeeping carts. Effective immediately all cleaner caddies are to be removed from carts that are left unattended in public areas. The caddies are to stay with the housekeeper that it is assigned to.

This plan will resolve this safety issue and is now being implemented.

Expected completion date: August 12, 2011

2. Measures to assure that it does not recur:

The lock on the maintenance room will be maintained in a locked position at all times requiring a key entry.

Maintenance Director will survey housekeeping carts frequently to be sure housekeeping staff is taking caddy of cleaning supplies with them into apartments, not allowing them to remain on cart unobserved.

3. How corrective actions will be monitored

Maintenance Director and Executive Director will conduct audits weekly during building walk through to ensure compliance.

*POC R266 accepted 8/18/11
May (Bath) RW*

R302

9.11.c Each Home shall have in effect, and available to staff and residents, written copies of the 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.

" . . .there were 6 fire drills completed during the prior year with 4 of 6 drills without a time of drill indicated, 2 drills had no staff signatures to indicate that staff participated in the drill. . ."

1. Action to correct the deficiency:

To address this issue The Lodge at Otter Creek has developed an Emergency Prepared Disaster Plan program. This will begin August 24th, 2011 at 10:30am with a residents meeting in our theatre. This meeting is meant to inform and instruct as to our policies and procedures in the event of an emergency or disaster. This meeting will take place on a quarterly basis. Our policies and procedures are stated in detail in the Lodge at Otter Creek employee handbook. The handbook is distributed to each new employee at an orientation meeting that is held periodically. The Maintenance Director explains this section of the manual in his segment of orientation. Instruction for residents are included in the Lodge at Otter Creek residents handbook.

Expected completion date: August 24, 2011

Fire drills will be carried out every two to three months. The times will alternate to encompass every shift and include as many of our staff as possible. Also, greater attention to details such

as; times, dates and a participants sign in sheet will be common practice. The Middlebury Volunteer Fire Department is going to conduct some drills and training at our facility. One of the Assistant Chiefs has been a valuable resource to our program. These drills will also be carried out to satisfy the requirements of each license.

Expected completion date: August 12, 2011

2. Measures to assure that it does not recur:

Executive Director, along with the Maintenance Director will lead quarterly building safety meetings for residents.

Executive Director will provide monthly audits to review documentation of fire drills and fire drill scheduling.

3. How corrective actions will be monitored

Executive Director will meet with the Maintenance Director monthly to review this process and to be sure that Training and fire drills are completed in a timely fashion.

*PAC R302 accepted 8/15/11
May Balth, RW*