VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

March 6, 2025

Paula Pelkey, Manager
The Residence At Otter Creek
350 Lodge Road
Middlebury, VT 05753-4498

Dear Ms. Pelkey:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 4, 2025.** 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.

If you have any questions, please feel free to contact me at (802) 585-0995.

Sincerely,

Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1008	A. BUILDING _____ B. WING _____	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT OTTER CREEK	350 LODGE ROAD MIDDLEBURY, VT 05753

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: On 2/3/25 and 2/4/25 the Division of Licensing and Protection conducted an unannounced on-site annual relicensure survey. The following regulatory deficiencies were identified:	R100	Corrective actions for all tags cited accepted by Jo A Evans RN on 3/2/25. Please refer to the attached Plan of Corrections to review the corrective actions accepted for individual tags.	
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. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure written signed physician's order are on file in Resident #2's record for two medications listed in the resident's February 2025 Medication Administration Record. Findings include: The home's New Orders and Change of Order policies and procedures do not indicate a signed medication order must be obtained for all resident medications. Per record review the medications Hydroxyzine (Antihistamine prescribed for Pruritis) and Desitin (topical medication prescribed as a barrier cream to prevent dashed and chafing) are listed in Resident #2's February 2025 Medication Administration Record. On the morning of 2/4/25 the Licensed Practical Nurse (LPN) was requested to provide a signed medication order for Hydroxyzine and Desitin for review.	R128		

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R128	Continued From page 1 At 1:25 PM on 2/4/25 the LPN confirmed a signed provider's order was not on file in Resident #2's record for Desitin, and at 1:31 PM the LPN confirmed a signed order for Hydroxyzine was not on file and available for review in Resident #2's record.	R128		
R176 SS=E	V. RESIDENT CARE AND HOME SERVICES 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: Based on observation and staff interview there was a failure to ensure prompt disposal of outdated medications belonging to 3 residents of the home (Residents #1, #2, and #3). Findings include: The home's policies and procedures governing medication disposal is consistent with this regulatory requirement. During a medication cart review conducted in the home's Reflections Memory Care Center on the morning of 2/4/25 the following outdated medication were observed to be stored in the medication cart: 1. Outdated medications belonging to Resident	R176		

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R176	Continued From page 2 #1 included an albuterol inhaler expired on 11/2024 and Acetaminophen 325 mg tablets expired on 9/28/24. 2. Outdated medication belonging to Resident #2 included Acetaminophen 325 mg tablets expired on 12/27/24. 3. Outdated medication belonging to Resident #3 included Docusate Sodium 100 mg capsules expired on 11/8/24. These findings were confirmed by the Med Tech on duty at 11:08 AM on 2/4/25.	R176		
R190 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure completion of all required background checks for 4 out of 5 applicable staff. Findings include: The home's policies and procedures governing completion of staff background checks provided for review on 2/3/25 is not consistent with this regulatory requirement. Per review of criminal record and abuse registry checks on file for a sample of 5 staff, all required background checks were not completed for 4 out of the 5 sampled staff. This finding was confirmed by the Business	R190		

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R190	Continued From page 3 Manager at 3:30 PM on 2/3/25.	R190		
R247 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure perishable foods and beverages are labeled with the dates the items are opened or prepared. Findings include: Policies and procedures governing labeling and storage of perishable items have been developed by the home. During a tour of the home commencing at 10:48 AM on 2/3/25 the following perishables food and beverage were observed without labels indicating the date the items were opened or prepared: 1. Undated items observed in the kitchen walk-in refrigerator and freezer included an unsealed bag with unidentified cubed meat, a container of beef stock, an uncovered tray of baked sweet potatoes, unlabeled meat that appeared to be ham covered with plastic wrap, unidentified foods wrapped in aluminum foil, an unlabeled tub of cooked cabbage, and unsealed bags of vegetables and fruit.	R247		

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R247	Continued From page 4 2. Undated items observed in a kitchen reach in refrigerator included heavy cream, olives, parmesan cheese, an unsealed bag of shredded cheese, an unlabeled tub of pasta, a gallon container of mayonnaise, and an unlabeled tub of shredded cabbage. 3. Undated items stored in a refrigerated prep unit located in the kitchen contained fig jam, and unsealed bag of sandwich wraps, and an unlabeled squeeze bottle of what appeared to be honey mustard with dried spills on the outside of the bottle. The top section of this prep unit contained uncovered bins mayonnaise, mushrooms, tuna salad, chicken salad, and egg salad, unsealed deli meat, and cheeses confirmed by Staff to be routinely stored without lids. This prep unit also contained a large partially uncovered bin of roast beef dated "1/31". The areas of this bin left open and exposed to air contained roast beef observed with areas that were darkened and dried. A second prep unit in the kitchen contained undated items including a bottle of balsamic glaze, 12 bottles of salad dressing, and a large unlabeled bin covered with foil. 4. An ice cream freezer in the kitchen contained multiple 3 gallon containers of ice cream without dates indicating when the containers were opened. These findings were confirmed by the Chef during the kitchen tour conducted on 2/3/25.	R247		
R291 SS=F	IX. PHYSICAL PLANT	R291		

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R291	Continued From page 5 9.6 Plumbing 9.6.d Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure water temperatures are maintained at or below 120 degrees Fahrenheit in two areas of the home accessible to residents. Findings include: Policies and procedures governing water temperatures in resident accessible areas have been developed by the home. During the facility tour commencing at 10:48 AM on 2/3/25 water temperatures were observed to be 127.5 degrees in the women's bathroom near the lobby on the 2nd floor of the home and 121.8 degrees in the bathroom near the elevator on the 3rd floor of the home. This finding was confirmed by the Executive Director during the tour of the home on the morning of 2/3/25. Following adjustments made to the water heating system by the home's staff, water temperatures in the observed resident accessible areas were maintained at or below 120 degrees Fahrenheit. This finding was confirmed with the Executive Director at approximately 9:40 AM on 2/4/25.	R291		

Deficiency Statement Plan of Correction (POC)

Survey Date: February 4, 2025

Facility Name: The Residence at Otter Creek-ALR

Deficiency Regulation	How the deficiency was corrected	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R 128 Corrective actions accepted by Jo A Evans RN on 3/2/25	Missing orders were requested from resident PCP (resident is between offices and switching PCP's)	Implemented: 2/20/2025	Resident charts will be audited to ensure there are signed physician orders for all medications. Thereon, nurses will ensure that all new orders are accompanied by a physician signed order in the resident physical chart. Date of completion: March 24, 2025 The Resident Care Director will review the policy for obtaining orders with all nurses. Date of Completion: February 28, 2025	Resident Care Director
R 176 Corrective actions accepted by Jo A Evans RN on 3/2/25	Expired meds were immediately removed from the medication cart and wasted per policy.	2/4/2025	Review the medication disposal policy with all MT's and nurses. Completion Date: March 15th, 2025	Resident Care Director
R 190	VCIC Background Checks	2/20/25	All associate VCIC background checks will be completed before the date of hire and annually on hire date.	Business Office Director
Corrective actions accepted by Jo A Evans RN on 3/2/25	Background Checks with exceptions	2/20/2025	All files will have a letter if an associate was deemed hirable with a report on record. Current files will be audited and corrected if needed by 3/31/25.	Business Office Director
R247 Corrective actions accepted by Jo A Evans RN on 3/2/25	Daily Log Compliance	02/15/2025	Daily LCB Food Safety and Sanitation Checklist to be completed as part of the server checklist. The chef on duty must audit and turn into the Restaurant Operations Director and all audits kept for weekly review with the Executive Director.	Restaurant Operations Director and Executive Director

PPLLKeegan 2/14/2025

R291 Corrective actions accepted by Jo A Evans RN on 3/2/25	Install digital mixing valve	2/12 Digital Mixing Valve ordered by VHV HVACR professionals. Installation asap upon arrival at Community.	Current system manually controlled temperature mixing valve – created inconsistent temperatures and inaccurate readings. Digital Mixing Valve replaces the current manual system and accurately maintains constant safe water temperature. Also, ongoing weekly water temperature spot checks on 10 random locations and tracked in our TELS System.	Executive Director and Maintenance Director

P Pelfrey RN
3/12/2025