

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

March 18, 2014

Mr. Bruce Bodemer, Administrator
Helen Porter Healthcare & Rehab
30 Porter Drive
Middlebury, VT 05753-8422

Dear Mr. Bodemer:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 12, 2014**. 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



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

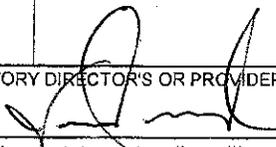
MAP 11 2014

PRINTED: 02/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/12/2014
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE 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) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p>	F 164	<p><u>Corrective Action for Individual Residents</u></p> <p>Resident #1- Resident has been transferred to our Long Term Care unit. In LTC, it is not our practice to conduct daily meetings with residents.</p> <p>Resident #2- Resident has since been discharged from HPHRC.</p> <p>Resident #6- Resident has since been discharged from HPHRC.</p> <p>Resident #190- Resident has since been discharged from HPHRC.</p> <p>Resident #191- Resident has since been discharged from HPHRC.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 3/10/14
--------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------	----------------------

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2014
NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE 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) COMPLETION DATE	
F 164	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and staff interview the facility failed to ensure that 5 residents (Residents #190, #191, #1, #6, #2) have the right to personal privacy and confidentiality of his or her personal information and clinical records. The findings include:</p> <p>1. Per direct observation on 2/10/14 at 3:23 PM on the sub-acute rehabilitation unit, the off going day nurse, along with the the on coming nurse and the on coming licensed nursing assistant, entered room 142, a semi-private room. At the time of the observation both Residents (#190 and #191) that resided in the room were present. The nurses and aide approached Resident #191 and proceeded to give bed side report. (Discussion of the resident's diagnosis, rehabilitation status, review of medical history at hospital prior to admission, cognitive level, behaviors exhibited, medications resident takes, assistance level needed by resident by staff and the resident's discharge status.) At the time of "bedside" report, Resident #190 was sitting approximately 5 feet away from the group only separated by a privacy curtain. The verbal volume of the discussion of the bedside report was loud enough that the surveyor sitting 5 feet away was able to hear all details of Resident #191's bedside report.</p> <p>The same group of staff went to the bed of Resident #190 on the other side of the privacy curtain and proceeded to review this resident's "bedside report". At the time of "bedside report", Resident #191 was sitting approximately 5 feet away from the group only separated by a privacy curtain.</p>	F 164	<p><u>Identifying Other Residents</u></p> <p>Effective 3/13/14, our practice will be to remind all Rehab residents, on a daily basis, of their right to decline discussion of personal and clinical records.</p> <p>The number of residents affected by this policy change includes, twenty (20) residents.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/12/2014
NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE 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) COMPLETION DATE
F 164	<p>Continued From page 2</p> <p>2. Per observation on 2/11/14 at approximately 3:15 PM, on the sub-acute rehabilitation unit, the off going day nurse, along with the on coming evening nurse and the on coming evening licensed nursing assistant, entered room 139, a semi-private room. At the time of the observation both Residents (#6 and #1) that resided in the room were present. The nurses and aide approached Resident #6 and proceeded to give bed side report. The verbal volume of the discussion of the bedside report was loud enough that the surveyor standing approximately 5 feet away on other side of room was able to hear all details of Resident #6's condition. The same group of staff went to Resident #1's bedside and proceeded to review this resident's "bedside report". The conversation was loud enough that it could be heard from the doorway.</p> <p>3. Per interview on 2/10/14 and 2/11/14, 5 residents were interviewed (#2, #191, #190, #6 and #1) regarding their knowledge of "bedside report". None of the residents interviewed indicated that staff had informed them that bedside report was going to be conducted daily by the nursing staff. None of the 5 residents interviewed received any verbal or written documentation on admission from the facility explaining "bedside report", and all 5 indicated that no consent was obtained by staff from them allowing the review of confidential resident information at the bedside. Per interview, 1 of the 5 residents (#2) verbalized that if he/she was aware that he/she could refuse to allow this information from being discussed at the bedside he/she would have refused.</p> <p>Per interviews on 2/11/14 with the Unit Manager (UM) and Director of Nursing (DNS), he/she</p>	F 164	<p>Systemic Changes</p> <p>Implementation of new policy which calls for the daily practice of explaining to Rehab residents their right to decline discussion of their personal and clinical records. The plan follows:</p> <ol style="list-style-type: none"> 1. Mandatory staff training 2. Implementation 3. Weekly follow-up (3 weeks) <p>- Bedside reporting consent and acknowledgement of document review completed for all current post-acute residents.</p> <p>- Create system to ensure nursing is notified of residents preference.</p> <p>-Modify documents to indicate residents preference on the care plan and report sheet</p> <p>- Create policy and procedure for bedside reporting</p> <p>- Update bedside binders to include explanation of bedside reporting.</p>	<p>3/14/14</p> <p>3/14/14</p> <p>thru 4/14</p> <p>(thereafter Monthly for 6 month)</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/12/2014
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE 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) COMPLETION DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

F 164	<p>Continued From page 3</p> <p>indicated that "bedside report" was conducted daily with the day and evening oncoming and off going shift to discuss diagnosis, medical, cognitive and behavioral conditions and disposition plan of each resident on the subacute unit. The UM and DNS indicated that the purpose was to provide information from one shift to another regarding residents. The UM confirmed that report is also given in written form and verbal form at the nurse's station.</p> <p>Per review of the facility Admission packet provided to all residents in the facility upon admission, there was no evidence in the admission information that bedside rounds would be conducted for residents admitted to the subacute rehabilitation unit. The information provided to the resident on the subacute rehabilitation unit regarding general information, kept in a binder and given to the resident for their review, had no information that bedside rounds would be conducted and no information indicating to the resident that they could refuse to participate in "bedside rounds" if they wish.</p>	F 164	<p>Monitoring</p> <p>Evaluation of process to become permanent agenda item at Quarterly Quality Assurance Meetings.</p> <p>Unit Manager will review bedside reporting documentation weekly.</p> <p>Mandatory Training for Rehab Staff</p> <p><i>F-164 POC accepted 3/17/14 pmeatare</i></p>	
F 241 SS=D	<p>See also F241.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff</p>	F 241	<p>Corrective Action for Individual Residents</p> <p>Resident #1- Resident has been transferred to our Long Term Care Unit. In LTC, it is not our practice to conduct daily meetings with residents.</p> <p>Resident #2- Resident has since been discharged from HPHRC.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/12/2014
NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE 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) COMPLETION DATE
F 241	<p>Continued From page 4</p> <p>interview the facility failed to ensure that each resident receives care in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality for 5 applicable residents. (Residents #190, #191, #6, #1, #2) The findings include;</p> <p>1. Per direct observation on 2/10/14 at 3:23 PM on the sub-acute rehabilitation unit, the off going day nurse, along with the the on coming nurse and the on coming licensed nursing assistant, entered room 142, a semi-private room. At the time of the observation both Residents (#190 and #191) that resided in the room were present. The nurses and aide approached Resident #191 and proceeded to give bed side report. (Discussion of the resident's diagnosis, rehabilitation status, review of medical history at hospital prior to admission, cognitive level, behaviors exhibited, medications resident takes, assistance level needed by resident by staff and the resident's discharge status.) At the time of "bedside" report, Resident #190 was sitting approximately 5 feet away from the group only separated by a privacy curtain. The verbal volume of the discussion of the bedside report was loud enough that the surveyor sitting 5 feet away was able to hear all details of Resident #191's bedside report.</p> <p>The same group of staff went to the bed of Resident #190 on the other side of the privacy curtain and proceeded to review this resident's "bedside report". At the time of "bedside report", Resident #191 was sitting approximately 5 feet away from the group only separated by a privacy curtain.</p> <p>2. Per observation on 2/11/14 at approximately</p>	F 241	<p>Residnet #6- Resident has since been discharged from HPHRC.</p> <p>Resident #190- Resident has since been discharged from HPHRC.</p> <p>Resident #191- Resident has since been discharged from HPHRC.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2014
NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE 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) COMPLETION DATE	
F 241	<p>Continued From page 5</p> <p>3:15 PM, on the sub-acute rehabilitation unit, the off going day nurse, along with the on coming evening nurse and the on coming evening licensed nursing assistant, entered room 139, a semi-private room. At the time of the observation both Residents (#6 and #1) that resided in the room were present. The nurses and aide approached Resident #6 and proceeded to give bed side report. The verbal volume of the discussion of the bedside report was loud enough that the surveyor standing approximately 5 feet away on other side of room was able to hear all details of Resident #6's condition. The same group of staff went to Resident #1's bedside and proceeded to review this resident's "bedside report". The conversation was loud enough that it could be heard from the doorway.</p> <p>3. Per interview on 2/10/14 and 2/11/14, 5 residents were interviewed (#2, #191, #190, #6 and #1) regarding their knowledge of "bedside report". None of the residents interviewed indicated that staff had informed them that bedside report was going to be conducted daily by the nursing staff. None of the 5 residents interviewed received any verbal or written documentation on admission from the facility explaining "bedside report", and all 5 indicated that no consent was obtained by staff from them allowing the review of confidential resident information at the bedside. Per interview, 1 of the 5 residents (#2) verbalized that if he/she was aware that he/she could refuse to allow this information from being discussed at the bedside he/she would have refused.</p> <p>Per interviews on 2/11/14 with the Unit Manager (UM) and Director of Nursing (DNS), he/she indicated that "bedside report" was conducted</p>	F 241	<p>Identifying Other Residents</p> <p>Effective 3/13/14, our practice will be to remind all Rehab residents, on a daily basis, of their right to decline discussion of personal and clinical records.</p> <p>The number of residents affected by this policy change includes, twenty (20) residents.</p> <p>Systemic Changes</p> <ul style="list-style-type: none"> -Implementation of a Consent Form upon admission to our Post Acute Care Unit. - Implementation of the new policy which calls for the daily practice of explaining to Rehab residents their right to decline discussion of their personal and clinical records. The plan includes mandatory staff training (by 3/14/14) and scheduled follow-up (weekly x 3 and monthly x 6) 		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2014
NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE 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) COMPLETION DATE	
F 241	Continued From page 6 daily with the day and evening oncoming and off going shift to discuss diagnosis, medical, cognitive and behavioral conditions and disposition plan of each resident on the subacute unit. The UM and DNS indicated that the purpose was to provide information from one shift to another regarding residents. The UM confirmed that report is also given in written form and verbal form at the nurse's station. Per review of the facility Admission packet provided to all residents in the facility upon admission, there was no evidence in the admission information that bedside rounds would be conducted for residents admitted to the subacute rehabilitation unit. The information provided to the resident on the subacute rehabilitation unit regarding general information, kept in a binder and given to the resident for their review, had no information that bedside rounds would be conducted and no information indicating to the resident that they could refuse to participate in "bedside rounds" if they wish.	F 241	- Bedside reporting consent and acknowledgement of document review completed for all current post-acute residents. - System to ensure nursing is notified of residents preference. -Modify documents to indicate residents preference on the care plan and report sheet - Create policy and procedure for bedside reporting - Bedside binders updated to include explanation of bedside reporting. <u>Monitoring</u> Evaluation of performance to become a permanent agenda item at Quarterly Quality Assurance Meetings. Unit Manager will review bedside reporting consent documentation weekly.		
F 280 SS=D	See also F164. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending	F 280	<i>F241 PDC accepted 3/17/14 Pmed arw</i> <u>Corrective Action for Individual Residents</u> Resident #15- Cushioning pads were fabricated from foam padding and secured to the point of contact on the bedrails to provide protection from further chafing or pressure. - Physical Therapy and Occupational Therapy screen initiated and provider notified.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2014
NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE 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) COMPLETION DATE	
F 280	<p>Continued From page 7</p> <p>physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to review and revise the care plan of 1 resident identified (Resident #15) to address prevention of injury. The findings include;</p> <p>1. Per observation and interview on 2/10/14, Resident #15 was observed by a member of the Survey Team to have a large aging bruise on the resident's right upper arm. Per interview with Resident #15 on 2/10/14, he/she indicated that he/she not sure how he/she received the bruise, that maybe it was from hitting the bed rail. Per observation on 2/12/14, Resident #15 was observed in his/her wheelchair with a large bruise on the right upper arm, yellowish green in color. Resident observed to be obese and skin appears to be very thin. Resident observed to have limited mobility on the left upper side. Per observation of the room, Resident #15 has bilateral siderails on his/her bed. Per interview with Resident #15 on 2/12/14, he/she indicated that he/she had a "stroke" awhile ago and doesn't move as well. Resident again communicated that the cause for the bruise to the right upper arm may have been</p>	F 280	<p><u>Identifying other Residents</u></p> <p>It will become our daily practise to note any resident bruising and record in the EHR all incidences.</p> <p><u>Systemic Changes</u></p> <p>- Update skin policy to include management of non-pressure skin issues then policy will be put on Silvershair to reflect acknowledgement of education.</p> <p>The EHR has been customized in such a way that when a bruise is documented the EHR will automatically open the resident's care plan for revision. Before the nurse will be able to close the cae plan folder he/she will need to provide a signature attesting to the following statement. "I have reviewed the care plan and can verify it is current or have made appropriate changes to ensure it is current. "</p> <p>- LNA staff are now required to chart in ECS any skin changes noted, where it is, what it is and who was notified. Notification will be sent to manager.</p>	3/14/14	4/01/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/12/2014
NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE 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) COMPLETION DATE
F 280	Continued From page 8 caused by hitting it on the siderail when moving. Per review of the medical record of Resident #15, Resident had a history of cerebral vascular accident resulting in weakness to the left side. On admission to the facility on 5/1/13 it was noted on the admission assessment to have three bruised areas on the right upper arm. The medical record indicated that Resident #15 takes Coumadin (blood thinner) daily. Per review of the comprehensive care plan titled "Impaired skin integrity" it indicates that the Licensed Nursing Assistant (LNA) is to observe resident skin daily with care and report to the nurse any skin changes. Per review of the care plan titled "Potential for uncontrolled bleeding" the LNA is to report any signs of bleeding such as stool, urine, gums, bruising etc. to the nurse. The care plan was not revised to address the prevention of further injury. Per interview on 2/11/13 with the Director of Nursing (DNS), he /she was unaware that Resident #15 had a bruise on his/her right upper arm. Per interview with the DNS he/she indicated that the facility did not have a policy and procedure that directed staff what to do with skin issues of a non pressure source like bruises. The DNS reviewed the medical record and care plan and confirmed that there were no interventions put into place to assist in the prevention of Resident #15 having a reoccurrence of bruising/injury.	F 280	<u>Monitoring</u> A QA tool will be completed weekly by the charge nurse and reviewed by the unit Manager to ensure compliance for all residents who experience bruising. Immediate corrective action will be taken by the Unit Manager for any deficient practice noted. Ongoing monitoring will continue on a weekly basis until 100% compliance has been achieved for six consecutive weeks. Monitoring thereafter will be weekly, then monthly, and thereafter quarterly. As long as 100% compliance is kept. <i>F380 POC accepted 3/17/14 pmcotaRN</i>	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility	F 282	<u>Corrective Action for Individual Residents</u> -Immediate review of C.P of both residents	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/12/2014
NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE 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 REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 9 must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide services to 3 residents identified (Resident #8, #10, #15) by qualified persons in accordance with each resident's written plan of care. The findings include: 1. Per review of the facility internal investigation and the medical record, the investigation indicated that on 1/15/14, Resident #8 had been very verbal throughout the day calling out. Resident #8 was in the Namaste room (a quiet calm room for residents) near the shut door calling out and another Resident (#10), who was in the room also, got up, walked across the room and slapped Resident #8 across the face. The internal investigation indicated that facility staff was present at the time of the altercation and that one staff member was assigned to provide 1:1 supervision with Resident #10 and oversee all the other residents present in the Namaste room. Per the staff statement, the facility staff indicated that Resident #8 was yelling out repetitively and Resident #10 was getting more and more agitated prior to Resident #10 getting up and walking across the room and slapping Resident #8 across the face. The medical record documentation dated 1/15/14 indicated that Resident #10 was agitated and began walking, 1:1 staff was with Resident #10 walking behind him/her as Resident #10 approached Resident #8 and slapped him/her across the left side of the face. Per review of the medical record of Resident #8	F 282	- Follow up eval by Geriatric Psychiatrist for #10 - Immediate agenda item for daily stand-up meeting - Follow up Social Worker weekly for #8 x 4 weeks <u>Identifying other Residents</u> Immediate agenda item for daily stand-up meetings	02/13/14 + 02/27/14 2/27/14 03/24/14 2/27/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2014
NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE 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) COMPLETION DATE	
F 282	<p>Continued From page 10</p> <p>he/she was admitted to the facility on 8/30/10 with diagnoses that include; senile dementia. Per review of the medical record indicates that Resident #8 has an extensive documented history since admission of wandering, verbal and physical aggressive behaviors, resistive to care, screams, makes disruptive sounds and yells as a form of attention seeking behavior.</p> <p>Per review of the comprehensive care plan of Resident #8 the care plan titled "Potential for anxiety" and last updated on 10/16/13, indicates for staff to remove the resident from situation and provide a quiet area for resident, if he/she appears restless/agitated.</p> <p>Per review of the medical record of Resident #10, he/she was admitted to the facility on 9/26/12 with diagnosis that include senile dementia and paranoia. Per review of the medical record, Resident #10 has a long documented history since admission of being verbally and physically abusive, wandering, screaming, and threatening to others.</p> <p>Per Psychology on 1/12/14, Resident #10 is in need of staff assist at times to supervise and monitor activities, staff must intervene in social interactions at all times.</p> <p>Per review of the comprehensive care plan for Resident #10 dated 3/7/13, it indicates that Resident #10 has disruptive interactions related to dementia, nurses are to provide a calm environment, and when resident is exhibiting any signs of verbal or physical anxiety or aggression be immediately responsive. The care plan dated 4/9/13 indicates that resident is at risk for delirium, paranoid delusions, increased physical and verbal abusiveness and inappropriate behaviors. The care plan last updated 9/30/13 indicates that if the resident is agitated, give her space, handle with gentle consideration.</p>	F 282	<p>Systemic Changes</p> <p>Mandatory staff in-service for 'handing-off' procedures when dealing with multiple residents suffering from dementia in same setting.</p> <p>Establish as standard agenda item for daily stand-up meetings residents at risk for extraordinary behaviors due to agitation.</p>	<p>3/31/14</p> <p>3/31/14</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/12/2014
NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE 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) COMPLETION DATE
F 282	<p>Continued From page 11</p> <p>Per interview with the Director of Nursing (DNS) on 2/12/14, he/she reviewed the medical record documentation, comprehensive care plan and internal investigation and confirmed that the Namaste Room is a calm quiet space for residents to utilize during the day. The the Namaste Room is a place to provide calm quiet environment.</p> <p>The DNS indicated that resident's with behaviors utilize this room as their "quiet" place. The DNS confirmed that Resident #8 and Resident #10 have extensive histories of physical and verbal aggressive behaviors towards other residents. The DNS confirmed after review of the comprehensive care plans for both Resident #8 and #10 and confirmed that prior to the incident on 1/16/14 where Resident #8 was slapped in the face by Resident #10, that both resident's had specific interventions to assist staff to assist the residents in managing their aggressive behaviors. The DNS confirmed that after review of the medical record and the internal investigation that staff did not utilize the interventions on the care plans to attempt to de-escalate a situation that resulted in Resident #8 being slapped across the face by Resident #10. The DNS confirmed that staff was aware based on the staff's statement that Resident #10 was becoming agitated by the yelling out of Resident #8 and that staff was present and witnessed Resident #10 walk across room and slap Resident #8 across the face. Per interview the DNS confirmed that if staff had utilized the interventions listed on the care plans for Resident #8 and #10 the staff may have been able to prevent the physical interaction between the residents.</p> <p>2. Per observation and interview on 2/10/14, Resident #15 was observed by a member of the Survey Team, to have a large aging bruise on the</p>	F 282	<p>Monitoring</p> <p>A QA tool will be completed by the charge nurse and reviewed by the Unit Manager to ensure compliance for all residents who are at risk for aggressive behaviors. Immediate corrective action will be taken by the Unit Manager for any deficient practice noted. Ongoing monitoring on a weekly basis until 100% compliance has been achieved for six consecutive weeks. Monitoring thereafter will be weekly, then monthly, and thereafter quarterly as long as 100% compliance is kept.</p> <p><i>F282 POC accepted 3/17/14 Pmcotaru</i></p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2014
NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE 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) COMPLETION DATE	
F 282	<p>Continued From page 12</p> <p>resident's right upper arm. Per interview with Resident #15 on 2/10/14, he/she indicated that he/she not sure how he/she received the bruise, that maybe it was from hitting the bed rail.</p> <p>Per observation on 2/12/14, Resident #15 was observed in his/her wheelchair with a large bruise on the right upper arm, yellowish green and color. Resident observed to be obese and skin appears to be very thin. Resident observed to have limited mobility on the left upper side. Per observation of the room of Resident #15, it was observed that Resident #15 had bilateral siderails on his/her bed. Per interview with Resident #15 on 2/12/14, he/she indicated that he/she had a "stroke" awhile ago and doesn't move as well. Resident again communicated that the cause for the bruise to the right upper arm may have been caused by hitting it on the siderail when moving.</p> <p>Per review of the medical record of Resident #15, Resident had a history of cerebral vascular accident resulting in weakness to the left side. On admission to the facility on 5/1/13 it was noted on the admission assessment to have three bruised areas on the right upper arm. The medical record indicated that Resident #15 takes Coumadin (blood thinner) daily.</p> <p>Per review of the comprehensive care plan titled "Impaired skin integrity" it indicates that the Licensed Nursing Assistant (LNA) is to observe resident skin daily with care and report to the nurse any skin changes. Per review of the care plan titled "Potential for uncontrolled bleeding" the LNA is to report any signs of bleeding such as stool, urine, gums, bruising etc. to the nurse.</p> <p>Per review of the medical record under nurse</p>	F 282			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/12/2014
NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE 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) COMPLETION DATE
F 282	<p>Continued From page 13</p> <p>charting on 2/4/14 there is a note that indicates bruise on right back near arm pit, yellowish green, continue to observe.</p> <p>Per review of the LNA daily shift charting under skin observation there is no documentation from the LNA's that Resident #15 has any bruising to his/her right upper arm.</p> <p>Per interview on 2/11/13 with the Director of Nursing (DNS), he /she was unaware that Resident #15 had a bruise on his/her right upper arm. Per review of the medical record and care plan, the DNS confirmed that there was no documentation regarding the discovery of the bruise prior to 2/4/14. The DNS confirmed that by the 2/4 description of the bruise it was an old bruise and had been there awhile. Then DNS confirmed that the care plan indicated that LNA's are to do daily skin checks and report findings to the nurse. The DNS confirmed that after review of the LNA and Nurse daily documentation there was no evidence that the LNA did the daily skin check and reported any bruising to the nurse.</p> <p>Per interview with the DNS he/she indicated that the facility did not have a policy and procedure that directed staff what to do with skin issues of a non pressure source like bruises.</p> <p>Per interview the DNS reviewed the medical record and care plan and confirmed that there was no careplan developed to assist Resident #15 and staff to assist in the prevention of bruising for a resident with a history of bruising.</p>	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 02/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2014
NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE 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) COMPLETION DATE	
F 323	Continued From page 14 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to ensure that the resident environment for 2 residents (Resident #8, #10) remained free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. The findings include: 1. Per review of the facility internal investigation and the medical record, the investigation indicated that on 1/15/14, Resident #8 had been very verbal throughout the day calling out. Resident #8 was in the Namaste room (a quiet calm room for residents) near the shut door calling out and another Resident (#10), who was in the room also, got up, walked across the room and slapped Resident #8 across the face. The internal investigation indicated that facility staff was present at the time of the altercation and that one staff member was assigned to provide 1:1 supervision with Resident #10 and oversee all the other residents present in the Namaste room. Per the staff statement, the facility staff indicated that Resident #8 was yelling out repetitively and Resident #10 was getting more and more agitated prior to Resident #10 getting up and walking across the room and slapping Resident #8 across the face. The	F 323	<u>Corrective Action of Individual Residents</u> Mandatory staff meeting for instruction on handling difficult residents. Immediate agenda item for daily stand up meeting. <u>Identifying of the Residents</u> Immediate agenda item for daily stand up meetings	3/31/14 2/24/14 2/27/14	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 02/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/12/2014
NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE 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)	(X6) COMPLETION DATE
F 323	Continued From page 15 medical record documentation dated 1/15/14 indicated that Resident #10 was agitated and began walking, 1:1 staff was with Resident #10 walking behind him/her as Resident #10 approached Resident #8 and slapped him/her across the left side of the face. Per review of the medical record of Resident #8 he/she was admitted to the facility on 8/30/10 with diagnoses that include; senile dementia. Per review of the medical record indicates that Resident #8 has an extensive documented history since admission of wandering, verbal and physical aggressive behaviors, resistive to care, screams, makes disruptive sounds and yells as a form of attention seeking behavior. Per review of the comprehensive care plan of Resident #8 the care plan titled "Potential for anxiety" and last updated on 10/16/13, indicates for staff to remove the resident from situation and provide a quiet area for resident, if he/she appears restless/agitated. Per review of the medical record of Resident #10, he/she was admitted to the facility on 9/26/12 with diagnosis that include senile dementia and paranoia. Per review of the medical record, Resident #10 has a long documented history since admission of being verbally and physically abusive, wandering, screaming, and threatening to others. Per Psychology on 1/12/14, Resident #10 is in need of staff assist at times to supervise and monitor activities, staff must intervene in social interactions at all times. Per review of the comprehensive care plan for Resident #10 dated 3/7/13, it indicates that Resident #10 has disruptive interactions related to dementia, nurses are to provide a calm environment, and when resident is exhibiting any signs of verbal or physical anxiety or aggression	F 323	<u>Systemic Changes</u> The EHR has been customized in such a way that when a resident is at risk for aggressive behavior the EHR will automatically open the residents care plan for revision. Before the nurse will be able to exit the care plan folder, he/she will need to provide a signature attesting to the following statement, "I have reviewed the care plan and can verify it is current or I have made appropriate changes to ensure it is current." The EHR will be customized to reflect when an LNA documents a behavior. They must document who was told and what interventions were initiated. An electronic message will then be sent to the manager. Implement one on one "hand off" procedure and job description. Provide formal staff education related to the management of residents with behaviors. Implementation of care plans to be placed in Namaste for staff access. Implementation of required reporting of resident to resident and resident to staff behaviors &/or altercations at change of shift report.	3/07/14 3/17/14 3/20/14 3/12/14 2/24/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 02/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2014
NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE 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) COMPLETION DATE	
F 323	Continued From page 16 be immediately responsive. The care plan dated 4/9/13 indicates that resident is at risk for delirium, paranoid delusions, increased physical and verbal abusiveness and inappropriate behaviors. The care plan last updated 9/30/13 indicates that if the resident is agitated, give her space, handle with gentle consideration. Per interview with the Director of Nursing (DNS) on 2/12/14, he/she reviewed the medical record documentation, comprehensive care plan and internal investigation and confirmed that the Namaste Room is a calm quiet space for residents to utilize during the day. The the Namaste Room is a place to provide calm quiet environment. The DNS indicated that resident's with behaviors utilize this room as their "quiet" place. The DNS confirmed that Resident #8 and Resident #10 have extensive histories of physical and verbal aggressive behaviors towards other residents. The DNS confirmed after review of the comprehensive care plans for both Resident #8 and #10 and confirmed that prior to the incident on 1/16/14 where Resident #8 was slapped in the face by Resident #10, that both resident's had specific interventions to assist staff to assist the residents in managing their aggressive behaviors. The DNS confirmed that after review of the medical record and the internal investigation that staff did not utilize the interventions on the care plans to attempt to de-escalate a situation that resulted in Resident #8 being slapped across the face by Resident #10. The DNS confirmed that staff was aware based on the staff's statement that Resident #10 was becoming agitated by the yelling out of Resident #8 and that staff was present and witnessed Resident #10 walk across room and slap Resident #8 across the face. Per interview the DNS confirmed that if staff had	F 323	Monitoring A QA tool will be completed by the charge nurse and reviewed by the Unit Manager to ensure compliance for all residents who are at risk for aggressive behaviors. Immediate corrective action will be taken by the Unit Manager for any deficient practice noted. Been achieved for six consecutive weeks. Monitoring thereafter will be weekly, then monthly, and thereafter quarterly as long as 100% compliance is kept. F323 POC accepted 3/17/14 PMA:ARN	3/31/14	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/12/2014
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE MIDDLEBURY, VT 05753
---------------------------------------------------------------------	----------------------------------------------------------------------------------

(X4) IO 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) COMPLETION DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

F 323	Continued From page 17 utilized the interventions listed on the care plans for Resident #8 and #10 the staff may have been able to prevent the physical interaction between the residents.	F 323		
F 431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>	F 431	<p><u>Corrective Action and Individual Residents</u></p> <p>-Medication rooms and carts will be cleaned and expired drugs will be discarded and replaced.</p> <p><u>Systemic Changes</u></p> <p>Implementation of policy and procedure that outlines the proper handling of medications upon a resident's temporary departure from the facility and upon their return. This policy will also outline the handling of medications brought into the facility by a patient/resident from home upon admission.</p> <p>Implementation of policy and procedure outlining the proper disposal of expired medication/narcotics.</p> <p>Implement a policy and procedure for the weekly purging of expired medications from medication rooms, carts and refrigerators.</p> <p>Silver Chair courses will be assigned to all nursing staff to verify that the above outlined policies and procedures have been read.</p>	<p>2/13/14</p> <p>3/21/14</p> <p>3/21/14</p> <p>3/31/14</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2014
NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE 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) COMPLETION DATE	
F 431	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, staff and other interviews and record review, the facility failed to assure that all drugs are stored in locked compartments and failed to assure only authorized personnel have access to drugs. The facility also failed to dispose of/return outdated medications. 1.) On 2/11/14 at 9:40 AM during observation of medication storage room located on Otter Creek, it was found that there were 7 (seven) tubes of Insta-glucose that were expired. 3 (three) of the tubes were dated for expiration 1/2013 and 3 (three) were dated for expiration 3/2013 and one (1) tube dated for expiration 4/2013. Confirmation of the expiration dates were made by the RN Unit Charge Nurse who had accompanied this surveyor. The RN charge nurse confirmed that medications that are outdated are to be removed and reordered per policy titled Medication Storage (page 3.23) that all out-dated, deteriorated or unusable drugs shall be stored in a designated area away from other drugs. 2.) On 2/11/14 at 9:40 AM during observation of medication storage room storage room located on Otter Creek, it was found that there was a multi-dose Flu vaccine vial that was dated as being opened on 11/24/13. Confirmation of the date of being opened on 11/24/13 was made by the RN unit charge nurse, who had accompanied this surveyor. Per phone conversation with a pharmacist from the facility's pharmacy on 2/11/14 at 12:07 PM s/he confirmed that	F 431	<u>Identifying othe Residents</u> Any resident leaving for LOA or coming from outside the facility with own medications. All pharmaceuticals verified to be current and accounted for. <u>Monitoring</u> Implement procedure for night nurse to conduct weekly cart inspection with removal of all expired medications. Implement electronic monitoring system to notify unit manager of task completion Conduct environmental rounds bi-weekly, to be done by unit manager or designee, to verify the removal of all expired medications from the medication rooms and refrigerators. F431 POL accepted 3/17/14 pncotarn	ongoing 3/3/14 3/14/14 3/6/14 3/19/14 ongoing	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2014
NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE 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) COMPLETION DATE	
F 431	<p>Continued From page 19</p> <p>multi-dose vials are to be discarded 28 days after opening. Review of facility policy titled Medication Storage presents on page 3.24, that Multi-dose vials are to be discarded 28 days after first use. Further confirmation was made from the RN charge nurse that Multi-dose vials are to be discarded after 28 days from opening.</p> <p>3.) On 2/11/2014 at 9:40 AM during observation of medication storage room located on Otter Creek, it was found that there was a multi-dose half full vial of Pneumovac without a date as to when it was opened. Confirmation that there was no date to indicate when vial was opened was confirmed by the RN charge nurse, who had accompanied this surveyor, that per facility policy titled Medication Storage (page 3.23), Multi-dose vials must be labeled with a new expiration date once it is opened or punctured. The expiration date is defined as "the last date that the product is to be used." Once the vial cap is removed or the vial is punctured, the manufacturer's expiration date is no longer valid and a "beyond use date" needs to be determined. Per phone conversation with a pharmacist with the facility's pharmacy on 2/11/14 at 12:07 PM s/he confirmed that multi-dose vials are to be discarded 28 days after opening.</p> <p>4.) On 2/11/14 at 9:40 AM during observation of medication storage room located on Otter Creek, it was found that there was a multi-dose vial of Tuberculin that was dated as being opened on 5/27/13. Confirmation of the date of being opened on 5/27/13 was made by the RN charge nurse who had accompanied this surveyor. Per phone conversation with a pharmacist with the facility's pharmacy on 2/11/14 at 12:07 PM s/he confirmed that multi-dose vials are to be</p>	F 431			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2014
NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE 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) COMPLETION DATE	
F 431	<p>Continued From page 20</p> <p>discarded 28 days after opening. Review of facility policy titled Medication Storage presents on page 3.24, that Multi-dose vials are to be discarded 28 days after first use. Further confirmation was made from the RN charge nurse that Multi-dose vials are to be discarded after 28 days from opening.</p> <p>5.) Observation of Medication Cart #2 on Otter Creek at 10:00 AM presented with a tube of Insta-glucose that was dated for expiration 1/2013. Confirmation of the expiration date was made by the RN Unit Manager charge nurse. The RN charge nurse confirmed that medications that are outdated are to be removed and reordered per policy titled Medication Storage (page 3.23) that all out-dated, deteriorated or unusable drugs shall be stored in a designated area away from other drugs.</p> <p>6.) On 2/11/13 at 11:50 AM during observation of medication storage room located on Memory Care, it was found that there was a multi-dose vial of Flu vaccine dated as being opened on 11/24/14. Confirmation of the date of being opened on 11/24/14 was made by the LPN charge nurse who had accompanied this surveyor. S/he further confirmed that it should have been discarded after 30 days. Per conversation with the pharmacist with the facility's pharmacy on 2/11/14 at 12:07 PM s/he confirmed that multi-dose vials are to be discarded 28 days after opening. The RN charge nurse confirmed that medications that are outdated are to be removed and reordered per policy titled Medication Storage (page 3.24) that that Multi-dose vials are to be discarded 28 days after first use.</p>	F 431			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2014
NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE 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) COMPLETION DATE	
F 431	<p>Continued From page 21</p> <p>7.) On 2/11/14 at 12:00 PM it was observed on Memory Care that the medication cart for Wait's River Way was unlocked and accessible to residents in an unsecured location in the hallway. There was no visualization of the medication cart by neither the charge nurse, who was at the nurse station nor the medication nurse, who was in the dining room feeding a resident. At 12:07 PM, the charge nurse confirmed that the medication was unlocked and unsecured and s/he stated that the cart should have been locked.</p> <p>8.) On 2/11/14 at 12:31 PM during medication administration observation, it was observed that after preparing medications for the resident being observed, the medication nurse walked away from the medication cart in search of the resident. S/he failed to lock the medication at this time. When unable to locate the resident on the unit, s/he found that that the resident was with visitors off the unit. At 12:34 PM as s/he passed the medication cart s/he realized that it wasn't locked and locked it at that time and s/he stated that the keypad was broken and because of that, the cart does not automatically lock and s/he is not used to having to lock it manually.</p> <p>9.) Observation of Medication cart #2 on the Post Acute Unit on 2/12/14 at 8:10 AM presented with a 3 (three) pack of single dosing Insta-glucose that was dated for 2/2013 for an expiration date. Confirmation was made by the RN medication nurse that accompanied me. She stated that it was the responsibility of the pharmacy to remove out dated medications.</p> <p>10.) Observatation of Medication cart #1 presented with 1 (one) tube of insta glucose that had an expiration date of 1/2013 and confirmation</p>	F 431			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/12/2014
NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE 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) COMPLETION DATE
F 431	Continued From page 22 was made by the RN that accompanied me that the expiration was dated for 1/2013. 11.) Per interview with the DON on 2/12/14 at 9:15 AM s/he stated that the pharmacy used for the facility is the pharmacy for the hospital. She stated that the pharmacist is responsible for checking and removal of out dated medications from storage and it is the responsibility of the nurses to insure that out dated meds are removed from the medication. S/he confirmed that there is no specific system in place as to who is responsible and when it needs to be done. Review of facility policy and Helen Porter Healthcare & Rehabilitation Center Policy & Procedures for Pharmacy Use, the pharmacist is only responsible for checking medication storage of the Pyxis (Machine for dispensing medications). Per interview with pharmacist at 10:40 AM, s/he confirmed that the responsibility of the pharmacist is only in regards to the Pyxis and the facility is responsible for medication carts, refrigerated and all other medications that need to be checked for expiration. Per interview confirmation with DON there is no system for checking and discarding of out-dated medications	F 431		

