

Division of Licensing and Protection
103 South Main Street
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

May 14, 2015

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 **April 21, 2015**. 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

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

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 C 04/21/2015
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NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE MIDDLEBURY, VT 05753
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000

INITIAL COMMENTS

F 000

An unannounced, on-site investigation for a self report was conducted by the Division of Licensing and Protection on 04/21/2015. One deficiency was found to be related to the facility reported incident and another one was identified that was unrelated to the allegations. The specifics are as follows:

F 282

483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

F 282

The services provided or arranged by the facility 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 medical record review and staff interviews, the facility staff failed to implement the plan of care for 1 of 1 resident reviewed. The findings are as follows:

Per medical record review on 04/21/2015 at 12:13 pm, Resident #1 has a care plan entry dated 01/02/2015 that directs staff to "offer reassurance, use calm tone of voice and to provide gentle encouragement" in the section listing behaviors as a problem. Resident #1 has episodes of being aggressive and lashing out at staff. Per interview with the social worker at 2:05 pm, Resident # 1 is in declining stages of Alzheimer's Disease and is currently exhibiting difficulty articulating what s/he wants to say. The social worker further reports that this decline and the inability to adequately communicate can be very distressing to the resident.

Corrective Action Accomplished For Those Residents Found To Have Been Affected:

- Nurse involved was immediately removed from resident #1's room and taken off this resident's assignment.
- Resident #1 was reassured
- Nurse was placed on extended orientation with direct supervision.
- Nurse was counseled by social services on how to approach residents with Dementia and the abuse and neglect policy and procedure was reviewed with her.
- Nurse was given a written warning/corrective action notice.
- Weekly review of this nurse's performance is reported to the manager by the charge nurse overseeing her.
- Staff educator conducted extended one on one training sessions with this nurse.

Other Residents Identified As Having The Potential To Be Affected:

- 105

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Interim Administrator* (X6) DATE: *5/9/15*

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 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 1 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.

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F 282 Continued From page 1

During interviews of four (4) staff members assigned to the unit where resident # 1 resides, the nurses indicate that they did not see the beginnings of an altercation between a staff nurse and this resident. What 2 of them witnessed was a staff nurse speaking loudly and pointing a finger to Resident # 1 who was in his/her bed at the time. The staff secured the room and reassured the resident and provided care. All the nurses indicate during interview that the behavior they heard from the staff person involved is not in character for how his/her work performance has been since hire in March 2015. Staff report that they do not always look at the care plan, but that it is available to them and that communication of care that is on the care plan is reported to each other during rounds at shift change. Staff confirm that the care plan is in place to assist staff to provide consistency when caring for residents and that the staff nurse involved did not carry out the directions on the care plan when tending to Resident # 1.

F 431 483.60(b), (d), (e) DRUG RECORDS, SS=D LABEL/STORE DRUGS & BIOLOGICALS

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.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the

F 282

F 431

Systemic Changes Put In Place To Ensure The Deficient Practice Does Not Recur:

- Implement new orientation process for nurses and LNAs to include the completion of care plan review of all residents for the unit to which that staff member has been assigned, prior to being released onto that unit for hands on training.
- All nursing staff will be required to read the care plan interventions of all residents identified as having the potential for behaviors that include but are not limited to agitation/violence/aggression, of the unit to which they are assigned.
- Implement check off system for unit charge nurses to ensure staff has read the changes/updates to the care plans prior to the start of each shift.

How The Corrective Actions Will Be Monitored:

- The staff educator will ensure that all new nursing staff has read the resident care plans prior to releasing them to the unit to which they have been assigned. This will be facilitated by use of a check off list that will be submitted to the director of nursing when complete.
- Unit Managers/designee will review staff check off system daily x 4 weeks until 100% compliance has been reached, to ensure that changes in the care plan are being reviewed at the beginning of each shift prior to staff working with residents. Then monthly thereafter.

5/22/15

5/22/15

5/22/15

Ongoing

6/3/15-on going

F282 POC accepted 5/13/15
Ciceman RWI PML

(Signature)

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

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F 431 Continued From page 2

appropriate accessory and cautionary instructions, and the expiration date when applicable.

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.

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 1978 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.

This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews at 2:33 pm on 04/21/2015, the facility failed to assure that medications were secured on the unit in a locked medication cart, that was unattended by the staff.

Per observation on Memory Lane at 2:33 pm on 04/21/2015, the medication cart that had been observed to have been locked at 1:55 pm was unlocked in a hallway that is accessible to residents. This was confirmed by the nurse who was passing meds from this cart. S/he indicated that s/he did not lock the cart when going into a resident's room. Another LPN leaving the unit and observing that the cart was unlocked, also

F 431

Corrective Action Accomplished For Those Residents Found To Be Affected:

- Medication cart was locked immediately.
- Nurse responsible for cart was counseled immediately regarding her responsibility to ensure the cart is locked every time she steps away from it.

Other Residents Identified As Having The Potential To Be Affected:

- 105

Systemic Changes Put In Place To Ensure The Deficient Practice Does Not Recur:

- DNS will implement communication to all nurses stating that it is the responsibility of each nurse to ensure that the medication cart to which they have been assigned is locked at all times when that nurse is away from their cart. 5/1/15
- Each nurse will be required to sign understanding of this facility practice. 5/22/15
- Implement understanding of this facility practice, by way of a read and sign form, into the facility orientation process for nurses. 5/22/15

How The Corrective Actions Will Be Monitored:

- Manager/designee will perform 2 random cart checks a day x 4 weeks until 100% compliance has been achieved then monthly thereafter.

F431 PDC accepted 5/13/15 [Signature]

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F 431	Continued From page 3 indicated that the cart should be locked when unattended.	F 431		
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