

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

October 11, 2016

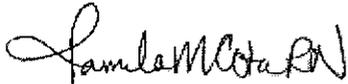
Mr. James Darragh, Administrator
Helen Porter Healthcare & Rehab
30 Porter Drive
Middlebury, VT 05753-8422

Dear Mr. Darragh:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 13, 2016**. 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 & MEDICAID SERVICES

PRINTED: 09/23/2016
FORM APPROVED
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 476017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/13/2016
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 000	INITIAL COMMENTS	F 000	514 Corrective Action: Follow up Social Service documentation on resident # 3 was removed from resident #4's chart and placed in resident #3's chart.	9/30/16	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by:	F 279	Systemic Changes: Following every Internal investigation Social Services will notify DNS or designee of the completion of their follow up documentation. Monitoring: DNS or designee will review Social Service note for completeness and ensure it is located in the correct resident's chart. <i>F514 POC accepted 10/11/16 DM [signature]</i>	On Going On Going	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X4) DATE 9/7/16

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.

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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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F 279	Continued From page 1 Based on staff interview and record review the facility failed to develop a comprehensive care plan to meet the needs for 1 out of 4 residents (Resident #2). Findings include: Per record review Resident #2 had the following diagnoses: non-rheumatic mitral valve prolapse (systolic click murmur syndrome in the heart), rheumatic tricupid insufficiency (blood flows backward in the heart reducing efficiency), a-fib (Irregular, fast heart rate), hypothyroidism (thyroid gland does not produce enough of certain important hormones), irritable bowel (disorder that affects the large intestine causing cramping, pain, diarrhea), and prosthetic valve (substitute valve used to replace a diseased valve in the heart). Per review of the physician's orders the nursing staff were to complete a cardiac (heart) system note in the morning and afternoon, check vital signs (blood pressure, pulse, temperature, respiration) in the morning and afternoon, complete a weekly weight, and call the physician if PT/INR (lab used to monitor effects of a blood thinner-Coumadin) was over 3.0. Per review of Resident #2's medication list s/he was receiving Coumadin daily. Resident #2's care plan addressed the following problems: activity intolerance, impaired physical mobility, self-care deficit, diarrhea, comfort, skin integrity, weight loss, and falls. There was no evidence in the care plan that addressed the cardiac (heart) and anticoagulation (blood thinner) needs of Resident #2. Per Interview on 9/13/16 at 10:14 AM with the Post-Acute Unit Manager, s/he confirmed that there was no care plan in place that identified the cardiac and anticoagulation needs for Resident #2. S/he stated that s/he would expect a care plan to be in place to address those identified	F 279	F 279 Corrective Action: Resident #2's care plan was corrected immediately to reflect her Cardiac and Anticoagulation needs. Others Identified: 105 Systemic Changes: Post-Acute Charge Nurse will be given a routine half day every week in which he/she will review all patient care plans for accuracy. DNS and Staff Educator will arrange for all nurses to receive care planning education. Monitoring: Nurse Managers or designee will conduct random care plan audits weekly and submit to DNS. <i>F279 PIC accepted 10/11/16 DWD/aw/ke/2/1/ PML</i>	9/13/16 On Going 11/8/16 On Going	

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NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE MIDDLEBURY, VT 05763		
(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 279	Continued From page 2 needs.	F 279			

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

AH
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNF _s AND NF _s		PROVIDER # 475017	MULTIPLE CONSTRUCTION A. BUILDING: _____ D. WING _____	DATE SURVEY COMPLETE: 9/13/2016
NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE MIDDLEBURY, VT		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES			
F 514	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to maintain clinical records that are accurately documented in accordance with accepted professional standards and practice for 2 of 4 residents (Resident #3, Resident #4). Findings include:</p> <p>Resident #3 and Resident #4 were involved in an altercation on 8/19/16. Per interview on 9/13/16 at 9:48 AM with one of the facility's social workers, s/he stated that the process for handling a resident to resident incident involved the social worker following up with each of the residents after the incident occurred. Per review of social work progress notes for Resident #3 there was no follow-up documentation noted for the incident that occurred on 8/19/16. Upon review of Resident #4's social work progress notes, there appeared to be follow-up documentation of the incident on 8/19/16 for both residents (Resident #3 & Resident #4) noted in Resident #4's record. Per interview on 9/13/16 at approximately 3:00 PM with the Unit Manager from the Memory Care Unit, s/he confirmed that the social worker had documented his/her follow-up with Resident #3 for the incident on 8/19/16 in Resident #4's record.</p> <p>*This is an "A" level finding.</p>			

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 patient. (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

The above isolated deficiencies pose no actual harm to the residents

031099

Event ID: 9FPJ11

If continuation sheet 1 of 1