

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 15, 2013

Mr. David Silver, Administrator
Newport Health Care Center
148 Prouty Drive
Newport, VT 05855-9821

Dear Mr. Silver:

Enclosed is a copy of your acceptable plans of correction for the on-site follow-up to the Recertification survey conducted on **February 19, 2013**. 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

PRINTED: 02/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/19/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER NEWPORT HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 148 PROUTY DRIVE NEWPORT, VT 05855
--	--

(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 An unannounced on-site follow-up to the Recertification survey was completed on 2/19/13 by the Division of Licensing and Protection. The following are regulatory violations that were found to be uncorrected.	{F 000}		
{F 273} SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to conduct a comprehensive assessment for 1 of 3 residents in the re-visit sample (Resident # 60) within 14 calendar days. Findings include: Per record review on 2/19/13 at 11:50 AM, there was no Minimum Data Set (MDS) assessment for Resident #60 who was admitted on 1/31/13. During interview with the DNS on 2/19/13 at 12:08 PM, the DNS confirmed the required 14 day assessment has not been completed for this resident.	{F 273}	All residents will have a comprehensive admission completed within 14 calendar days. The MDS will be completed within 14 days. This was reviewed with the MDS resident #60 MDS was completed on 02/19/13. The DON will monitor weekly with a checklist to make sure the MDS's are done timely. <i>F273 POC accepted 3/14/13 R Tremblay RN/PMC</i>	02/20/13
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	{F 323}	Fall risk assessments will be done after all falls. Residents will be monitored for head injuries after falls.	02/20/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 03/05/13
--	------------------------	-----------------------

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.

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

PRINTED: 02/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/19/2013	
NAME OF PROVIDER OR SUPPLIER NEWPORT HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 148 PROUTY DRIVE NEWPORT, VT 05855		
(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 1 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 staff interview and record review, the facility failed to complete assessments to ensure 1 of 3 residents in the re-visit sample (Resident #17) received adequate supervision and assistive devices to prevent accidents. Findings include: Per record review on 2/19/13 at 11:00 AM, there were no fall assessments done after Resident #17 had 2 falls. Per review of the nursing notes, Resident #17 fell on the 3 PM - 11 PM shift on 2/14/13 and again on 2/16/13. There is no evidence that the fall risk assessments were done after the 2/14 and 2/16/13 falls. Both the Plan of Correction and facility policy state that fall risk assessments are to be done after all falls. The Director of Nursing Services confirmed that the fall risk assessments had not been done during an interview on 2/19/13 at 11:31 AM.	{F 323}	On 02/20/13 a review was held again with the nursing staff regarding fall prevention and post fall protocol. DON will monitor after every fall to assure this is being followed. <i>F323 POC accepted 3/14/13 RTremblay RN/PMC</i>	02/20/13
{F 371} SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	{F 371}	The (3) hood vents above the main cook stove were cleaned on 02/20/13. The heat vent between the two main refrigerators was cleaned on 02/20/13. The dietary manager has instituted a checklist to monitor this and to assure that cleaning is done weekly and as needed.	02/20/13

*F371 POC accepted 3/14/13
RTremblay RN/PMC*

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

PRINTED: 02/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/19/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER NEWPORT HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 148 PROUTY DRIVE NEWPORT, VT 05855
--	--

(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 371}	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store, prepare, distribute and serve food under sanitary conditions. Findings include: Per observation on 2/19/13 at 10:40 AM, three hood vents operating above the main cook stove were coated with dark dust. Additionally, the heat vent between two main refrigerators while operating as a primary heat source for the kitchen was occluded with dark, thick dust. The Dietary Manager confirmed the above observations at 10:45 AM on 2/19/13 and stated h/she would "have to clean them more regularly".	{F 371}		