

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

June 26, 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 **May 21, 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

PRINTED: 06/04/2014
FORM APPROVED
OMB NO. 0938-0391

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 06/21/2014
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 157 SS=E	<p>An unannounced on-site self report complaint investigation was conducted by the Division of Licensing and Protection from 5/19/14 to 5/21/14. There were regulatory deficiencies identified. The findings include;</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's</p>	F 157	<p>1.) Corrective Action for Individual Residents Affected by Deficiency- NA Resident # 2 deceased</p> <p>2.) Identifying Other Residents- The number of residents affected by this deficiency includes, potentially 105 residents.</p> <p>3.) Systemic Change-</p> <ul style="list-style-type: none"> - DNS reviewed "Physician Notification Policy & Procedure". State Surveyor reviewed "Physician Notification Policy & Procedure" and concurred that the policy was clear and complete. All staff were required to read the policy and sign that they understood it's content. - Nursing staff will be required to review the "Physician Notification Policy and Procedure" monthly x 3 months, then quarterly thereafter. - Implement DNS/Unit Manager or designee will follow up with record review to ensure physician notification of all reported changes in condition, reported in morning stand up meeting or thereafter. <p>4.) Monitoring- Quarterly monitoring of compliance will be maintained through Silverchair Learning module by nursing leadership.</p> <p><i>F157 POC accepted 6/19/14 p.m. chern</i></p>	05/29/14 Ongoing Ongoing Ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Interim Administrator* (X6) DATE: *6/17/14*

Any deficiency identification 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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F 157	<p>Continued From page 1 legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to immediately inform the physician of Resident #2 of a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). The findings include;</p> <p>1. Per medical record review on 6/21/14, Resident #2 was admitted to the facility on 4/21/14 for short term rehabilitation after sustaining a fall and a cerebral vascular accident (CVA/stroke). Per record review Resident #2 also had diagnosis of atrial fibrillation, diabetes and chronic kidney disease. Per the record Resident #2 was alert and oriented and able to make his/her needs known.</p> <p>Per review of the comprehensive care plan under the heading of Potential for Alteration in Cardiac Output created on 4/21/14 indicates that the nurses are to provide several interventions including "check residents respiratory status" and "notify the physician as needed". Per review of the medical record the nurses documented a respiratory assessment each day on all three shifts.</p> <p>Per review of the nurse's documentation on 5/9/14 a respiratory assessment was completed</p>	F 157			

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F 167	<p>Continued From page 2</p> <p>and it was noted by the nurse that Resident #2 had "fine crackles heard with inspiratory bilateral upper lobe congestion." Per the record prior to 5/9/14 Resident #2 had no issues or concerns related to his/her respiratory status.</p> <p>On 5/10/14 the nurses documented abnormal respiratory assessment for Resident #2 that included expiratory fine crackles. On 5/11/14 the nurse documented at 4:27 AM that Resident #2 had a cough, mild nasal congestion, wheezing in the upper lobes and resident was running a low grade temp of 99.0. At 9:41 AM the nurse indicated that Resident #2 had scattered rhonchi (abnormal respiratory assessment) throughout lungs and the nurse documented at 3:28 PM that Resident #2 had both inspiratory and expiratory wheezes. On 5/12/14 the nurse documented at 2:20 AM the need to elevate Resident #2's head of the bed to a 30 degree angle because Resident #2 is short of breath when laying flat.</p> <p>Per nurses documentation from 5/12 to 5/16 each shift nurses were documenting abnormal respiratory assessments for Resident #2 that included wheezing, non productive cough, coarse crackles throughout all lung fields.</p> <p>On 5/16 the medical record indicates that at 9:38 PM the Licensed Nurse Assistant (LNA) informed the nurse that Resident #2 "wants something for shortness of breath." The nurse documents that he/she assessed the resident to have pulse of 120 (high), respirations of 28 (high) and oxygen saturation of 88% (low) on room air. The nurse documents that at 9:45 PM Resident #2 was given 2 liters of oxygen via nasal cannula.</p> <p>On 5/16/14 the medical record indicates that at</p>	F 167		

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F 157	<p>Continued From page 3</p> <p>10:45 PM the night shift LNA informed the nurse that the LNA had "found [Resident #2] to be unresponsive." The nurse documented that he/she found Resident #2 in absence of human responses, spontaneous breathing and absent of heart rate for two full minutes.</p> <p>Per review of the medical record there was no evidence in the physician's notes that indicated that Resident #2 had any respiratory issues. Per review of the medical record a care plan meeting was conducted on 5/16/14 at 10:20 AM and that it was noted at the meeting that "over a week ago this patient came down with a cold."</p> <p>Per review of the notes, a late entry note written on 5/17/14 indicates that the evening nurse at 7:00 PM received report that a call was placed to Resident #2's physician at the end of day shift related to shortness of breath on exertion, wheezes and a cough and that it would be followed up on the next day.</p> <p>Per review of the medical record a nurse sent a fax to the physician on 5/16/14 at 1:02 PM that indicated "patients cold symptoms are a lot worse...inspiratory and expiratory wheezes throughout. The patient is short of breath with minimal exertion. The patient has congested nonproductive cough. Just an FYI." The fax was dated by the primary physician on 5/16/14 and sent back to the facility that indicated "Just learned patient has died."</p> <p>Per review of the medical record "a call was placed to on-call physician at 12:15 AM, informing physician of resident's death." The note indicates that the physician came to the facility and pronounced Resident #2's passing at 1:30 AM.</p>	F 157		

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F 157	<p>Continued From page 4</p> <p>Per review of the physicians documentation there was no evidence that the physician was aware that Resident #2 had a change in condition related to his/her respiratory status until 5/17 at 1:30 AM when the on call physician documented that "see through nurse documentation of the events leading up to the death, reportedly resident had been having cold symptoms of nasal congestion, cough, wheezing and was having some wheezing and was given O2 at 2 liters."</p> <p>Per review of all the documentation provided by the facility there was no evidence that the staff notified Resident #2's physician of the change in respiratory status from 5/9 to 5/18/14.</p> <p>Per review of the facility policy and procedure titled "Protocol for Physician Notification", the policy indicates to notify the physician when a patient presents with an acute change of condition (defined as sudden clinical important deviation for a patients baseline in physical, cognitive, behavioral or functional domains) that may require the attention of the medical provider. And that Clinical importance means "a deviation that without intervention may result in complications or death."</p> <p>Per interview on 5/21/14 with the Unit Manager and the Director of Nursing, of all the nurses documentation, physicians documentation, faxes, care plan meeting documentation, and care plan the DNS and UM confirmed that Resident #2 had a change in condition from his/her normal baseline and that the physician should have been contacted and informed of the change of condition and inquire regarding medical interventions to assist Resident #2. The DNS</p>	F 157			

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F 157	Continued From page 6 confirmed that from 5/9 to 5/16 numerous nurses on all shifts documented the changes to resident condition and no one notified the physician. The DNS confirmed that there was no death certificate in the medical record that it had to stay with the deceased but that the Physician indicated the cause of death was a Upper Respiratory Infection.	F 157		
F 280 SS=D	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 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that a comprehensive care plan was reviewed and revised for Resident #1 by	F 280	1.) Corrective Action for Individual Residents Affected by Deficiency- NA Resident #1 deceased 2.) Identifying Other Residents- The number of resident affected by this deficiency includes, potentially 105 residents. 3.) Systemic Changes- - Implement " Fall Policy & Procedure" which will include the process of implementing fall intervention on care plans following all falls. - Implement Fall Committee consisting of interdisciplinary team members to review all falls and aid in intervention implementation. - Unit Managers will conduct a care plan review after falls to ensure implementation of interventions. - DNS/Unit Manager or designee will follow up with all falls reported in the morning stand up meeting. 4.) Monitoring- Evaluation of process to become permanent agenda item at Quarterly Quality Assurance meeting. FABO POC accepted 6/19/14 Pmcotaren	06/27/14 Ongoing Ongoing Ongoing

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F 280	<p>Continued From page 8</p> <p>a team of qualified persons to address current needs around safety. The findings include;</p> <p>1. Per review of the medical record, Resident #1 was admitted to the facility on 6/9/14 with diagnoses that include pathologic neck fracture, Parkinson's and dementia. Per review of the medical record and facility incident reports, Resident #1 fell on 10/19/13, 11/20/13, 12/1/13 and 12/3/13. All falls were recorded as to have occurred from the resident's bed at various times during the day and night. Per review of the facility fall assessment tools that were completed on Admission, and then 10/19/13, 11/20/13, 12/1/13, and 12/3/13. All the assessments indicate that Resident is at high risk for falls.</p> <p>Per review of the comprehensive care plan that addresses the Resident's risk for falls, it indicates that Resident #1 is at risk for falls. There was no indication that the care plan had been reviewed and revised to meet Resident #1's needs related to frequent falls, and there was no evidence of any supervision initiated for this resident to help prevent recurrence from 8/30/13 to 12/12/13.</p> <p>Per interview with the Unit Manager (UM) on 5/21/14, the UM reviewed the medical record and facility incident reports and confirmed that Resident #1 fell out of bed on the above dates. The UM reviewed the progress notes and incident reports and confirmed there was no evidence that the facility intervened after each fall for Resident #1 to review the care plan and develop interventions to prevent recurrence. Per interview the UM confirmed after reviewing the care plan that the care plan did not reflect Resident #1's status related to falls and did not reflect any interventions to prevent recurrence.</p>	F 280		

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F 280	Continued From page 7 The UM confirmed that there was no evidence of supervision of Resident #1 to help prevent recurrence, and the UM indicated that the 12/5/13 update to the care plan was related to the quarterly review and not any falls and that none of the interventions listed for 12/5/13 were different than those documented on 8/30/13. Per interview with the Director of Nursing on 5/21/14, he/she reviewed the medical record, incident reports and comprehensive care plan and confirmed that there was no evidence that interventions were put into place after the falls on 10/18, 11/20, 12/1, and 12/3/13 to help prevent recurrence. The DNS confirmed that his/her expectation is that each incident be reviewed and interventions utilized to prevent recurrence. The DNS confirmed that there was no method of supervision used to assist the resident to prevent recurrence of falls.	F 280			
F 323 SS=D	See also F323. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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 record review and staff interview the facility failed to ensure that the resident	F 323			

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F 323	<p>Continued From page 8</p> <p>environment for one resident (Resident #1) remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. The findings include;</p> <p>1. Per review of the medical record, Resident #1 was admitted to the facility on 6/9/14 with diagnoses that include pathologic neck fracture, Parkinson's and dementia. Per review of the medical record and facility incident reports, Resident #1 fell on 10/18/13, 11/20/13, 12/1/13 and 12/3/13. All falls were recorded as to have occurred from the resident's bed at various times during the day and night. Per review of the facility fall assessment tools that were completed on Admission, and then 10/18/13, 11/20/13, 12/1/13, and 12/3/13. All the assessments indicate that Resident is at high risk for falls.</p> <p>Per review of the comprehensive care plan that addresses the Resident's risk for falls, it indicates that Resident #1 is at risk for falls. There was no indication that the care plan had been reviewed and revised to meet Resident #1's needs related to frequent falls, and there was no evidence of any supervision initiated for this resident to help prevent reoccurrence from 8/30/13 to 12/12/13.</p> <p>Per interview with the Unit Manager (UM) on 5/21/14, the UM reviewed the medical record and facility incident reports and confirmed that Resident #1 fell out of bed on the above dates. The UM reviewed the progress notes and incident reports and confirmed there was no evidence that the facility intervened after each fall for Resident #1 to review the care plan and develop interventions to prevent reoccurrence. Per interview the UM confirmed after reviewing the</p>	F 323	<p>1.) Corrective Action for Individual Residents Affected by Deficiency- NA Resident #1 deceased</p> <p>2.) Identifying Other Residents- The number of resident affected by this deficiency includes, potentially 105 residents.</p> <p>3.) Systemic Changes-</p> <ul style="list-style-type: none"> - Implement " Fall Policy & Procedure" which will include the process of implementing fall intervention on care plans following all falls. - Implement Fall Committee consisting of interdisciplinary team members to review all falls and aid in intervention implementation. - Unit Managers will conduct a care plan review after falls to ensure implementation of interventions. - DNS/Unit Manager or designee will follow up with all falls reported in the morning stand up meeting. <p>4.) Monitoring- Evaluation of process to become permanent agenda item at Quarterly Quality Assurance meeting.</p> <p>F323 PDC accepted 6/19/14 pmatarn</p>	06/27/2014 Ongoing Ongoing Ongoing Ongoing	

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F 323	<p>Continued From page 9</p> <p>care plan that the care plan did not reflect Resident #1's status related to falls and did not reflect any interventions to prevent recurrence. The UM confirmed that there was no evidence of supervision of Resident #1 to help prevent recurrence, and the UM indicated that the 12/5/13 update to the care plan was related to the quarterly review and not any falls and that none of the interventions listed for 12/5/13 were different than those documented on 8/30/13.</p> <p>Per interview with the Director of Nursing on 5/21/14, he/she reviewed the medical record, incident reports and comprehensive care plan and confirmed that there was no evidence that interventions were put into place after the falls on 10/19, 11/20, 12/1, and 12/3/13 to help prevent recurrence. The DNS confirmed that his/her expectation is that each incident be reviewed and interventions utilized to prevent recurrence. The DNS confirmed that there was no method of supervision used to assist the resident to prevent recurrence of falls.</p>	F 323		
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