



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection

103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

February 16, 2010

Neil Gruber, Administrator
Helen Porter Healthcare & Rehab
30 Porter Drive
Middlebury, VT 05753

Provider #: 475017

Dear Mr. Gruber:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 13, 2010**. Please post this document in a prominent place in your facility.

We will 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,

Suzanne Leavitt, RN, MS
Licensing Chief

Enclosure



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

PRINTED: 01/26/2010
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 01/13/2010
--	---	--	---

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	<p>INITIAL COMMENTS</p> <p>An unannounced recertification survey was conducted from January 11, 2010 through January 13, 2010.</p>	F 000	<p><i>Corrective measures & compliance reports for F272, F279, F280, F281 will be reported monthly to Nursing RI, the Administrator, and the HPHRC Quality Improvement Committee for 12 months.</i></p> <p><i>Doc account 2-12-10 RT. unit / SSA</i></p>	<p><i>Ongoing \$ Jan 2011</i></p>
F 272 SS=D	<p>483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 272	<p><i>F272 HPHRC will conduct initial & periodic comprehensive, accurate, standardized reproducible assessments of each resident's functional capacity.</i></p> <p><i>The care plan of Resident #213 has been amended to reflect 1) comprehensive assessment regarding dental & pain status.</i></p> <p><i>All individuals admitted or readmitted to HPHRC would potentially be affected by failure to comply with F272.</i></p>	<p><i>01/14/10</i></p> <p><i>01/14/10</i></p>

LABORATORY/DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>M. H. [Signature]</i>	TITLE <i>Administrator</i>	(X6) DATE <i>2/05/2010</i>
---	-----------------------------------	-----------------------------------

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: 01/26/2010
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 01/13/2010
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 272	Continued From page 1 by: Based on record review and interview the facility failed to initially conduct an accurate assessment of 1 applicable resident's care needs. (Resident's # 213) Findings include: 1. Per record review on 01/11/10, there was no care plan or comprehensive pain assessment for Resident #213 who was admitted on 01/05/10 with a diagnosis of pain from a recent fall. In addition there was no comprehensive assessment regarding dental status, in which the Resident has visible dental carries. Per interview on 01/12/10 at 2:40 PM the Unit Manager confirmed the pain and dental assessments were not completed.	F 272	All policies & procedures at HPHRC pertaining to F272 will undergo review and a revision. All individuals admitted or readmitted to HPHRC since 1/13/10 will have their records carefully audited within five (5) days of arrival and then at day twenty-five (25) (pls see page 2 A) HPHRC will use the results of the assessment to develop, review, and revise the resident's comprehensive plan of care.	2/10/10
F 279 SS=D	483.20(d), 483.20(k)(1) 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).	F 279	Per unit 2-12-10 HPHRC will use the results of the assessment to develop, review, and revise the resident's comprehensive plan of care. The care plans of resident # 213, 220, & 54 have been amended to ensure that which was done & not documented is now complete and in compliance with F279.	2/10/10 & ongoing 01/14/10 02/02/10

Page 2A

Helen Porter Healthcare
and Rehabilitation Center
Middlebury VT 05753
(475017)

Plan of Correction
Annual Survey
January 11 - 13, 2010

F272 Any deviations from expectations related to compliance with F272 will immediately be corrected. Ongoing compliance will be monitored. 2/10/10
At six (6) months, if two (2) consecutive months of 100% compliance has been achieved, 25% of monthly admissions/readmissions will undergo careful audit. 2/10/10
ongoing

ABC count 2-12-10
R. Tinkley 18

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

PRINTED: 01/26/2010
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 01/13/2010
--	---	--	---

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 279	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, for 3 residents in the applicable sample, the care plans failed to address all of the residents' identified needs, including measurable goals and specific interventions to direct care. (Residents #213, 220 & 57) Findings include:</p> <p>1. Per record reviews on 1/21/10, there was no care plan to address the use of pain medication, measurable outcomes or alternative treatments for Resident #213 who was admitted on 01/05/10 with a diagnosis of pain from a recent fall. Per interview on 01/12/10 at 2:40 PM the Unit Manager confirmed the a pain care plan was not completed.</p> <p>2. Per record review, Resident # 220 was admitted to the facility on 12/26/09 with an indwelling Foley catheter in place. The plan of care was not developed to reflect the ongoing use of the Foley with measurable goals and interventions to direct care. Per interview on 1/12/10 at 4:50 PM, the charge nurse confirmed that the care plan related to the Foley catheter was not completed for this resident.</p> <p>3. Per staff interview and record review on 1/13/10, Resident #57 did not have a comprehensive care plan to address an indwelling Foley catheter present upon admission on 7/28/09. Per interview on 1/13/10 at 8:12 AM, an LPN (Licensed Professional Nurse) confirmed that a plan of care was not developed to reflect the use, goals and interventions related to the indwelling Foley catheter. Per interview on</p>	F 279	<p><i>All individuals admitted or readmitted to HPHRC would potentially be affected by failure to comply with F 279. All HPHRC policies & procedures pertaining to F-279 will undergo review and or revision. 2/10/10</i></p> <p><i>All individuals admitted or readmitted to HPHRC since 1/13/10 will have their records carefully audited within five (5) days of arrival & then at day twenty-five (25) 2/10/10 & ongoing</i></p> <p><i>Any deviations from expected compliance with F279 will immediately be corrected. Ongoing compliance will be monitored in the same manner documented above for F272. 2/10/10 & ongoing</i></p> <p><i>Per comment 2-12-10</i></p>	
-------	---	-------	--	--

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

PRINTED: 01/26/2010
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 01/13/2010
--	--	--	--

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 279	Continued From page 3 1/13/10 at 9:31 AM, the Charge Nurse also confirmed that a plan of care was not developed to reflect the use, goals and interventions for the indwelling Foley catheter.	F 279		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to assure that the comprehensive care plan was revised to reflect the current needs and care interventions for 2 residents in the applicable sample. (Residents #56 and #80). Findings include:</p> <p>1. Per record review Resident #80's care plan</p>	F 280	<p><i>HPHRC will ensure a comprehensive care plan is developed within seven (7) days after the completion of the comprehensive assessment and will ensure periodic review with revisions, by a team of qualified persons & the resident or their representative, after each assessment</i></p> <p><i>The care plans of residents #56 and #80 have been amended to ensure compliance with F280, specifically to ensure reflection of current needs and care interventions</i></p> <p><i>All residents of HPHRC would potentially be</i></p>	<p><i>01/14/10</i></p> <p><i>02/02/10</i></p>

Print 2-12-10
RTW/JS

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

PRINTED: 01/26/2010
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 01/13/2010
--	--	--	--

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 4 was not revised to reflect recent falls from bed or interventions to assure a bed alarm, utilized to alert staff to the resident's attempts to exit the bed, was applied appropriately. The fall and incident record revealed that the resident fell from bed on the morning of 12/29/09 and that the bed alarm was present and "did not go off, as bed was rolled up putting pressure on pad". Although the issue with placement of the bed alarm pad had been identified there was no evidence that the alarm had been replaced and the care plan was not revised to assure proper placement of the alarm pad when the bed was in the rolled up position. The resident subsequently fell from bed again, 2 days later, on 12/31/09 and the incident report, again, stated that the bed alarm was on "but not functioning properly" at the time of the incident. During interview, at 8:20 am on 1/13/10, the charge nurse stated that s/he had conducted the investigation after the fall on 12/29/09 and concluded that the rolled up position of the bed had put pressure on the alarm pad and prevented it from alarming. The nurse further confirmed that the care plan had not been revised to reflect the need to assure proper placement of the bed alarm pad. 2. Per record review on 1/12/10 of Resident #56's care plan, there was no revision or updates to the current care plan or the LNA care sheet regarding transferring or alarm equipment. Per a care plan conference note dated 12/11/09 at 2:00 PM "bed alarm was placed in bed as resident continues to fall" and a care plan dated 11/18/09 directing staff to transfer from bed to chair with 1 assist. Per observation on 1/12/10 and 1/13/10 the resident did have a bed alarm but did not get out of bed. Per interview staff confirmed that Resident #56 remains in bed most of the time and no longer transfers with 1 assist. On 1/13/10 at	F 280	<i>affected by failure to comply with F280. All HPHRC policies and procedures pertaining to F280 will undergo review and a revision. The comprehensive care plans developed within seven (7) days after the completion of the comprehensive assessment will be carefully audited for compliance with F280. This will apply to all residents at HPHRC. Any deviations from expected compliance with F280 will immediately be corrected. Ongoing compliance will be monitored in the same manner previously documented for F282.</i>	2/10/10 2/10/10 & ongoing 2/10/10 & ongoing
-------	---	-------	--	---

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

PRINTED: 01/26/2010
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 01/13/2010
--	--	--	--

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 5 9:33 AM the Clinical Manager confirmed that the care plan has not been revised or updated to reflect the bed alarm use or transferring.	F 280		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review the facility failed to assure that care and services were provided in accordance with physician orders and professional standards of nursing practice for 2 applicable sampled residents. (Residents #32 & #213). Findings include: 3. Per interview and record review, staff failed to monitor weekly weights. The facilities's policy and procedure directed staff upon admission to weigh weekly x 4 weeks. Per review of the weight and bath log, Resident #32 was admitted on 11/14/09 and weights taken on 11/20/09, 12/14/09, 12/21/09, 12/25/09 and on 01/04/10. The weights were not documented for the week of 11/22/09, 11/29/09 or 12/06/09. Per interview on 01/13/10 at 11:00 AM the Charge Nurse confirmed that staff failed to monitor and weigh weekly as indicated. 2. Per record review of Resident #213's MAR (medication administration record) the facility failed to implement their policy and procedure regarding assessing the resident's pain every shift. There was no documentation that pain was assessed consistently on all days at all shifts	F 281	<i>HPHRC will provide services which meet professional standards of quality.</i> <i>Resident #32 is being weighed & weight documented per HPHRC policy</i> <i>Resident #213 achieved compliance relative to staff following HPHRC pain assessment policies.</i> <i>all residents residing at HPHRC would potentially be affected by failure to comply with F 281.</i> <i>all HPHRC policies & procedures pertaining to F281 will undergo review and or revision</i> <i>DC unit 2-12-10</i>	<i>01/14/10</i> <i>2/2/10</i> <i>1/14/10</i> <i>2/10/10</i>

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

PRINTED: 01/26/2010
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 01/13/2010
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 281	<p>Continued From page 6</p> <p>since the Resident's admission on 01/05/10. Pain assessment was documented as being monitored twice daily, instead of three times daily, on 01/05/10, 01/07/10, 01/08/10, 01/09/10. Per interview on 01/12/10 at 2:40 PM, the Charge Nurse confirmed that no indication for every shift monitoring for pain was completed.</p> <p>Reference: Nettina, S.M. (2006). Lippincott Manual of Nursing Practice 8th Edition, Lippincott, Williams & Wilkins, Philadelphia</p> <p><i>This plan of correction constitutes our written Allegation of Compliance. For the deficiencies cited. However submission of this plan of correction is not an admission that any deficiencies exist or were cited correctly. This plan of correction is submitted to meet requirements established by State and Federal Law.</i></p>	F 281	<p><i>The records of all HPHRE residents will be carefully audited relative to weight protocols and pain assessment. The records will also be reviewed for interventions deemed necessary. Ongoing compliance will be monitored in the same manner. documented previously for F272.</i></p> <p><i>2/10/10 # ongoing</i></p> <p><i>2/10/10 # ongoing</i></p> <p><i>NAG 2/05/2010</i></p>

*BC 2-12-10
RPM*