

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

June 1, 2016

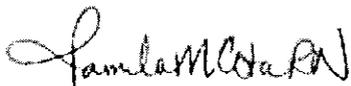
Mr. James Darragh, Administrator
Helen Porter Healthcare & Rehab
30 Porter Drive
Middlebury, VT 05753-8422

Dear Mr. Darragh:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on May 10, 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: 05/17/2016
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 05/10/2016
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)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

An unannounced, on-site investigation of 4 facility self-reported incidents was conducted by the Division of Licensing and Protection on 5/9/16 -5/10/16. The following regulatory violation was identified during the survey:

F 280 483.20(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 observation, record review and staff interview, the facility failed to review and revise the care plans for 2 of 5 residents (Resident #3 and #5) to address their current care needs. Findings include:

F 000 *Corrective Action taken for those residents found to have been affected by the deficient practice:*

- Resident #3's care plan was revised immediately to reflect his current code status.

- Resident # 5's care plan was revised immediately to reflect the discontinuation of use of a stop barrier in her doorway and revised to indicate the need for safety checks on resident when her door is closed.

Other residents identified as having the potential to be affected by the same deficient practice:

- 105 residents

Corrective Action:

- Care plan review/revision of all current residents will be completed. 6/27/16

Systemic Changes made to ensure the deficient practice does not recur:

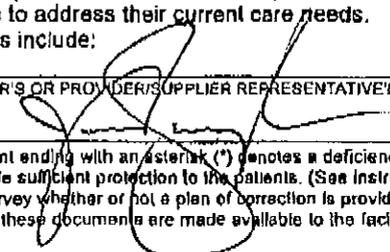
- Review the responsibility of revising resident/patient care plans upon receiving new orders or becoming aware of any/all changes in patient status with all nurses. 6/15/16

- Assign a designated weekly care planning review/revision day for all full time day charge nurses or designee, all units. 6/15/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



ADMINISTRATOR

5/26/16

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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F 280	<p>Continued From page 1</p> <p>1. Per record review, the care plan for Resident #3 was not revised to reflect his/her current code status (the level of medical intervention a patient wishes to have started if their heart or breathing stops). Per review, Resident #3's 3/22/16 care plan listed his/her code status as "Full Code" and a sticker on the resident's medical binder listed the resident as "Full Code;" however, the resident's physician orders (dated 3/22/16) stated "Please change code status to DNR (Do not resuscitate).</p> <p>On 6/9/16 at 12:33 PM, a staff nurse on the post-acute unit confirmed the above findings. S/he reported that when an order is changed, the staff nurse who noted the change should have changed the resident's care plan and binder sticker to reflect the current orders and that this had not occurred.</p> <p>2. The care plan related to potential for violence for Resident #5 was not revised to reflect current interventions to assure that wandering residents do not enter his/her room. Per record review and interviews on 5/9 and 5/10/16 with the Memory Care Unit Manager (UM), Resident #5 does not like his/her space invaded; s/he has been involved in resident to resident (res to res) incidents when other residents with cognitive issues enter his/her space/room. After a res to res incident on 3/7/16 with Resident #4, Resident #5's care plan was revised to include that a magnetic "stop sign" be hung in the resident's doorway to discourage people from wandering in. On 3/13/16, Resident #4 again entered Resident #5's room and per incident report, Resident #5 was heard yelling from [his/her] room, "get the f*** out of here...". Staff intervened and both residents</p>	F 280	<p><i>Monitoring to ensure the deficient practice will not recur:</i></p> <ul style="list-style-type: none"> Unit Nurse Manager or designee will conduct random patient care plan audits monthly for (3) three months or until no discrepancies are found for (3) three consecutive audits beginning 6/1/16. <p><i>F280 POC accepted 5/31/16 SDennis/PMC</i></p>
			9/1/16 or until goal achieved as outlined above. Then quarterly thereafter.

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NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE MIDDLEBURY, VT 06763
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F 280 Continued From page 2
were separated. Per review of the incident investigation with the UM, it was not determined if the "stop" barrier had been in place at the time of the second incident.

Per observation during the 2 days of the survey, no stop barrier was in place on Resident #5's door; instead the door to his/her room was observed to be closed. On 5/10/16 at 11:45 AM, the UM reported that s/he was not sure when the use of the stop barrier was discontinued and confirmed that Resident #5's care plan had not been revised to indicate that his/her door to the hallway was being kept closed and that staff were to check him/her for safety when the door was closed.

F 280