

Division of Licensing and Protection
103 South Main Street
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

May 14, 2015

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

Dear Mr. Silver:

Enclosed is a copy of your corrected acceptable plans of correction for the survey conducted on **April 15, 2015**. 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: 04/28/2015
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 C 04/15/2015 |
|--|--|--|---|---|
| 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 | F 000 | | |
| F 225 SS=0 | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. | F 225 | <i>PLEASE SEE ATTACHED DS.</i> | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE *ADMINISTRATOR* (X6) DATE *4/15/15*

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

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| F 000 | INITIAL COMMENTS | F 000 | | | |
| F 225 SS=D | <p>An unannounced investigation of 2 entity self-reported incidents and one complaint concerning quality of care and treatment was conducted by the Division of Licensing and Protection on 4/15/15. As a result of the investigation, the following regulatory violations were identified:</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> | F 225 | <p>Please see attached Plans of Correction.</p> | | |

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

TITLE

(X6) DATE

05/11/2015

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 225 | <p>Continued From page 1</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon staff interview and record review, the facility failed to report allegations of verbal abuse of 1 of 4 residents immediately to the State Survey and Certification agency (SA), according to their facility policy and as required by Federal regulation and failed to protect the resident from further abuse (Resident # 1). Findings include:</p> <p>Per nursing progress note review, nursing staff documented that on 1/13/15 Resident #2 was rude to his/her roommate [Resident #1] calling him/her names. On 1/14/15, staff documented that Resident #2 was again rude to [Resident #1] calling him/her a "fat ass" and telling him/her that s/he "stinks." Resident #2 was redirected but stated..."kick me out of here, I don't care." On 1/23/15, Resident #2 called Resident #1 "fat ass" and "dumb" and reportedly said to staff, "I don't care what you say" when they tried to re-educate him/her. On 1/24/15 Resident #2 stated that [Resident #1] ...was "disgusting" and on 1/25/15 Resident #1 "smells" [when s/he needed to be toileted in their shared room]. On 1/27/15 Resident #2 called Resident #1 "fatso." On 1/30/15, when Resident #1 was brought into their room, Resident #2 said, "Oh stinky-ass is here." On 2/18/15 Resident #2 told Resident #1, "get out</p> | F 225 | | | |

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| F 225 | <p>Continued From page 2</p> <p>if you don't like it you smelly, fat [expletives]."</p> <p>Per 4/15/15 review, the facility Abuse policy (effective 3/29/14) defines verbal abuse as "the use of oral, written or gestural language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability." The policy further states under paragraph 11, that "if the accused is a resident or the resident's roommate, the individual shall be placed in a supervised temporary location in order to ensure that the rights of the other residents will be protected." Under paragraph 13, the policy states the Director of Nursing will inform the state survey, certification, and licensing agencies of: All alleged violations involving mistreatment, neglect or abuse ... and d. the results of all investigations within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action that was taken.</p> <p>On 4/15/15 at approximately 1:33 PM, the DNS confirmed the information in the above nursing progress notes and that incidents of verbal name calling by Resident #2 started on 1/13/15. S/he confirmed that staff had reported Resident #2's verbal behavior toward Resident #1 and confirmed that the facility did not report the allegations of verbal abuse to the State Agency (SA) until 2/19/15, more than 1 month after the first documented incident. Additionally, per review of social service notes, Resident #1 and Resident #2 continued to share the same room until 2/26/15 when Resident #2 accepted a room change.</p> <p>Per interview with Resident #1 on 4/16/15, s/he</p> | F 225 | | | |

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| F 225 | Continued From page 3 reported that s/he felt better when Resident #2 was moved to another room as s/he didn't have to listen to his/her comments. (Refer F280 and F226) | F 225 | | |
| F 226 SS=D | 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record and policy review, the facility failed to operationalize their abuse policies regarding protecting 1 of 4 residents following allegations of verbal abuse and failed to ensure physician notification for 3 of 4 residents involved in resident to resident incidents (Resident #1, #3 and #4). Findings include: 1. Per nursing progress note review on 4/15/15, nursing staff documented that on 1/13/15 Resident #2 was rude to his/her roommate [Resident #1] calling him/her names. On 1/14/15, staff documented that Resident #2 was again rude to [Resident #1] calling him/her a "fat ass" and telling him/her that s/he "stinks." Resident #2 was redirected but stated "...kick me out of here, I don't care." On 1/23/15, Resident #2 called Resident #1 "fat ass" and "dumb" and reportedly said to staff, "I don't care what you say" when they tried to re-educate him/her. On 1/24/15 Resident #2 stated that [Resident #1] ...was "disgusting" and on 1/25/15 Resident #1 "smells" [when s/he needed to be toileted in their shared | F 226 | | |

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F 226 Continued From page 4

room]. On 1/27/15 Resident #2 called Resident #1 "fatso." On 1/30/15, When Resident #1 was brought into their room, Resident #2 said, "Oh stinky-ass is here." On 2/18/15 Resident #2 told Resident #1, "get out if you don't like it you smelly, fat [expletives]."

Per 4/15/15 review, the facility Abuse policy (effective 3/29/14) defines verbal abuse as "the use of oral, written or gestural language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability." Under paragraph 9., the policy states that "Suspected or substantiated cases of resident abuse, neglect, misappropriation of property or mistreatment shall be thoroughly investigated and documented by the Administrator or Director of Nursing, and reported to the Agency of Protective Services, the physician, families and/or representatives. The policy further states under paragraph 11, that "if the accused is a resident or the resident's roommate, the individual shall be placed in a supervised temporary location in order to ensure that the rights of the other residents will be protected."

On 4/15/15 at approximately 1:33 PM, the DNS confirmed the information in the above nursing progress notes and that allegations of verbal abuse by Resident #2 to Resident #1 started on 1/13/15. S/he further confirmed that the facility did not report the allegations of abuse to the SA until 2/19/15, more than 1 month after the first documented incident. Additionally, per review of social service notes, Resident #1 and Resident #2 continued to share the same room until 2/26/15 when Resident #2 accepted a room change. Additionally, per interview, the DNS was not able to provide evidence that Resident #1's

F 226

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| F 226 | Continued From page 5 physician was not notified of the allegations of verbal abuse. 2. Per 4/15/15 record and incident report review; Resident #3, who has a history of disruptive behavior and wandering put a hand on Resident #4's door. Resident #4 who has a history of dementia with physical and verbal violence saw Resident #3 touch the door and said "no" and then proceeded to slap Resident #3's hand. On 4/15/15 at 11:55 AM, the DNS confirmed that there was no evidence that the two resident's physicians were notified of the resident to resident incident as per facility policy. (Refer F225 and F280) | F 226 | | |
| 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. | F 280 | | |

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| F 280 | Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to revise the care plans for 2 of 4 residents involved in resident to resident incidents in a timely manner to assure that interventions were in place to address the abusive behavior (Resident #1 and Resident #2). Findings include: Per nursing progress note review on 4/15/15, nursing staff documented that on 1/13/15 Resident #2 was rude to his/her roommate [Resident #1] calling him/her names. On 1/14/15, staff documented that Resident #2 was again rude to [Resident #1] calling him/her a "fat ass" and telling him/her that s/he "stinks." Resident #2 was redirected but stated..."kick me out of here, I don't care." On 1/23/15, Resident #2 called Resident #1 "fat ass" and "dumb" and reportedly said to staff, "I don't care what you say" when they tried to re-educate him/her. On 1/24/15 Resident #2 stated that [Resident #1] ...was "disgusting" and on 1/25/15 Resident #1 "smells" [when s/he needed to be toileted in their shared room]. On 1/27/15 Resident #2 called Resident #1 "fatso." On 1/30/15, When Resident #1 was brought into their room, Resident #2 said, "Oh stinky-ass is here." On 2/18/15 Resident #2 told Resident #1, "get out if you don't like it you smelly, fat [expletives]." Per 4/15/15 review, the facility Abuse policy (effective 3/29/14) defines verbal abuse as "the use of oral, written or gestural language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability." The policy further states that "if the accused is a resident or the | F 280 | | |

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| F 280 | <p>Continued From page 7</p> <p>resident's roommate, the individual shall be placed in a supervised temporary location in order to ensure that the rights of the other residents will be protected." Under section 13., the policy states the Director of Nursing will inform the state survey, certification, and licensing agencies of: b. All alleged violations involving mistreatment, neglect or abuse...and d. the results of all investigations within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action that was taken.</p> <p>On 4/15/15 at approximately 1:33 PM, the DNS confirmed the information in the above nursing progress notes and that the allegations of verbal abuse were first documented on 1/13/15 per progress note review. S/he further confirmed that a care plan for Resident #1's potential for anxiety (related to the comments of his/her roommate) and interventions to address his/her psychosocial well-being were not developed until 2/23/15. The DNS also confirmed that for Resident #2, a care plan to address his/her inappropriate behavior towards Resident #1 and specific interventions to address these behaviors was not developed until 2/23/15. Both Resident #1 and Resident #2's care plans were not revised for over 1 month from the time the allegations of verbal abuse were first documented. Additionally, per review of social service notes, Resident #1 and Resident #2 continued to share the same room until 2/26/15 when Resident #2 accepted a room change. Per interview with Resident #1 on 4/16/15, s/he reported that s/he felt better when Resident #2 was moved to another room as s/he didn't have to listen to his/her comments. (Refer F225 and F226)</p> | F 280 | | | |

**Newport Health Care Center
148 Prouty Drive
Newport VT 05855
802-334-7321**

**Department Of Licensing and Protection
103 South Main Street
Waterbury VT 05671**

May 8, 2015

Plan of Correction for Complaint Survey on April 15, 2015

F 225

**The Director of Nursing will report any and all allegations of abuse to the state agency of survey, certification and licensing as required in the policy within 24 hours as per federal requirement. The Administrator or designated representative will be advised of the investigations. The abuse policy has been reviewed with all staff regarding the reporting requirement as well as who to report to. Completed 4/30/15.
Policy amended 5/13/15**

F 226

The Director of Nursing or authorized designee will notify the physician, families and/or representatives of any suspected or substantiated case of abuse, neglect or misappropriation of property or mistreatment. All reports will be investigated and documented. If the accused is a resident or resident's roommate the individual will be placed in a supervised temporary location. This has been reviewed with staff as part of the policy. Completed 4/30/15.

F 280

**The Director of Nursing will ensure that the care plans are updated and reviewed after any and all incidents involving abuse, neglect and misappropriation of property or mistreatment. This has been reviewed with all staff as part of the policy.
Completed 4/30/15.**

Abuse Policy will be reviewed with all new employees as part of their orientation. Current staff will have yearly and periodic reviews of the policy.

F225, F226 + F280 POC's accepted 5/15/15 SDennis RN/pme