

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

August 4, 2016

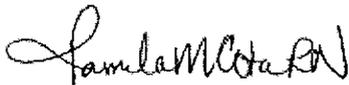
Mr. David Silver, Administrator  
Newport Health Care Center  
148 Prouty Drive  
Newport, VT 05855-9821

Dear Mr. Silver:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 13, 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: 07/21/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475026	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(K3) DATE SURVEY COMPLETED  C 07/13/2016
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)	LSC COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
	The Division of Licensing and Protection conducted an unannounced onsite investigation of a facility self report on 7/13/16. A regulatory violation was cited as a result.		Please see attached.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		
	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, staff interview and record review, the facility failed to revise the plan of care for 1 sampled resident (Resident #1). Findings include:  Per record review, the facility did not revise			

LABORATORY SIGNATURE OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Administrator DATE: 7/21/16

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 disclosure 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 disclosure 15 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: 07/21/2016  
FORM APPROVED  
OMB NO. 0938-0301

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 07/13/2016
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NAME OF PROVIDER OR SUPPLIER  NEWPORT HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 148 PROUTY DRIVE NEWPORT, VT 05855
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(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)	ISS. CORRECTION DATE
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F 280	Continued From page 1 Resident # 1's care plan. Resident #1 was involved in 2 physical altercations with another resident, 1 on 6/24/16 and the other on 7/1/16. There were no new measurable goals or interventions on the care plan. Per interview with the Co-Director of Activities, several new interventions had been put in place to address Resident #1's aggressive behaviors. Staff interviews indicated that staff were unaware of the new interventions.  Additionally, there is a physician's order effective 2/15/16 for Resident #1 to be on 15 minute checks. This was not indicated on any plan of care and staff were on aware of the physician order. There is also a physician order for wander guard to be checked daily. The wander guard was on the Resident's care plan. Per observation, Resident #1 had no wander guard. The Director of Nurses stated that the Resident refused the wander guard and was able to remove it at will. The Director of Nurses confirmed that the wander guard had not been removed from the plan of care  The above was confirmed by the Co-Director of Activities and the Director of Nurses on 7/13/16 at 12:30 PM.	F 280		
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Newport Health Care Center

148 Prouty Drive

Newport VT 05855

802-334-7321

Plan of Corrections for self report incident.

F280 The care plan will be revised as soon as any new interventions are instituted. All staff will be advised of the changes. All changes will also be documented in the treatment record and on the ADL sheets. The Director of Nursing or designated alternate will audit the care plan immediately after an incident as well as weekly for a monthly, then monthly. A portion of the audit will include interviews with staff to make sure they are aware of interventions.

An activity plan was done for both residents and documented on the care plan.

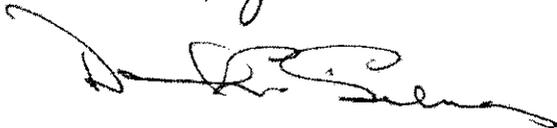
A Safety check log form has been developed to use as documentation for the 15 minute checks as ordered. These will be kept in the resident chart under nurses notes. These forms are to be monitored by the nurse on duty as well as during the audits by the Director of Nursing or alternate.

The wanderguard order has been revised on the care plan as well as the treatment record.

The treatment plan as well as the care plan will be reviewed during the audits to make sure they match will what is being done for the resident.

07//22/16

Helen Gagnon, RN, DON



F280 POC accepted 7/28/16 RtremlayRN/pms