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 17, 2017

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 **July 17, 2017.** 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

AUG 14 2017

PRINTED: 08/01/2017
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475017	A. BUILDING _____ B. WING _____	C 07/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELEN PORTER HEALTHCARE & REHAB	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 An on-site complaint investigation was completed by the Divison of Licensing and Protection, in conjunction with two entity reported incidents, on 7/17/17. There were regulatory findings.	F 000	**Corrective action for those residents affected:** Mrs. Dudley was moved to another room as both residents involved were roommates at the time of the incident. Further, both residents were assigned to eat all meals in separate dining areas.	
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to provide adequate supervision to prevent an altercation for 1 of 4 residents,	F 323	**Residents identified as having the potential of being affected:** 105 **Systemic changes:** •Will implement a staff huddle process immediately following an incident or near miss •Will require all staff to immediately separate all residents involved as a first intervention in all resident to resident altercations and near misses. •Staff will be oriented to observe residents for 5-10 minutes post altercation and near miss. •Charge nurse or nurse assigned to patient's care will document the behavior, the implementation of a post incident or near miss huddle and the immediate intervention put in place as the outcome of the huddle. **Monitoring process:** •Unit manager or designee will review all resident altercations and near misses reported with staff to ensure that post huddles have occurred and that residents were separated as an initial intervention. **All systemic changes will be implemented by- 8/28/17.** F323 POC accepted 8/17/17 BBurkell RN/PMC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bruce Sodem — TITLE: ADMINISTRATOR — (X6) DATE: 8/11/17

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: 08/01/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475017	A. BUILDING _____ B. WING _____	C 07/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELEN PORTER HEALTHCARE & REHAB	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 323	Continued From page 1	F 323		

Resident #1. Findings include:

Per record review on 7/17/17, Resident #1 has a diagnosis that includes: dementia, depressive disorder and anxiety. Per record review, or per nursing notes, On 6/26/17 s/he was in the outer dining area waiting for lunch and was yelling out and banging on the table wanting his/her food. Per interview with the unit clerk at 11:58 AM on 7/17/17, s/he said that the behavior was not usual. The unit clerk further stated that s/he was in the process of getting the tickets ready for lunch when another resident, Resident #2, who was in an inner dining area got up from his/her table and came toward Resident #1 and called him/her a derogatory name. When staff heard this they intervened and stepped between the two residents. Resident #2 was directed back to his/her seat and within a few minutes, Resident #1 started to bang on the table and calling out again. When the unit clerk turned from the tray line with Resident #1's lunch tray, s/he saw Resident #2 hit Resident #1 with the flat palm of their hand. The unit clerk stated that these two residents have had a history of altercations with incidents happening a few days prior to this incident in which Resident #2 required a room change. Interview with the Licensed Nursing Assistant (LNA) at 12:21 PM , that prior to this incident the two residents had been "bumping heads". S/he further stated that Resident #1 was sitting at the table and calling out, and Resident #2 tried to confront him/her and was calling him/her names, the unit clerk directed Resident #2 back to their own table, but did not ask anyone to keep an eye on him/her and confirmed that no one was watching either resident when Resident #2 got up and went after Resident #1 and hit him/her. Interview with the unit manager at 1:15

BB

PRINTED: 08/01/2017
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475017	A. BUILDING _____ B. WING _____	C 07/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELEN PORTER HEALTHCARE & REHAB	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 323	Continued From page 2	F 323		

PM, s/he confirmed that there had been an altercation between the two residents prior to the incident that occurred on 6/26/17 and after the staff intervened to prevent an altercation, there was no follow supervision of either residents. S/he also stated that staff was aware that there was a "history" between the two residents and should have because of the yelling out behavior that Resident #1 exhibits, and the other incidents that have occurred with Resident #1, staff should have been alert and supervised resident #1.