VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

April 27, 2018

Ms. Mary Jane Nottonson, Administrator
Helen Porter Healthcare & Rehab
30 Porter Drive
Middlebury, VT 05753-8422

Dear Ms. Nottonson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 28, 2018.** 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: 03/12/2018
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 02/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELEN PORTER HEALTHCARE & REHAB	30 PORTER DRIVE MIDDLEBURY, VT 05753

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E 000	Initial Comments During an unannounced on-site re-certification survey 2/26/18 through 2/28/18, the Division of Licensing and Protection conducted a review of the facility's Emergency Preparedness Program. The facility was found to be in substantial compliance with Emergency Preparedness planning.	E 000		
F 000	INITIAL COMMENTS An unannounced on-site re-certification survey was conducted on 2/26/28 through 2/28/18 by the Division of Licensing and Protection. The following regulatory violations were identified:	F 000		
F 567 SS=B	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(I0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on	F 567	**Corrective Action:** Resident was offered the opportunity to establish a resident trust account on admission and chose not to open an account at that time. As a corrective action, Social worker offered resident another opportunity to open an account and educated resident on how to access food when desired. **Others Identified as Having Potential to be Affected:** 105 **Systemic Changes:** A "Resident Trust Account" policy & procedure will be created. This policy will be provided to all residents and their representatives; A lock box will be issued to the Otter Creek medication room containing $350.00 and a list of all resident accounts, this money is to be accessed by the Porter Medical Center In-House Supervisor after hours	4/30/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Lee Nattest TITLE: Administrator (X6) DATE: April 23, 2018

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 567	Continued From page 1 resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to assure that residents have reasonable access to their personal funds. Findings include: Per interview on 2/26/18 at 4:52 PM with Resident # 84, s/he stated that s/he was not able to get his/her money on weekends. Per interview on 2/28/18 at 10:47 AM with the social worker, s/he stated that the individual who handled the residents' personal funds was at the facility Monday through Friday until 4:30 PM. S/he stated that residents' were not able to get their money on evenings and/or weekends unless prior arrangements were made.	F 567	and on weekends for residents requesting money from their account; A receipt will be provided to all residents or representatives upon removal of money from their account; All employees will be educated to the "Resident Trust Account" policy and procedure; The "Resident Trust policy & procedure" will be included in the admission packet and reviewed by Social Services on admission. The policy will be reviewed annually at the community council meeting. **Monitoring:** Front Office receptionist will monitor the cash balance provided in the lock box weekly; Replenish funds and scan resident receipts to appropriate accounts. Social Services will monitor the completion of review of this policy with new admissions and annually for all other residents. Maryfaa Natterster April 17, 2018 F567 POC accepted 4/23/18 PMcotoren	
F 585 SS=C	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice	F 585	**Corrective Action:** Social Services held a special community council meeting with residents to review the new elements of the grievance policy & procedure.	

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F 585 Continued From page 2

grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:

(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of

F 585

Others Identified as Having Potential to be Affected: 105

Systemic Changes: The current grievance policy & procedure will be revised to include all elements up to including those outlined in phase two (2) of the new regulations; Implementation of a grievance procedure form; an official grievance officer will be identified; all staff will review the grievance policy & procedure; All official forms such as the admission packet, posters, etc. will be updated to reflect the new grievance policy & procedure and contact information; All residents and their representatives will be provided a summary of the new grievance process. — 4/12/2018

Monitoring: Grievance officer or designee will maintain the grievance complaint log to ensure the timely completion of grievance resolution. Grievances will be reported at the quarterly Quality Assurance meeting.

F585 POC accepted 4/15/18 [illegible] RN/PM

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F 585	Continued From page 3	F 585		

independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in

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accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on staff and resident interview and record review the facility failed to establish a grievance policy that ensures the prompt resolution of all grievances and protection of residents' rights.
Findings include:

Per interview on 2/27/18 at 3:11 PM with the Resident Council, it was discussed that not all residents were aware of the grievance procedure. Per review of the facility's current Grievance Procedure for Residents dated 2/11/16, it did not contain the contact information of the grievance official. Per interview at 1:25 PM with the Administrator, s/he confirmed that the facility grievance policy was not updated with the necessary regulatory requirements and was in the process of being updated. S/he further stated that information needed to be included about the Ombudsman and Grievance official. The facility provided additional information which contained a copy of the grievance procedure that was given to residents on admission. In reviewing this information, there was no information stating that the resident has the right to make an anonymous grievance. There was also no contact information for the grievance official; nothing

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F 585	Continued From page 5 documented about the right to obtain a written decision; the immediate reporting of all alleged violations involving neglect, abuse, including injuries of unknown origin, and/or misappropriation of resident property; and there was no information that stated the results of all grievances will be maintained for a period of no less than three years.	F 585		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph	F 655	**Corrective Action:** The care plan of every long-term care resident was mailed to the resident's representative, with an offer to meet to discuss the care plan. All residents, long term care and short term care, were offered a copy of their care plan and offered an opportunity to review. **Others Identified as Having Potential to be Affected:** 105 **Systemic Changes:** Will implement the process of the unit charge nurse or designee providing a copy of the baseline care plan to the resident and representative within 48 hours of admission and offer to review. A signature sheet will be provided and placed in the resident's physical chart. All nurses will be provided education on the baseline care plan procedure. IT will implement an alert within ECS that will alert/remind the nurse of the 48 hour deadline to complete the care plan review with resident/	4/12/2018

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F 655	Continued From page 6 (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to provide 2 of 23 sampled residents (Resident #58 and #194) and their representative, a summary of the baseline care plan that includes, but is not limited to: 1) the initial goals of the resident, 2) a summary of the resident's medications and dietary instructions, 3) any services and treatments to be administered by the facility and personnel acting on behalf of the facility and 4) any updated information as necessary. The findings include the following: 1. Per record review, Resident #194 was admitted on 1/30/18. Review of the Electronic Medical Record (EMR) identifies that a baseline care plan was developed for this resident within the forty-eight (48) hour time frame. However, there is no evidence that the resident and or family representative was provided with the necessary information as outlined above. The Director of Nurses (DNS) confirms, during interview on 2/27/18 at approximately 2:45 PM,	F 655	**Monitoring:** Nurse Manager or designee will monitor the completion of baseline care plan within 48 hours and ensure the resident and representative has been offered a copy and opportunity to review. Baseline care plan compliance will be reviewed at the quarterly Quality Assurance meetings. F655 POC accepted 4/5/18 DWiedemaker RN/PMC	

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F 655	Continued From page 7 that the required information in the 48-hour care plan was not provided to the resident and /or representative. 2. Resident #58 was admitted to the facility on 12/28/17, and a baseline care plan had been developed. Per interview on 2/28/18 at 2:33 PM with the social worker, s/he stated that the written summary of the baseline care plan was not provided to the resident and/or resident's representative. S/he further stated that the facility had not been providing the resident and/or resident's representative a written summary per the new regulations.	F 655		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880	**Corrective Action:** RN received education pertaining to infection control during dressing changes and hand hygiene by the Clinical Nurse Educator. **Others Identified as Having Potential to be Affected:** 105 **Systemic Changes:** All nurses will receive education on proper dressing change and infection control protocol.	4/12/2018

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F 880 Continued From page 8

providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.

F 880

Monitoring: Clinical Nurse Educator or designee will perform random monthly dressing change audits, and provide further education as deemed necessary. Audits will be reviewed at the quarterly Quality Assurance meetings.

F880 POC accepted 4/5/18 DWidenwaterRN/PMC

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F 880	Continued From page 9	F 880		

Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to provide a safe, sanitary, and comfortable environment to prevent the development and transmission of communicable diseases and infections for 1 resident in the applicable sample (Resident# 148). Findings include:

Per observation on 2/27/18 at 9:47 AM of a disconnection of an intravenous (IV) tubing from a peripherally inserted central catheter (PICC-a line to help access the blood stream), a Registered Nurse (RN) donned gloves; touched his/her pocket, and then with the same gloved hands disconnected the IV tubing from the connector of the PICC line. With the same gloved hands, s/he proceeded to scrub the connector with alcohol for approximately 2-3 seconds; and then attached a saline (salt water) syringe to flush the line. Per interview with the RN at that time s/he confirmed that s/he touched multiple surfaces prior to disconnecting the IV tubing from the PICC line and stated that s/he should have removed his/her gloves, sanitized his/her hands and donned new gloves prior to disconnecting and flushing the PICC line. When asked how long s/he was to scrub the connector end of the IV extension of the PICC line, s/he stated approximately 10 seconds.

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F 880	Continued From page 10 Per review of the policy titled Flushing Peripheral Catheter and Midline it read, "5) Cleanse needleless connector end of IV extension set with alcohol or Chloraprep pad x 20-30 seconds. Allow to air dry." Per observation on 2/27/18 at 10:10 AM of a PICC line dressing change, a RN donned gloves, touched the resident's pillow, touched the resident's arm, removed the old dressing, disposed of the old dressing, and then removed his/her gloves. Without sanitizing his/her hands, the RN opened up the package that contained the sterile dressing, donned sterile gloves, proceeded to clean the exit site of the PICC line, and then applied a new dressing to the site. Per interview with the RN at that time s/he stated that s/he had washed his/her hands prior to the procedure and did not need to wash/sanitize after removing the gloves as long as s/he did not touch anything that was contaminated. Per interview on 2/28/18 at 8:59 AM with the Infection Prevention RN, s/he stated that when gloves were removed for any reason staff needed to wash and/or sanitize their hands prior to donning a new pair. Per review of the policy titled Central Line Dressing Change Procedure it read, "1) Perform hand hygiene; 2) Gather supplies; 3) Explain procedure to patient; 4) Place patient in comfortable position; 5) Perform hand hygiene; 6) Set up sterile field with supplies; 7) Put mask on patient and operator; 8) Perform hand hygiene; 9) Put on non-sterile gloves; .....13) Remove gloves and discard; 14) Perform hand hygiene; 15) Put on sterile gloves."	F 880		