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

May 9, 2022

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 investigation conducted on **April 6, 2022**. 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

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 04/06/2022

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 unannounced onsite investigation of a facility reported incident, a complaint investigation, and a staff vaccination requirement review were completed by the Division of Licensing and Protection from 4/5 -4/6/2022. There were regulatory violations identified related to the complaint during this investigation.	F 000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;	F 842	See attached Plan of Correction **TAG F 842 POC Accepted on 5/9/22 by S. Freeman/P. Cota**	5/20/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: MaryJane Wallenzen — TITLE: Administrator — (X6) DATE: May 6, 2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 842	Continued From page 1 (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the	F 842	See attached Plan of Correction	5 5/20/22

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 04/06/2022

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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F 842	Continued From page 2 facility failed to ensure that records are complete, accurately documented, readily accessible, and systematically organized related to a resident's Advanced Directives for one of 6 sampled residents (Resident #1). Findings include: Per record review Resident #1 was found unresponsive on 1/28/2022 at approximately 8:30 PM. A progress note written by a Licensed Practical Nurse (LPN) states "Unable to determine code status at this time. Provider on call notified. Stated to follow last code status order. Administrator on call notified, stated due to current circumstances to initiate CPR (Cardiopulmonary resuscitation) and call 911. Initiated CPR at approximately 2045 (8:45 PM). Transferred to [hospital ER] @ 2110 (9:10 PM) via ambulance." Resident #1 received CPR and was intibated at the hospital, s/he died at 9:24 PM. A note written by the Emergency Room Physician states "Per report, pt had previously been DNR/DNI but then had reverse it and was full code." The Physician also includes "After the patient's death, the patient's chart was reviewed more extensively, and it appears that as of 1/25/2022, his CODE STATUS was LLST [Limited Life Saving Treatment]/DNR/DNI." Per interview with the facility Administrator on 4/5/2022 at 11:30 AM Resident #1's code status had been changed several times. When the resident was readmitted from their last hospital stay the physician did not enter a current code status. The Administrator confirmed that there was conflicting documentation in the chart related to the resident's end of life wishes.	F 842	See attached Plan of Correction	5/20/22

F 000 INITIAL COMMENTS

An unannounced onsite investigation of a facility reported incident, a complaint investigation, and a staff vaccination requirement review were completed by the Division of Licensing and Protection from 4/5 - 4/6/2022. There were regulatory violations identified related to the complaint during this investigation

F842 Resident Records – Identification Information
SS=D=, CFR(s): 483.20(f)(5), 483.10(i)(1)-(5)

§483.20(f)(5) Resident-identifiable information.

- *(i) A facility may not release information that is resident-identifiable to the public.*
- *(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.*

§483.70(i) Medical records.

§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-

- *(i) Complete;*
- *(ii) Accurately documented;*
- *(iii) Readily accessible; and*
- *(iv) Systematically organized*

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is

- *(i) To the individual, or their resident representative where permitted by applicable law;*

Required by Law;

- *(i) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;*
- *(iii) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.*

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-

- *(i) The period of time required by State law; or*
- *(ii) Five years from the date of discharge when there is no requirement in State law; or*
- *(iii) For a minor, 3 years after a resident reaches legal age under State law.*

§483.70(i)(5) The medical record must contain-

- *(i) Sufficient information to identify the resident;*
- *(ii) A record of the resident's assessments;*
- *(iii) The comprehensive plan of care and services provided;*
- *(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;*

(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and record review, the facility failed to ensure that records are complete, accurately documented, readily accessible, and systematically organized related to a resident's Advanced Directives for one of 6 sampled residents (Resident #1). Findings include:

Per record review Resident #1 was found unresponsive on 1/28/2022 at approximately 8:30 PM. A progress note written by a Licensed Practical Nurse (LPN) states "Unable to determine code status at this time. Provider on call notified. Stated to follow last code status order. Administrator on call notified, stated due to current circumstances to initiate CPR (Cardiopulmonary resuscitation) and call 911. Initiated CPR at approximately 2045 (8:45 PM). Transferred to [hospital ER] @ 2110 (9:10 PM) via ambulance." Resident #1 received CPR and was intubated at the hospital, s/he died at 9:24 PM.

A note written by the Emergency Room Physician states "Per report, pt had previously been DNR/DNI but then had reverse it and was full code." The Physician also includes "After the patient's death, the patient's chart was reviewed more extensively, and it appears that as of 1/25/2022, his CODE STATUS was LLST [Limited Life Saving Treatment]/DNR/DNI."

Per interview with the facility Administrator on 4/5/2022 at 11:30 AM Resident #1's code status had been changed several times. When the resident was readmitted from their last hospital stay the physician did not enter a current code status. The Administrator confirmed that there was conflicting documentation in the chart related to the resident's end of life wishes.

ACTION PLAN

- Under the Direction of the Medical Director, Administrator and Director of Nursing, an immediate review of all residents' health records was conducted to assure presence of a current code status on all residents on January 28, 2022.

- Under the Direction of the Medical Director, Administrator and Director of Nursing, a Best Practice Alert for nursing and providers was built in the electronic health record to assure that the code status is entered upon admission.

- The Helen Porter admission process will be updated to reflect the electronic health record system hard stop to prompt code status entry upon admission.

- Providers and Staff applicable to their role were educated through a combination of meetings and electronic communication on the Best Practice Alert. In addition specifically highlighted will be the provisions and process to ensure medical records are complete, accurate, accessible, and organized related to Advanced Directives.

- A system report was created that will be reviewed daily by the Administrator, Director of Nursing or designee to review resident medical records to ensure the availability of a current code status in the medical record. Frequency will be reevaluated based on sustained performance by leadership. Performance feedback will be shared with Helen Porter leadership and organizational leadership for action as required at the Weekly Safety Adjudication Meeting and at Helen Porter Quality Assurance Meeting.

- All actions will be completed effective 5/20/22

TAG F 842 POC Accepted on 5/9/22 by S. Freeman/P. Cota

THE
University of Vermont
HEALTH NETWORK

Porter Medical Center

HELEN PORTER
REHABILITATION & NURSING

May 6, 2022

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060

Re: CMS Certification Number (CCN): 475017

Dear Pamela Cota,

Please find the attached Plan of Corrections and form CMS-2567 in response to the Statement of Deficiencies and Findings in regards to survey number 475017.

Helen Porter Healthcare & Rehab is committed to continuously improving the quality of services we provide to respond to the regulatory deficiencies that were cited.

If you have questions regarding the attached Plan of Correction or require further clarification, please do not hesitate to contact me.

Sincerely,

Mary Jane Nottonson, Administrator
Helen Porter Healthcare and Rehab

CC: Karen Fromhold, MD Medical Director