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

June 7, 2022

Ms. Maryj 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 recertification survey completed on **May 11, 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

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 ______	05/11/2022

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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E 000	Initial Comments A review of the facility's Emergency Preparedness Program was conducted in conjunction with the annual recertification survey on 5/11/22 There were no regulatory deficiencies as a result of the review.	E 000		
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced onsite recertification survey and a staff vaccination review 5/9/22 - 5/11/22. The following regulatory violations were cited as a result:	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all	F 609	See attached Plan of Correction **POC Accepted on 06/07/22 by R. Tremblay/P. Cota**	07/07/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Lee Watson
TITLE: Administrator
(X6) DATE: June 7, 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.

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F 609	Continued From page 1 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and record review, the facility failed to ensure that all alleged violations involving abuse are reported immediately to officials in accordance with state law through established procedures for two of 22 residents (Resident #41 and Resident #8). Findings include: 1. Per interview on 5/10/22 at approximately 9:30 AM, Resident #41 stated that they had concerns in the past of rough handling by staff, that they had reported it to facility leadership, and that the issue had been resolved. Per interview on 5/10/22 at approximately 12:45 PM, the DON (Director of Nursing) confirmed that a previous allegation of rough handling by staff had been investigated for Resident #41 by the DON and the Resident's social worker, but that they had not reported the allegation to the State Survey and Certification Agency or any other required officials. The DON confirmed that the results of the investigation had also not been reported. 2. Per record review it was noted on 4/11/22 resident #63 repeatedly struck resident #8 with a cloth clothing protector (2 layers of cloth one being water repellant 18"x31" with a metal snap closure). Nursing reported this incident to the DON (Director of Nursing) with a subsequent	F 609		

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

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F 609	Continued From page 2 investigation being completed. Per interview with the DON on 5/10/2022 at approximately 12:45 PM the DON confirmed that this incident had been reported to her and investigated but because the residents involved both have dementia the act was not willful nor did it result in injury therefore it was not reported to the Division of Licensing and Protection, Adult Protective Services or the Ombudsman.	F 609		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that the comprehensive assessment accurately reflects the Residents' statuses for 11 of 22 residents in the sample (Residents #7, #14, 28, #32, #34, #41, #42, #43, #44, #61, and #72). Findings include: 1. Per record review, Residents, #42, #43 and #72 did not have BIMS (Brief Interview of Mental Status) assessments performed as required for their most recent MDS (Minimum Data Set) assessment. Resident #42 was marked in section C (Cognitive Patterns) as "resident is rarely/never understood" during their 3/21/22 Admission MDS assessment. As a result, the rest of the BIMS assessment was not completed. In section B of the same Admission MDS assessment (Hearing, Speech, and Vision) the resident's speech was marked as clear with distinct intelligible words, able to make	F 641	**See Attached POC** **POC Accepted on 06/07/22 by R. Tremblay/P. Cota**	

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F 641	Continued From page 3	F 641		

themselves understood and able to understand other with clear comprehension. Additionally, in an interview with the resident during the annual recertification survey, the resident was very capable of answering all questions. They were able to articulate with their answers and they were able to convey their thoughts clearly.

Resident #43 was marked in section C (Cognitive Patterns) as "resident is rarely/never understood" during their 3/24/22 Admission MDS assessment. As a result, the rest of the BIMS assessment was not completed. In section B of the same Admission MDS assessment (Hearing, Speech, and Vision) the resident's speech was marked as clear with distinct intelligible words, able to make themselves understood and able to understand other with clear comprehension. Additionally, in an interview with the resident during the annual recertification survey, the resident was very capable of answering all questions. They were able to articulate with their answers and they were able to convey their thoughts clearly.

Resident #72 was marked in section C (Cognitive Patterns) as "resident is rarely/never understood" during their 4/20/22 Admission MDS assessment. As a result, the rest of the BIMS assessment was not completed. In section B of the same Admission MDS assessment (Hearing, Speech, and Vision) the resident's speech was marked as clear with distinct intelligible words, able to make themselves understood and able to understand other with clear comprehension. Additionally, in an interview with the resident during the annual recertification survey, the resident was very capable of answering all questions. They were able to articulate with their answers and they were able to convey their thoughts clearly.

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F 641	Continued From page 4	F 641		

2. Per record review, Residents #7, #32, and #34 did not have BIMS (brief interview of mental status) assessments performed as required for their most recent MDS (minimum data set) assessment.

Per review of Resident #7's 2/1/22 Quarterly MDS section B is marked as resident has clear speech, is understood, and understands. However, the BIMS assessment was not completed.

Per review of Resident #32's 3/12/22 Quarterly MDS section B is marked as resident has clear speech, is understood, and understands. However, section C is marked as "resident is rarely/never understood". As a result the rest of the BIMS assessment was not completed.

Per review of Resident #34's 3/25/22 Significant Change MDS section B is marked as resident has clear speech, is understood, and understands. However, section C is marked as "resident is rarely/never understood" As a result the rest of the BIMS assessment was not completed.

Per interview on 5/11/22 at approximately 3:00 PM, the facility's MDS coordinator confirmed that Residents # 7, # 32, and #34 were capable of having a BIMS completed and that they had not.
3. Per record review, Residents #61, #41, #44, #28, and #14 did not have BIMS (brief interview of mental status) assessments performed as required for their most recent MDS (minimum data set) assessment.

Resident #61 was marked in section C (Cognitive Patterns) as "resident is rarely/never understood" during their 3/29/22 annual MDS assessment. As

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F 641 Continued From page 5 F 641

a result, the rest of the BIMS assessment was not completed. The BIMS assessment conducted for Resident #61 as part of the 12/28/21 MDS was scored as 15 (no cognitive impairment).

Resident #41 was marked in section C (Cognitive Patterns) as "resident is rarely/never understood" during their 3/19/22 quarterly MDS assessment. As a result, the rest of the BIMS assessment was not completed. The BIMS assessment conducted for Resident #41 as part of the 12/17/21 MDS was scored as 14 (no cognitive impairment).

Resident #44 was marked in section C (Cognitive Patterns) as "resident is rarely/never understood" during their 4/4/22 quarterly MDS assessment. As a result, the rest of the BIMS assessment was not completed. The BIMS assessment conducted for Resident #44 as part of the 1/2/22 MDS was marked as unable to be completed, but Resident #44 was marked as capable of being assessed.

Resident #28 was marked in section C (Cognitive Patterns) as "resident is rarely/never understood" during their 3/4/22 quarterly MDS assessment. As a result, the rest of the BIMS assessment was not completed. The BIMS assessment conducted for Resident #28 as part of the 12/2/21 MDS was scored as 15 (no cognitive impairment).

Resident #14 was marked in section C (Cognitive Patterns) as "not assessed" during their 2/14/22 quarterly MDS assessment. As a result, the rest of the BIMS assessment was not completed. The BIMS assessment conducted for Resident #14 as part of the 11/14/21 MDS was scored as 14 (no cognitive impairment).
Per interviews with residents #61, #41, #44, #28, and #14 between 5/9/22 and 5/10/22, all five

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F 641	Continued From page 6 Residents had clear speech and were able to be understood during conversation. Per interview on 5/10/22 at approximately 12:30 PM, the facility's MDS coordinator confirmed that, since the facility's COVID-19 outbreak began in approximately early March 2022, no resident BIMS assessments have been conducted during required MDS assessments to date. The MDS Coordinator stated that they were instructed by facility leadership that staff who are not direct caregivers avoid interaction with residents to prevent COVID-19 spread.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to– (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657		

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F 657	Continued From page 7 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. 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 to include implemented fall prevention interventions for one resident in the sample (Resident #53). Findings include: During observations of Otter Creek East on 5/9/2022 at approximately 3:30 PM Resident #53 was seen sitting in a recliner in her/his room. A large, square, black mat was seen propped up between the recliner and the resident's bed, resting on it's edge. Per interview with a Licensed Nursing Assistant (LNA) the black mat was an alarm used to notify staff when the resident was standing up from the chair. The LNA entered the room and placed the mat on the floor under the resident's feet. Per record review Resident #53 has a history of falls with and without injury. A care plan focus of impaired physical mobility implemented on 3/25/2022 includes two staff assist for bed and chair transfers and two staff assist for ambulation. A care plan focus for "Potential for Trauma - Falls" includes interventions to encourage resident to use walker when getting up from recliner, leave walker within reach of resident, and rearrange resident's room so that s/he can access walker while getting out of bed. There is also no mention of the floor alarm as a safety intervention.	F 657	**See Attached POC** **POC Accepted on 06/07/22 by R. Tremblay/ P. Cota**	

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F 657	Continued From page 8 Per interview with the Charge Nurse on 5/11/2022 at approximately 11:15 AM Resident #53 is at risk for falls. The alarm is used to alert staff when s/he was trying to get up unassisted. The Charge Nurse also confirmed that the care plan should reflect the use of the alarm and it did not.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to provide appropriate and sufficient supervision to Resident #65 to prevent an avoidable accident for 1 of 5 residents in the sample (resident #8). Findings include: On 4/11/2022 resident #65 was not supervised as his/her care plan outlines resulting in him/her becoming agitated and repeatedly hitting another resident. Resident #8 who has advanced dementia was seated in a recliner resting with his/her eyes closed in a common area on the memory care unit. Resident #65 who has dementia with behavioral disturbances was also in the common area at this time. Per nursing documentation, a LNA (licensed nursing assistant) walked through the common area when resident #65 became agitated and began	F 689	**See Attached POC**	

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F 689	Continued From page 9 yelling "get out of my GD house". The unit nurse was able to observe the activity in the common area through a window as she was attending to another resident. Per documentation, the nurse heard something being hit repeatedly and found resident #65 standing over resident #8 striking him/her with an 18" x 31" 2-layer cloth clothing protector with a metal snap closure. The nurse called for assistance, resident #65 was removed from the common area while resident #8 was examined by the nurse. Per the MDS assessment section D on 1/19/2022 and 4/19/2022 resident #65 is coded as being short tempered and easily annoyed. Resident #65's care plan includes the problem of potential for violence with a goal of won't harm others, will interact appropriately, will be diverted, will allow care to be completed. Interventions for nurses include close supervision, watch for signs of increasing anxiety and agitation, approach calmly, identify source of irritation, remove from setting if resident appears to be agitated, stay with resident and redirect/engage in other activities. Interventions for LNA's include all the above with the addition of report episodes of violence to the nurse. Per record review the care plan interventions including close supervision and removal from settings in which the resident exhibits anxious or agitated behaviors were not employed resulting in assaultive behavior. The above was confirmed by the Director of Nursing during an interview on May 9, 2022.	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		

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F 758	Continued From page 10 §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their	F 758	**See Attached POC** **POC Accepted on 06/07/22 by R. Tremblay/P. Cota**	

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F 758	Continued From page 11 rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that PRN (as needed) orders for psychotropic drugs are limited to 14 days, or if the prescribing provider believes that it is appropriate for the PRN order to be extended beyond 14 days, that there is a documented rationale in the resident's medical record and an indicated duration for the PRN order for one of 5 sampled residents (Resident #28). Findings include: 1. Per record review, Resident #28 has diagnoses of hemiparesis affecting left side as late effect of cerebrovascular accident (left sided weakness as a result of a stroke) and seizure disorder. Per record review, an order was placed in Resident #28's medical record on 5/6/22 that reads, "Lorazepam (an antianxiety medication) 1 mg (2mg/ml solution) by mouth every 15 minutes PRN for seizures, maximum 3 doses in a day." There was no indicated end date or time for this order. The record also showed previous orders for this medication with the same indications and administration instructions that had since been discontinued. Per interview on 5/11/22 at approximately 12:00	F 758	**See Attached POC** **POC Accepted on 06/07/22 by R. Tremblay/P. Cota**	

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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)	(X5) COMPLETION DATE
F 758	Continued From page 12 PM, Resident #28's physician stated it was their understanding that, because the Lorazepam is ordered for seizures and not for anxiety despite its classification as an antianxiety medication, that the order did not require reevaluation. They confirmed that the Lorazepam order was not intended to have an end date or time, as they want this medication to be available for the resident on a PRN basis for seizures for the foreseeable future.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to ensure that 1 resident in the sample (Resident #7) was free from significant medication errors. Findings include: Per record review Resident #7 has a diagnosis of atrial fibrillation (an irregular heart rhythm that increases the risk of blood clots and stroke). Physician orders for Coumadin (a medication that prevents blood from clotting, reducing the risk of stroke) are determined by the results of scheduled of blood work. A Pharmacy review written on 4/6/22 states "I noticed that resident does not have a current warfarin (Coumadin) order. [The unit charge nurse] helped me research and it appears that [the resident's] INR was missed on 3/28/22, [s/he] has now missed 9 days of therapy. [The unit charge nurse] will obtain a stat (urgent) INR (a	F 760		

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 ______	05/11/2022

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 760	Continued From page 13 diagnostic test that provides a calculation based on blood clotting factors) and update providers." Review of the facilities internal investigation system reflects that the resident had orders for a PT/INR to be completed on 3/28/22. The PT/INR was not completed. As a result the resident missed all of the Coumadin dosing for 3/28/22 - 4/5/22. A blood draw on 4/6/2022 revealed that the resident's INR was 1.0 (INR goal range range 2.0-3.0) putting the resident at a higher risk of developing blood clots and stroke. On 5/11/2022 at 1:09 PM during interview with the Director of Nursing s/he confirmed that the prescribed blood work had not been completed, and that the resident did not receive any doses of Coumadin from 3/28/2022- 4/5/2022.	F 760	**See Attached POC** **POC Accepted on 06/07/22 by R. Tremblay/P. Cota**	
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to ensure that residents were served meals at a safe temperature. Findings include: During observation on the Memory Care Unit on	F 804		

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 ____	05/11/2022

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 804	Continued From page 14 5/11/2022 at 11:00 AM a Licensed Nursing Assistant (LNA) was observed removing a plate of food from the microwave for a resident who had missed their breakfast meal. The LNA did not ensure temperature with the use of a thermometer, nor did s/he stir the food to distribute temperature. During interview at the time the LNA confirmed that the food had not been checked for safe temperature. The LNA stated that s/he was not sure if there was a procedure for warming food in the microwave. Review of the facility policy titled Maintaining Food Temperatures Internal Temperature Guidelines: Microwave foods; All foods reheated in microwave must reach a minimum of 165 degrees Fahrenheit after standing for a minimum of 2 minutes to ensure temperatures are even throughout the food item. On 5/11/2022 at 12:40 PM during an interview with the Food Service Director (FSD) and the two Dietary Supervisors, the FSD confirmed that food reheated in a microwave should be checked with a thermometer to ensure a safe temperature to prevent foodborne illness and scalding from extreme heat.	F 804	**See Attached POC** **POC Accepted on 06/07/22 by R. Tremblay/P. Cota**	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812		

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 ______	05/11/2022

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 812	Continued From page 15 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to prepare, distribute and serve food in accordance with professional standards for food service safety regarding monitoring the temperatures of served food items. Findings include: Per review of the food temperature logs for the past 4 months (January, February, March, April 2022), there are 142 meals with no evidence of monitoring temperatures of food being served. None of the temperature logs reflect evidence of beverages being monitored for appropriate safe temperatures. During interview with the Director of Food Service on 5/11/2022 at 12:40 PM s/he confirmed that the food temperatures were not consistently monitored or documented on the temperature logs.	F 812	**See Attached POC** **POC Accepted on 06/07/22 by R. Tremblay/P. Cota**	

E 000 INITIAL COMMENTS
A review of the facility's Emergency Preparedness Program was conducted in conjunction with the annual recertification survey on 5/11/22 There were no regulatory deficiencies as a result of the review.

F 000 INITIAL COMMENTS
The Division of Licensing and Protection conducted an unannounced onsite recertification survey and a staff vaccination review 5/9/22 - 5/11/22. The following regulatory violations were cited as a result:

F 609 REPORTING OF ALLEGED VIOLATIONS
SS=D, CFR(s): 483.12(c)(1)(4)

TAG F 609 POC Accepted on 06/07/22 by R. Tremblay/P. Cota

483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, and record review, the facility failed to ensure that all alleged violations involving abuse are reported immediately to officials in accordance with state law through established procedures for two of 22 residents (Resident #41 and Resident #8).

Findings include:

1. *Per interview on 5/10/22 at approximately 9:30 AM, Resident #41 stated that they had concerns in the past of rough handling by staff, that they had reported it to facility leadership, and that the issue had been resolved. Per interview on 5/10/22 at approximately 12:45 PM, the DON (Director of Nursing) confirmed that a previous allegation of rough handling by staff had been investigated for Resident #41 by the DON and the Resident's social worker, but that they had not reported the allegation to the State Survey and Certification Agency or any other required officials. The DON confirmed that the results of the investigation had also not been reported.*
2. *Per record review it was noted on 4/11/22 resident #63 repeatedly struck resident #8 with a cloth clothing protector (2 layers of cloth one being water repellant 18"x31" with a metal snap closure). Nursing reported this incident to the DON (Director of Nursing) with a subsequent investigation being completed. Per interview with the DON on 5/10/2022 at approximately 12:45 PM the DON confirmed that this incident had been reported to her and investigated but because the residents involved both have dementia the act was not willful nor did it result in injury therefore it was not reported to the Division of Licensing and Protection, Adult Protective Services or the Ombudsman.*

ACTION PLAN

- Under the Direction of the Medical Director/ Administrator/ Director of Nursing, Relias training on abuse, neglect, exploitation mistreatment, resident to resident altercation, or misappropriation of property to include reporting has been deployed for completion.

- A prompt will now be included in the Daily Report Agenda to capture concerns for abuse, neglect, exploitation, or mistreatment, resident to resident altercation, or misappropriation of property, in accordance with the requirement outlined in 483.12 c at the daily multidisciplinary safety huddles.

- A documentation log to support the intake and timeliness of reporting and follow up was created to support practice.
- In order to monitor performance and compliance with the reporting requirements, the referenced log will be reviewed weekly by the Administrator/ Director of Nursing. Frequency will be revaluated based on sustained performance.
- All actions will be completed effective July 7, 2022.

TAG F 641 POC Accepted on 06/07/22 by R. Tremblay/P. Cota

F 641 ACCURACY OF ASSESMENTS
SS=E, CFR(s): 483.20(g)

483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to ensure that the comprehensive assessment accurately reflects the Residents' statuses for 11 of 22 residents in the sample (Residents #7, #14, 28, #32, #34, #41, #42, #43, #44, #61, and #72). Findings include:
1. Per record review, Residents, #42, #43 and #72 did not have BIMS (Brief Interview of Mental Status) assessments performed as required for their most recent MDS (Minimum Data Set) assessment. Resident #42 was marked in section C (Cognitive Patterns) as "resident is rarely/never understood" during their 3/21/22 Admission MDS assessment. As a result, the rest of the BIMS assessment was not completed. In section B of the same Admission MDS assessment (Hearing, Speech, and Vision) the resident's speech was marked as clear with distinct intelligible words, able to make themselves understood and able to understand other with clear comprehension. Additionally, in an interview with the resident during the annual recertification survey, the resident was very capable of answering all questions. They were able to articulate with their answers and they were able to convey their thoughts clearly. Resident #43 was marked in section C (Cognitive Patterns) as "resident is rarely/never understood" during their 3/24/22 Admission MDS assessment. As a result, the rest of the BIMS assessment was not completed. In section B of the same Admission MDS assessment (Hearing, Speech, and Vision) the resident's speech was marked as clear with distinct intelligible words, able to make themselves understood and able to understand other with clear comprehension. Additionally, in an interview with the resident during the annual recertification survey, the resident was very capable of answering all questions. They were able to articulate with their answers and they were able to convey their thoughts clearly. Resident #72 was marked in section C (Cognitive Patterns) as "resident is rarely/never understood" during their 4/20/22 Admission MDS assessment. As a result, the rest of the BIMS assessment was not completed. In section B of the same Admission MDS assessment (Hearing, Speech, and Vision) the resident's speech was marked as clear with distinct intelligible words, able to make themselves understood and able to understand other with clear comprehension. Additionally, in an interview with the resident during the annual recertification survey, the resident was very capable of answering all questions. They were able to articulate with their answers and they were able to convey their thoughts clearly,
2. Per record review, Residents #7, #32, and #34, did not have BIMS (brief interview of mental status) assessments performed as required for their most recent MDS (minimum data set) assessment. Per review of Resident #7's 2/1/22 Quarterly MDS section B is marked as resident has clear speech, is understood, and understands. However, the BIMS assessment was not completed. Per review of Resident #32's 3/12/22 Quarterly MDS section B is marked as resident has clear speech, is understood, and understands. However, section C is marked as "resident is rarely/never understood". As a result the rest of the BIMS assessment was not completed. Per review of Resident #34's 3/25/22 Significant Change MDS section B is marked as resident has clear speech, is understood, and understands. However, section C is marked as "resident is rarely/never understood" As a result the rest of the BIMS assessment was not completed. Per interview on 5/11/22 at approximately 3:00 PM, the facility's MDS coordinator confirmed that Residents # 7, # 32, and #34 were capable of having a BIMS completed and that they had not.
3. Per record review, Residents #61, #41, #44, #28, and #14 did not have BIMS (brief interview of mental status) assessments performed as required for their most recent MDS (minimum data set) assessment. Resident #61 was marked in section C (Cognitive Patterns) as "resident is rarely/never understood" during their 3/29/22 annual MDS assessment. As a result, the rest of the BIMS assessment was not completed. The BIMS assessment conducted for Resident #61 as part of the 12/28/21 MDS was scored as 15 (no cognitive impairment). Resident #41 was marked in section C (Cognitive Patterns) as "resident is rarely/never understood" during their 3/19/22 quarterly MDS assessment. As a result, the rest of the BIMS assessment was

not completed. The BIMS assessment conducted for Resident #41 as part of the 12/17/21 MDS was scored as 14 (no cognitive impairment). Resident #44 was marked in section C (Cognitive Patterns) as "resident is rarely/never understood" during their 4/4/22 quarterly MDS assessment. As a result, the rest of the BIMS assessment was not completed. The BIMS assessment conducted for Resident #44 as part of the 1/2/22 MDS was marked as unable to be completed, but Resident #44 was marked as capable of being assessed. Resident #28 was marked in section C (Cognitive Patterns) as "resident is rarely/never understood" during their 3/4/22 quarterly MDS assessment. As a result, the rest of the BIMS assessment was not completed. The BIMS assessment conducted for Resident #28 as part of the 12/2/21 MDS was scored as 15 (no cognitive impairment). Resident #14 was marked in section C (Cognitive Patterns) as "not assessed" during their 2/14/22 quarterly MDS assessment. As a result, the rest of the BIMS assessment was not completed. The BIMS assessment conducted for Resident #14 as part of the 11/14/21 MDS was scored as 14 (no cognitive impairment).
Per interviews with residents #61, #41, #44, #28, and #14 between 5/9/22 and 5/10/22, all five Residents had clear speech and were able to be understood during conversation. Per interview on 5/10/22 at approximately 12:30 PM, the facility's MDS coordinator confirmed that, since the facility's COVID-19 outbreak began in approximately early March 2022, no resident BIMS assessments have been conducted during required MDS assessments to date. The MDS Coordinator stated that they were instructed by facility leadership that staff who are not direct caregivers avoid interaction with residents to prevent COVID-19 spread.

ACTION PLAN

- In order to limit exposure during the COVID-19 outbreak, the performance of the in person interviews for BIMS assessments was paused in effort to prevent COVID-19 spread. The MDS coordinator used the staff assessment option to complete utilizing the unable to complete selection of resident is rarely/never understood.
- Going forward, to limit exposure during future COVID-19 outbreaks, Helen Porter will use a telehealth pad to conduct and document the referenced BIMS assessments.
- Under the Direction of the Medical Director/ Administrator/ Director of Nursing and MDS coordinator, the referenced records were reviewed and updated or corrected as applicable (i.e., BIMS assessments were completed).
- Under the direction of the Administrator/ Director of Nursing, MDS Coordinator will review remaining residents on or before the quarterly due date to monitor for accuracy
- Performance feedback will be shared with local leadership and organizational leadership for action as required at the Quarterly Helen Porter Quality Assurance Meeting beginning in July 2022.
- All actions will be completed effective July 7, 2022.

TAG F 657 POC Accepted on 06/07/22 by R. Tremblay/P. Cota

F 657 CARE PLAN TIMING REVISION
SS=DFC(S): 483.21(b)(2)(i)-(iii)

§483.21(b) Comprehensive Care Plans

§483.21(b)(2) A comprehensive care plan must be-
- *(i) Developed within 7 days after completion of the comprehensive assessment.*
- *(ii) Prepared by an interdisciplinary team, that includes but is not limited to—*
  - *(A) The attending physician.*
  - *(B) A registered nurse with responsibility for the resident.*
  - *(C) A nurse aide with responsibility for the resident.*
  - *(D) A member of food and nutrition services staff.*

(E) To the extent practicable, the participation of the resident and the resident's representative(s).An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined ot practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

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 to include implemented fall prevention interventions for one resident in the sample Resident #53). Findings include: During observations of Otter Creek East on 5/9/2022 at approximately 3:30 PM Resident #53 was seen sitting in a recliner in her/his room. A large, square, black mat was seen propped up between the recliner and the resident's bed, resting on it's edge. Per interview with a Licensed Nursing Assistant (LNA) the black mat was an alarm used to notify staff when the resident was standing up from the chair. The LNA entered the room and placed the mat on the floor under the resident's feet.

Per record review Resident #53 has a history of falls with and without injury. A care plan focus of impaired physical mobility implemented on 3/25/2022 includes two staff assist for bed and chair transfers and two staff assist for ambulation. A care plan focus for "Potential for Trauma - Falls" includes interventions to encourage resident to use walker when getting up from recliner, leave walker within reach of resident, and rearrange resident's room so that s/he can access walker while getting out of bed. There is also no mention of the floor alarm as a safety intervention.

Per interview with the Charge Nurse on 5/11/2022 at approximately 11:15 AM Resident #53 is at risk for falls. The alarm is used to alert staff when s/he was trying to get up unassisted. The Charge Nurse also confirmed that the care plan should reflect the use of the alarm and it did not.

ACTION PLAN

- Providers and Staff applicable to their role were educated through a combination of meetings/ electronic communication the requirements for care plans to be reviewed and revised with a change in condition. The importance to reference the most current care plan was specifically highlighted in these meetings/communications.

- Fall with injury or change in status/condition will trigger a review of the entire care plan. A prompt will be added to the daily multidisciplinary safety huddles to identify residents that have had a fall or change in resident condition that will trigger a care plan review.

- Administrator/ Director/ designee to review a sample of resident medical records to ensure care plans were (i) updated with change in condition; and (ii) for documentation that the care plans have been followed. Frequency will be reevaluated based on sustained performance by leadership. Performance feedback will be shared with local leadership and organizational leadership for action as required at the Quarterly Helen Porter Quality Assurance Meeting beginning in July 2022.

- All actions will be completed effective July 7, 2022.

F 689 FREE OF ACCIDENT HAZARDS/SUPERVISION DEVICES SS=D, DFR(s): 483.25(d)(1)(2)

TAG F 689 POC Accepted on 06/07/22 by R. Tremblay/P. Cota

§483.25(d) Accidents, the facility must ensure that –

§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review the facility failed to provide appropriate and sufficient supervision to Resident #65 to prevent an avoidable accident for 1 of 5 residents in the sample (resident #8). Findings include: On 4/11/2022 resident #65 was not supervised as his/her care plan outlines resulting in him/her becoming agitated and repeatedly hitting another resident. Resident #8 who has advanced dementia was seated in a recliner resting with his/her eyes closed in a common area on the memory care unit. Resident #65 who has dementia with behavioral disturbances was also in the common area at this time. Per nursing documentation, a LNA (licensed nursing assistant) walked through the common area when resident #65 became agitated and began yelling "get out of my GD house". The unit nurse was able to observe the activity in the common area through a window as she was attending to another resident.

Per documentation, the nurse heard something being hit repeatedly and found resident #65 standing over resident #8 striking him/her with an 18" x 31" 2-layer cloth clothing protector with a metal snap closure. The nurse called for assistance, resident #65 was removed from the common area while resident #8 was examined by the nurse. Per the MDS assessment section D on 1/19/2022 and 4/19/2022 resident #65 is coded as being short tempered and easily annoyed. Resident #65's care plan includes the problem of potential for violence with a goal of won't harm others, will interact appropriately, will be diverted, will allow care to be completed. Interventions for nurses include close supervision, watch for signs of increasing anxiety and agitation, approach calmly, identify source of irritation, remove from setting if resident appears to be agitated, stay with resident and redirect/engage in other activities. Interventions for LNA's include all the above with the addition of report episodes of violence to the nurse. Per record review the care plan interventions including close supervision and removal from settings in which the resident exhibits anxious or agitated behaviors were not employed resulting in assaultive behavior. The above was confirmed by the Director of Nursing during an interview on May 9, 2022

ACTION PLAN

- Providers and Staff (as applicable to their role) were educated through a combination of meetings/ electronic communication the requirements for care plans to be reviewed and revised with a change in condition. In addition specifically highlighted was the importance to reference the most current care plan.
- Fall with injury or change in status/condition will trigger a review of the entire care plan.
- A prompt will be added to the daily multidisciplinary safety huddles to identify residents that have had a fall or change in resident condition that will trigger a care plan review.
- Administrator/ Director/ designee to review a sample of resident medical records to ensure care plans were updated with change in condition and for documentation that the care plans have been followed. Frequency will be reevaluated based on sustained performance by leadership. Performance feedback will be shared with local leadership and organizational leadership for action as required at the Quarterly Helen Porter Quality Assurance Meeting beginning in July 2022.
- All actions will be completed effective July 7, 2022.

TAG F 758 POC Accepted on 06/07/22 by R. Tremblay/P. Cota

F758 FREE FROM UNNEC PSYCHOTRIPIC MEDS/PRN USE
SS=D, CFR(s) (3)(e)(1)-(5)

§483.45(e) Psychotropic Drugs.

§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:

(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in

§483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.

This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that PRN (as needed) orders for psychotropic drugs are limited to 14 days, or if the prescribing provider believes that it is appropriate for the PRN order to be extended beyond 14 days, that there is a documented rationale in the resident's medical record and an indicated duration for the PRN order for one of 5 sampled residents (Resident #28).

Findings include:

1. *Per record review, Resident #28 has diagnoses of hemiparesis affecting left side as late effect of cerebrovascular accident (left sided weakness as a result of a stroke) and seizure disorder.*

Per record review, an order was placed in Resident #28's medical record on 5/6/22 that reads, "Lorazepam (an antianxiety medication) 1 mg (2mg/ml solution) by mouth every 15 minutes PRN for seizures, maximum 3 doses in a day." There was no indicated end date or time for this order. The record also showed previous orders for this medication with the same indications and administration instructions that had since been discontinued.

Per interview on 5/11/22 at approximately 12:00 PM, Resident #28's physician stated it was their understanding that, because the Lorazepam is ordered for seizures and not for anxiety despite its classification as an antianxiety medication, that the order did not require reevaluation. They confirmed that the Lorazepam order was not intended to have an end date or time, as they want this medication to be available for the resident on a PRN basis for seizures for the foreseeable future

ACTION PLAN

- Lorazepam prescribed for seizures requirement for an indicated end date or time was reviewed with Providers and Staff (as applicable to their role) through a combination of meetings/ electronic communications.

- Based on a review the resident referenced was the only resident impacted. Under the Direction of the Medical Director/ Administrator/ Director of Nursing, ongoing compliance with the required regulation §483.45(c)(3) order time limitation for PRN psychotropic medications will be monitored during the Consultant Pharmacist's monthly medication review. Performance feedback will be shared with local leadership and Quarterly Helen Porter Quality Assurance Meeting beginning in July 2022.

- All actions will be completed effective July 7, 2022.

F 760 RESIDENTS ARE FREE OF SIGNIFICANT MED ERRORS
SS=D, CFR(s): 483.45(f)(2)

TAG F 760 POC Accepted on 06/07/22 by R. Tremblay/P. Cota

The facility must ensure that its-
§483.45(f)(2) Residents are free of any significant medication errors.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review the facility failed to ensure that 1 resident in the sample (Resident #7) was free from significant medication errors.
Findings include: Per record review Resident #7 has a diagnosis of atrial fibrillation (an irregular heart rhythm that increases the risk of blood clots and stroke). Physician orders for Coumadin (a medication that prevents blood from clotting, reducing the risk of stroke) are determined by the results of scheduled of blood work. A Pharmacy review written on 4/6/22 states "I noticed that resident does not have a current warfarin (Coumadin) order. [The unit charge nurse] helped me research and it appears that [the resident's] INR was missed on 3/28/22, [s/he] has now missed 9 days of therapy. [The unit charge nurse] will obtain a stat (urgent) INR (a diagnostic test that provides a calculation based on blood clotting factors) and update providers." Review of the facilities internal investigation system reflects that the resident had orders for a PT/INR to be completed on 3/28/22. The PT/INR was not completed. As a result the resident missed all of the Coumadin dosing for 3/28/22 - 4/5/22. A blood draw on 4/6/2022 revealed that the resident's INR was 1.0 (INR goal range 2.0-3.0) putting the resident at a higher risk of developing blood clots and stroke. On 5/11/2022 at 1:09 PM during interview with the Director of Nursing s/he confirmed that the prescribed blood work had not been completed, and that the resident did not receive any doses of Coumadin from 3/28/2022- 4/5/2022.

ACTION PLAN

- Under the Direction of the Medical Director/ Administrator/ Director of Nursing an electronic medical record system update is being reviewed to support a more streamlined workflow for the PT/INR process.

- Staff appropriate to their role were educated utilizing the EPIC (Electronic Health Record) Tip Sheet for Long Term Care Nurses, Documentation of PT/INR. Specifically highlighted was the requirement to enter a PT/INR value, and not to enter "Done" as a result.

- Administrator/ Director of Nursing/ designee in collaboration with the pharmacy will review residents on Coumadin to ensure prescribed bloodwork and doses have been completed. Frequency will be reevaluated based on sustained performance by leadership. Performance feedback will be shared with local leadership and Quarterly Helen Porter Quality Assurance Meeting beginning in July 2022.

- All actions will be completed effective July 7, 2022.

F 804 NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP
SS=D, CFR(s): 783.60(d)(1)(2)

TAG F 804 POC Accepted on 06/07/22 by R. Tremblay/P. Cota

§483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;

§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, and record review the facility failed to ensure that residents were served meals at a safe temperature.

Findings include:

During observation on the Memory Care Unit on 5/11/2022 at 11:00 AM a Licensed Nursing Assistant (LNA) was observed removing a plate of food from the microwave for a resident who had missed their breakfast meal. The LNA did not ensure temperature with the use of a thermometer, nor did s/he stir the food to distribute temperature. During interview at the time the LNA confirmed that the food had not been checked for safe temperature. The LNA stated that s/he was not sure if there was a procedure for warming food in the microwave. Review of the facility policy titled Maintaining Food Temperatures Internal Temperature Guidelines: Microwave foods; All foods reheated in microwave must reach a minimum of 165 degrees Fahrenheit after standing for a minimum of 2 minutes to ensure temperatures are even throughout the food item.

On 5/11/2022 at 12:40 PM during an interview with the Food Service Director (FSD) and the two Dietary Supervisors, the FSD confirmed that food reheated in a microwave should be checked with a thermometer to ensure a safe temperature to prevent foodborne illness and scalding from extreme heat.

ACTION PLAN

- Under the Direction of the Nutrition Services Manager/ Administrator/ Director of Nursing, the Maintaining Food Temperatures Internal Temperature Guidelines was reviewed to better articulate the procedure for safe food handling.

- Staff applicable to their role were educated through a combination of meetings/ electronic communication on the policy and practice updates.

- In order to minimize the need to warm food Under the Direction of the Manager of Nutrition Services/lead cook temperature of Food will be monitored by an audit of a sample of tray temperatures at point of delivery. Performance feedback will be shared with local leadership and organizational leadership for action and at the Quarterly Helen Porter Quality Assurance Meeting beginning in July 2022.

- All actions will be completed effective July 7, 2022.

F 812 FOOD PROCUREMENT, STORE/PREPARE/SERVE-SANITARY
SS=F: CFR(s): 483.60 (i)(1)(2)

TAG F 812 POC Accepted on 06/07/22 by R. Tremblay/P. Cota

§483.60(i) Food safety requirements. The facility must –

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.

- (i) *This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.*
- (ii) *This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.*
- (iii) *This provision does not preclude residents from consuming foods not procured by the facility.*

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and record review, the facility failed to prepare, distribute and serve food in accordance with professional standards for food service safety regarding monitoring the temperatures of served food items. Findings include:

Per review of the food temperature logs for the past 4 months (January, February, March, April 2022), there are 142 meals with no evidence of monitoring temperatures of food being served. None of the temperature logs reflect evidence of beverages being monitored for appropriate safe temperatures. During interview with the Director of Food Service on 5/11/2022 at 12:40 PM s/he confirmed that the food temperatures were not consistently monitored or documented on the temperature logs.

ACTION PLAN

- Under the Direction of the Medical Director/ Administrator/ Director of Nursing/ Manager of Nutrition Services, the Nutrition Supervisor, Cooks, and Nutrition Assistants will be educated on the recording of temperature logs and requirement to immediately notify Manager of Nutrition Services of any missing temperatures.

- Nutrition Services staff existing and new hires will complete Food Safety Fundamentals - Relias online training. Curriculum includes module on safe temperatures for preparing, storing and serving food, both hot and cold.

- Infection Preventions to conduct weekly rounding in the kitchen to ensure compliance with recording of temperatures for food storage, preparation and serving temperatures.

- Compliance with appropriate temperature monitoring and documentation will be monitored by Manager of Nutrition Services or designee. Performance feedback will be shared with local leadership and organizational leadership for action as required at the Quarterly Helen Porter Quality Assurance Meeting beginning in July 2022

POC Accepted on 06/07/22 by R. Tremblay/P. Cota

THE
University of Vermont
HEALTH NETWORK

Porter Medical Center

HELEN PORTER
REHABILITATION & NURSING

June 7, 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