Division of Licensing and Protection HC 2 South, 280 State Drive Waterbury, VT 05671-2060 <u>http://www.dail.vermont.gov</u> 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,

Jamela McotaRN

Pamela M. Cota, RN Licensing Chief

CENTERS FOR MEDICARE & MEDICAID SERVICES

			(X2) MULT	PLE CONSTRUCTION	Ç	X3) DATE S	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		COMPL	ETED
		475017	B. WING _			05/1	1/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	05/1	11/2022
			······	30 PORTER DRIVE	•		
HELEN PC	ORTER HEALTHCARE &	KENAD	ĺ	MIDDLEBURY, VT 05753			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	····			(X5) COMPLETION
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX	CROSS-REFERENC	IVE ACTION SHOULD BE ED TO THE APPROPRIATI FICIENCY)	E	DATE
E 000	Initial Comments	a a construction of the state of the	E 0	00			
F 000		am was conducted in annual recertification survey are no regulatory deficiencies ew.	F0	00			
F 609	The Division of Licer conducted an unanno survey and a staff var	nsing and Protection ounced onsite recertification ccination review 5/9/22 - g regulatory violations were	F 6	See attached F	Plan of Correc		07/07/22
	CFR(s): 483.12(c)(1) §483.12(c) In respon						UTIONE
	involving abuse, negl mistreatment, includin source and misappro are reported immedia hours after the allegat that cause the allegat serious bodily injury, the events that cause abuse and do not res the administrator of th officials (including to adult protective servin for jurisdiction in long accordance with Stat procedures.	ng injuries of unknown priation of resident property, ately, but not later than 2 tion is made, if the events tion involve abuse or result in or not later than 24 hours if a the allegation do not involve suit in serious bodily injury, to the facility and to other the State Survey Agency and ces where state law provides pterm care facilities) in e law through established		POC Accepted R. Tremblay/P		у     	
	§483.12(c)(4) Report	the results of all				(	X6) DATE
LABORATORY	DIRECTOR'S OF PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATU		A Jon's ist	ater h.		2422
ny deficiency		so to the patients. (See instructions.)		be excused from Collecting Orb			,2022

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 1/ 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 C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
		475017	B. WING		05/11/2022
	NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB			EET ADDRESS, CITY, STATE. ZIP CODE PORTER DRIVE PDLEBURY, VT 05753	÷
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 609	investigations to the designated represen accordance with Stat Survey Agency, withi incident, and if the al appropriate correctiv This REQUIREMEN' by: Based on resident in record review, the far alleged violations invi immediately to official law through establish residents (Resident # Findings include: 1. Per interview on 5 AM, Resident #41 stat in the past of rough the had reported it to fact issue had been resol Per interview on 5/10 PM, the DON (Direct a previous allegation had been investigate DON and the Residet they had not reported Survey and Certificials. The results of the investig reported. 2. Per record review resident #63 repeate cloth clothing protect being water repellant	administrator or his or her tative and to other officials in the law, including to the State in 5 working days of the leged violation is verified e action must be taken. Γ is not met as evidenced hterview, staff interview, and cility failed to ensure that all olving abuse are reported hts in accordance with state hed procedures for two of 22 #41 and Resident #8).	F 609		
FORM CMS-256		rsing) with a subsequent	Y11 Facilit	y ID: 475017 If c	continuation sheet Page 2 of 16

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY
				A. BUILDING		
	ROVIDER OR SUPPLIER	475017		STREET ADDRESS, CITY, STATE, ZIP		05/11/2022
	ORTER HEALTHCARE 8	REHAB		30 PORTER DRIVE MIDDLEBURY, VT 05753		
	CUMMADY C				CODECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIOI DATE
F 609	Continued From pag	e 2	F 60	19		
	investigation being of the DON on 5/10/20 PM the DON confirm been reported to her because the residen dementia the act wa injury therefore it wa	completed. Per interview with 22 at approximately 12:45 ned that this incident had and investigated but ts involved both have s not willful nor did it result in s not reported to the Division tection, Adult Protective				
	Services or the Omb					
F 641 SS=E	Accuracy of Assessr CFR(s): 483.20(g)	nents	F 64	See Attached PO	с	
	resident's status.	st accurately reflect the				
	by: Based on staff inter facility failed to ensu assessment accurate statuses for 11 of 22	T is not met as evidenced view and record review, the re that the comprehensive ely reflects the Residents' residents in the sample 28, #32, #34, #41, #42, #43, Findings include:		POC Accepted o by R. Tremblay/F		
	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.					
	Patterns) as "resider during their 3/21/22 As a result, the rest not completed. In se Admission MDS ass	arked in section C (Cognitive ht is rarely/never understood" Admission MDS assessment. of the BIMS assessment was ection B of the same essment (Hearing, Speech, lent's speech was marked as				
	,	elligible words, able to make				

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 475017

If continuation sheet Page 3 of 16

	F DEFICIENCIES			TIO	E CONOTOLIOTION			
ND PLAN OF CORRECTION IDENTIFIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		475017	B. WING			05/11/2022		
AME OF PR	OVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODI	Ξ		
IELEN PO	RTER HEALTHCARE &	REHAB		1	30 PORTER DRIVE			
					MIDDLEBURY, VT 05753			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CON (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 641	Continued From page	33	F	64 <sup>.</sup>	1			
		od and able to understand	I	04				
1		rehension. Additionally, in						
1	•	resident during the annual						
1		the resident was very						
		all questions. They were						
	able to articulate with	their answers and they						
	were able to convey t	heir thoughts clearly.						
	Resident #43 was ma	arked in section C (Cognitive						
		t is rarely/never understood"						
	•	dmission MDS assessment.						
	-	f the BIMS assessment was						
	not completed. In se	ction B of the same						
1		ssment (Hearing, Speech,						
	,	ent's speech was marked as						
(		lligible words, able to make						
		od and able to understand						
	•	rehension. Additionally, in resident during the annual						
		the resident was very						
	•	all questions. They were						
1	• •	their answers and they						
	were able to convey t	heir thoughts clearly.						
-		arked in section C (Cognitive						
		t is rarely/never understood"						
	•	dmission MDS assessment.						
1	not completed. In se	f the BIMS assessment was						
		essment (Hearing, Speech,						
1		ent's speech was marked as	a management of the second					
	•	ligible words, able to make						
1		od and able to understand						
í	•	rehension. Additionally, in						
		resident during the annual						
		the resident was very						
		all questions. They were						
1	able to articulate with were able to convey t	their answers and they						

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Facility ID: 475017

If continuation sheet Page 4 of 16

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

PRINTED: 05/26/2022 FORM APPROVED OMB NO. 0938-0391

DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	475017	B. WING				05/11/2022
NAME OF PROVIDER OR SUPPLIER			:	30 PORTER DRIVE		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOUL	BE	(X5) COMPLETION DATE
<ol> <li>Per record review, did not have BIMS (bi status) assessments their most recent MDS assessment.</li> <li>Per review of Resider section B is marked a is understood, and un BIMS assessment wat</li> <li>Per review of Resider MDS section B is mar speech, is understood However, section C is rarely/never understoo the BIMS assessment</li> <li>Per review of Resider Change MDS section has clear speech, is u understands. However "resident is rarely/nev the rest of the BIMS a completed.</li> <li>Per interview on 5/11/ PM, the facility's MDS Residents # 7, # 32, a having a BIMS compl 3. Per record review, #28, and #14 did not of mental status) asse required for their mos data set) assessment</li> </ol>	Residents #7, #32, and #34 rief interview of mental performed as required for S (minimum data set) Int #7's 2/1/22 Quarterly MDS is resident has clear speech, iderstands. However, the as not completed. Int #32's 3/12/22 Quarterly rked as resident has clear d, and understands. Is marked as "resident is od". As a result the rest of t was not completed. Int #34's 3/25/22 Significant B is marked as resident understood, and er, section C is marked as ver understood" As a result assessment was not /22 at approximately 3:00 S coordinator confirmed that and #34 were capable of eted and that they had not. Residents #61, #41, #44, have BIMS (brief interview essments performed as t recent MDS (minimum Int work in section C (Cognitive	F	641	1		
•	•					
	ROVIDER OR SUPPLIER DRTER HEALTHCARE & SUMMARY ST. (EACH DEFICIENC) REGULATORY OR I Continued From page 2. Per record review, did not have BIMS (b status) assessments their most recent MDS assessment. Per review of Resider Section B is marked a is understood, and ur BIMS assessment wa Per review of Resider MDS section B is marked a is understood, and ur BIMS assessment wa Per review of Resider MDS section B is marked a is understood, and ur BIMS assessment wa Per review of Resider MDS section B is marked a is understood, and ur BIMS assessment wa Per review of Resider MDS section B is marked a is understood, and ur BIMS assessment wa Per review of Resider MDS section B is marked a is understood, and ur BIMS assessment wa Per review of Resider MDS section B is marked a is understood, and ur BIMS assessment wa Per review of Resider MDS section B is marked a is understood, and ur BIMS assessment wa Per review of Resider MDS section B is marked a speech, is understood However, section C is rarely/never understood However, sect	IDENTIFICATION NUMBER:         ORTER HEALTHCARE & REHAB         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 4         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	IDENTIFICATION NUMBER:       A. BUILD         475017       B. WING.         ROVIDER OR SUPPLIER       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID         Continued From page 4       ID         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.       F         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.       F         Per review of Resident #32's 3/12/22 Quarterly MDS section B is marked as resident has clear speech, is understood". As a result the rest of the BIMS assessment was not completed.       F         Per review of Resident #34's 3/25/22 Significant Change MDS section B is marked as resident is rarely/never understood". As a result the rest of the BIMS assessment was not completed.       F         Per review of Resident #34's 3/25/22 Significant Change MDS section C 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) assessment.	CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING         475017       B. WING	CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING         475017       B. WING         ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCES       IDE         (PCH DEFICIEW WINE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PRECENT TAG         Continued From page 4       IDE         2. Per record review, Residents #7, #32, and #34 did not have BIMS (brief interview of mental status) assessment.       F 641         Per review of Resident #7's 2/1/22 Quarterly MDS section D 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 D is marked as resident has clear speech, is understood, and understands.         Per review of Resident #32's 3/25/22 Significant Chas Cear speech, is understood, and understands. However, section C is marked as resident has clear speech, is understood, and understands. However, section C is marked as really/never inderstood'. As a result the rest of the BIMS assessment was not completed.         Per review of Resident #34's 3/25/22 Significant Chas 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 recoid review, Resident \$61, #41, #41, #42, #28, and #14 did not have BIMS (infer interview of m	CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING       Color         AT5017       B. WHG       STREET ADDRESS, CITY, STATE, ZIP CODE         ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       DO PORTER DRIVE         SUMMARY STATEMENT OF DEFICIENCIES       DD       PROVIDERS PLANOF CORRECTION         REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX       TAG         Continued From page 4       F641       CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCIES         2. Per record review, Residents #7, #32, and #34       fib of interview of mental status) assessments performed as required for their most recent MDS (minimum data set) assessment was not completed.       F641         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, section C is marked as resident is rarely/never understood, and understands. However, section C is marked as resident has clear speech, is understood, and understands. However, section C is marked as resident has clear speech, is understood, and understands. However, section C is marked as resident has clear speech, is understood, and understands. However, section C is marked as resident has clear speech, is understood, and understands. However, section C is marked as resident has clear speech, is understood, and understands. However, section C is marked as resident has clear speech, is understood, and understands. However, section C is marked as resident has clear speech, is understood, and understands. However, section C is marked as resident has clear speech, is understood, and understands. However, section C is marked as resi

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:011Y11

Facility ID: 475017

If continuation sheet Page 5 of 16

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/26/202 FORM APPROVE( <u>OMB NO. 0938-039</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475017		B. WING		05/11/2022
	ROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP 30 PORTER DRIVE MIDDLEBURY, VT 05753	CODE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 641	completed. The BIMS Resident #61 as part scored as 15 (no cog Resident #41 was ma Patterns) as "residen during their 3/19/22 of As a result, the rest of not completed. The B for Resident #41 as p was scored as 14 (no Resident #44 was ma Patterns) as "residen during their 4/4/22 of a result, the rest of th completed. The BIMS Resident #44 as part marked as unable to #44 was marked as of Resident #28 was ma Patterns) as "residen during their 3/4/22 of a result, the rest of th completed. The BIMS Resident #28 was ma Patterns) as "residen during their 3/4/22 of a result, the rest of th completed. The BIMS Resident #28 as part scored as 15 (no cog Resident #14 was ma Patterns) as "not ass quarterly MDS assess of the BIMS assessment co part of the 11/14/21 M cognitive impairment Per interviews with re	e BIMS assessment was not assessment conducted for of the 12/28/21 MDS was nitive impairment). arked in section C (Cognitive t is rarely/never understood" uarterly MDS assessment. of the BIMS assessment was BIMS assessment conducted part of the 12/17/21 MDS o cognitive impairment). arked in section C (Cognitive t is rarely/never understood" arterly MDS assessment. As e BIMS assessment was not assessment conducted for of the 1/2/22 MDS was be completed, but Resident apable of being assessed. arked in section C (Cognitive t is rarely/never understood" is arterly MDS assessment. As e BIMS assessment was not assessment conducted for of the 1/2/22 MDS was be completed, but Resident apable of being assessed. arked in section C (Cognitive t is rarely/never understood" is assessment conducted for of the 12/2/21 MDS was nitive impairment). arked in section C (Cognitive essed" during their 2/14/22 sment. As a result, the rest pent was not completed. The inducted for Resident #14 as ADS was scored as 14 (no	F 6	341	

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Facility ID: 475017

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#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 475017 05/11/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **30 PORTER DRIVE HELEN PORTER HEALTHCARE & REHAB** MIDDLEBURY, VT 05753 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 641 Continued From page 6 F 641 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 657 Care Plan Timing and Revision F 657 SS=D 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

Event ID:011Y11

Facility ID: 475017

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 05/26/2022

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**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

PRINTED: 05/26/2022 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		475017	B. WING			05/	/11/2022
	ROVIDER OR SUPPLIER	REHAB		30	REET ADDRESS, CITY, STATE, ZIP CODE PORTER DRIVE DDLEBURY, VT 05753		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 657	team after each asse comprehensive and of assessments. This REQUIREMENT by: Based on observation review the facility failut to include implementar interventions for one (Resident #53). Findi During observations of 5/9/2022 at approxim was seen sitting in a large, square, black r between the recliner resting on it's edge. F Nursing Assistant (LM alarm used to notify s standing up from the room and placed the resident's feet. Per record review Re falls with and without impaired physical mo 3/25/2022 includes tw chair transfers and tw A care plan focus for Falls" includes intervor resident to use walker and rearrange reside access walker while g	e resident. ised by the interdisciplinary ssment, including both the quarterly review T is not met as evidenced an, staff interview, and record ed to revise the plan of care ed fall prevention resident in the sample ngs include: of Otter Creak East on tately 3:30 PM Resident #53 recliner in her/his room. A mat was seen propped up and the resident's bed, Per interview with a Licensed NA) the black mat was an staff when the resident was chair. The LNA entered the mat on the floor under the esident #53 has a history of injury. A care plan focus of ability implemented on wo staff assist for bed and wo staff assist for ambulation. "Potential for Trauma -	F	657	See Attached PO POC Accepted on 06/07/22 by R. Tremblay P. Cota		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 475017

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/26/2022 FORM APPROVED OMB NO. 0938-0391

	S FUR MEDICARE &	MEDICAID SERVICES			ONID INC. 0936-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		475017	B. WING		05/11/2022
NAME OF P	ROVIDER OR SUPPLIER	•	ST	REET ADDRESS, CITY, STATE, ZIP CODE	······································
			30	PORTER DRIVE	
HELEN PO	ORTER HEALTHCARE &	REHAB	MI	DDLEBURY, VT 05753	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	CTION (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 657	Continued From page	<b>a</b> 8	F 657		
1 007	Per interview with the		1 007		
	1	mately 11:15 AM Resident			
	{ · ·	The alarm is used to alert			a ann an Ann
		rying to get up unassisted.			
	1	so confirmed that the care			
	-	e use of the alarm and it did			
	not.				
F 689		ards/Supervision/Devices	F 689		
SS=D			1 000		
00-0		(-)			
	§483.25(d) Accidents			See Attached POC	
	The facility must ensu				
	_	sident environment remains			
	as free of accident ha	azards as is possible; and			
	§483.25(d)(2)Each re	esident receives adequate			
	• • • • • •	stance devices to prevent			
	accidents.				
	This REQUIREMENT	is not met as evidenced			
	by:				
	Based on staff interv	iew and record review the			
	facility failed to provid	le appropriate and sufficient			
	supervision to Reside	•			
		r 1 of 5 residents in the			
	sample (resident #8).	Findings include:			
	On 4/44/0000				
		nt #65 was not supervised as			
	•	ines resulting in him/her nd repeatedly hitting another			
	resident. Resident #8				
		in a recliner resting with			
		a common area on the			
	memory care unit. Re				
	-	ioral disturbances was also			
	)	at this time. Per nursing			
	documentation, a LN	5			
		ough the common area	non and and		
	-	ecame agitated and began			
FORM CMS-256	7(02-99) Previous Versions Obs	solete Event ID: 011	Y11 Faci	lity ID: 475017	continuation sheet Page 9 of 16

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475017				E CONSTRUCTION		TE SURVEY MPLETED
		475017	B. WING		05/11/2022	
	ROVIDER OR SUPPLIER	REHAB	:	STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE MIDDLEBURY, VT 05753		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	was able to observe t area through a windo another resident. Per documentation, th being hit repeatedly a standing over residen 18" x 31" 2-layer cloth metal snap closure. T assistance, resident a common area while re the nurse. Per the MDS assess and 4/19/2022 reside short tempered and e #65's care plan includ for violence with a go interact appropriately care to be completed include close supervi increasing anxiety an identify source of irrit resident appears to b and redirect/engage i Interventions for LNA the addition of report nurse. Per record rev interventions includin removal from settings exhibits anxious or ag employed resulting in above was confirmed during an interview o	GD house". The unit nurse the activity in the common w as she was attending to he nurse heard something and found resident #65 at #8 striking him/her with an h clothing protector with a The nurse called for #65 was removed from the esident #8 was examined by ment section D on 1/19/2022 at #65 is coded as being easily annoyed. Resident des the problem of potential al of won't harm others, will , will be diverted, will allow . Interventions for nurses sion, watch for signs of d agitation, approach calmly, ation, remove from setting if e agitated, stay with resident in other activities. 's include all the above with episodes of violence to the riew the care plan g close supervision and s in which the resident gitated behaviors were not a assaultive behavior. The I by the Director of Nursing n May 9, 2022.	F 689			
	Free from Unnec Psy CFR(s): 483.45(c)(3)	chotropic Meds/PRN Use	F 758	3		

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/26/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA	IO. 0938-03 TE SURVEY MPLETED	
		475017	B. WING		0	5/11/2022	
NAME OF PROVIDER OR SUPPLIER			3	BTREET ADDRESS, CITY, STATE, ZIP COD O PORTER DRIVE AIDDLEBURY, VT 05753	E	<u>L</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE	
F 758	affects brain activities processes and behave		F 758	See Attached PO	C		
	<ul> <li>(i) Anti-psychotic;</li> <li>(ii) Anti-depressant;</li> <li>(iii) Anti-anxiety; and</li> <li>(iv) Hypnotic</li> </ul>			POC Accepted on by R. Tremblay/P.			
1	resident, the facility n §483.45(e)(1) Reside psychotropic drugs at unless the medication specific condition as in the clinical record;	ents who have not used re not given these drugs n is necessary to treat a diagnosed and documented					
	drugs receive gradua behavioral interventio	ents who use psychotropic I dose reductions, and ons, unless clinically a effort to discontinue these					
	unless that medicatio	ursuant to a PRN order n is necessary to treat a ondition that is documented					
	are limited to 14 days §483.45(e)(5), if the a prescribing practition appropriate for the PI	rders for psychotropic drugs c. Except as provided in attending physician or er believes that it is RN order to be extended or she should document their					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:011Y11

Facility ID: 475017

If continuation sheet Page 11 of 16

TATEMENT (	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED 05/11/2022		
		475017	B. WING				
	ROVIDER OR SUPPLIER	REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE MIDDLEBURY, VT 05753				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 758	Continued From pag		F 758	3			
	indicate the duration	ent's medical record and for the PRN order.		See Attached POC			
	drugs are limited to 1 renewed unless the a prescribing practition the appropriateness This REQUIREMENT by: Based on staff intervi- facility failed to ensure orders for psychotrop days, or if the prescr is appropriate for the beyond 14 days, that rationale in the reside indicated duration for sampled residents (F include: 1. Per record review, diagnoses of hemipa	T is not met as evidenced view and record review, the re that PRN (as needed) pic drugs are limited to 14 ibing provider believes that it PRN order to be extended t there is a documented ent's medical record and an r the PRN order for one of 5 Resident #28). Findings		POC Accepted on 06/ R. Tremblay/P. Cota	07/22 by		
	weakness as a resul disorder. Per record review, ar Resident #28's media	t of a stroke) and seizure n order was placed in cal record on 5/6/22 that					
	mg (2mg/ml solution PRN for seizures, ma There was no indicat order. The record als for this medication w	an antianxiety medication) 1 ) by mouth every 15 minutes aximum 3 doses in a day." ted end date or time for this so showed previous orders ith the same indications and ctions that had since been					
	Per interview on 5/11						

CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		475017	B. WING _		;	05/11/2022
	NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP 30 PORTER DRIVE MIDDLEBURY, VT 05753	° CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BI	
F 758 F 760 SS=D	understanding that, b ordered for seizures a its classification as ar the order did not requ confirmed that the Lo intended to have an e want this medication resident on a PRN ba foreseeable future.	e 12 hysician stated it was their ecause the Lorazepam is and not for anxiety despite n antianxiety medication, that irre reevaluation. They razepam order was not end date or time, as they to be available for the asis for seizures for the f Significant Med Errors	F 7 F 7			
	The facility must ensu §483.45(f)(2) Resider medication errors. This REQUIREMENT by: Based on staff interv facility failed to ensur sample (Resident #7) medication errors. Fin Per record review Re atrial fibrillation (an in increases the risk of I Physician orders for 0 prevents blood from 0 stroke) are determine scheduled of blood w A Pharmacy review w noticed that resident warfarin (Coumadin) nurse] helped me res	<ul> <li>is not met as evidenced</li> <li>is not met as evidenced</li> <li>iew and record review the</li> <li>e that 1 resident in the</li> <li>was free from significant</li> <li>indings include:</li> <li>sident #7 has a diagnosis of</li> <li>regular heart rhythm that</li> <li>blood clots and stroke).</li> <li>Coumadin (a medication that</li> <li>clotting, reducing the risk of</li> <li>ed by the results of</li> </ul>				
	has now missed 9 da	ys of therapy. [The unit ain a stat (urgent) INR (a		Facility ID: 475017		nation sheet Page 13 of 16

Facility ID: 475017

PRINTED: 05/26/2022 FORM APPROVED

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/11/2022	
		475017				
	ROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE MIDDLEBURY, VT 05753		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COMPLETIC	
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.		F 76(	See Attached POC		
				POC Accepted on 06 R. Tremblay/P. Cota	6/07/22 by	
F 804 SS=D	Director of Nursing s prescribed blood wor and that the resident Coumadin from 3/28 Nutritive Value/Appe	ar, Palatable/Prefer Temp	F 804	ł		
	§483.60(d)(1) Food	d drink es and the facility provides- prepared by methods that lue, flavor, and appearance;				
	§483.60(d)(2) Food a attractive, and at a s temperature. This REQUIREMEN by: Based on observation review the facility fail	and drink that is palatable,				
	_	on the Memory Care Unit on				

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 093	ROVE
CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         475017		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/11/2022	
		475017				
		STREET ADDRESS, CITY, STATE, ZIP CODE				
HELEN PO	ORTER HEALTHCARE &	REHAB	1	0 PORTER DRIVE NIDDLEBURY, VT 05753		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMP	(X5) PLETIO DATE
F 804	Continued From page	ə 14	F 804			
	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.			See Attached POC		
				POC Accepted on 06/ by R. Tremblay/P. Co		
	Food Temperatures I Guidelines: Microway in microwave must re degrees Fahrenheit a	re foods; All foods reheated each a minimum of 165 ifter standing for a minimum e temperatures are even				
	with the Food Service Dietary Supervisors, reheated in a microw a thermometer to ens	0 PM during an interview e Director (FSD) and the two the FSD confirmed that food ave should be checked with sure a safe temperature to ness and scalding from				
		tore/Prepare/Serve-Sanitary 2)	F 812			
	§483.60(i) Food safe The facility must -	ty requirements.				
	state or local authorit (i) This may include f	ed satisfactory by federal,				

Facility ID: 475017

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**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		475017	B. WING			05/11/20	22
	ROVIDER OR SUPPLIER ORTER HEALTHCARE &	REHAB		STREET ADDRESS, CITY, STAT 30 PORTER DRIVE MIDDLEBURY, VT 05753	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD B ED TO THE APPROPRI FICIENCY)	E COM	(X5) PLETION DATE
F 812	and local laws or regu (ii) This provision doe facilities from using pr gardens, subject to co safe growing and foor (iii) This provision doe from consuming food §483.60(i)(2) - Store, serve food in accorda standards for food se This REQUIREMENT by: Based on staff intervi facility failed to prepa in accordance with pr food service safety re temperatures of serve include: Per review of the food past 4 months (Janua 2022), there are 142 f monitoring temperatu None of the temperatu beverages being mon temperatures. During interview with on 5/11/2022 at 12:40 the food temperatures	ulations. es not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices. es not preclude residents s not procured by the facility. prepare, distribute and ance with professional	F	See Attache POC Accept by R. Tremb	ed on 06/07/	22	
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR I Continued From page and local laws or regu (ii) This provision doe facilities from using pi gardens, subject to co safe growing and food (iii) This provision doe from consuming food §483.60(i)(2) - Store, serve food in accorda standards for food se This REQUIREMENT by: Based on staff intervi facility failed to prepa in accordance with pr food service safety re temperatures of serve include: Per review of the food past 4 months (Janua 2022), there are 142 f monitoring temperatu None of the temperat beverages being mon temperatures. During interview with on 5/11/2022 at 12:40 the food temperatures monitored or docume	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) = 15 ulations. es not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices. es not preclude residents s not procured by the facility. prepare, distribute and ance with professional rvice safety. T is not met as evidenced iew and record review, the re, distribute and serve food ofessional standards for egarding monitoring the ed food items. Findings d temperature logs for the ary, February, March, April meals with no evidence of rises of food being served. ure logs reflect evidence of hitored for appropriate safe the Director of Food Service 0 PM s/he confirmed that s were not consistently anted on the temperature	F	PROVIDER'S P (EACH CORRECT CROSS-REFERENC DE 312 See Attache POC Accept	ed POC ed on 06/07/ lay/P. Cota	E COM	

#### 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.

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

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

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, the BIMS 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 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 12/2/21 MDS was scored as 15 (no cognitive impairment). Resident #14 was marked in section C (Cognitive Patterns) as "16 (no cognitive impairment). Resident #14 was marked in section C (Cognitive Patterns) as "16 (no cognitive impairment). Resident #14 was marked in section C (Cognitive Patterns) as "16 (no cognitive impairment). Resident #14 was marked in section C (Cognitive Patterns) as "16 (no cognitive impairment). Resident #14 was marked in section C (Cognitive Patterns) as "not assessed" during their 2/14/22 quarterly MDS 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 of 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 Creak 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 –

#### 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.

(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 TEMPTAG F 804 POC Accepted onSS=D, CFR(s): 783.60(d)(1)(2)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 –

- (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



#### **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 Jan Wottonson, Administrator