

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection HC 2 South, 280 State Drive Waterbury, VT 05671-2060 http://www.dail.vermont.gov Survey and Certification Voice/TTY (802) 241-0480 Survey and Certification Fax (802) 241-0343 Survey and Certification Reporting Line: (888) 700-5330 To Report Adult Abuse: (800) 564-1612December 21, 2022

January 12, 2023

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

Dear Ms. Nottonson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on November 3, 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 Mcota RN

Pamela M. Cota, RN Licensing Chief

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					: 01/06/2023 APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		LETED
		475017	B. WING			11/0	3/2022
				ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 1115	
NAME OF PR	ROVIDER OR SUPPLIER				PORTER DRIVE		
HELEN PO	ORTER HEALTHCARE &	REHAB	1		IDDLEBURY, VT 05753		
					PROVIDER'S PLAN OF CORRECTION		(ME)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000 F 622 SS=G	of three facility report complaint between 11 The following regulat identified: Transfer and Dischar CFR(s): 483.15(c)(1) §483.15(c) Transfer a §483.15(c)(1) Facility (i) The facility must p remain in the facility, discharge the resider (A) The transfer or di resident's welfare an cannot be met in the (B) The transfer or di because the resider sufficiently so the res services provided by (C) The safety of ind endangered due to ti status of the residen (D) The health of ind otherwise be endang (E) The resident has appropriate notice, to under Medicare or M Nonpayment applies submit the necessar payment or after the	nsing and Protection unannounced investigation led incidents and one 0/18/2022 and 11/3/2022. ory deficiencies were ge Requirements (i)(ii)(2)(i)-(iii) and discharge- / requirements- vermit each resident to and not transfer or nt from the facility unless- ischarge is necessary for the d the resident's needs facility; ischarge is appropriate t's health has improved sident no longer needs the the facility; ividuals in the facility is he clinical or behavioral t; lividuals in the facility would		622	This plan of correction (POC) cor a written allegation of compliance deficiencies cited. However, subt of the POC is not admission the deficiencies exist or were cited c nor is it an admission that the fac the 2567 are accurate. This POC submitted to meet the requireme established by federal and state See attached Plan of Correction See attached Plan of Correction	e for the mission orrectly, cts on cts on c is nts law.	12/18/22
	resident refuses to p resident who becom admission to a facilit	ay for his or her stay. For a es eligible for Medicaid after y, the facility may charge a ble charges under Medicaid;					
							L
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATU	Amini	st	rator January 10, 20.	23	(X6) DATE 12/02/2022
PU And Give					e excused from correcting providing it is determin		

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.

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C 11/03/2022	
		475017					
NAME OF PF	OVIDER OR SUPPLIER			STREETADE	DRESS, CITY, STATE, ZIP CODE		
	RTER HEALTHCARE	& REHAB		30 PORTER			
				MIDDLEBU	JRY, VT 05753		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	، م	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 622	Continued From pa	age 1	F6	522			
(I (i s e d 4 d c f	or						
	(F) The facility cea	ses to operate. / not transfer or discharge the					
		appeal is pending, pursuant to					
	§ 431.230 of this c	hapter, when a resident					
		er right to appeal a transfer or					
		om the facility pursuant to § his chapter, unless the failure to					
	discharge or trans	fer would endanger the health					1
	or safety of the res	ident or other individuals in the					
		y must document the danger					2
	that failure to trains	sfer or discharge would pose.					
	§483.15(c)(2) Doc		ŝ.				
		ransfers or discharges a					
		y of the circumstances specified 1)(i)(A) through (F) of this					
	section, the facility	must ensure that the transfer					
		cumented in the resident's					
		d appropriate information is the receiving health care					
	institution or provi	-					
	(i) Documentation	in the resident's medical record					
	must include:	b = b = a + b = a + a + a + a + a + a + a + a + a + a					
	(A) The basis for t (i) of this section.	he transfer per paragraph (c)(1)					
	(B) In the case of	paragraph (c)(1)(i)(A) of this					
	section, the specif	fic resident need(s) that cannot					
		empts to meet the resident rvice available at the receiving					
	facility to meet the						
	(ii) The document	ation required by paragraph (c)					
		on must be made by-					-
		physician when transfer or sary under paragraph (c) (1)					
	(A) or (B) of this s	ection; and					
	(D) A unbrustation and	hen transfer or discharge is	11				

Facility ID: 475017

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ENIER	S FOR MEDICARE &	MEDICAID SERVICES				0.0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING			E SURVEY PLETED
			A. BOILDING			С
		475017	B. WING	11/03/2022		
AME OF PF	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
			30 PC	DRTER DRIVE		
IELEN PO	ORTER HEALTHCARE &	REHAB	MIDI	DLEBURY, 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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 622	Continued From pag	e 2	F 622			
	this section.					
	(iii) Information provi	ded to the receiving provider				
	must include a minin	_				
		ion of the practitioner				
	responsible for the c	are of the resident. Intative information including				
	contact information	sittative information inclosing				
	(C) Advance Directiv	e information				
	(D) All special instru	ctions or precautions for				
	ongoing care, as ap					
	(E) Comprehensive					
		ary information, including a				
		s discharge summary, 5.21(c)(2) as applicable, and				
	any other document	ation, as applicable, to ensure				
	a safe and effective	transition of care.				
		T is not met as evidenced				
		and record review the facility				
		ident's discharge was				
	completely assesse	d, evaluated, and				
	documented for 1 of	1 [Resident #1] residents				
	facility.	ily discharged from the				
		Resident #1's discharge 's inability to meet the				
		d because the behavioral				
		nt endangered the safety of				
		the facility. However, upon				
	complaint investigat	ion, it was determined by				
	interview and record	d review that, while Resident				
	#1 had challenging	aggressive behavior requiring				
		did not have needs which that facility to allow for a				
		discharge honoring the				_
	resident's rights aro	und discharge, and there was				6
	evidence that the fa	cility was caring for other				
		essive behaviors. It was also	1 1			

A. BUILDING	TE SURVEY	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HELEN PORTER HEALTHCARE & REHAB STREET ADDRESS, CITY, STATE, ZIP CODE (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) F 622 Continued From page 3 determined that the facility did not meet behavioral care needs to prevent aggressive behaviors for Resident #1. The facility based Resident #1's discharge on their status at the time of transfer, did not have the required documentation specified in the regulation, and discharged the resident on 9/8/22. Findings include: Record review reveals that Resident #1 was initially admitted to the facility on 7/23/2020 and most recently readmitted to the facility on 1	C	
30 PORTER DRIVE MIDLEBURY, VT 05753 30 PORTER DRIVE MIDLEBURY, 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) F 622 Continued From page 3 determined that the facility did not meet behavioral care needs to prevent aggressive behavioral for Resident #1. The facility based Resident #1's discharge on their status at the time of transfer, did not have the required documentation specified in the regulation, and discharged the resident on 9/8/22. Findings include: Record review reveals that Resident #1 was initially admitted to the facility on 7/23/2020 and most recently readmitted to the facility on BIO PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	11/03/2022	
HELEN PORTER HEALTHCARE & REHAB MIDDLEBURY, VT 05753 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 622 Continued From page 3 determined that the facility did not meet behavioral care needs to prevent aggressive behaviors for Resident #1. The facility based Resident #1's discharge on their status at the time of transfer, did not have the required documentation specified in the regulation, and discharged the resident on 9/8/22. Findings include: F 622 Record review reveals that Resident #1 was initially admitted to the facility on most recently readmitted to the facility on F 622		
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 b) 20/2022 following a residunced with a whore we way that a start of the start of the		

Facility ID: 475017

If continuation sheet Page 4 of 29

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					C
		475017	B. WING			11/03/2022	
NAME OF PF	OVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
	RTER HEALTHCARE &	REHAB					
				MID	DLEBURY, VT 05753		
(X4) ID PREFIX TAG				(PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S) CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 622	Continued From page	e 4	F	522			
	ongoing since his/her initial admission on 7/23/2020. A readmission note written by Resident #1's physician on 3/28/2022 describes Resident #1 as having a problem with anxiety and depression and that s/he "has had issues related to dysregulated behavior, verbal abuse and						
pi ha a su Pirn 1 9 a s fir a irr r r F F V c s u 2							
	aggression directed setting."	toward staff in nursing home					
	instances at the facil 11/16/2020, 7/1/202 9/6/2022, and 9/7/20	esident #1's record reveal ity on 9/24/2020, 10/27/2020, 1, 5/13/2022, 9/4/2022, 022 where s/he was physically staff including: hitting,					
	slapping, striking, gra frequent verbal abus aggression and threa in Resident #1's pro- reveals that verbal th	abbing, shoving, along with e. Instances of verbal ats towards staff are frequent gress notes. Record review nreats towards a specific					
	Per interview on 10/ Licensed Practical N worked with Resider	esident #2] began 7/8/2022. 18/2022 at 5:00 PM, a lurse stated that when s/he nt #1 on the rehabilitation unit, ry aggressive and mean.					
	Worker confirmed the of physically aggres	1/2022 at 12:30 PM, a Social hat Resident #1 had a history sive behaviors with facility ived on the long-term care					
	2. It was established care for residents w	t that the facility is able to that the facility is able to the aggressive behaviors.					
	The facility assessm 2021, states "The fa	nent as of December 31,					

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				01/06/2023 APPROVED
		MEDICAID SERVICES			OMB NO.	2007-02112-020
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A, BUILDING	INSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		475017	B. WING		C 11/03/2022	
NAME OF P	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
			30 P	ORTER DRIVE		
HELEN PO	ORTER HEALTHCARE &	REHAB	MID	DLEBURY, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 622	1		F 622			
		the needs of our resident				
	population. Our facilit	ty embraces a e culture in which we provide				
		sed upon our resident				
		the following:" "Behavior			1	
		al support," and "dementia			8	
	care."					
	Desistantious on 11/1	/2022 at 10:55 AM, a Nurse				
		ere were other residents in				
		aggressive behaviors, but				
		uency as Resident #1.				
	Per interview on 11/1	/2022 at 2:15 PM, a				
		stated that there are				
	residents in the facili	ty that are physically				
	aggressive.				1	
	Review of a list of re-	sidents with aggressive				
	behaviors in the facil	ity revealed that 16 residents				
	with aggressive beha	aviors reside at the facility as				
		16 residents listed, at least				
		ysically aggressive with other				
		sidents were admitted after				
		charged for aggressive confirmed by the Director of			1	
		2 at 4:30 PM. The DON			1	
	stated that Resident					
		9/7/2022 about at what point				
		e Resident #1. The facility				
		nt #1 would need to be				
		/her behavior impacted the				
		ents. The DON stated that				
		ver hurt another resident, but				
	Bood abo of the the a	reatened to hurt another				
	resident on 9/6/2022	2, the facility was concerned				
	there was a risk to the	hat resident's safety. Record				
		erbal threats to hurt another				
	resident [Resident #	2] began 7/8/2022. The DON				

Facility ID: 475017

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		MEDICAID SERVICES				O. 0938-039 E SURVEY
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			PLETED
1000	Sourcement		A. BUILDING			С
		475017	B. WING		1	1/03/2022
		4,0011		EET ADDRESS, CITY, STATE, ZIP CODE		HOULDER
AME OF PF	OVIDER OR SUPPLIER					
ELEN PC	RTER HEALTHCARE &	REHAB		DLEBURY, VT 05753		
	CLIMMADY CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRE	CTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETION DATE
F 622	Continued From page	e 6	F 622			
)22 wasn't the first time				
ļi		reats about hurting Resident				
1		that Resident #1 was	8			
	discharged based or transfer.	his/her status at the time of				
	Progress notes date	d 9/7/2022 and 9/8/2022 by				
		an pertaining to Resident				
		charge do not contain				
	assessment informa	tion about Resident #1 at the				
	time of discharge on	9/8/22.				
		discharge summary [from				
	hospital emergency	room to a swing bed in the				
	hospital] reveals the	following:				
	o "Reason for Admis	ssion (chief complaint): , Principal/Final Diagnosis:				
	Agitation."	, Thirdpart mar Diagnosio.	1 1			
		The staff at [the nursing				
		d no longer care for [Resident				
		aken to the [hospital] ED on				
	9/7/22 and then adm	nitted. During [his/her] stay				
	[s/he] was calm and	redirectable. [S/he] wanted				
		sing facility] where [s/he] lived				
	for 2 years."	eeding Follow-up: 1. Pertinent				1
		: n/a, 2. Recommended				
		edures needs: work on				
	placement, 3. Antico	bagulation on discharge: No 4:				
	Changes to goals ca	are at time of discharge (if				
	applicable): n/a"					
	o "Assessment: [Re	sident #1 is] here for				
	placement as [s/he]	is displaying behaviors at [the ne] will remain at [the hospital]				_
	awaiting placement.					
	Per interview with m	nembers of Resident #1's				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1		STRUCTION		E SURVEY IPLETED
						С	
		475017	B. WING		11/03/2022		
AME OF P	ROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP CODE		
ELEN PO	ORTER HEALTHCARE &	REHAB					
					LEBURY, VT 05753	OTION	017)
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			<	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 622	Continued From pag	e 7	F	322			
		n 11/1/2022 at 4:01 PM, a					1
	Registered Nurse fro	m the admitting hospital					1
		#1 was calm for the first few					
		the hospital. The Director of tated that there had been no					
	discussions with the	nursing facility about what it					
	would take for Resid	ent #1 to go back to the					
		r the nursing facility and					
		liscussing how best to					
	support him/her in th	e nospital.					
	Per interview on 11/	1/2022 at 4:30 PM, the					
	Director of Nursing s	tated that there was no					
		dent #1 to return to the facility		195			
		2022. The Director of					
	that discharge from	ursing Officer both confirmed the facility was based on					
	his/her behavior whe	en s/he was transferred to the					
	hospital.						
		I that Resident #1's care plan					
		nclude interventions based on					
		ew diagnoses to prevent					
	aggressive behavior	'S.					
	Progress notes reve	al Resident #1 made a					
	complaint to social s	services about the nightly					
	noise of a resident r	eighbor [Resident #2] on					
	7/7/2022. On 7/8/20	22, Resident #1 complained					
	to social services ag	gain and expressed a desire Progress notes continue to					
		t #1 was triggered by Resident					
	#2 and threats by R	esident #1 were only made					1
	about Resident #2.	A note from 9/6/22, the last					
		Resident #1 making threats					
		dent stated that Resident #1 ck to [his/her] room when					
	Is/hel made comme	ents at staff and a patient who					
	Lune telling out loud	I [Resident #2]. [Resident #1]					

ENTER	S FOR MEDICARE &	MEDICAID SERVICES	1			O. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			PLETED
U PLAN OF	CORRECTION	DENTIFICATION DEL	A. BUILDING		1	С
		475017	B, WING		4	1/03/2022
		475017		EET ADDRESS, CITY, STATE, ZIP CODE		1/05/2022
AME OF PF	OVIDER OR SUPPLIER			PORTER DRIVE		
ELEN PO	RTER HEALTHCARE	& REHAB		DLEBURY, VT 05753		
						(NE)
(X4) ID PREFIX TAG	(EACH DEFICIEN	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 AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
E 622	Continued From pag	ne 8	F 622			
1 022		about [Resident #2] saying				
		take a brick and knock				
		d with it." There was no				
	documentation in re	cord review from 7/1/2022				
		at Resident #1 made threats				
		esident other than Resident #2				
		eal threats to any other				
	residents in any of t	he interviews conducted.				
	Destistes (out on 11)	/1/2022 at 1:04 PM, a Charge				
	Nurse confirmed the	at the Resident #2's yelling				
	was a trigger for Re	sident #1. S/he stated that the				
	facility put intervent	ions into Resident #2's care				
	plan to address the	noise and confirmed that no				
		added into Resident #1's care				
	plan to address this	i.				
	A geriatric psychiat	ry evaluation and request for				
	behavioral manage	ment was made by Resident				
	#1's physician, con	ducted on 7/6/2022 revealed				
		osis: "Major Neurocognitive				
	disorder, vascular t	ype with behavioral				
		nol use disorder- in remission,				
	antisocial personali	ity traits." The following				
		were made to Resident #1's				
		ement DICE approach [method pehavior experts] to address				
		ors in the long-term care				
		nend that you revisit				
		equently to evaluate for				
	efficacy," and "staff	f psychoeducation around				
	patient's diagnosis.	. Specifically that the difficult				
		ements resultant from his				
	underlying persona	ality structure have been				-
	exacerbated by dis	inhibition resultant from his				
		om this visit was signed by the nt on 7/7/2022 and signed by				
	the attending provi	der on 7/13/22, Notes from this				
	visit are automatica		3			

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			1	O. 0938-039
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY
ID PLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING			С
			D. MUNIC			-
		475017	B. WING			/03/2022
IAME OF PF	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE		
ELEN PC	RTER HEALTHCARE &	REHAB		DRTER DRIVE DLEBURY, VT 05753		
				PROVIDER'S PLAN OF CORF	RECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETION DATE
F 622	Continued From pag	e 9	F 622			
	record.					
		hat Resident #1's care plan 7/2022. "Care plan has been				
		rtments and has been				
		as of this date. Complete				4
		d and continued." Review of				
	a Care Plan Event L	og shows that Resident #1's				
		d on 7/19/22 but the facility				
		ce the revisions that were				
		n Event Log also revealed are plan had not been				
		22. This was confirmed by				
		10/20/2022 at 2:33 PM.				
	Record review revea	als that it wasn't until an				
		plinary staff meeting, held to				
		ehavior plan, that the				
		implement the DICE method	1. L			
		for staff psychoeducation				1
		s behaviors was discussed				
	as part of Resident	#1's behavior plan. Review of				
		recent care plan does not				
		for: dementia, the DICE				
		g Resident #1 from being nt #2, or verbal threats to				
	other residents.	nt n2, or voidal and a to				
	E Deview of a prog	roos noto writton by Pesident				
		ress note written by Resident 8/2022 regarding his/her				
		he basis for discharge is				
		cerns for staff and that the				
	facility does "not fee	el that they can meet [his/her]				
	care needs in this s	etting." This progress note				
	does not document	the following required				
	information in the re	sident's medical record: the				
	specific resident ne	eds the facility could not met				
	provide to meet the	vices the receiving facility will				

ATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			STRUCTION		E SURVEY PLETED
ID PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUILDI	NG		C	
		475017	B. WING			11/03/2022	
NAME OF PR	OVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
HELEN PO	RTER HEALTHCARE &	REHAB			RTER DRIVE LEBURY, VT 05753		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 622	Continued From page	e 10	F	622			
e	cannot be met at the						
	6. Resident #1 suffer return to the nursing	ed harm by not being able to facility.					
	3:45 PM, Resident #	e hospital on 11/1/2022 at 1 was in bed. S/he was omments about wanting to ave and go home.					
	approximately 4:00 F stated that Resident to hurt other residen	nospital on 11/1/2022 at PM, a Registered Nurse #1 does not have a chance ts at the hospital because her room. Staff do try to bring k once a day.					
	Per interview with R 4:01 PM on 11/2/202 believes Resident # hospital than s/he w the hospital Residen most of the time and activities or other re- stated that the nursi	esident #1's representative at 22, s/he stated that s/he 1 is getting less care at the as at the nursing home. At t #1 stays in his/her room 1 does not have access to sidents. The representative ng facility was Resident #1's year and s/he should be able					
	both a discharge su room and admissior bed status reveals t return to [nursing fa years." Under "Asse remain at the hospit	physician note serving as mmary from the emergency a summary for hospital swing hat Resident #1 "wanted to cility] where [s/he] lived for 2 assment" it states that s/he will al awaiting placement.		F 625			10/10/
F 625 SS=D		Policy Before/Upon Trnsfr		F 023	See attached Plan of Co	rrection	12/18/:

ATEMENT C	FDEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			STRUCTION		TE SURVEY MPLETED
D PLAN OF	CORRECTION	IDENTIFICATION NOWBER.	A, BUILDI	NG			С
		475017	B. WING			1	1/03/2022
IAME OF PF	OVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
IELEN PC	RTER HEALTHCARE &	REHAB			EBURY, VT 05753		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 625	Continued From page §483.15(d) Notice of	e 11 bed-hold policy and return-	F	625			
	nursing facility transfe the resident goes on nursing facility must the resident or reside specifies- (i) The duration of the any, during which the return and resume re facility; (ii) The reserve bed plan, under § 447.40 (iii) The nursing facili bed-hold periods, wh paragraph (e)(1) of the resident to return; an	before transfer. Before a ers a resident to a hospital or therapeutic leave, the provide written information to ent representative that e state bed-hold policy, if e resident is permitted to esidence in the nursing payment policy in the state of this chapter, if any; ity's policies regarding hich must be consistent with his section, permitting a ad specified in paragraph (e)(1)					
	the time of transfer of hospitalization or the facility must provide resident representat specifies the duratio described in paragra This REQUIREMEN by: Based on record re facility failed to prov upon transfer for Re Record review revea transferred to an action	erapeutic leave, a nursing to the resident and the ive written notice which n of the bed-hold policy aph (d)(1) of this section. T is not met as evidenced view and staff interviews, the ide a written bed-hold notice sident #1. Findings include: als that Resident #1 was ute facility on 9/7/2022 for an hysical aggressive behaviors.					

Facility ID: 475017

If continuation sheet Page 12 of 29

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		NSTRUCTION	(X3) DATE S COMPL	ETED
		475017	B. WING	_		11/03/2022	
AME OF PI	ROVIDER OR SUPPLIER	•			ET ADDRESS, CITY, STATE, ZIP CODE		
IELEN PO	ORTER HEALTHCARE &	REHAB			DRTER DRIVE DLEBURY, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 625	feel that we can mee setting and need to p discharge from the fa On 11/1/2022 at 11:5 Nursing confirmed th bed hold notice was representative in Res Per interview on 11/1 Worker stated that s/ transfer, notice of dis hold all in the same d mail to Resident #1's confirmed that the be Resident #1 record. Progress notes rever mailed to the resider and the discharge no mail to the resident r Per interview on 11/ #1's representative s certified letter from th was transferred to th 9/7/2022 which cont psychiatric evaluatio scanned copy of all letter to this surveyo psychiatric evaluatio "Notice before Trans 9/7/2022. S/he confir a written bed hold m Permitting Resident	this/her care needs in this roceed with formal acility." 5 AM, the Director of at there is no evidence that a sent to Resident #1's sident #1's record. 1/2022 at 12:30 PM, a Social /he sent the notice of scharge, and notice of bed envelope through certified a representative. She ed hold notice was not in al that the transfer notice was not representative on 9/7/2022 otice was mailed via certified representative on 9/8/2022. 1/2022 at 2:59 PM, Resident stated that s/he received one he facility after Resident #1 he emergency department on ained one notice and a in. The representative sent a the contents in the certified in dated 7/6/2022 and the sfer to Hospital" dated irmed that s/he did not receive otice from the facility. s to Return to Facility	F	626	See attached Plan of Correction	on	12/18/2

ATEMENT	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (TE SURVEY
D PLAN OF	CORRECTION	475017	A. BUILDING			C 1/03/2022
AME OF P	ROVIDER OR SUPPLIER	473011		REET ADDRESS, CITY, STATE, ZIP COD		1700/LOLD
ELEN PO	ORTER HEALTHCARE &	REHAB	1.0	PORTER DRIVE DDLEBURY, 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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE
F 626	on permitting resider after they are hospita therapeutic leave. The following. (i) A resident, whose leave exceeds the bo State plan, returns to room if available or in availability of a bed in resident- (A) Requires the services or Medicaid nursing facility service (ii) If the facility that who was transferred returning to the facility facility, the facility man requirements of para discharges. §483.15(e)(2) Read distinct part. When returns is a composis § 483.5), the residen to an available bed in composite distinct p previously. If a bed at the time of return availability of a bed This REQUIREMEN by: Based on interview	ish and follow a written policy this to return to the facility alized or placed on the policy must provide for the hospitalization or therapeutic ed-hold period under the the facility to their previous mmediately upon the first in a semi-private room if the vices provided by the facility; dicare skilled nursing facility dicare skilled nursing facility ess. determines that a resident with an expectation of ity, cannot return to the ust comply with the agraph (c) as they apply to mission to a composite the facility to which a resident it must be permitted to return in the particular location of the art in which he or she resided is not available in that location it the resident must be given to that location upon the first	F 626			

Facility ID: 475017

		MEDICAID SERVICES	1				IO. 0938-039 TE SURVEY
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION		MPLETED
		475017	B. WING			C 11/03/2022	
AME OF PF	OVIDER OR SUPPLIER		-	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
IELEN PO	ORTER HEALTHCARE &	REHAB			ORTER DRIVE DLEBURY, VT 05753		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 626	Continued From page	e 14	F	626			
		d on therapeutic leave and					
1		one sampled residents					
	[Resident #1] to retuin behavioral episode. I	n to the facility after a Findings include:					
	Record review revea	Is that Resident #1 was					
		te facility on 9/7/2022 for an					
	evaluation due to phy A progress note writt	ysical aggressive behaviors.					
		2 states the facility initiated					
	discharge, discussed	1 on 9/8/2022, is due to					
		staff and vulnerable residents loes not feel they can meet					
		The notice of discharge					
	reveal that Resident	#1 was discharged from the					
		An appeal for discharge was					2
		ator on 9/16/2022 by entative. As of 11/1/2022					
		I residing at the hospital					
	awaiting placement						
		d interview reveal that					
		charged based on his/her					
	status at the time of	transter.					
		d 9/7/2022 and 9/8/2022 by					
	Resident #1's physic	cian pertaining to Resident					
	#1's transfer and dis	charge do not contain tion about Resident #1 at the					
	time of discharge or						
		l discharge summary [from					
	hospital emergency hospital] reveals the	room to a swing bed in the					
		sion (chief complaint):					
	aggressive behavior	r, Principal/Final Diagnosis:					
	Agitation."	The staff at Ithe purging			2		
	-"Hospital Course: [facility] felt they cou	The staff at [the nursing	1				

		D HUMAN SERVICES				FORM	01/06/2023 APPROVED 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD		CONSTRUCTION	(X3) DATE S COMPL	SURVEY ETED
		475017	B, WING			C 11/0	3/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		251140		3	0 PORTER DRIVE		
HELEN PO	ORTER HEALTHCARE &	REHAB		N	NDDLEBURY, VT 05753		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 626	9/7/22 and then admi [s/he] was calm and r to return to [the nursh for 2 years." -"Clinical Issues Neer medication changes: follow-up tests/procer placement, 3. Anticos Changes to goals can applicable): n/a" -"Assessment: [Resid placement as s/he is nursing facility]. [S/he awaiting placement." Per interview with me hospital care team or Registered Nurse fro stated that Resident days s/he arrived at 1 Case Management s discussions with the would take for Resid nursing facility, rathe hospital have been of support him/her in th Per interview on 11/ ⁻ Director of Nursing s expectation for him/f after s/he left on 9/7/ Nursing and Chief N that discharge from 1 Resident #1's behav transferred to the ho	ken to the [hospital] ED on tted. During [his/her] stay redirectable. [S/he] wanted ing facility] where [s/he] lived ding Follow-up: 1. Pertinent n/a, 2. Recommended dures needs: work on agulation on discharge: No 4: re at time of discharge (if dent #1 is] here for displaying behaviors at [the e] will remain at [the hospital] embers of Resident #1's in 11/1/2022 at 4:01 PM, a im the admitting hospital #1 was calm for the first few the hospital. The Director of itated that there had been no nursing facility about what it ent #1 to go back to the ir the nursing facility and liscussing how best to e hospital. 1/2022 at 4:30 PM, the tated that there was no her to return to the facility /2022. The Director of ursing Office both confirmed the facility was based on ior when s/he was	F	626			
FORM CMS-25	67(02-99) Previous Versions Ot	solele Event ID: Z7J	511	F	Facility ID: 475017 If con	linuation shee	et Page 16 of 2

		MEDICAID SERVICES			NONSTRUCTION	(X3) DATE	0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		LETED
			N, DOIED			÷	с
		475017	B. WING			11/	03/2022
AME OF PF	OVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	_	
				30 1	PORTER DRIVE		
IELEN PO	RTER HEALTHCARE &	REHAB		MI	DDLEBURY, VT 05753		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TO MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 626	Continued From pag	e 16	F	626			
	back as to whether F	Resident #1 could return back					
		PM on 11/2/2022, s/he					
		eves Resident #1 is getting vital than s/he was at the					
	nursing home. At the	hospital Resident #1 stays					
	in his/her room most	of the time and does not					
		ities or other residents. The					
		that the nursing facility was					
		for the past 2 year and s/he back to his/her home.					
		back to momentation.					
		11/1/2022 at 2:45 PM the					
		confirmed that the facility did					
		blicy on permitting residents ty after they are hospitalized					
	or placed on therape						
F 740	•		F	740	See attached Plan of Correctio	n	12/18/2
SS=G	CFR(s): 483.40						
	§483.40 Behavioral						
		receive and the facility must ry behavioral health care and					
		maintain the highest					6
		, mental, and psychosocial					1
		ance with the comprehensive					
		n of care. Behavioral health					
		ident's whole emotional and which includes, but is not					
		ntion and treatment of mental					
	and substance use	disorders.					
		IT is not met as evidenced					
	by: Based on record re	view and staff interviews, the					
	facility failed to deve						
	interventions related	to a resident's diagnosed					
		endations from a geriatric					
	psychiatric consulta order to attain or ma	tion, and identified triggers in					
	order to attain of the	annan men nignest			1		1

ENTER	S FOR MEDICARE	MEDICAID SERVICES	1				O, 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION		E SURVEY IPLETED
51500			A. BUILDI	NG		С	
		475017	B. WING			1	1/03/2022
AME OF PF	ROVIDER OR SUPPLIER		-	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
				30 PC	DRTER DRIVE		
IELEN PO	ORTER HEALTHCARE	& REHAB		MIDE	DLEBURY, VT 05753		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 740	Continued From pa	ae 17	F	740			
1 740		I, mental and psychosocial					
		residents [Resident #1].					
	Findings include:	· · · · · · · · · · · · · · · · · · ·					
1	-						
		eals that Resident #1 was	1				
		the facility on 7/23/2020 and mitted to the facility on	ų.				
		a hospital stay. At the time of		1			
		is/her diagnoses included:					
		I hemisphere cerebrovascular					
	accident (CVA) [str	oke], reactive depression,		2			
		of left non dominant side [left					
		onstant state of contraction]. A					
		vritten by Resident #1's s Resident #1 as having a					
		ty and depression and that					
		es related to dysregulated					
	behavior, verbal at	ouse and aggression directed					
	toward staff in nurs	sing home setting." Progress	1				
		nces on 9/24/2020, 10/27/2020,					
	11/16/2020, 7/1/20	21, 5/13/2022, 9/4/2022, 2022 where s/he was physically					
	9/6/2022, and 9/7/	s staff including hitting,					
	slapping, striking,	grabbing, shoving, along with		ŧ.			
	frequent verbal ab	use. Instances of verbal					
	aggression and thi	reats towards staff are frequent					
	in Resident #1's pr	ogress notes. Record review					
	reveals that verbal	threats towards a specific					
	resident neignbor	began in early July 2022.					
	A geriatric psychia	try evaluation and request for					
	behavioral manag	ement was made by Resident					
	#1's physician, col	nducted on 7/6/2022 revealed					
		nosis: "Major Neurocognitive					
		type with behavioral					_
		hol use disorder- in remission,					
		were made to Resident #1's					
	plan of care: "Impl	the second of the second	1				

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '			E SURVEY PLETED
		475017	B. WING)	C /03/2022
	OVIDER OR SUPPLIER	4,0011		STREET ADDRESS, CITY, STATE, ZIP (TUCILORM
VAME OF PF	OVIDER OR SUPPLIER			30 PORTER DRIVE		
HELEN PC	RTER HEALTHCARE 8	REHAB		MIDDLEBURY, VT 05753		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5) COMPLETIO
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	DATE
F 740	Continued From pag	ie 18	F 74	0		
		ehavior experts] to address				
		rs in the long-term care				
	setting. We recomm		1			
		quently to evaluate for		51		
	efficacy," and "staff	psychoeducation around				
		Specifically that the difficult				1
		ments resultant from his ity structure have been				
		nhibition resultant from his				
		om this visit was signed by the				
		on 7/7/2022 and signed by				
	the Attending Provid	ler on 7/13/22. Notes from				
	this visit are automa	tically in the resident's				
	medical record.	9				
		that Resident #1's care plan				
		17/2022. "Care plan has been				
		artments and has been				
		as of this date. Complete ed and continued." Review of				
		_og shows that Resident #1's				
		ed on 7/19/22 but the facility				1
		uce the revisions that were				
		an Event Log also revealed				
		care plan had not been				
	updated since 8/2/2	2022. This was confirmed by				
	the Administrator or	n 10/20/2022 at 2:33 PM.				
	Review of Resident	t #1's most recent care plan				
	does not reveal inte	erventions for: dementia, the				
		eventing Resident #1 from				
	being triggered by t	the resident neighbor who				
	yells, or verbal thre	ats to other residents. Record it wasn't until an 8/29/2022				
		aff meeting, held to formulate a				
	natient behavior nia	an, that the recommendation to	_			-
	implement the DIC	E method and develop a plan				
	for staff psychoedu	cation around Resident #1's cussed as part of Resident #1's				

Facility ID: 475017

If continuation sheet Page 19 of 29

		D HUMAN SERVICES MEDICAID SERVICES			FO	RM APPROVED
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED
		475017	B. WING		1	1/03/2022
NAME OF PF	OVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP CO		
				30 PORTER DRIVE		
HELEN PC	ORTER HEALTHCARE &	REHAB		MIDDLEBURY, VT 05753		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF 0 (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE	(X5) COMPLETION DATE
F 740	behavior plan. Progress notes revea complaint to social sec noise of a resident ne 7/7/2022. On 7/8/202 to social services aga to hurt Resident #2. If reveal that Resident # was triggered by this threats by Resident # Resident #2. Per interview on 11/1 asked why the diagn interventions were ne #1's care plan, a Nur the team was getting about implementing for of care but that it "lik S/he stated that it wo Physicians and Direct to incorporate diagnointo the resident's plan- did not address dementia and that it that were recommen- evaluation. S/he also were not put into Re address how the res- aggressive behavior later confirmed on 1 Director of Nursing.	Al Resident #1 made a ervices about the nightly eighbor [Resident #2] on (2, Resident #1 complained ain and expressed a desire Progress notes continue to #1 transfer reveal that s/he resident neighbor and #1 were only made about (2022 at 11:55 AM, when oses and behavioral of incorporated into Resident se Practitioner stated that the conversation started the psychiatric consult plan ely fell through the cracks." build ultimately be the ctor of Nursing's responsibility oses and recommendations	F 7			
		ted that the team did have	J511	Facility ID: 475017	If continuation	sheet Page 20 o

		MEDICAID SERVICES			ONSTRUCTION	(X3) DATE	. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:				COMPL	
							;
		475017	B. WING			11/0	3/2022
AME OF PR	OVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
		DELLAR		30 F	PORTER DRIVE		
ELEN PO	RTER HEALTHCARE &	КЕЛАВ		MID	DDLEBURY, VT 05753		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TO MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 740	Continued From pag	e 20	F	740			
		periatric psychiatric consult,					
	and it would be the E	OON and nurses to					
		mation into his/her chart and					
		rmed that the information art of Resident #1's medical					
	record, including the						
	D	20000 at 401 DM Basidant					
		2/2022 at 4:01 PM, Resident stated that s/he did not					
		ity exhausted all options for					
		ent #1 did not get care based					
		of dementia and the facility					
		e DICE approach. S/he not update any interventions					
		changes since Resident #1's					
		consultation and that s/he					
	dementia.	ty that he did not have					
		s that Resident #1 was ute facility on 9/7/2022 with					
	physical aggressive	behaviors for an evaluation.					
	A progress note writ	ten by Resident #1's					
		22 states the facility initiated d on 9/8/2022, is due to					
	safety concerns for	staff and vulnerable residents					
	and that the facility	does not feel they can meet		1			
	his/her care needs.	The notice of discharge	i.				
		t #1 was discharged from the An appeal for discharge was					
		rator on 9/16/2022 by					
		sentative. As of 11/1/2022					
		II residing at the hospital to a nursing facility.					
F 741		nt Staff-Behav Health Needs		741	See attached Plan of Correction	n	12/18/2
	CFR(s): 483.40(a)(1			-			
	6492 40(a) The feet	ility must have sufficient staff					1

		D HUMAN SERVICES			FOR	D: 01/06/2023 MAPPROVED D: 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE COMP	SURVEY PLETED
		475017	B. WING		20123	/03/2022
NAME OF PI	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
HELEN PO	RTER HEALTHCARE &	REHAB				
		14 17 14 17 19 19 19 19 19 19 19 19 19 19 19 19 19		PROVIDER'S PLAN OF CORRE	CTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	COMPLETION DATE
	appropriate competer provide nursing and r resident safety and a practicable physical, well-being of each re resident assessment and considering the diagnoses of the faci accordance with §48 competencies and sk limited to, knowledge and supervision for: §483.40(a)(1) Caring	lity's resident population in				
	stress disorder, that facility assessment of §483.70(e), and [as linked to history of post-traumatic stress implemented beginn (Phase 3)].	s disorder, will be ing November 28, 2019				
	interventions. This REQUIREMEN by: Based on record re- facility failed to provi the training to addre needs for 1 of 2 resi include:	nenting non-pharmacological T is not met as evidenced view and staff interviews, the de sufficient staff who have ss behavioral health care dents [Resident #1] Findings				
EORM CMC 25	initially admitted to t most recently readm	als that Resident #1 was he facility on 7/23/2020 and hitted to the facility on a hospital stay. At the time of posite Event ID:27J	1511 Fa	cility ID: 475017	If continuation st	neet Page 22 of 2

		MEDICAID SERVICES	Tana			(X3) DATE	0.0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION		PLETED
	Contraction		A, BUILDI	NG		c	
		475017	B. WING			11/03/20	
		4/501/			EET ADDRESS, CITY, STATE, ZIP CODE	1 10	03/2022
NAME OF PI	ROVIDER OR SUPPLIER						
HELEN PO	ORTER HEALTHCARE &	REHAB					
				MIL	DLEBURY, VT 05753		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 741	Continued From pag	e 22	E F	741			
		/her diagnoses included:					
	1	nemisphere cerebrovascular			2,52		
		ke], reactive depression,					
	spastic hemiplegia o	f left non dominant side [left		2			1
	side of body in a con	stant state of contraction]. A					
		itten by Resident #1's		1			
		Resident #1 as having a		s.			
		and depression and that					
		related to dysregulated					
	behavior, verbal abu	se and aggression directed					
	toward starr in nursin	ng home setting." A geriatric n and request for behavioral					
		ade by Resident #1's					
		d on 7/6/2022 revealed the					
		"Major Neurocognitive		1			
	disorder, vascular ty						
		ol use disorder- in remission,		1			
	antisocial personality	y traits." The following					
	recommendations w	ere made to Resident #1's					1
		nent DICE approach [method	1				
		ehavior experts] to address					
		rs in the long-term care					
	setting. We recomm						
		quently to evaluate for psychoeducation around					
	enicacy, and stan	Specifically that the difficult					
	behaviors and state	ments resultant from [his/her]					
		ity structure have been					
		nhibition resultant from					
	[his/her] CVA."						
	The facility assessm	nent as of December 31,					
		cility provides care and					
		n the needs of our resident					
	population, Our faci	lity embraces a					
		re culture in which we provide					
		ased upon our resident					1
	population, including	g the following:" "Behavior cial support," and "dementia					1

Facility ID: 475017

If continuation sheet Page 23 of 29

		MEDICAID SERVICES	(X2) MULTIPLE CO	NSTRUCTION	r	O. 0938-039 E SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:	A, BUILDING			PLETED
						С
		475017	B. WING		11	/03/2022
NAME OF PI	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE		
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				DLEBURY, VT 05753		
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F 741	Continued From pag	e 23	F 741			
	care." The Staff Edu					
	Competencies section	on states" additional				
		etermined according to the knowledge, skills and				
		eeded to care for a specific	-			
	resident population."					
	Desintention on 10/	18/22 at 12:45 PM, a				
		ated that travel nursing staff				
	do not get adequate	training to work with				
	residents with deme	ntla.				
	Per interview on 10/	19/22 at approximately 11:25				
	AM, the Director of N	lursing stated that staff were				
		d "[Resident #1] Tip Sheet" Resident #1. Review of this				
	document does not					
	psychoeducation are	ound Resident #1's diagnosis.				
	Per interview on 10/	19/22 at approximately 2:00				
	PM, a Licensed Nur	sing Assistant stated s/he did				
		raining regarding Resident				
	#1.					
		1/2022 at 11:24 AM, a				
		e (LNA) stated that the ne received from the facility				
		d training and s/he only got				
	one day of training of	on the floor and the was on				
		onfirmed that she did not get Resident #1 and that it would				
		to get more training about				
	Resident #1 specific	cally.				
	On 11/1/2022 at 11.	55, the Director of Nursing				
	confirmed that there	e was no staff				
	psychoeducation ar	ound patient's diagnoses.				
	0- 11/1/2022 at 1:0	4 PM, a Charge Nurse stated				

a distant de la companya	and the second line of the secon	MEDICAID SERVICES	1		ONSTRUCTION	(X3) DATE S	0938-0391
ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDI		C 11/03/2022			
475017							
NAME OF PR	OVIDER OR SUPPLIER			-	REET ADDRESS, CITY, STATE, ZIP CODE		
IELEN PO	RTER HEALTHCARE &	REHAB			PORTER DRIVE DDLEBURY, VT 05753		
0(4) 15	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 741	Continued From page	e 24	F	741			
		ss training than permanent					
	staff, as they do not l	nave a full-blown training.					
	On 11/1/2022 at 2:15	PM, an LNA stated that they					
	did not have any specific training about Resident		1			1	
	#1 or his/her diagnos	ses.	÷.	8			
	Record revel reveals	that Resident #1 was					
	transferred to an acu						
	physical aggressive A progress note writt	behaviors for an evaluation.					
		2 states the facility initiated					
		d on 9/8/2022, is due to					
		staff and vulnerable residents loes not feel they can meet	1				
	his/her care needs.	The notice of discharge					
	reveal that Resident	#1 was discharged from the	i i				
		An appeal for discharge was ator on 9/16/2022 by					
	Resident #1's repres	sentative. As of 11/1/2022		1			
		I residing at the hospital					
F 842	awaiting placement	Identifiable Information	F	842	See attached Plan of Correction	ı	12/18/2
	CFR(s): 483.20(f)(5)						
	\$483.20(f)(5) Reside	ent-identifiable information.					
	(i) A facility may not	release information that is					
	resident-identifiable	to the public. release information that is					
	resident-identifiable			1			
		ontract under which the agent					
		r disclose the information the facility itself is permitted	10				-
	to do so.						
	§483.70(i) Medical I	records.					
	§483.70(i)(1) In acc	ordance with accepted					
		rds and practices, the facility					

		MEDICAID SERVICES					IO. 0938-039
ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONS		(X3) DATE SURVEY COMPLETED		
	PLAN OF CORRECTION IDENTIFICATION NONIDER.		A, BUILDI	NG		с	
		475017	B. WING				1/03/2022
		475017		CTOCE.	T ADDRESS, CITY, STATE, ZIP CODE		1/05/2022
IAME OF PF	ROVIDER OR SUPPLIER				RTER DRIVE		
IELEN PO	ORTER HEALTHCARE &	REHAB			LEBURY, VT 05753		
	CURRENT OF	ATEMENT OF DEFICIENCIES	ID	1	PROVIDER'S PLAN OF CORR	ECTION	(X5)
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F 842	Continued From page	25	F	842			
1 042		al records on each resident		012			
	that are-	a records on each resident					
	(i) Complete;						
	(ii) Accurately docum	ented;					
	(iii) Readily accessibl						
	(iv) Systematically or	ganized					
	8483 70(i)(2) The fac	ility must keep confidential					
		ned in the resident's records,					
	regardless of the forr	n or storage method of the					
	records, except when						
	(i) To the individual, o	or their resident					
		permitted by applicable law;					
	(ii) Required by Law;	yment, or health care		L.			
	operations as permit	tted by and in compliance		5			
	with 45 CFR 164.500						
	(iv) For public health	activities, reporting of abuse,					
		violence, health oversight					
		administrative proceedings,					
		poses, organ donation					
		burposes, or to coroners,	ł				
		funeral directors, and to avert ealth or safety as permitted					
		e with 45 CFR 164.512.					
	§483.70(i)(3) The fac	cility must safeguard medical					
	record information a	gainst loss, destruction, or	1				
	unauthorized use.						
	1 -	al records must be retained					
	(i) The period of time	e required by State law; or					
		he date of discharge when					
	there is no requirem						
		ears after a resident reaches	-	1			
	legal age under Stat	e law.					

Facility ID: 475017

If continuation sheet Page 26 of 29

ENTER	S FOR MEDICARE &	MEDICAID SERVICES					IO. 0938-039
ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
DIENTO	oon a comon		A. BUILD	ING			С
		475017	B. WING			1	1/03/2022
AME OF PF	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
				30 P	ORTER DRIVE		
ELEN PC	DRTER HEALTHCARE &	REHAB		MID	DLEBURY, VT 05753		
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F 842	Continued From pag	e 26	F	842			
		edical record must contain-					
	(i) Sufficient informat	ion to identify the resident;					
		sident's assessments;		4			
		ive plan of care and services					
	provided;	y preadmission screening					
	and resident review						
	determinations cond						
		e's, and other licensed					
	professional's progre						
		blogy and other diagnostic					
		equired under §483.50. T is not met as evidenced					
	by:	I IS NOT THET AS EVIDENCED					
		view and staff interviews, the					
		tain complete revisions of					
		cords for 1 of 2 sampled					
		#1] and have care plans					
	staff. Findings inclu	2 of 4 sampled direct care de:					
		on 10/18/2022, 10/19/2022, surveyor could not discover					
		ntation of changes in care					
		es and/or interventions for		ļ			
	Resident #1. There	was no way to ensure that					
		nprehensive in addressing					
		s or how to evaluate the	1				
	effectiveness of spe	cific interventions.					
	This survevor receiv	red two separate copies of					
		an effective at the time of					
		uring the investigation. One					
		Care Meeting 5/23/2022." This					
		d "Draft" and has an effective					
		The other care plan received ation is untitled and was					
	printed on 9/20/202	2. Per this surveyor's review,		3			
		pear to be identical in the					

DEPARTMENT OF HEALT						FORM	: 01/06/2023 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	1	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		475017	B, WING			11/0	3/2022
NAME OF PROVIDER OR SUPPLIE	ER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
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HELEN PORTER HEALTHCA	ARE & F	KEHAB		M	IDDLEBURY, VT 05753		
PREFIX (EACH DEF	ICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
sections titled " aside from form Resident #1's c since 5/23/2022 access the mos investigation on 11/1/2022 and w changes were r Per interview of Director of Nurs to show if modi plan but not wh that the electroi capable of proo care plans and something that Per interview of Administer com produce care p 2. Per interview 2:00 PM, a Lice stated s/he did care plan chan and someone w the changes. Per interview of Licensed Nursi could not access therefore would interventions to LNA stated tha care plans and access them but care of residen	ORTER HEALTHCARE & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 27 sections titled "Encounter Problems (Active)" aside from formatting differences, indicating that Resident #1's care plan had not been revised since 5/23/2022. This surveyor was only able to access the most recent care plan throughout the investigation on 10/18/2022, 10/19/2022, and 11/1/2022 and was unable to confirm what changes were made to Resident #1's care plan. Per interview on 10/19/22 at 4:15 PM, the Director of Nursing explained that there was a log to show if modifications were made to the care plan but not what the revisions were. S/he stated that the electronic medical record was not capable of producing past revisions to residents' care plans and acknowledged that this is something that needs to change. Per interview on 10/19/22 at 4:15 PM, the Administer confirmed that the facility could not produce care plan revisions. 2. Per interview on 10/19/22 at 4:15 PM, the Administer confirmed that the facility could not produce care plan revisions. 2. Per interview on 10/19/22 at approximately 2:00 PM, a Licensed Nursing Assistant (LNA) stated s/he did not have a way to know about care plan changes for residents on his/her own and someone would have to tell him/her about			842	cliity ID: 475017 f cor		et Page 28 of 2

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 01/06/2023 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		475017	B. WING		11	C /03/2022
	ROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, 30 PORTER DRIVE MIDDLEBURY, VT 05753	ZIP CÔDE	
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F 842	Per interview on 11/1 Nurse stated that it is staff read residents' of with them. Per interview on 11/1 confirmed that all dire	e 28 /2022 at 1:04 PM, a Charge expected that all direct care care plans before working /2022 at 4:30 PM, the DON ect care staff are expected to olans before caring for them.	F	842		
FORM CMS-25	67(02-99) Previous Versions Ob	solete Event ID: Z7.	J511	Facility ID: 475017	If continuation sh	eet Page 29 of 29

F 000 INITIAL COMMENTS

The Division of Licensing and Protection conducted an onsite, unannounced investigation of three facility reported incidents and one complaint between 10/18/2022 and 11/3/2022. The following regulatory deficiencies were identified:

F622 Transfer and Discharge Requirements SS=G CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge-§483.15(c)(1) Facility requirements-

(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-

- A. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
- B. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
- C. The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
- D. The health of individuals in the facility would otherwise be endangered;
- E. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
- F. The facility ceases to operate.

(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include:

(A) The basis for the transfer per paragraph (c)(1)

- (i) of this section.
- (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
 - (ii) The documentation required by paragraph (c) (2)(i) of this section must be made by
 - a. The resident's physician when transfer or discharge is necessary under paragraph (c)

(A) or (B) of this section; and

A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following:

- (A) Contact information of the practitioner responsible for the care of the resident.
 - (B) Resident representative information including contact information
 - (C) Advance Directive information
 - (D) All special instructions or precautions for ongoing care, as appropriate.
 - (E) Comprehensive care plan goals;
 - (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review the facility did not ensure a resident's discharge was completely assessed, evaluated, and documented for 1 of 1 [Resident #1] residents who were involuntarily discharged from the facility.

The facility initiated Resident #1's discharge based on the facility's inability to meet the resident's needs and because the behavioral status of the resident endangered the safety of other individuals in the facility. However, upon complaint investigation, it was determined by interview and record review that, while Resident #1 had challenging aggressive behavior requiring staff attention, s/he did not have needs which could not be met in that facility to allow for a planned involuntary discharge honoring the resident's rights around discharge, and there was evidence that the facility was caring for other residents with aggressive behaviors. It was also determined that the facility did not meet behavioral care needs to prevent aggressive behaviors for Resident #1. The facility based Resident #1's discharge on their status at the time of transfer, did not have the required documentation specified in the regulation, and discharged the resident on 9/8/22. Findings include:

Record review reveals that Resident #1 was initially admitted to the facility on 7/23/2020 and most recently readmitted to the facility on 3/28/2022 following a hospital stay. At the time of this re-admittance, his/her diagnoses included right sided cerebral hemisphere cerebrovascular accident (CVA) [stroke], reactive depression [adjustment disorder], and spastic hemiplegia of left non-dominant side [left side of body in a constant state of contraction]. Resident #1 transferred from the rehabilitation unit into a room on the long-term care unit on 5/17/2022. A geriatric psychological consult from 7/6/2022 reveals that Resident #1 has the diagnoses of major neurological disorder, vascular type with behavioral disturbance [dementia with behaviors] and antisocial personality traits. Physician progress notes from 9/7/2022 reveal that emergency medical services [EMS] and police were called into the facility on 9/7/2022 following events where Resident #1 was verbally and physically aggressive. Resident #1 was then transferred to the emergency department for evaluation. Physician progress notes from 9/8/2022 reveal that the decision to discharge was made on 9/8/2022 due to safety concerns and the facility not being able to meet the care needs of Resident #1.

1. It was established that while Resident #1's had aggressive behaviors, these behaviors had been ongoing since his/her initial admission on 7/23/2020. A readmission note written by Resident #1's physician on 3/28/2022 describes Resident #1 as having a problem with anxiety and depression and that s/he "has had issues related to dysregulated behavior, verbal abuse and aggression directed toward staff in nursing home setting."

Progress notes in Resident #1's record reveal instances at the facility on 9/24/2020, 10/27/2020, 11/16/2020, 7/1/2021, 5/13/2022, 9/6/2022, and 9/7/2022 where s/he was physically aggressive towards staff including hitting, slapping, striking, grabbing, and shoving, along with frequent verbal abuse. Instances of verbal aggression and threats towards staff are frequent in Resident #1's progress notes. Record review reveals that verbal threats towards a specific resident neighbor [Resident #2] began 7/8/2022.

Per interview on 10/18/2022 at 5:00 PM, a Licensed Practical Nurse stated that when s/he worked with Resident #1 on the rehabilitation unit, Resident #1 was very aggressive and mean.

Per interview on 11/1/2022 at 12:30 PM, a Social Worker confirmed that Resident #1 had a history of physically aggressive behaviors with facility staff before s/he arrived on the long-term care unit.

2. It was established that the facility is able to care for residents with aggressive behaviors.

The facility assessment as of December 31, 2021, states "The facility provides care and services based upon the needs of our resident population. Our facility embraces a person-centered care culture in which we provide care and services based upon our resident population, including the following:" "Behavior health," "psycho social support," and "dementia care."

Per interview on 11/1/2022 at 10:55 AM, a Nurse Practitioner stated there were other residents in the facility that have aggressive behaviors, but not at the same frequency as Resident #1.

Per interview on 11/1/2022 at 2:15 PM, a Licensed Nurse Aide stated that there are residents in the facility that are physically aggressive.

Review of a list of residents with aggressive behaviors in the facility revealed that 16 residents with aggressive behaviors reside at the facility as of 11/1/2022. Of the 16 residents listed, at least one resident was physically aggressive with other residents and two residents were admitted after Resident #1 was discharged for aggressive behaviors. This was confirmed by the Director of

Nursing on 11/1/2022 at 4:30 PM. The DON stated that Resident #1's care team had discussions prior to 9/7/2022 about at what point they would discharge Resident #1. The facility decided that Resident #1 would need to be discharged when his/her behavior impacted the safety of other residents. The DON stated that Resident #1 had never hurt another resident, but because s/he had threatened to hurt another resident on 9/6/2022, the facility was concerned there was a risk to that resident's safety. Record review shows that verbal threats to hurt another resident [Resident #2] began 7/8/2022. The DON confirmed that 9/6/2022 wasn't the first time Resident #1 made threats about hurting Resident#2

3. It was established that Resident #1 was discharged based on his/her status at the time of transfer.

Progress notes dated 9/7/2022 and 9/8/2022 by Resident #1's physician pertaining to Resident #1's transfer and discharge do not contain assessment information about Resident #1 at the time of discharge.

Review of a hospital discharge summary [from hospital emergency room to a swing bed in the hospital] reveals the following: • "Reason for Admission (chief complaint): aggressive behavior, Principal/Final Diagnosis: Agitation."

- "Hospital Course: The staff at [the nursing facility] felt they could no longer care for [Resident #1] and [s/he] was taken to
- the [hospital] ED on 9/7/22 and then admitted. During [his/her] stay [s/he] was calm and redirect able. [S/he] wanted to return to [the nursing facility] where [s/he] lived for 2 years.

"Clinical Issues Needing Follow-up: 1. Pertinent medication changes: n/a, 2. Recommended follow-up tests/procedures needs: work on placement, 3. Anticoagulation on discharge: No 4: Changes to goals care at time of discharge (if applicable): n/a" "Assessment: [Resident #1 is] here for placement as [s/he] is displaying behaviors at [the nursing facility]. [S/he] will remain at [the hospital] awaiting placement."

Per interview with members of Resident #1's hospital care team on 11/1/2022 at 4:01 PM, a Registered Nurse from the admitting hospital stated that Resident #1 was calm for the first few days s/he arrived at the hospital. The Director of Case Management stated that there had been no discussions with the nursing facility about what it would take for Resident #1 to go back to the nursing facility, rather the nursing facility and hospital have been discussing how best to support him/her in the hospital.

Per interview on 11/1/2022 at 4:30 PM, the Director of Nursing stated that there was no expectation for Resident #1 to return to the facility after s/he left on 9/7/2022. The Director of Nursing and Chief Nursing Officer both confirmed that discharge from the facility was based on his/her behavior when s/he was transferred to the hospital.

4. It was established that Resident #1's care plan was not revised to include interventions based on new behaviors or new diagnoses to prevent aggressive behaviors.

Progress notes reveal Resident #1 made a complaint to social services about the nightly noise of a resident neighbor [Resident #2] on 7/7/2022. On 7/8/2022, Resident #1 complained to social services again and expressed a desire to hurt Resident #2. Progress notes continue to reveal that Resident #1 was triggered by Resident #2 and threats by Resident #1 were only made about Resident #2. A note from 9/6/22, the last reported incident of Resident #1 making threats about hurting a resident stated that Resident #1 "started heading back to [his/her] room when [s/he] made comments at staff and a patient who was talking out loud [Resident #2]. [Resident #1] made the comment about [Resident #2] saying '[s/he] was going to take a brick and knock [him/her] in the head with it.''' There was no documentation in record review from 7/1/2022 through 9/7/2022 that Resident #1 made threats about hurting any resident other than Resident #2 and staff did not reveal threats to any other residents in any of the interviews conducted.

Per interview on 11/1/2022 at 1:04 PM, a Charge Nurse confirmed that the Resident #2's yelling was a trigger for Resident #1. S/he stated that the facility put interventions into Resident #2's care plan to address the noise and confirmed that no interventions were added into Resident #1's care plan to address this.

A geriatric psychiatry evaluation and request for behavioral management was made by Resident #1's physician, conducted on 7/6/2022 revealed the following diagnosis: "Major Neurocognitive disorder, vascular type with behavioral disturbances, Alcohol use disorder- in remission, antisocial personality traits." The following recommendations were made to Resident #1's plan of care: "Implement DICE approach [method used by dementia behavior experts] to address problematic behaviors in the long-term care setting. We recommend that you revisit behavioral plans frequently to evaluate for efficacy," and "staff psychoeducation around patient's diagnosis. Specifically that the difficult behaviors and statements resultant from his underlying

personality structure have been exacerbated by disinhibition resultant from his CVA." The report from this visit was signed by the Psychiatry Resident on 7/7/2022 and signed by the attending provider on 7/13/22. Notes from this visit are automatically in the resident's medical record.

Nursing notes state that Resident #1's care plan was reviewed on 7/17/2022. "Care plan has been reviewed by all departments and has been updated as needed as of this date. Complete Care Plan is reviewed and continued." Review of a Care Plan Event Log shows that Resident #1's care plan was revised on 7/19/22 but the facility was unable to produce the revisions that were made. The Care Plan Event Log also revealed that Resident #1's care plan had not been updated since 8/2/2022. This was confirmed by the Administrator on 10/20/2022 at 2:33 PM.

Record review reveals that it wasn't until an 8/29/2022 multidisciplinary staff meeting, held to formulate a patient behavior plan, that the recommendation to implement the DICE method and develop a plan for staff psychoeducation around Resident #1's behaviors was discussed as part of Resident #1's behavior plan. Review of Resident #1's most recent care plan does not reveal interventions for: dementia, the DICE approach, preventing Resident #1 from being triggered by Resident #2, or verbal threats to other residents.

5. Review of a progress note written by Resident #1's physician on 9/8/2022 regarding his/her discharge indicate the basis for discharge is based on safety concerns for staff and that the facility does "not feel that they can meet [his/her] care needs in this setting." This progress note does not document the following required information in the resident's medical record: the specific resident needs the facility could not met and the specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility.

6. Resident #1 suffered harm by not being able to return to the nursing facility.

Per observation at the hospital on 11/1/2022 at 3:45 PM, Resident #1 was in bed. S/he was agitated and made comments about wanting to die and wanting to leave and go home.

Per interview at the hospital on 11/1/2022 at approximately 4:00 PM, a Registered Nurse stated that Resident #1 does not have a chance to hurt other residents at the hospital because s/he is mostly in his/her room. Staff do try to bring him/her out for a walk once a day.

Per interview with Resident #1's representative at 4:01 PM on 11/2/2022, s/he stated that s/he believes Resident #1 is getting less care at the hospital than s/he was at the nursing home. At the hospital Resident #1 stays in his/her room most of the time and does not have access to activities or other residents. The representative stated that the nursing facility was Resident #1's home for the past 2 year and s/he should be able to go back to his/her home.

A 9/9/2022 hospital physician note serving as both a discharge summary from the emergency room and admission summary for hospital swing bed status reveals that Resident #1 "wanted to return to [nursing facility] where [s/he] lived for 2 years." Under "Assessment" it states that s/he will remain at the hospital awaiting placement.

ACTION PLAN

- The facility Notice Before Discharge policy and the Bed Hold policy language was reviewed by a multidisciplinary group comprised of representation from University of Vermont Health Network (UVMHN) Legal, University of Vermont Medical Center (UVMMC) Accreditation and Regulatory Affairs and facility Leadership to ensure alignment with the expectations set forth in CFR 483.15(c) Transfer and discharge and *CFR(s): 483.15(d)(1)(2)* Bed Hold notification requirements. Language and process specific to the regulatory requirements were added to the existing policy. Policy reviewers will now contain representation from UVMHN Legal Team and UVMMC Accreditation Team.
- A process checklist with required regulatory elements outlined in the above referenced policies was created to support practice. This checklist guides practice and required documentation.
- Under the direction of the Administration and Medical Director, compliance with the referenced policies will be measured through monthly review of the completed checklist and the associated required regulatory elements. Performance feedback will be shared with local leadership and organizational leadership for action as required. Data will be shared at the Quarterly Helen Porter Quality Assurance Meeting. Audit frequency will be reevaluated by leadership based on sustained performance.

- A required review and approval by facility Leadership and Legal/ Accreditation for the Involuntary Discharge process will be utilized before the process is carried out and quality assurance with process conducted has been incorporated.
- A review of existing residents over the past 12 months by the Director of Nursing has been conducted with finding that there were no other facility residents that were subject to an Involuntary Discharge Process.
- Staff appropriate to their role will be educated through a combination of electronic, written attestation and/ or in person education under the direction of Director of Nursing on the updated Notice Before Discharge policy and the Bed Hold policy.
- An electronic system upgrade completed November 6, 2022 provides viewable care plan revisions to be readily accessible and by report in the resident's electronic record. The Care Plan Snapshot Comparison report allows users to compare two snapshots of a resident's care plan side-by-side to highlight changes between two points in time.
- In order to assure individualized care plans containing interventions related to an each resident's diagnosed conditions, accountabilities for addition of new diagnosis / and related care planning were reinforced. Specifically: The facility provider and/or consulting specialist will add any new diagnosis to the resident record as applicable. The provider will notify nursing of the new diagnosis entry with the expectation that care planning will be updated to include interventions based on new behaviors or new diagnoses to manage aggressive behaviors.
- Going forward, under the direction the Director of Nursing, monitoring the presence of up to date individualized care plans with accompanying interventions based on diagnosis will be monitored as part of the process through the MDS assessment process and daily morning huddles 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.
- A review of existing resident care plans by the Director of Nursing and delegates will be conducted to ensure the care plans were complete and include interventions based on new behaviors or new diagnoses to manage aggressive behaviors. Resident #1 no longer resides at the facility.
- All staff appropriate to their role will be educated through a combination of electronic, in person attestation and/or Relias training on the Care Planning Process Electronic Health Record Upgrade, addition of diagnosis and required care planning updates.

• All actions will be completed by 12/18/2022.

F1022 POL accepted 1/12/23 PM outaRin

F625 Notice of Bed Hold Policy Before/Upon Transfer SS=D CFR(s): 483.15(d)(1)(2)

§483.15(d) Notice of bed-hold policy and return-

§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-

(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;

- (ii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
- (iii) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interviews, the facility failed to provide a written bed-hold notice upon transfer for Resident #1. Findings include:

Record review reveals that Resident #1 was transferred to an acute facility on 9/7/2022 for an evaluation due to physical aggressive behaviors. A progress note written by Resident #1's physician on 9/8/2022 states the facility does "not feel that we can meet his/her care needs in this setting and need to proceed with formal discharge from the facility." On 11/1/2022 at 11:55 AM, the Director of Nursing confirmed that there is no evidence that a bed hold notice was sent to Resident #1's representative in Resident #1's record.

Per interview on 11/1/2022 at 12:30 PM, a Social Worker stated that s/he sent the notice of transfer, notice of discharge, and notice of bed hold all in the same envelope through certified mail to Resident #1's representative. She confirmed that the bed hold notice was not in Resident #1' record.

Progress notes reveal that the transfer notice was mailed to the resident representative on 9/7/2022 and the discharge notice was mailed via certified mail to the resident representative on 9/8/2022.

Per interview on 11/1/2022 at 2:59 PM, Resident #1's representative stated that s/he received one certified letter from the facility after Resident #1 was transferred to the emergency department on 9/7/2022, which contained one notice and a psychiatric evaluation. The representative sent a scanned copy of all the contents in the certified letter to this surveyor. The contents included a psychiatric evaluation dated 7/6/2022 and the "Notice before Transfer to Hospital" dated 9/7/2022. S/he confirmed that s/he did not receive a written bed hold notice from the facility.

Action Plan

- The facility Bed Hold Policy language will be reviewed by a multidisciplinary group comprised of representation from University of Vermont Health Network (UVMHN) Legal, University of Vermont Medical Center (UVMMC) Accreditation and Regulatory Affairs and facility Leadership to ensure alignment with the expectations set forth in *CFR(s): 483.15(d)(1)(2)* Bed Hold notification requirements. Language and process specific to the regulatory requirements were added to the existing policy. Policy reviewers will now contain representation from UVMHN Legal Team and UVMMC Accreditation Team.
- A process checklist with required regulatory elements outlined in the referenced Bed Hold policy was created to support
 practice. This checklist guides practice and documentation. Social Services will follow up when transfer or discharge occurs
 outside of normal business hours to ensure transfer rights and bed hold were understood by resident and/or representative.
- Under the direction of the Administration and Medical Director, compliance with the referenced Bed Hold policy will be measured through monthly review of the completed checklist and the associated required regulatory elements. Performance feedback will be shared with local leadership and organizational leadership for action as required and at the Quarterly Helen Porter Quality Assurance Meeting. Audit frequency will be reevaluated by leadership based on sustained performance.
- A review of existing residents by the Director of Nursing has been conducted with no other residents being impacted. Resident #1 no longer resides at the facility.
- Staff appropriate to their role will be educated through a combination of electronic, written attestation and/or in person education under the direction of Director of Nursing on the updated Bed Hold Policy.

• All actions will be completed by 12/18/2022. F625 POL accepted 1/12/23 Procedurew F626 Permitting Residents to Return to Facility SS=G CFR(s): 483.15(e)(1)(2)

§483.15(e)(1) Permitting residents to return to facility.

A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following.

(i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident-Requires the services provided by the facility; and Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services.

(ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot

return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges.

§483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.

This **REQUIREMENT** is not met as evidenced by:

Based on interview and record review the facility failed to establish a protocol on permitting resident to return to the facility after they are hospitalized or placed on therapeutic leave and failed to allow one of one sampled residents [Resident #1] to return to the facility after a behavioral episode. Findings include:

Record review reveals that Resident #1 was transferred to an acute facility on 9/7/2022 for an evaluation due to physical aggressive behaviors. A progress note written by Resident #1's physician on 9/8/2022 states the facility initiated discharge, discussed on 9/8/2022, is due to safety concerns for staff and vulnerable residents and that the facility does not feel they can meet his/her care needs. The notice of discharge reveal that Resident #1 was discharged from the facility on 9/7/2022. An appeal for discharge was sent to the Administrator on 9/16/2022 by Resident #1's representative. As of 11/1/2022, Resident #1 was still residing at the hospital awaiting placement to a nursing facility.

1. Record review and interview reveal that Resident #1 was discharged based on his/her status at the time of transfer.

Progress notes dated 9/7/2022 and 9/8/2022 by Resident #1's physician pertaining to Resident, #1's transfer and discharge do not contain assessment information about Resident #1 at the time of discharge on 9/8/22.

Review of a hospital discharge summary [from hospital emergency room to a swing bed in the hospital] reveals the following: -"Reason for Admission (chief complaint): aggressive behavior, Principal/Final Diagnosis: Agitation."

-"Hospital Course: The staff at [the nursing facility] felt they could no longer care for [Resident #1] and [s/he] was taken to the [hospital] ED on 9/7/22 and then admitted. During [his/her] stay [s/he] was calm and redirectable. [S/he] wanted to return to [the nursing facility] where [s/he] lived for 2 years."

-"Clinical Issues Needing Follow-up: 1. Pertinent medication changes: n/a, 2. Recommended follow-up tests/procedures needs: work on placement, 3. Anticoagulation on discharge: No 4: Changes to goals care at time of discharge (if applicable): n/a" -"Assessment: [Resident #1 is] here for placement as s/he is displaying behaviors at [the nursing facility]. [S/he] will remain at [the hospital] awaiting placement."

Per interview with members of Resident #1's hospital care team on 11/1/2022 at 4:01 PM, a Registered Nurse from the admitting hospital stated that Resident #1 was calm for the first few days s/he arrived at the hospital. The Director of Case Management stated that there had been no discussions with the nursing facility about what it would take for Resident #1 to go back to the nursing facility, rather the nursing facility and hospital have been discussing how best to support him/her in the hospital.

Per interview on 11/1/2022 at 4:30 PM, the Director of Nursing stated that there was no expectation for him/her to return to the facility after s/he left on 9/7/2022. The Director of Nursing and Chief Nursing Office both confirmed that discharge from the facility was based on Resident #1's behavior when s/he was transferred to the hospital.

Per interview on 11/1/2022 at 2:59 PM, Resident #1's representative stated that s/he never heard back as to whether Resident #1 could return back to the facility. At 4:01 PM on 11/2/2022, s/he stated that s/he believes Resident #1 is getting less care at the hospital than s/he was at the nursing home. At the hospital Resident #1 stays in his/her room most of the time and does not have access to activities or other residents. The representative stated that the nursing facility was Resident #1's home for the past 2 year and s/he should be able to go back to his/her home.

2. Per interview on 11/1/2022 at 2:45 PM the Director of Nursing confirmed that the facility did not have a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave.

Action Plan

- The facility Bed Hold Policy language will be reviewed by a multidisciplinary group comprised of representation from University of Vermont Health Network (UVMHN) Legal, University of Vermont Medical Center (UVMMC) Accreditation and Regulatory Affairs and facility Leadership to ensure alignment with the expectations set forth in CFR(s): 483.15(e)(1) Return to Facility notification requirements language and process specific to the regulatory requirements to be added to Bed Hold policy. Policy reviewers will now contain representation from UVMHN Legal Team and UVMMC Accreditation Team.
- A process checklist with required regulatory elements outlined in the referenced Bed Hold policy was created to support practice. This checklist guides practice and documentation.
- Monthly Performance monitoring for compliance with the process checklist will be carried out under the direction of the facility Administration and Medical Director. Performance feedback will be shared with local leadership and organizational leadership for action as required at the Quarterly Helen Porter Quality Assurance Meeting. Audit frequency will be revaluated based on sustained performance by leadership.
- A review of existing residents over the past 12 months by the Director of Nursing has been conducted with finding that there were no other facility residents that were subject to an Involuntary Discharge Process affecting return to the facility while pending an appeal for discharge. Resident #1 no longer resides at the facility.
- Staff appropriate to their role will be educated through a combination of electronic, written attestation and/or in person education under the direction of Director of Nursing on the updated Bed Hold Policy.
- All actions will be completed by 12/18/2022.

FG26 POC accepted 1/12/23 pmcotaren

F470 Behavioral Health Services SS=G CFR(s): 483.40

§483.40 Behavioral health services.

Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.

This **REQUIREMENT** is not met as evidenced by:

Based on record review and staff interviews, the facility failed to develop individualized interventions related to a resident's diagnosed conditions, recommendations from a geriatric psychiatric consultation, and identified triggers in order to attain or maintain their highest practicable physical, mental and psychosocial wellbeing for 1 of 3 residents [Resident #1]. Findings include:

Record review reveals that Resident #1 was initially admitted to the facility on 7/23/2020 and most recently readmitted to the facility on 3/28/2022 following a hospital stay. At the time of this re-admittance, his/her diagnoses included right sided cerebral hemisphere cerebrovascular accident (CVA) [stroke], reactive depression, spastic hemiplegia of left non-dominant side [left side of body in a constant state of contraction]. A readmission note written by Resident #1's physician describes Resident #1 as having a problem with anxiety and depression and that s/he "has had issues related to dysregulated behavior, verbal abuse and aggression directed toward staff in nursing home setting." Progress notes reveal instances on 9/24/2020, 10/27/2020, 11/16/2020, 7/1/2021, 5/13/2022, 9/6/2022, and 9/7/2022 where s/he was physically aggressive towards staff including hitting, slapping, striking, grabbing, shoving, along with frequent verbal abuse. Instances of verbal aggression and threats towards staff are frequent in Resident #1's progress notes. Record review reveals that verbal threats towards a specific resident neighbor began in early July 2022.

A geriatric psychiatry evaluation and request for behavioral management was made by Resident #1's physician, conducted on 7/6/2022 revealed the following diagnosis: "Major Neurocognitive disorder, vascular type with behavioral disturbances,

Alcohol use disorder- in remission, antisocial personality traits." The following recommendations were made to Resident #1's plan of care: "Implement DICE approach [method used by dementia behavior experts] to address problematic behaviors in the long-term care setting. We recommend that you revisit behavioral plans frequently to evaluate for efficacy," and "staff psychoeducation around patient's diagnosis. Specifically that the difficult behaviors and statements resultant from his underlying personality structure have been exacerbated by disinhibition resultant from his CVA." The report from this visit was signed by the Psychiatry Resident on 7/7/2022 and signed by the Attending Provider on 7/13/22. Notes from this visit are automatically in the resident's medical record.

Nursing notes state that Resident #1's care plan was reviewed on 7/17/2022. "Care plan has been reviewed by all departments and has been updated as needed as of this date. Complete Care Plan is reviewed and continued." Review of a Care Plan Event Log shows that Resident #1's care plan was revised on 7/19/22 but the facility was unable to produce the revisions that were made. The Care Plan Event Log also revealed that Resident #1's care plan had not been updated since 8/2/2022. This was confirmed by the Administrator on 10/20/2022 at 2:33 PM.

Review of Resident #1's most recent care plan does not reveal interventions for: dementia, the DICE approach, preventing Resident #1 from being triggered by the resident neighbor who yells, or verbal threats to other residents. Record review reveals that it wasn't until an 8/29/2022 multidisciplinary staff meeting, held to formulate a patient behavior plan, that the recommendation to implement the DICE method and develop a plan for staff psychoeducation around Resident #1's behaviors was discussed as part of Resident #1's behavior plan. Progress notes reveal Resident #1 made a complaint to social services about the nightly noise of a resident neighbor [Resident #2] on 7/7/2022. On 7/8/2022, Resident #1 complained to social services again and expressed a desire to hurt Resident #2. Progress notes continue to reveal that Resident #1 transfer reveal that s/he was triggered by this resident neighbor and threats by Resident #1 were only made about Resident #2.

Per interview on 11/1/2022 at 11:55 AM, when asked why the diagnoses and behavioral interventions were not incorporated into Resident #1's care plan, a Nurse Practitioner stated that the team was getting the conversation started about implementing the psychiatric consult plan of care but that it "likely fell through the cracks." S/he stated that it would ultimately be the Physicians and Director of Nursing's responsibility to incorporate diagnoses and recommendations into the resident's plan of care.

Per interview on 11/1/2022 at 1:04 PM the Charge Nurse confirmed that Resident #1's care plan did not address the resident's diagnosis of dementia and that it did not include interventions that were recommended in geriatric psychiatric evaluation. S/he also stated that interventions were not put into Resident #1's care plan to address how the resident neighbor triggers aggressive behaviors for Resident #1. This was later confirmed on 11/1/2022 at 4:30 PM by the Director of Nursing.

Per interview on 11/1/2022 at 6:15 PM, the Medical Director stated that the team did have meetings about the geriatric psychiatric consult, and it would be the DON and murses to incorporate the information into his/her chart and care plan. S/he confirmed that the information from this consult is part of Resident #1's medical record, including the new diagnoses.

Per interview on 11/2/2022 at 4:01 PM, Resident #1's representative stated that s/he did not believe that the facility exhausted all options for interventions. Resident #1 did not get care based on his/her diagnosis of dementia and the facility did not implement the DICE approach. S/he stated that they did not update any interventions except medications changes since Resident #1's geriatric psychiatric consultation and that s/he was told by the facility that he did not have dementia.

Record revel reveals that Resident #1 was transferred to an acute facility on 9/7/2022 with physical aggressive behaviors for an evaluation. A progress note written by Resident #1's physician on 9/8/2022 states the facility initiated discharge, discussed on 9/8/2022, is due to safety concerns for staff and vulnerable residents and that the facility does not feel they can meet his/her care needs. The notice of discharge reveal that Resident #1 was discharged from the facility on 9/7/2022. An appeal for discharge was sent to the Administrator on 9/16/2022 by Resident #1's representative. As of 11/1/2022, Resident #1 was still residing at the hospital awaiting placement to a nursing facility.

Action Plan

• An electronic system upgrade completed November 6, 2022 provides viewable care plan revisions to be readily accessible and by report in the resident's electronic record. The Care Plan Snapshot Comparison report allows users to compare two snapshots of a resident's care plan side-by-side to highlight changes between two points in time.

- In order to assure individualized care plans containing interventions related to an each resident's diagnosed conditions, accountabilities for addition of new diagnosis / and related care planning were reinforced. Specifically: The facility provider and/or consulting specialist will add any new diagnosis to the resident record as applicable. The provider will notify nursing of the new diagnosis entry with the expectation that care planning will be updated to include interventions based on new behaviors or new diagnoses to manage aggressive behaviors.
- Going forward, under the direction the Director of Nursing, the presence of up to date individualized care plans with
 accompanying interventions based on diagnosis will be monitored as part of the daily process through the MDS assessment
 cycle and reported on daily at morning huddle for accuracy. Performance feedback will be shared with local leadership and
 organizational leadership for action as required and at the Quarterly Helen Porter Quality Assurance Meeting.
- A review of existing resident care plans by the Director of Nursing and delegates will be conducted to ensure the care plans were complete and include interventions based on new behaviors or new diagnoses to manage aggressive behaviors. Resident #1 no longer resides at the facility.
- All staff appropriate to their role will be educated through a combination of electronic, in person attestation and/or Relias training on the Care Planning Process Electronic Health Record Upgrade, addition of diagnosis and required care planning updates.
- All actions will be completed by 12/18/2022.

F740 POC accepted 1/12/23 PMCotuPN

F741 Sufficient/Competent Staff-Behavioral Health Needs SS=G CFR(s): 483.40(a)(1)(2)

§483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to ensure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:

§483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)].

§483.40(a)(2) Implementing non-pharmacological interventions.

This **REQUIREMENT** is not met as evidenced by:

Based on record review and staff interviews, the facility failed to provide sufficient staff who have the training to address behavioral health care needs for 1 of 2 residents [Resident #1] Findings include:

Record review reveals that Resident #1 was initially admitted to the facility on 7/23/2020 and most recently readmitted to the facility on 3/28/2022 following a hospital stay. At the time of this re-admittance, his/her diagnoses included: right sided cerebral hemisphere cerebrovascular accident (CVA) [stroke], reactive depression, spastic hemiplegia of left non dominant side [left side of body in a constant state of contraction]. A readmission note written by Resident #1's physician describes Resident #1 as having a problem with anxiety and depression and that s/he "has had issues related to dysregulated behavior, verbal abuse and aggression directed toward staff in nursing home setting." A geriatric psychiatry evaluation and request for behavioral management was made by Resident #1's physician, conducted on 7/6/2022 revealed the following diagnosis: "Major Neurocognitive disorder, vascular type with behavioral disturbances, Alcohol use disorder- in remission, antisocial personality traits." The following recommendations were made to Resident #1's plan of care: "Implement DICE approach [method used by dementia behavior experts] to address problematic behaviors in the long-term care setting. We recommend that you revisit behavioral plans frequently to evaluate for efficacy," and "staff psychoeducation around patient's diagnosis. Specifically that the difficult behaviors and statements resultant from [his/her] underlying personality structure have been exacerbated by disinhibition resultant from [his/her] CVA."

The facility assessment as of December 31, 2021, states "The facility provides care and services based upon the needs of our

resident population. Our facility embraces a person-centered care culture in which we provide care and services based upon our resident population, including the following:" "Behavior health," "psycho social support," and" dementia care." The Staff Education, Training, and Competencies section states" additional competencies are determined according to the job role, job specific knowledge, skills and abilities and those needed to care for a specific resident population."

Per interview on 10/18/22 at 12:45 PM, a Registered Nurse stated that travel nursing staff do not get adequate training to work with residents with dementia.

Per interview on 10/19/22 at approximately 11:25 AM, the Director of Nursing stated that staff were given a handout titled "[Resident #1] Tip Sheet" as education around Resident #1. Review of this document does not reveal any staff psychoeducation around Resident #1's diagnosis.

Per interview on 10/19/22 at approximately 2:00 PM, a Licensed Nursing Assistant stated s/he did not receive special training regarding Resident #1.

Per interview on 11/1/2022 at 11:24 AM, a Licensed Nurse Aide (LNA) stated that the behavior training s/he received from the facility was computer-based training and s/he only got one day of training on the floor and the was on his/her own. S/he confirmed that she did not get any training about Resident #1 and that it would have been valuable to get more training about Resident #1 and that it would have been valuable to get more training about Resident #1 and that it would have been valuable to get more training about Resident #1 and that it would have been valuable to get more training about Resident #1 and that it would have been valuable to get more training about Resident #1 specifically.

On 11/1/2022 at 11:55, the Director of Nursing confirmed that there was no staff psychoeducation around patient's diagnoses.

On 11/1/2022 at 1:04 PM, a Charge Nurse stated that travelers have less training than permanent staff, as they do not have a fullblown training.

On 11/1/2022 at 2:15 PM, an LNA stated that they did not have any specific training about Resident #1 or his/her diagnoses.

Record revel reveals that Resident #1 was transferred to an acute facility on 9/7/2022 with physical aggressive behaviors for an evaluation. A progress note written by Resident #1's physician on 9/8/2022 states the facility initiated discharge, discussed on 9/8/2022, is due to safety concerns for staff and vulnerable residents and that the facility does not feel they can meet his/her care needs. The notice of discharge reveal that Resident #1 was discharged from the facility on 9/7/2022. An appeal for discharge was sent to the Administrator on 9/16/2022 by Resident #1's representative. As of 11/1/2022, Resident #1 was still residing at the hospital awaiting placement to a nursing facility.

Action Plan

- Recruited new full time RN Nurse Educator effective November 28, 2022.
- RN Nurse Educator sitting for recertification in Dementia Capable Care on December 8, 2022.
- Assistant Director of Nursing holds an active certification in Dementia Capable Care.
- The Relias Training module entitled Behavioral Health for Older Adults will be added to new employee orientation.
- All Staff appropriate to their role will complete education to address resident behavioral health care needs through the Relias Training module entitled Behavioral Health for Older Adults.
- Sufficient competent staff will be monitored through completion of the initial Relias behavioral health care training. The plan
 to monitor and maintain competency going forward will be the requirement of completion of annual behavioral health care
 updates by all applicable staff. Helen Porter Administration will monitor completion rates annually for 100% completion rate
 for new employees and existing employees. Performance feedback will be shared with local leadership and organizational
 leadership for action as required and at the Quarterly Helen Porter Quality Assurance Meeting.
- A review of existing resident behavioral care plans by the Director of Nursing and delegates will be conducted to ensure the care plans were complete and not impacted by staff training. Resident #1 no longer resides at the facility

- Director of Nursing and delegates will conduct an in-person review with return demonstration to ensure staff appropriate to their roles can access and review care plans, including behavioral health care plans. Resident #1 is no longer resides at the facility
- All actions will be completed by 12/18/2022.

F741 POL accepted 1/12/23 pmeaturen

F842 Resident Records – Identifiable Information **SS=E** CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)

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

(i) A facility may not release information that is resident-identifiable to the public.

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

§483.70(i) Medical records.

 $\sqrt{\frac{9}{8}}$ 483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-

(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized

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

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

(ii) Required by Law;

(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;

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

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

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

(i) The period of time required by State law; or

(ii) Five years from the date of discharge when there is no requirement in State law; or

(iii) For a minor, 3 years after a resident reaches legal age under State law.

(i) §483.70(i)(5) The medical record must contain- Sufficient information to identify the resident;

(ii) A record of the resident's assessments;

(iii) The comprehensive plan of care and services provided;

(iv) The results of any preadmissionscreening and resident review evaluations and determinations conducted by the State;

(v) Physician's, nurse's, and otherlicensed professional's progress notes; and

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:

(vii)

Based on record review and staff interviews, the facility failed to maintain complete revisions of resident care plan records for 1 of 2 sampled residents [Resident #1] and have care plans readily accessible to 2 of 4 sampled direct care staff. Findings include:

1. Per record review on 10/18/2022, 10/19/2022, and 11/1/2022, this surveyor could not discover an accurate representation of changes in care plan goals, objectives and/or interventions for Resident #1. There was no way to ensure that care plans were comprehensive in addressing Resident #1's needs or how to evaluate the effectiveness of specific interventions.

This surveyor received two separate copies of Resident #'1 care plan effective at the time of his/her discharge during the

investigation. One was titled "Plan of Care Meeting 5/23/2022." This document is marked "Draft" and has an effective date of 5/23/2022. The other care plan received prior to the investigation is untitled and was printed on 9/20/2022. Per this surveyor's review, both documents appear to be identical in the sections titled "Encounter Problems (Active)" aside from formatting differences, indicating that Resident #1's care plan had not been revised since 5/23/2022. This surveyor was only able to access the most recent care plan throughout the investigation on 10/18/2022, 10/19/2022, and 11/1/2022 and was unable to confirm what changes were made to Resident #1's care plan.

Per interview on 10/19/22 at 4:15 PM, the Director of Nursing explained that there was a log to show if modifications were made to the care plan but not what the revisions were. S/he stated that the electronic medical record was not capable of producing past revisions to residents' care plans and acknowledged that this is something that needs to change.

Per interview on 10/19/22 at 4:15 PM, the Administer confirmed that the facility could not produce care plan revisions.

2. Per interview on 10/19/22 at approximately 2:00 PM, a Licensed Nursing Assistant (LNA) stated s/he did not have a way to know about care plan changes for residents on his/her own and someone would have to tell him/her about the changes.

Per interview on 11/1/2022 at 11:24 AM, a Licensed Nursing Assistant (LNA) stated that s/he could not access care plans on her own and therefore would not know all residents' interventions to care for them appropriately. The LNA stated that s/he had to ask nurses to see care plans and that s/he wishes s/he could access them because it would help him/her take care of residents.

Per interview on 11/1/2022 at 1:04 PM, a Charge Nurse stated that it is expected that all direct care staff read residents' care plans before working with them.

Per interview on 11/1/2022 at 4:30 PM, the DON confirmed that all direct care staff are expected to read resident's care plans before caring for them.

Action Plan

- An electronic system upgrade completed November 6, 2022 provides viewable care plan revisions to be readily accessible and by report in the resident's electronic record. The Care Plan Snapshot Comparison Report allows users to compare two snapshots of a resident's care plan side-by-side to highlight changes between two points in time.
- Going forward, under the direction the Director of Nursing, the presence of up to date individualized care plans with accompanying interventions based on diagnosis will be monitored as part of the daily process through the MDS assessment cycle and reported on daily at morning huddle 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.
- A review of existing resident care plans by the Director of Nursing and delegates will be conducted to ensure the care plan revisions are viewable and readily accessible by the Care Plan Snapshot Comparison report. Resident #1 no longer resides at the facility.
- All staff applicable to their role will be educated through a combination of electronic training and/or in person attestation with return demonstration on access to resident Care Plan and interventions as well as Care Plan Snapshot Comparison report.
- All sections will be completed by 12/18/2022.

F842 poc accepted 1/12/23 PMcolaRW