AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

July 3, 2024

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

Dear Ms. Nottonson:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **June 5, 2024.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475017	A. BUILDING ______ B. WING ______	C 06/05/2024

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

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E 000	Initial Comments The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey on 6/3-6/5/24. There were no regulatory violations identified.	E 000		
F 000	INITIAL COMMENTS An unannounced, on-site re-certification survey was conducted in conjunction with complaint investigation #22718 by the Division of Licensing and Protection on 6/3/24 through 6/5/24 at Helen Porter Healthcare and Rehab to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. There were no findings regarding complaint #22718. The following regulatory violations were identified regarding the re-certification survey:	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to provide care and services according to accepted standards of clinical practice regarding Physician Orders and notification for 1 resident [Res.#83] of 35 sampled residents. Findings include: Per record review, after a stay in the hospital, Res. # 83 was admitted to the facility on 2/6/24	F 658	See attached plan of correction **Tag F 658 POC accepted on 7/3/24 by T. Dougherty/P. Cota**	July 20, 2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Jane Watson   TITLE: Administrator   (X6) DATE: July 2, 2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 658	Continued From page 1 with acute back pain. The resident was placed on a post-hospitalization nursing unit, where resident's vital signs, including their blood pressure, are measured at least twice a day. Res. #83's blood pressure upon admission to the facility was recorded as 121/75. Physician Orders for Res.#83 upon admission included: "Notify provider ... for: Systolic Blood Pressure: less than 100 mmHg". Review of Nursing Notes for Res.#83 included the resident's vital signs, including blood pressures. If Res.#83's blood pressure is below 90 systolic [The first (upper) number] the number is preceded by a red "!", which per the electronic medical record program indicates "abnormal". The electronic medical record also includes a section where the Nursing Note can be routed to a physician to alert them of the content. Additionally, the facility's electronic medical record under "Vitals" [Vital signs including blood pressure, temperature, heart rate, and respirations] includes a section labeled "Provider Notification". In this section, there are areas to record the name of the provider[s] notified, the method of communication, the reason for communication, and the provider's response. Per review of Res.#83's medical record, during the resident's stay on the post-hospitalization unit from 2/6/24 to 5/27/24, the resident's blood pressure was recorded below the Physician Orders' parameters 82 times. Of the 82 times the blood pressure was recorded below the parameters of less than 100, 38 times the blood pressure was highlighted as "abnormal"; being below 90. Of the 38 instances, eight different nurses recorded abnormal blood pressures. An interview was conducted with the Assistant	F 658		

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F 658	Continued From page 2	F 658		

Director of Nursing [ADON] and Res. #83's Unit Manager of the post-hospitalization unit on 6/4/24 at 2:11 PM.
During the interview, the ADON and Unit Manager reviewed a Nursing Note, dated 5/24/24. The Nursing Note documented Res.#83's blood pressure recorded by a Staff LPN [Licensed Practical Nurse] as "66/43", preceded by a red "!", which per the electronic medical record program indicates "abnormal". The remainder of the note records the resident as 'alert' and 'oriented' and does not include any documentation that the resident's physician was alerted to the abnormal blood pressure reading. The section of the medical record where the Nursing Note can be routed to a physician to alert them of the content lists "no routing history on file". Additionally, on 5/24/24 under Res.#83's record of vital signs, below the blood pressure recording of "! 66/43", all areas of the "Provider Notification" section are left blank.
After reading the Nursing Note from 5/24/24, the Unit Manager stated "I don't understand that. As a nurse, I would take a manual blood pressure and recheck and notify the doctor."
The ADON stated h/her expectation would be to notify the physician any time the systolic blood pressure number was under 100.
Both the ADON and Unit Manager confirmed that Physician Orders for Res. #83 included "Notify provider ... for: Systolic Blood Pressure: less than 100 mmHg". Both the ADON and Unit Manager confirmed per record review since Res.#83's admission on 2/6/24, the resident's blood pressure was recorded by Nursing as under 100 mmHg 82 times. The ADON and Unit Manager confirmed per record review, of the 82 times, there was a single documented incident, on 3/11/24, where Physician Orders were

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followed and a note recorded that 'abnormal' blood pressure was "reported to provider".

References:
According to the Mayo Clinic:
"Blood pressure is determined by the amount of blood the heart pumps and the amount of resistance to blood flow in the arteries. A blood pressure measurement is given in millimeters of mercury (mm Hg). It has two numbers:
Systolic pressure. The first (upper) number is the pressure in the arteries when the heart beats.
Diastolic pressure. The second (bottom) number is the pressure in the arteries when the heart rests between beats.
Low blood pressure is generally considered a blood pressure reading lower than 90 millimeters of mercury (mm Hg) for the top number (systolic) or 60 mm Hg for the bottom number (diastolic).
The causes of low blood pressure range from dehydration to serious medical conditions. It's important to find out what's causing low blood pressure so that it can be treated, if necessary.
Potential complications of low blood pressure (hypotension) include:
Dizziness
Weakness
Fainting
Injury from falls
Severely low blood pressure can reduce the body's oxygen levels, which can lead to heart and brain damage."
(https://www.mayoclinic.org/diseases-conditions/low-blood-pressure/symptoms-causes/syc-2)

Per review of the Lippincott Manual of Nursing, "Common Departures from the Standards of Nursing Care include: failure to follow physician orders, follow appropriate nursing measures,

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F 658	Continued From page 4 communicate information about the patient". [Lippincott Manual of Nursing Practice-11th Edition 2018]	F 658		
F 699 SS=E	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to ensure that residents who are trauma survivors receive trauma-informed care that mitigates triggers that may re-traumatize residents for 3 of 8 sampled residents (Resident #33, #71, and #34). Findings include: 1) Per record review, Resident #33 was admitted to the facility on 8/6/2020 with a diagnosis of PTSD (post-traumatic stress disorder), anxiety, and depression. Resident #33's care plan includes a focus of alterations in mood related to the diagnosis of anxiety, PTSD, and depression, with manifestations that include negative verbalizations about others, tearfulness, sudden mood changes, anger, and self-harming behavior at times. A mental health clinician assessment note dated 1/26/24 mentions details of Resident #33's past trauma. Per review of Resident #33's record, no evidence was found that the resident was assessed for triggers that may re-traumatize the resident. No	F 699	**See Attached** **Tag F 699 POC accepted on 7/3/24 by T. Dougherty/P. Cota**	

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F 699	Continued From page 5 evidence was found in Resident 33's plan of care regarding the resident's triggers or how staff can provide care that avoids re-traumatizing the resident. Per interview on 6/4/20244 at approximately 11:45 AM, an LPN (Licensed Practical Nurse) with 4 years on that unit was unable to identify Resident # 33's specific triggers related to their trauma experience. Per interview on 6/5/24 at approximately 12:00 PM, the Unit Manager confirmed that Resident #33's trauma experience and associated triggers are not identified in the resident's record. 2. Per record review, Resident #71 was admitted to the facility on 6/13/23 with diagnoses of PTSD (post-traumatic stress disorder) and depression. Resident #72's care plan includes a focus of depression PTSD (post-traumatic stress disorder), manifested by statements of sadness and decreased participation in activities. The mental health assessment dated 1/12/24 mentions chronic post-traumatic stress disorder after military combat, with ongoing issues. There are no additional details about the trauma or associated triggers. Per interview on 6/5/24 at approximately 11:15 AM, an LNA was unable to identify Resident # 71's specific triggers related to their trauma experience. Per interview on 6/5/24 at approximately 12:00 PM, the Unit Manager confirmed that Resident #71's trauma-specific triggers have not been identified or care planned for a resident with a history of trauma.	F 699		

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F 699	Continued From page 6 3. Per record review, Resident #34 has resided at this facility since 10/10/2018 with diagnoses that include PTSD (post-traumatic stress disorder). Resident #34's care plan includes a focus of alteration in thought processes and in mood related to depression, anxiety, and PTSD but does not include identification of Resident #34's associated triggers about his/her trauma experience or how staff can provide care that avoids re-traumatizing resident. Per interview on 6/5/24 at approximately 12:00 PM, the Unit Manager confirmed that Resident #34's care plan does not contain identified triggers specific to their trauma.	F 699		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812	**See Attached** **Tag F 812 POC accepted on 7/3/24 by T. Dougherty/P. Cota**	

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by:
Based on observation, interview, and record review the facility failed to ensure that food was stored in accordance with professional standards for food safety by leaving a used ice scoop in the ice machine. The facility also failed to monitor the temperatures of refrigerators and freezers daily and report abnormal values for further intervention. Findings include:

During the initial tour of the kitchen on 6/3/24 at 10:32 AM with the lead chef it was discovered that the ice scoop was found lying on the ice in the ice machine that is used for 3 out of 3 kitchenettes. Per facility policy of Storage of Food and Non-Food Items reads, "Store scoop in storage bin ...Do not store the provided ice scoop in the machine." The lead chef confirmed that the ice scoop was in the ice machine per interview at 10:35 AM and 11:06 AM.

On 6/3/24 at 10:47 AM in the main dining room meal service area it was discovered that the refrigerator temperature log for 6/3/24 was documented as "44 [degrees]" in the AM temperature log. The AM freezer log temperature was not documented.

Per record review of the "Recording and Maintaining Nutritional Services Logs" policy states, "Freezer temperature range is 0 degrees [Fahrenheit] and lower ...Cooler and refrigerator ranges are 33-41 degrees ...Any reading noted to be out of specified ranges shall be reported to a Nutrition Services Leader and recorded on the log sheet."

Per interview on 6/3/24 at 10:55 AM the lead chef confirmed that the temperature was recorded as

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F 812	Continued From page 8 44 [degrees] and was not reported to a Nutrition Specialist. S/he also confirmed that the AM freezer log for 6/3/24 was not documented. Review of the kitchen refrigerator and freezer temperature logs for the months of December 2023 through April 2024 shows five abnormally high freezer temperatures in December 2023, five abnormally elevated freezer temperatures in January 2024, and one abnormally high freezer temperature in February 2024. There is no documentation that the abnormal temperatures were addressed. In December 2023 there were 87 undocumented temperatures for the refrigerator and 91 undocumented temperatures for the freezer. In January 2024 there were 95 undocumented temperatures for the refrigerator and 91 undocumented temperatures for the freezer. Per interview on 6/3/24 at 12:32 PM the Nutrition Specialist confirmed that there is missing documentation in December 2023 and January 2024 temperature logs. Further record review of February 2024 temperature logs shows 29 undocumented temperatures for the refrigerator and 30 undocumented temperatures for the freezer. Temperature logs for the refrigerator and freezer for March 2024 shows 51 undocumented temperatures for the refrigerator and 25 undocumented temperatures for the freezer. There are 21 undocumented temperatures for the refrigerator and 18 undocumented temperatures for the freezer for April 2024.	F 812		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The	F 887	**See Attached** **Tag F 887 POC accepted on 7/3/24 by T. Dougherty/P. Cota**	

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F 887	Continued From page 9 LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or	F 887		

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F 887	Continued From page 10 (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each eligible resident receives the COVID-19 vaccine for 2 of 5 sampled residents on the rehabilitation unit (Residents #39 and #60). Findings include: 1. Per record review, Resident #39 was admitted to the facility on 01/16/2023 and has diagnoses that include cerebral palsy (disorder of movement that affects muscle tone, and posture, developed before birth), spinal bifida (failure of the spinal completely close), chronic stage 4 pressure ulcers (deep wounds that may expose bone, tendon or muscle), and osteomyelitis (infection of the bone), The Resident #39 is currently receiving negative pressure wound therapy to treat the stage 4 pressure ulcers. Resident # 39 is considered high risk for COVID-19 complications because of his/her diagnoses. Per record review, Resident #39's last COVID-19 vaccination was administered on 5/21/21 and was	F 887		

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F 887	Continued From page 11 not provided the 2023-2024 seasonal COVID-19 immunization. There is no evidence in the record that Resident #36 was screened for eligibility, or s/he had a medical contraindication to not receive the vaccine, that Resident #36 or their representative were provided education regarding the benefits or side effects of the immunization, or that Resident #36 or representative had signed consent to receive or not receive the immunization. A 1/8/24 nursing note reveals that Resident #39 tested positive for COVID-19. Per interview with Resident #39 and their Representative on 06/05/2024 at 1:30 PM, both indicated that Resident #39 was not offered the COVID-19 vaccine this year and would have accepted it if it was. Resident #39 explained that s/he had gotten COVID this winter and was sick with flu-like symptoms. Per interview with the Advanced Practice Registered Nurse (APRN) on 6/5/2024 at 1:40 PM, s/he explained that Resident # 39 is eligible for COVID-19 vaccine and should have been offered the 2023-2024 season COVID-19 vaccine. The APRN stated that there is not a consistent process for screening and identifying residents that need the COVID-19 vaccine on the rehab unit. 2. Per record review, Resident # 60, who is 87 years old, was admitted to the facility on 4/11/2024 with diagnoses that include hip fracture with surgical repair, Alzheimer's and hypertension. Resident #60 is considered high risk for COVID-19 complications because of his/her diagnoses and age. Per record review, Resident # 60's last COVID-19	F 887		

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HELEN PORTER HEALTHCARE & REHAB	30 PORTER DRIVE MIDDLEBURY, VT 05753

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F 887	Continued From page 12 vaccination was administered on 10/3/23 and was not provided a second 2023-2024 seasonal COVID-19 immunization. There is no evidence in the record that Resident #60 was screened for eligibility, or s/he had a medical contraindication to not receive the vaccine, that Resident #60 or their representative were provided education regarding the benefits or side effects of the immunization, or that Resident #60 or representative had signed consent to receive or not receive the immunization. Per interview with the APRN on 6/5/2024 at 1:40 PM, s/he explained that Resident # 60 is eligible for a COVID-19 vaccine and should have been offered his/her second 2023-2024 season COVID-19 vaccine. Per interview with the Director of Nursing on 6/5/2024 at 2:46 PM, he/she revealed there is no written procedure for staff to follow for identifying residents who are not up-to-date with their COVID-19 immunizations. Per facility policy titled "SNF COVID-19 Mitigation and care" effective 06/19/2023 states "COVID-19 vaccination will be offered to all residents not up-to-date, in which there are no medical contraindications, (unless the resident or legal representative refuses vaccination after education), per the CDC/ACIP's recommendation. Record vaccination or declination in the electronic health record."	F 887		

E 000 Initial Comments
The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey on 6/3-6/5/24. There were no regulatory violations identified.

F 000 Initial Comments
An unannounced, on-site re-certification survey was conducted in conjunction with complaint investigation #22718 by the Division of Licensing and Protection on 6/3/24 through 6/5/24 at Helen Porter Healthcare and Rehab to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. There were no findings regarding complaint #22718. The following regulatory violations were identified regarding the re-certification survey:

F 658 Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)
SS=D CFR)s): 483.21(b)(3)(i)

§483.21(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to provide care and services according to accepted standards of clinical practice regarding Physician Orders and notification for 1 resident [Res.#83] of 35 sampled residents.
Findings include Per record review, after a stay in the hospital, Res. # 83 was admitted to the facility on 2/6/24 with acute back pain. The resident was placed on a post-hospitalization nursing unit, where resident's vital signs, including their blood pressure, are measured at least twice a day. Res. #83's blood pressure upon admission to the facility was recorded as 121/75. Physician Orders for Res.#83 upon admission included: "Notify provider ... for: Systolic Blood Pressure: less than 100 mmHg".

Review of Nursing Notes for Res.#83 included the resident's vital signs, including blood pressures. If Res.#83's blood pressure is below 90 systolic [The first (upper) number] the number is preceded by a red "!", which per the electronic medical record program indicates "abnormal".
The electronic medical record also includes a section where the Nursing Note can be routed to a physician to alert them of the content.

Additionally, the facility's electronic medical record under "Vitals" [Vital signs including blood pressure, temperature, heart rate, and respirations] includes a section labeled "Provider Notification". In this section, there are areas to record the name of the provider[s] notified, the method of communication, the reason for communication, and the provider's response.
Per review of Res.#83's medical record, during the resident's stay on the post-hospitalization unit from 2/6/24 to 5/27/24, the resident's blood pressure was recorded below the Physician Orders' parameters 82 times. Of the 82 times the blood pressure was recorded below the parameters of less than 100, 38 times the blood pressure was highlighted as "abnormal"; being below 90. Of the 38 instances, eight different nurses recorded abnormal blood pressures

An interview was conducted with the Assistant Director of Nursing [ADON] and Res. #83's Unit Manager of the post-hospitalization unit on 6/4/24 at 2:11 PM. During the interview, the ADON and Unit Manager reviewed a Nursing Note, dated 5/24/24. The Nursing Note documented Res.#83's blood pressure recorded by a Staff LPN [Licensed Practical Nurse] as "66/43", preceded by a red "!", which per the electronic medical record program indicates "abnormal". The remainder of the note records the resident as 'alert' and

'oriented' and does not include any documentation that the resident's physician was alerted to the abnormal blood pressure reading. The section of the medical record where the Nursing Note can be routed to a physician to alert them of the content lists "no routing history on file". Additionally, on 5/24/24 under Res.#83's record of vital signs, below the blood pressure recording of "! 66/43", all areas of the "Provider Notification" section are left blank.

After reading the Nursing Note from 5/24/24, the Unit Manager stated "I don't understand that. As a nurse, I would take a manual blood pressure and recheck and notify the doctor."
The ADON stated h/her expectation would be to notify the physician any time the systolic blood pressure number was under 100.

Both the ADON and Unit Manager confirmed that Physician Orders for Res. #83 included "Notify provider ... for: Systolic Blood Pressure: less than 100 mmHg". Both the ADON and Unit Manager confirmed per record review since Res.#83's admission on 2/6/24, the resident's blood pressure was recorded by Nursing as under 100 mmHg 82 times. The ADON and Unit Manager confirmed per record review, of the 82 times, there was a single documented incident, on 3/11/24, where Physician Orders were followed, and a note recorded that 'abnormal' blood pressure was "reported to provider".

References:
According to the Mayo Clinic:
"Blood pressure is determined by the amount of blood the heart pumps and the amount of resistance to blood flow in the arteries. A blood pressure measurement is given in millimeters of mercury (mm Hg). It has two numbers:

Systolic pressure. The first (upper) number is the pressure in the arteries when the heart beats.
Diastolic pressure. The second (bottom) number is the pressure in the arteries when the heart rests between beats.

Low blood pressure is generally considered a blood pressure reading lower than 90 millimeters of mercury (mm Hg) for the top number (systolic) or 60 mm Hg for the bottom number (diastolic). The causes of low blood pressure range from dehydration to serious medical conditions. It's important to find out what's causing low blood pressure so that it can be treated, if necessary. Potential complications of low blood pressure (hypotension) include Dizziness Weakness Fainting

Injury from falls
Severely low blood pressure can reduce the body's oxygen levels, which can lead to heart and brain damage." (https://www.mayoclinic.org/diseases-conditions/l ow-blood-pressure/symptoms-causes/syc-2)

Per review of the Lippincott Manual of Nursing, "Common Departures from the Standards of Nursing Care include failure to follow physician orders, follow appropriate nursing measures, communicate information about the patient". [Lippincott Manual of Nursing Practice-11th Edition 2018]

PLAN OF CORRECTION

• What corrective action will be accomplished for those residents found to have been affected by the deficient practice;
A record review performed for resident #83 demonstrated vital sign documentation and notification to provider per order deficiencies. All licensed nursing staff applicable to their role will be re-educated on the policy "Change in Patient/Resident Condition" specific to nursing assessment and provider notification for change in patient/resident condition.

• How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
All residents had potential to be impacted by the deficient practice. A review of vital sign orders blood pressure parameters and provider notification was completed for a subset of existing residents on post-acute unit by the Director of Nursing (DON) or designee and while all residents were at risk to be potentially impacted, a subset of residents were reviewed, and action was taken accordingly.

• What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
The HPNH policy titled "Change in Patient/Resident Condition" has been reviewed by the HPNH Administrator, Director of Nursing, AVP/Chief Nursing Officer, and Director of Quality, and updated to include language documenting provider notification.

Reeducation to all applicable staff of provider notification as directed by provider order per existing policy "Change in Patient/Resident Condition" will be completed via the electronic learning management system (Cornerstone).

• How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.
An audit of existing residents for vital signs including blood pressure orders will be conducted weekly x4 by the HPNH DON or designee, then reassessed for compliance and transitioned to monthly x3 with ongoing frequency to be reevaluated based on sustained performance.

Data will be reviewed/reported on at the quarterly Quality Assurance (QA) meeting.

• The dates corrective action will be completed.
All actions will be completed by July 20, 2024.

F 699 Trauma Informed Care
SS=E CFR(s): 483.25(m)

§483.25(m) Trauma-informed care
The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.

This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record reviews , the facility failed to ensure that residents who are trauma survivors receive trauma-informed care that mitigates triggers that may re-traumatize residents for 3 of 8 sampled residents (Resident #33, #71, and #34). Findings include:

1. Per record review, Resident #33 was admitted to the facility on 8/6/2020 with a diagnosis of PTSD (post-traumatic stress disorder), anxiety, and depression. Resident #33's care plan includes a focus of alterations in mood related to the diagnosis of anxiety, PTSD, and depression, with manifestations that include negative verbalizations about others, tearfulness, sudden mood changes, anger, and self-harming behavior at times. A mental health clinician assessment note dated 1/26/24 mentions details of Resident #33's past trauma.

Per review of Resident #33's record, no evidence was found that the resident was assessed for triggers that may re-traumatize the resident. No evidence was found in Resident 33's plan of care regarding the resident's triggers or how staff can provide care that avoids re-traumatizing the resident.

Per interview on 6/4/20244 at approximately 11:45 AM, an LPN (Licensed Practical Nurse) with 4 years on that unit was unable to identify Resident # 33's specific triggers related to their trauma experience.

Per interview on 6/5/24 at approximately 12:00 PM, the Unit Manager confirmed that Resident #33's trauma experience and associated triggers are not identified in the resident's record.

2. Per record review, Resident #71 was admitted to the facility on 6/13/23 with diagnoses of PTSD (post-traumatic stress disorder) and depression. Resident #72's care plan includes a focus of depression PTSD (post-traumatic stress disorder), manifested by statements of sadness and decreased participation in activities. The mental health assessment dated 1/12/24 mentions chronic post-traumatic stress disorder after military combat, with ongoing issues. There are no additional details about the trauma or associated triggers.

Per interview on 6/5/24 at approximately 11:15 AM, an LNA was unable to identify Resident # 71's specific triggers related to their trauma experience.

Per interview on 6/5/24 at approximately 12:00 PM, the Unit Manager confirmed that Resident #71's trauma-specific triggers have not been identified or care planned for a resident with a history of trauma.

3. Per record review, Resident #34 has resided at this facility since 10/10/2018 with diagnoses that include PTSD (post-traumatic stress disorder). Resident #34's care plan includes a focus of alteration in thought processes and in mood related to depression, anxiety, and PTSD but does not include identification of Resident #34's associated triggers about his/her trauma experience or how staff can provide care that avoids re-traumatizing resident.

Per interview on 6/5/24 at approximately 12:00 PM, the Unit Manager confirmed that Resident #34's care plan does not contain identified triggers specific to their trauma.

PLAN OF CORRECTION

• What corrective action will be accomplished for those residents found to have been affected by the deficient practice;
The care plans for Residents #33, #71, and #34 have been updated to reflect the history of trauma accounting for the resident's experience and preferences in order to mitigate or eliminate triggers that may cause re-traumatization.

• How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
The DON or designee will perform an audit of existing residents to identify those with documented history of trauma. While all residents were at risk to be potentially impacted, a subset of residents were identified as impacted. Care plans for those identified will be updated to reflect the history of trauma accounting for the resident's experience and preferences in order to mitigate or eliminate triggers that may cause re-traumatization.

• What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and
The facility assures that trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization.

The HPNH policy titled "Comprehensive Person-Centered Care Plan" has been reviewed by the HPNH Administrator, Director of Nursing, AVP/Chief Nursing Officer, and Director of Quality, and updated as defined under F656 Comprehensive Care Plans (b)(3)(iii) Be culturally-competent and trauma-informed.

Reeducation on existing policy "Comprehensive Person-Centered Care Plan" will be provided via electronic learning system (Cornerstone), as well as a staff training titled "About Trauma Informed Care" in electronic learning system (Relias) to all applicable disciplines including nursing and social services staff on the evaluation of trauma ensuring a comprehensive care plan is in place to mitigate or eliminate triggers that may cause re-traumatization for anyone with a history of trauma.

• How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.
The DON or designee will review documentation and care plans on all newly admitted residents to ensure identified trauma survivors have a comprehensive care plan that addresses preferences to eliminate or mitigate triggers that may cause re-traumatization for anyone with a history of trauma. This audit will validate trauma-informed care is addressed in the care plan for applicable residents to ensure identified trauma survivors have a comprehensive care plan that addresses preferences to eliminate or mitigate triggers that may cause re-traumatization for anyone with a history of trauma in their care plan reviews.

Data will be reviewed/reported on at the quarterly QA meeting.

• The dates corrective action will be completed.
All actions will be completed by July 20, 2024.

F 812 Food Procurement Store/Prepare/Serve-Sanitary
SS=F CFR(s): 483.60(i)(1)(2)

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

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

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

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

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record
review the facility failed to ensure that food was stored in accordance with professional standards for food safety by leaving a used ice scoop in the ice machine. The facility also failed to monitor the temperatures of refrigerators and freezers daily and report abnormal values for further intervention. Findings include:

During the initial tour of the kitchen on 6/3/24 at 10:32 AM with the lead chef it was discovered that the ice scoop was found lying on the ice in the ice machine that is used for 3 out of 3 kitchenettes. Per facility policy of Storage of Food and Non-Food Items reads, "Store scoop in storage bin ...Do not store the provided ice scoop in the machine." The lead chef confirmed that the ice scoop was in the ice machine per interview at 10:35 AM and 11:06 AM.

On 6/3/24 at 10:47 AM in the main dining room meal service area it was discovered that the refrigerator temperature log for 6/3/24 was documented as "44 [degrees]" in the AM temperature log. The AM freezer log temperature was not documented.

Per record review of the "Recording and Maintaining Nutritional Services Logs" policy states, "Freezer temperature range is 0 degrees [Fahrenheit] and lower cooler, and refrigerator ranges are 33-41 degrees any reading noted to be out of specified ranges shall be reported to a Nutrition Services Leader and recorded on the log sheet."

Per interview on 6/3/24 at 10:55 AM the lead chef confirmed that the temperature was recorded as 44 [degrees] and was not reported to a Nutrition Specialist. S/he also confirmed that the AM freezer log for 6/3/24 was not documented.

Review of the kitchen refrigerator and freezer temperature logs for the months of December 2023 through April 2024 shows five abnormally high freezer temperatures in December 2023, five abnormally elevated freezer temperatures in January 2024, and one abnormally high freezer temperature in February 2024.

There is no documentation that the abnormal temperatures were addressed. In December 2023 there were 87 undocumented temperatures for the refrigerator and 91 undocumented temperatures for the freezer. In January 2024 there were 95 undocumented temperatures for the refrigerator and 91 undocumented temperatures for the freezer.

Per interview on 6/3/24 at 12:32 PM the Nutrition Specialist confirmed that there is missing documentation in December 2023 and January 2024 temperature logs. Further record review of February 2024 temperature logs shows 29 undocumented temperatures for the refrigerator and 30 undocumented temperatures for the freezer. Temperature logs for the refrigerator and freezer for March 2024 shows 51 undocumented temperatures for the refrigerator and 25 undocumented temperatures for the freezer. There are 21 undocumented temperatures for the refrigerator and 18 undocumented temperatures for the freezer for April 2024

PLAN OF CORRECTION

• What corrective action will be accomplished for those residents found to have been affected by the deficient practice;
No known residents have been impacted by the deficient practice.

The ice scoop in the ice machine was promptly removed at time of survey. Temperature monitoring of refrigerators and freezers assuring daily temperatures surveillance was promptly initiated as well as notification process to temperatures presenting out-of-range.

• How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
A review of existing residents completed by the DON or designee has been conducted and while all residents were at risk to be potentially impacted, no residents were identified.

• What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,
The HPNH Policy titled "Food Safety Systems: Surveillance, Prevention and Control" has been reviewed and updated by the HPNH Administrator, Director of Nursing, Director of Quality, Director of Support Services and Infection Preventionist roles to include language specific to §483.60(i) and to include temperature monitoring for kitchen refrigerators and freezers and ice scoop storage logs.

Education on food safety including temperature monitoring and sanitary practices of storing the ice scoop in designated spot will be provided by the Director of Support Services via monthly staff meetings to all applicable personnel including foodservice staff and leadership on the updated policy "Food Safety Systems: Surveillance, Prevention and Control" to remain in accordance with professional standards for foodservice safety.

• How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.
The HPNH Director of Support Services or designee will perform ongoing weekly audits of temperature logs including proper ice scoop storage as per updated policy "Food Safety Systems: Surveillance, Prevention and Control".

Data will be reviewed/reported on at the monthly nutrition services staff meetings and quarterly at QA meeting.

• The dates corrective action will be completed.
All actions will be completed by July 20, 2024.

F 887 COVID-19 Immunization
SS-E CFR(s): 483.80(d)(3)(i)-(vii)

§483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following:

i. When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated, or the resident or staff member has already been immunized.
ii. Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine.
iii. Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine.
iv. In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses.
v. The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine and change their decision.
vi. The resident's medical record includes documentation that indicates, at a minimum, the following:
    a. That the resident or residentrepresentative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and

Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and

vii. The facility maintains documentationrelated to staff COVID-19 vaccination that includes at a minimum, the following:
    a. That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine.
    b. Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and
    c. The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to ensure that each eligible resident receives the COVID-19 vaccine for 2 of 5 sampled residents on the rehabilitation unit (Residents #39 and #60). Findings include:

1. Per record review, Resident #39 was admitted to the facility on 01/16/2023 and has diagnoses that

include cerebral palsy (disorder of movement that affects muscle tone, and posture, developed before birth), spinal bifida (failure of the spinal completely close), chronic stage 4 pressure ulcers (deep wounds that may expose bone, tendon or muscle), and osteomyelitis (infection of the bone), The Resident #39 is currently receiving negative pressure wound therapy to treat the stage 4 pressure ulcers. Resident # 39 is considered high risk for COVID-19 complications because of his/her diagnoses.

Per record review, Resident #39's last COVID-19 vaccination was administered on 5/21/21 and was not provided the 2023-2024 seasonal COVID-19 immunization. There is no evidence in the record that Resident #36 was screened for eligibility, or s/he had a medical contraindication to not receive the vaccine, that Resident #36 or their representative were provided education regarding the benefits or side effects of the immunization , or that Resident #36 or representative had signed consent to receive or not receive the immunization. A 1/8/24 nursing note reveals that Resident #39 tested positive for COVID-19.

Per interview with Resident #39 and their Representative on 06/05/2024 at 1:30 PM, both indicated that Resident #39 was not offered the COVID-19 vaccine this year and would have accepted it if it was. Resident #39 explained that s/he had gotten COVID this winter and was sick with flu-like symptoms.

Per interview with the Advanced Practice Registered Nurse (APRN) on 6/5/2024 at 1:40 PM, s/he explained that Resident # 39 is eligible for COVID-19 vaccine and should have been offered the 2023-2024 season COVID-19 vaccine. The APRN stated that there is not a consistent process for screening and identifying residents that need the COVID-19 vaccine on the rehab unit.

2. Per record review, Resident # 60, who is 87 years old, was admitted to the facility on 4/11/2024 with diagnoses that include hip fracture with surgical repair, Alzheimer's and hypertension. Resident #60 is considered high risk for COVID-19 complications because of his/her diagnoses and age.

Per record review, Resident # 60's last COVID-19 vaccination was administered on 10/3/23 and was not provided a second 2023-2024 seasonal COVID-19 immunization. There is no evidence in the record that Resident #60 was screened for eligibility, or s/he had a medical contraindication to not receive the vaccine, that Resident #60 or their representative were provided education regarding the benefits or side effects of the immunization, or that Resident #60 or representative had signed consent to receive or not receive the immunization.

Per interview with the APRN on 6/5/2024 at 1:40 PM, s/he explained that Resident # 60 is eligible for a COVID-19 vaccine and should have been offered his/her second 2023-2024 season COVID-19 vaccine.

Per interview with the Director of Nursing on 6/5/2024 at 2:46 PM, he/she revealed there is no written procedure for staff to follow for identifying residents who are not up to date with their COVID-19 immunizations.

Per facility policy titled "SNF COVID-19 Mitigation and care" effective 06/19/2023 states "COVID-19 vaccination will be offered to all residents not up to date, in which there are no medical contraindications, (unless the resident or legal representative refuses vaccination after education), per the CDC/ACIP's recommendation. Record vaccination or declination in the electronic health record."

PLAN OF CORRECTION

• What corrective action will be accomplished for those residents found to have been affected by the deficient practice;
Resident #39 was screened for eligibility and determined to be eligible for the COVID-19 vaccination. Education was provided and reviewed for benefits and/or side effects of the immunization for resident #39 via VIS handout. The COVID-19 vaccine was accepted and given to resident #39.

Resident #60 was determined to be no longer eligible for the COVID-19 vaccination as the resident is deceased.

• How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

A review of all existing residents completed by the DON or designee including (any existing eligible residents who did not received the COVID-19 vaccine, any existing residents with identified medical contraindication(s) to vaccination, whether the resident or representative has signed consent to receive or not receive the COVID-19 vaccination) has been conducted and while all residents were at risk to be potentially impacted, a subset of residents were identified and action was taken accordingly.

• What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,

The HPNH policy titled "SNF COVID-19 Mitigation and Care" has been reviewed by HPNH Administrator, Medical Director, Director of Nursing, Director of Quality, Pharmacy Consultant, and Infection Preventionist to include updated language specific to COVID-19 vaccination upon admission, updating vaccination status for existing residents, documentation of vaccination consent and declination, and ongoing monitoring.

An internal log owned by the Asst. Director of Nursing and managed by the Charge Nurses of COVID-19 vaccinations will be kept on all residents and updated with each new admission, existing resident change in status and when an existing resident has a new vaccine or scanned declination.

• How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.
The internal log will be updated with each resident admission, re-admission, and transfer and audited for accuracy of all residents monthly x3 ongoing frequency to be reevaluated based on sustained performance by the Asst. Director of Nursing.

Data will be reviewed/reported to quarterly QA meeting.

• The dates corrective action will be completed.
All actions will be completed by July 20, 2024.