VERMONT

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

June 10, 2019

Seleem Choudhury, Ceo
Porter Hospital, Inc
115 Porter Drive
Middlebury, VT 05753-8423

Dear Mr. Choudhury.

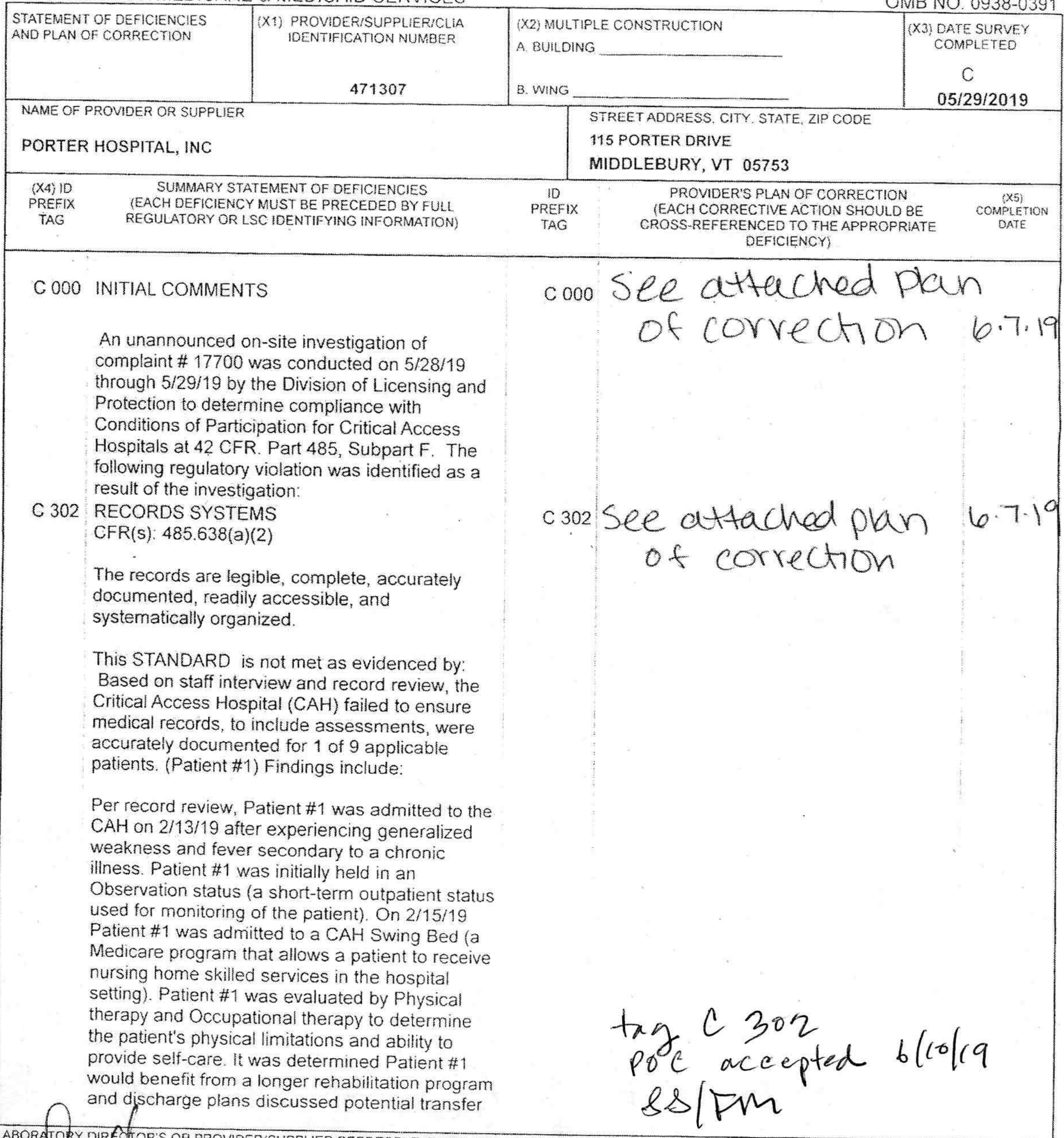
The Division of Licensing and Protection completed a survey at your facility on **May 29, 2019**. The purpose of the survey was to determine if your facility met the conditions of participation for Critical Access Hospitals found in 42 CFR Part 485.

Following the survey, your facility submitted a Plan of Corrections (POC) which was found to be acceptable on **June 10, 2019.**

Sincerely,

Suzanne Leavitt, RN, MS
State Survey Agency Director
Assistant Director, Division of Licensing & Protection

Enclosure



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

PRINTED: 05/31/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	471307	A. BUILDING ______ B. WING ______	C 05/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTER HOSPITAL, INC	115 PORTER DRIVE MIDDLEBURY, VT 05753

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 000	INITIAL COMMENTS An unannounced on-site investigation of complaint # 17700 was conducted on 5/28/19 through 5/29/19 by the Division of Licensing and Protection to determine compliance with Conditions of Participation for Critical Access Hospitals at 42 CFR. Part 485, Subpart F. The following regulatory violation was identified as a result of the investigation:	C 000	See attached plan of correction	6.7.19
C 302	RECORDS SYSTEMS CFR(s): 485.638(a)(2) The records are legible, complete, accurately documented, readily accessible, and systematically organized. This STANDARD is not met as evidenced by: Based on staff interview and record review, the Critical Access Hospital (CAH) failed to ensure medical records, to include assessments, were accurately documented for 1 of 9 applicable patients. (Patient #1) Findings include: Per record review, Patient #1 was admitted to the CAH on 2/13/19 after experiencing generalized weakness and fever secondary to a chronic illness. Patient #1 was initially held in an Observation status (a short-term outpatient status used for monitoring of the patient). On 2/15/19 Patient #1 was admitted to a CAH Swing Bed (a Medicare program that allows a patient to receive nursing home skilled services in the hospital setting). Patient #1 was evaluated by Physical therapy and Occupational therapy to determine the patient's physical limitations and ability to provide self-care. It was determined Patient #1 would benefit from a longer rehabilitation program and discharge plans discussed potential transfer	C 302	See attached plan of correction tag C 302 POC accepted 6/10/19 SS/FM	6.7.19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: President/COO
(X6) DATE: 7th June 2019

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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C 302	Continued From page 1 to an available bed in a skilled nursing facility (SNF). Eventually, a discharge plan became acceptable for Patient #1 and s/he was discharged to a local SNF for continued rehabilitation. A Federal requirement mandates a PASRR (Pre-Admission Screening and Resident Review) prior to Patient #1's admission to the SNF. PASRR preliminary screening helps to ensure that individuals are not inappropriately placed in a SNF, specifically those with a diagnosis with an intellectual or developmental disability without additional services to meet all their care needs. The Case Management department at the CAH was identified to be responsible for the completion of the PASRR prior to a patient's discharge to a SNF. On 2/21/19 a RN/Case Manager completed an inaccurate PASRR screening for Patient #1. Under Part C - Intellectual Disability or Related Condition the RN/Case Manager answered "yes" to question #4: "Is there presenting evidence (cognition or behavioral) that indicated this individual may have an intellectual/developmental disability or related condition ?" The RN/Case Manager further documents per SLUMS (St. Louis University Mental Status Exam) the patient scored "25" and has "dementia". Per interview on 5/29/19 at 10:35 AM, a Occupational Therapist (OT) who evaluated/assessed Patient #1's physical abilities/self care deficits stated a SLUMS test was never performed on Patient #1, which is generally the responsibility of the therapies department to conduct. The therapist also noted a score of "25" was also inaccurate when rating an individual for dementia. In further review of Patient #1's medical record "dementia" was not identified as an issue or diagnosis. The inaccurate PASRR screening was sent to the	C 302	See attached plan of correction	6-7-19

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C 302	Continued From page 2 Department of Mental Health as required and also to the receiving SNF. Per interview on 5/28/19 at 8:15 AM, Patient #1 stated s/he was upset the PASRR identified her/him to have dementia and this inaccurate information was reported directly to the SNF. Per interview on 5/29/19 at 2:00 PM, the Director of Population Health & Care Management confirmed s/he does not routinely review completed PASRR screenings and identified there were opportunities for improvement with the RN/Case Manager's understanding of various patient screenings and assessments and reinforcing the accuracy of the medical record.	C 302	See attached plan of correction	6-7-19

C 000 INITIAL COMMENTS:

An unannounced on-site investigation of complaint # 17700 was conducted on 5/28/19 through 5/29/19 by the Division of Licensing and Protection to determine compliance with Conditions of Participation for Critical Access Hospitals at 42 CFR. Part 485, Subpart F. The following regulatory violation was identified as a result of the investigation:

C 302 RECORDS SYSTEMS CFR(S) 485.638(a)(2)

The records are legible, complete, accurately documented, readily accessible, and systematically organized.

This STANDARD is not met as evidenced by: Based on staff interview and record review, the Critical Access Hospital (CAH) failed to ensure medical records, to include assessments , were accurately documented for 1 of 9 applicable patients (Patient #1) Findings include:

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Per record review, Patient #1 was admitted to the CAH on 2/13/19 after experiencing generalized weakness and fever secondary to a chronic illness. Patient #1 was initially held in an Observation status (a short-term outpatient status used for monitoring of the patient). On 2/15/19 Patient #1 was admitted to a CAH Swing Bed (a Medicare program that allows a patient to receive nursing home skilled services in the hospital setting). Patient #1 was evaluated by Physical therapy and Occupational therapy to determine the patient's physical limitations and ability to provide self-care. It was determined Patient #1 would benefit from a longer rehabilitation program and discharge plans discussed potential transfer to an available bed in a skilled nursing facility (SNF). Eventually, a discharge plan became acceptable for Patient #1 and s/he was discharged to a local SNF for continued rehabilitation. A Federal requirement mandates a PASRR (Pre-Admission Screening and Resident Review) prior to Patient #1's admission to the SNF. PASRR preliminary screening helps to ensure that individuals are not inappropriately placed in a SNF, specifically those with a diagnosis with an intellectual or developmental disability without additional services to meet all their care needs. The Case Management department at the CAH was identified to be responsible for the completion of the PASRR prior to a patient's discharge to a SNF

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Per interview on 5/29/19 at 2:00 PM, the Director of Population Health & Care Management confirmed s/he does not routinely review completed PASRR screenings and identified there were opportunities for improvement with the RN/Case Manager's understanding of various patient screenings and assessments and reinforcing the accuracy of the medical record

PoC accepted
6/10/19 SS/PM

ACTION PLAN

- The Director of Population Health & Care Management will review with the RN/Case Managers the St. Louis University Mental Status Exam (SLUMS) screening tool related to the case and reinforce the importance of accurately documenting the Preadmission Screening and Resident Review (PASRR). In addition, the education will focus on the importance of medical record accuracy. The case referenced will be used as a case study and learning opportunity. This review and education will be documented. The Director of Population Health & Care Management will review and ensure that related content is included in RN/Case Management new employee orientation.

- The Director of Population Health & Care Management will review 100% of PASRR screening documentation for accuracy monthly for three months. Performance feedback will be given at the individual level as needed and performance data will be reported quarterly to the Quality and Safety Committee. Once sustained compliance is achieved, The Director of Population Health & Care Management in collaboration with the Director of Quality and Patient Safety will reevaluate the frequency and sample size.

- All actions will be completed effective 7/5/19.

POC accepted
6/10/19 SS/FM