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

April 13, 2022

Thomas Thompson, Administrator Porter Hospital, Inc 115 Porter Drive Middlebury, VT 05753-8423

Dear Mr. Thompson:

The Division of Licensing and Protection completed a recertification survey at your facility on **March 16, 2022**. 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 **April 13, 2022.**

Sincerely,

Suzanne Leavitt, RN, MS State Survey Agency Director

Shanne Eherth

Assistant Director, Division of Licensing & Protection

cc: Carol Muzzy, UVM Health Network Regulatory Compliance

PRINTED: 03/24/2022 FORM APPROVED OMB NO. 0938-0391

The second of th	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		471307	B. WING		03/16/2022
	ROVIDER OR SUPPLIER	1 110	111	REET ADDRESS, CITY, STATE, ZIP CODE S PORTER DRIVE DDLEBURY, VT 05753	
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C 000	INITIAL COMMENT	S n-site re-certification survey	C 000		
04104	and staff vaccination conducted on 3/14/2 of Licensing and Pro- compliance with the for Critical Access H Part 485, Subpart F- violations were identified.	n requirement review were 22 to 3/16/22 by the Division of Division of Participation lospitals (CAH) at 42 CFR. The following regulatory tified.	C1104	See attached plan of correct	tion 5/3/2
	documented, readily systematically organ This STANDARD is Based upon intervie facility failed to ensu complete, accurately accessible, and syst to Patient Code Stat Treatment for one pasampled patients. Findings include: Review of Medical R treated at Porter Medical Review of Medical R treated at Porter Medical Review for Life Susta [DNR/COLST] form opatient as "DNR/Do (allow natural death) physician. The DNR/COLST organization of the porter of the porter of the porter of the position.	ible, complete, accurately accessible, and nized. not met as evidenced by: ew and record review, the are the records are legible, and documented, readily rematically organized related as for Life Sustaining attent [Patient #14] of 20 Records for Patient #14 dical Center [PMC] reveal the Not Resuscitate/ Clinician aining Treatment dated 11/5/21 which listed the Not Attempt Resuscitation with the order signed by a der was electronically	C1104	C1104 POC ALLER D. Wideaux RV	
	medical record syste	er Medical Center electronic m on 11/12/21, and the tered into the system on		IDS	ON DATE

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.

4/4/2022

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		471307	B. WNG			03/16/2022
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C1104	Review of Medical Porter Medical Cer Code Status Histor The PMC Code Strecords: 11/11/21: Limitation records the order of 12/10/21, though the replace/change it. 12/10/21: Full Code order as then 'inact Code Status Histor the Full Code is the 'inactive' on 12/31/Review of Advance Patient #14 record patient #14 record patient #5 DNR/COU physician's order of 'received' on 11/12 "DNR/Do Not Atterdeath)". The PMC Code Stream date, 1/3/22, is "Full Code", with 1/25/22. On 1/25/22, the PM records the patient Treatment" and the Review of Hospital Center, dated 1/25 status as "Full Code returning to the nur Review of Palliativ Porter Medical Cerrecord "This visit in and an advance ca CODE status and refurther review of the status and returner review of the status and record statu	Records for Patient #14 for other [PMC] include the patient's y. atus History for Patient #14 In of Treatment. The history changed to 'inactive' on there is no new written order to de. The history records the tive' on 12/13/21. Next on the ry, on the same date, 12/13/21, en listed as 'active', then 21. In Care Planning Documents for on 1/3/22 PMC 'received' the lasted 11/5/21 [and first 1/21] that ordered the patient as npt Resuscitation (allow natural latus History records on the that Patient #14's code status in the status 'active' until	C110	4		

FORM CMS-2567(02-99) Previous Versions Obsolete 5 7 4 F

Event ID: H50E11

Facility ID: 471307

If continuation sheet Page 2 of 14

CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING	LE CONSTRUCTION		DATE SURVEY COMPLETED
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C1104	death and not en- Further review of reveals on 1/28/2 "patient was foundetermine code scall notified. Statiorder." Per review of Pat 3/16/22, listed un Historical Code S 1/25/22): "Question-When the patient DNR When the patient DNR When the patient respiratory distret Who Made the DFurther review of 1/28/22 reveals stated due to cur CPR [Cardiopuln 911. Initiated CP Transferred to Pthe PMC Emergine The The The The The The The The The Th	nt to be left alone to a peaceful d up on machines." Patient #14's medical record 12, at approximately 8:30 PM, and unresponsive. Unable to status at this time. Provider on 12 and to follow last code status tient #14's Medical Record on 13 and the Grant 14's Medical Record on 14 and 15 and 15 and 16 and 16 and 17 and 17 and 18	C110	4		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		SURVEY
		471307	B. WNG_		03	16/2022
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(X4) ID PREFIX TAG	(EACH DEFICIEN	ITATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
C1104	reveals on 1/26/22, patient at the nursin the patient's Code Stalk about it. FULL. No". There is no acc the patient as a Full Further review of Pl Patient #14 reveals patient being found record "[staff] from [8:43 PM on 1/28/22 been unresponsive have reviewed avail reports Patient is a An interview was concerned to the patient of the patient is a An interview was concerned avail reports Patient is a An interview was concerned avail reports Patient is a An interview was concerned avail reports Patient is a An interview was concerned avail reports Patient is a Profit of the patient included conflicting patient's code statu multiple occasions in PROTECTION OF CFR(s): 485.638(b) The CAH maintains information and profit of the patient in STANDARD is Based on observat Critical Access Hos medical records in against loss, destructions, de	edical record for Patient #14 a Physician attending the g home recorded regarding status "He does not want to " And "COLST Complete? companying order recording Code. MC's medical record for Physician notes regarding the unresponsive on 1/28/22 inursing home] calls on call at stating that [Patient #14] has for the last 6 minutes. We lable COLST form. [Staff] DNR." Inducted with PMC's Chief O] and the Director of Quality ance Improvement [DQS] on M. The CNO and DQS ent #14's medical record documentation regarding the s on the same date[s] on and from multiple sources. RECORD INFORMATION (1) I the confidentially of record vides safeguards against loss, atthorized use. Is not met as evidenced by: ion and staff interview the pital (CAH) failed to store a manner that safeguarded ction, and unauthorized use at in Campus, Clinic A, and	C110			5/3/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
16		471307	B WNG		03/16/2022
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C1120	attic area of Porter I- records were stored were noted to be ha These records were potential for water di system and/or dama interview with the Di	Je 4 3/14/2022, at 3:00 PM of the Hospital where paper medical piping with sprinkler heads nging above the shelving. uncovered and there was a amage from the sprinkler age from fire. During an rector of Health Information on 03/15/22 at 3:00 PM, S/He	C1120		
	stored in a maintain must be protected. 2. During a tour of p 3/14/2022 at 3:30 P Practice Manager, p observed to be store wooden shelves und valves. The Practice records were not store.	rimary care Clinic A on M accompanied by the saper medical records were ed in the basement on open derneath copper piping and Manager confirmed the bred in a protected manner to ed no damage from water or			
C1206	3/14/2022 at 10:30 staff technician, x-ra observed in an unpr the front office space records were not stothem from fire or wall INFECTION PREVE CFR(s): 485.640(a)(). The infection prever documented in its permploys methods for	ENT & CONTROL POLICIES	C1206	See attached plan of correction C1306 Poc accepted). widcausk PV	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	INSTRUCTION	ION (X3) DATE SURVE COMPLETED	
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C1206	This STANDARD is Based on observatifailed to ensure that and controlling the twere followed during of patient equipment. Per observation on a Registered Nurse (Fithat was used to perprocedure in which a instrument is inserted examine the colonal finished cleaning the gloves and without a donned a new pair of treatment room with into the dirty utility a touched several are then removed his/he hands. Per interview that time, S/He confineeds be done each and prior to new glower interview on 3/1 Infection Prevention hand hygiene must be removed. Per review of the polygiene"-approved are not visibly soiled for routinely decontar alternatively wash hand water a Before defored the second of the polygiene and water a Before defored the second of the polygiene and water a Befored the second of the polygiene and water a Before defored the second of the polygiene and water a Befored the second of the polygiene and water a Befored the second of the polygiene and water a Before defored the second of the polygiene and water a Befored the second of the polygiene and water a Befored the polygiene and the po	and other healthcare settings; not met as evidenced by: on and interview the CAH the methods for preventing ransmission of infections the cleaning and disinfecting the cleaning as scope form a colonoscopy (A affectible fiber-optic distribution of the cleaning as scope form a colonoscopy (A affectible fiber-optic distribution of the cleaning as scope form a colonoscopy (A affectible fiber-optic distribution of the cleaning as scope form a colonoscopy (A affectible fiber-optic distribution of the cleaning as scope form a colonoscopy (A affectible fiber-optic distribution of the cleaning as scope form a colonoscopy (A affectible fiber-optic distribution of the cleaning as scope form a colonoscopy (A affectible fiber-optic distribution of the cleaning as scope form a colonoscopy (A affectible fiber-optic distribution of the cleaning as scope form a colonoscopy (A affectible fiber-optic distribution of the cleaning as scope form a colonoscopy (A affectible fiber-optic distribution of the cleaning as scope form a colonoscopy (A affectible fiber-optic distribution of the cleaning as scope form a colono	C1206			

STATEMENT O	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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C1206	equipment)h. Aft COVID-19 Vaccination CFR(s): 485 640 (f)(§ 485.640 Condition prevention and contribrograms. (f) Standard: COVID The CAH must deve and procedures to evaccinated for COVI section, staff are conhas been 2 weeks of a primary vaccination completion of a primic COVID-19 is defined a single-dose vaccin required doses of a (1) Regardless of contact, the policies to the following CAH treatment, or other spatients: (i) CAH employees; (ii) Licensed practition (iv) Individuals who other services for the under contract or by (2) The policies and do not apply to the fi (i) Staff who exclusion and who do not hav patients and other s (1) of this section; a (iii) Staff who provides (iiii) Staff who provides (iiiiii) Staff who provides (iiiiii) Staff who provides (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	er removing gloves". In of Facility Staff 1)-(3)(i)-(x) of participation: Infection of and antibiotic stewardship -19 Vaccination of CAH staff. Iop and implement policies Insure that all staff are fully D-19. For purposes of this Issidered fully vaccinated if it or more since they completed on series for COVID-19. The Insure as the administration of Ine, or the administration of all multi-dose vaccine. Initical responsibility or patient and procedures must apply I staff, who provide any care, I services for the CAH and/or its oners; I se, and volunteers; and provide care, treatment, or I or CAH and/or its patients, other arrangement. I grocedures of this section ollowing CAH staff: vely provide telehealth or as outside of the CAH setting e any direct contact with taff specified in paragraph (f)	C1206 C1260	See attached plan of correction CIBGO POC Alcepts 4 B. Widewske Rd		5/3/22

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED
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	NOVIDER OR SUPPLIER		115 F	ET ADDRESS, CITY, STATE, ZIP CODE PORTER DRIVE DLEBURY, VT 06753	
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C1260	contact with patier paragraph (f)(1) of (3) The policies at a minimum, the foil (i) A process for exparagraph (f)(1) of staff who have perbeen granted, exerequirements of the whom COVID-19 delayed, as reconclinical precaution received, at a min vaccine, or the first vaccination series vaccine prior to state treatment, or othe patients; (iii) A process for additional precaut transmission and who are not fully (iv) A process for documenting the all staff specified section; (v) A process for documenting the any staff who have secommended (vi) A process by exemption from the requirements bas (vii) A process for documenting info who have requesting info	who do not have any direct ints and other staff specified in it this section. Indeprocedures must include, at allowing components: Insuring all staff specified in it this section (except for those inding requests for, or who have emptions to the vaccination is section, or those staff for vaccination must be temporarily interest by the CDC, due to send considerations) have imum, a single-dose COVID-19 at dose of the primary if or a multi-dose COVID-19 aff providing any care, or services for the CAH and/or its ensuring the implementation of the interest of COVID-19, for all staff vaccinated for COVID-19; tracking and securely COVID-19 vaccination status of the paragraph (f)(1) of this tracking and securely COVID-19 vaccination status of the obtained any booster doses	C1260		

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471307		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	COM	E SURVEY IPLETED 3/16/2022
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE
C1260	vaccination requirem clinical contraindicati laws; (viii) A process for er documentation, which clinical contraindicati and which supports exemptions from vac and dated by a licent the individual reques is acting within their as defined by, and ir applicable State and ensuring that such d (A) All information spauthorized COVID-1 contraindicated for the contraindications; and (B) A statement by the recommending that exempted from the crequirements for statclinical contraindications (ix) A process for ensecure documentatic staff for whom COVI temporarily delayed, CDC, due to clinical considerations, incluindividuals with acut COVID-19, and indivinonclonal antibodifor COVID-19 treatments.	neents based on recognized ons or applicable Federal assuring that all the confirms recognized ons to COVID-19 vaccines staff requests for medical extination, has been signed sed practitioner, who is not sting the exemption, and who respective scope of practice in accordance with, all local laws, and for further ocumentation contains becifying which of the 9 vaccines are clinically the staff member to receive clinical reasons for the staff member be CAH's COVID-19 vaccination of the vaccination status of D-19 vaccination must be as recommended by the precautions and ding, but not limited to, a illness secondary to viduals who received es or convalescent plasma tent; and its for staff who are not fully D-19.	C1260			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OATE SURVEY COMPLETED
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C1260	(ii) A process for ens paragraph (f)(1) of th vaccinated for COVII who have been gran vaccination requirer staff for whom COVI temporarily delayed, CDC, due to clinical considerations; This STANDARD is Based on interview failed to develop pol ensured the implement precautions and con mitigate the transmis COVID-19 for all state vaccinated for COVID-19 for interview on 3/11 AM with the Director Performance Improvements of CAH had "other COVID-19 for all state of CAH had "ot	uring that all staff specified in all is section are fully D-19, except for those staff ted exemptions to the lents of this section, or those D-19 vaccination must be as recommended by the precautions and not met as evidenced by: and record review the CAH icies and procedures that entation of additional tingency plans intended to sign and spread of ff who were not fully D-19. Findings include: Licy, "COVID-19 Vaccine 12/21, it states, "Monitoring Employee Health or Human or employees' leaders of the accommodations, including the ecessary. They will not share the additional approved to approve the additional approved to a staff who are not fully D-19. Engloye at approximately 9:30 for Quality, Safety, and the process of the process of the country of the stated that the policy of the stated that the process of the stated that	C12	60		

CENTERS FOR MEDICARE & MEDICAID SERVICES

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A BUILDING	E CONSTRUCTION	COMPLETED
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C1260	policies did not conti the regulation. FREEDOM FROM A EXPLOITATION CFR(s): 485.645(d)(ned that the staff vaccination ain the required elements of ABUSE, NEGLECT &	C1260		5/3/22 4/13/22
	(§483.12(a)(1), (a)(2)(b)(1), (b)(2), (c)(1), this chapter). "§483.12(a)(1) and exploitation. The free from abuse, neresident property, at this subpart. This inferedom from corpor seclusion and any prot required to treat symptoms.(a) The fiverbal, mental, sexucorporal punishmen. "§483.12(a)(2) Efrom physical or che purposes of disciplir are not required to tryptoms. When the indicated, the facility alternative for the ledocument ongoing restricts. "§483.12(a)(3) Nengage individuals with the four four four four four four four four	nd guilty of abuse, neglect, ropriation of property, or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	INSTRUCTION	(X3) DATE SURVEY COMPLETED	
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C1612	nurse aide registry exploitation, mistrer misappropriation of "§483.12(a)(4) registry or licensing has of actions by a employee, which w service as a nurse "§483.12(b) Thimplement written property, (1) Prohibit and prexploitation of resident property, (2) Establish policinvestigate any such such as the allegation or eported immediate after the allegation cause the allegation serious bodily injur the events that cau abuse and do not reported or the administrator of the service of service and se	ading entered into the State concerning abuse, neglect, atment of residents or their property. Report to the State nurse aide authorities any knowledge it court of law against an ould indicate unfitness for aide or other facility staff. The facility must develop and procedures that: The event abuse, neglect, and dents and misappropriation of the concerning abuse.	C1612			

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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C1612	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on interview and record review the CAH failed to develop comprehensive policies and procedures for Swing Bed residents that prohibit and prevent, abuse, neglect, exploitation, and misappropriation of property. Findings include: Per review of the policy, "Identification and Reporting of Suspected Abuse (Domestic, Child, and Vulnerable Adult)"-approved 11/2020. There was no evidence that the policy and/or procedure contained the time frame in which allegations involving abuse, neglect, exploitation, or mistreatment, to include injuries of an unknown		C161	2			

F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING				(X3) DATE SURVEY COMPLETED 03/16/2022	
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Continued From page 13		C1	612				
Chief Medical Officer CAH policies govern confirmed that the ab	r (CMO), S/He stated that the the Swing Bed residents and						
Initial Comments		E	000				
survey, on 3/14/22 to Licensing and Protect the Critical Access H Preparedness Progra be in substantial com	o 3/16/22, the Division of ction conducted a review of lospital's (CAH's) Emergency am. The facility was found to appliance with the Condition of						
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Porter Medical Center

Porter Medical Center 115 Porter Drive Middlebury, VT 05753-8423

April 4, 2022

Division of Licensing and Protection HC 2 South, 280 State Drive Waterbury VT 05671-2060 Re:

Provider ID#: 471307 - 3/16/2022

Dear Suzanne Leavitt,

Please find the attached Plan of Corrections and form CMS-2567 in response to the Statement of Deficiencies and Findings in regard to survey number 471307.

The Porter Medical Center is committed to continuously improving the quality of services we provide to respond to the regulatory deficiencies that were cited.

If you have questions regarding the attached Plan of Correction or require further clarification, please do not hesitate to contact me.

Sincerely,

Thomas Thompson, COO

A 900 INITIAL COMMENTS

An ununnounced on-site re-certification survey and staff vaccination requirement review were conducted on 3/14/22 to 3/16/22 by the Division of Licensing and Protection to determine compliance with the Conditions of Participation for Critical Access Hospitals (CAH) at 42 CFR. Part 485, Subpart F. The following regulatory violations were identified.

CLINA RECORDS SISTEM CFRish: 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 upon interview and record review, the facility failed to ensure the records are legible, complete, accurately documented, readily accessible, and systematically organized related to Patient Code Status for Life-Sustaining Treatment for one patient [Patient #14] of 20 sampled patients.

Findings include:

Review of Medical Records for Patient ±14 treated at Porter Medical Center (PMC) reveal the patient signed a Do Not Resuscitate! Clinician Orders for Life-Sustaining Treatment (DNR/COLST) form dated 11/5/21 which listed the patient as "DNR/Do Not Attempt Resuscitation (allow natural death)" with the order signed by a physician. The DNR/COLST order was electronically entered into the Porter Medical Center electronic medical record system on 1/1/12/21, and the same order again entered into the system on 1/5/22.

Review of Medical Records for Patient #14 for Porter Medical Center [PMC] include the patient's Code Status History. The PMC Code Status History for Patient #14 records: 11/11/21: Limitation of Treatment. The history records the order changed to 'mactive' on 12/10/21, though there is no new written order to replace/change it.

12/10/21: Full Code. The history records the order as then 'inactive' on 12/13/21. Next on the Code Status History, on the same date, 12/13/21, the Full Code is then listed as 'active', then 'inactive' on 12/31/21.

Review of Advance Care Planning Documents for Patient #14 record on 1/3/22 PMC 'received' the patient's DNR/COLST form, which was the physician's order dated 11/5/21 [and first 'received' on 11/12/21] that ordered the patient as "DNR/Do Not Attempt Resuscitation (allow natural death)". The PMC Code Status History records on the same date, 1/3/22, that Patient #14's code status is "Full Code", with the status 'active' until 1/25/22.

On 1/25/22, the PMC Code Status History records the patient's status as 'Limitation of Treatment' and the status 'active'.

Review of Hospitalist notes from Porter Medical Center, dated 1/25/22 record Patient #14's code status as "Full Code", noting the patient is returning to the nursing home the following day. Review of Pulliative Care Physician notes from Porter Medical Center on the same day, 1/25/22, record "This visit included a regular follow up visit and an advance care planning visit discussing CODE status and reaffirming DNR, DNI status". Further review of the Pulliative Physician notes reveals Patient #14 "understands that if he is very sick he would want to be left alone to a ponceful death and not end up on machines."

Further review of Patient #14's medical record reveals on 1/28/22, at approximately 8:30 PM, "patient was found unresponsive. Unable to determine code status at this time. Provider on call notified. Stated to follow last code status order."

Per review of Patient #14's Medical Record on 3/16/22, listed under Questions for Most Recent Historical Code Status (Order 224847216-dated 1/25/22): "Question-

When the patient has NO PULSE: Answer- DNR

When the patient HAS A PULSE and is in respiratory distressifiailure: Do not intubate (DNI) Who Made the Decision? Patient".

Further review of Patient #14's medical record for 1/28/22 reveals "Administrator on call notified, stated due to current circumstances to initiate CPR [Cardiopulmonary Resuscitation] and call 911. Initiated CPR at

approximately 8:45. Transferred to PMC ER @ 9:10 via ambulance." The PMC Emergency Room Physician writes: "Per report, pt had previously been DNR/DNI but then had reverse it and was full code." The physician records the patient was then intubated, and later expired at 9:24 PM. The Physician also includes "After the patient's death, the patient's chart was reviewed more extensively, and it appears that as of 1/25/2022, his CODE STATUS was LLST [Limited Life Saving Treatment]/DNR/DNI." The PMC Code Status History for Patient #14 records the patient's Limitation of Treatment status, initiated on 1/25/22, now listed as 'inactive' on 1/26/22.

Review of PMC's medical record for Patient#14 reveals on 1/26/22, a Physician attending the patient at the nursing home recorded regarding the patient's Code Status "He does not want to talk about it. FULL." And "COLST Complete? No". There is no accompanying order recording the patient as a Full Code.

Further review of PMC's medical record for Patient #14 reveals Physician notes regarding the patient being found unresponsive on 1/28/22 record "[staff] from [nursing home] calls on call at 8:43 PM on 1/28/22 stating that [Patient #14] has been unresponsive for the last 6 minutes. We have reviewed available COLST form. [Staff] reports Patient is a DNR."

An interview was conducted with PMC's Chief Nursing Officer [CNO] and the Director of Quality Safety and Performance Improvement [DQS] on 3/16/22 at 12:35 PM. The CNO and DQS confirmed that Patient #14's medical record included conflicting documentation regarding the patient's code status on the same date[s] on multiple occasions and from multiple sources.

ACTION PLAN

- Under the Direction of the Chief Medical Officer, Providers and Staff applicable to their role will be educated
 through a combination of meetings/electronic communication on The Porter Medical Center Advance Directive
 Policy. Specifically highlighted will be the provisions and process around conflicting documents/ discussions, if
 there is a conflict in documents or discussions, the most recent document or discussion takes precedence.
- Under the direction of the Director of Quality, Safety and Performance Improvement, Clinical Quality and Safety
 Nurse will perform monthly chart reviews to ensure the availability and accuracy of Advance Directive
 information within the medical record. Frequency will be reevaluated based on sustained performance by
 leadership. Performance feedback will be shared with local leadership and organizational leadership for action as
 required.
- All actions will be completed effective 5/3/22

Polacepted 4/13/22 8. Witcarte Ad

C1120 PROTECTION OF RECORD INFORMATION CFR(s):485.638(b))1)

The CAH maintains the confidentially of record information and provides safeguards against loss, destruction, or unauthorized use.

This STANDARD is not met as evidenced by: Based on observation and staff interview the Critical Access Hospital (CAH) failed to store medical records in a manner that safeguarded against loss, destruction, and unauthorized use at three locations (Main Campus, Clinic A, and Clinic B). Findings include:

- 1. During a tour on 3/14/2022, at 3:00 PM of the attic area of Porter Hospital where paper medical records were stored, piping with sprinkler heads were noted to be hanging above the shelving. These records were uncovered and there was a potential for water damage from the sprinkler system and/or damage from fire. During an interview with the Director of Health Information Management (HIM) on 03/15/22 at 3:00 PM, S/He confirmed that the medical records were not stored in a maintained location where records must be protected.
- 2. During a tour of primary care Clinic A on 3/14/2022 at 3:30 PM accompanied by the Practice Manager, paper medical records were observed to be stored in the basement on open wooden shelves underneath copper piping and valves. The Practice Manager confirmed the records were not stored in a protected manner to assure they sustained no damage from water or fire.
- 3. During a tour of a podiatry Clinic B on 3/14/2022 at 10:30 AM and accompanied by a staff technician, x-ray medical records were observed in an unprotected wooden shelf behind the front office space. Office staff confirmed the records were not stored in a manner to protect them from fire or water damage.

ACTION PLAN

- The Records in the attic area, basement and Porter Podiatry are now covered to protect against water damage and protected against fire damage through the required sprinkler system.
- Under the direction of the Manager of Health Information Services, The Porter Medical Center Policy Security of
 Health Information Department was reviewed and will be updated in accordance with C1120 PROTECTION OF
 RECORD INFORMATION CFR(s):485.638(b))1).
- Under the direction of Director of Quality, Safety, and Performance Improvement surveillance for record storage in accordance with 485.638(b))1) has been added to the Readiness Rounds and Environment of Care Round process in accordance with 485.638(b)). Performance data for action will be reported to the Senior Leadership Team
- All actions will be completed effective 5/3/22.

D. Wideauda RV

C1206 INFECTION PREVENT & CONTROL POLICIES CFR(s): 485.640(a)(2)

The infection prevention and control program, as documented in its policies and procedures, employs methods for preventing and controlling the transmission of infections within the CAH and Continued From page 5 between the CAH and other healthcare settings;

This STANDARD is not met as evidenced by: Based on observation and interview the CAH failed to ensure that the methods for preventing and controlling the transmission of infections were followed during the cleaning and disinfecting of patient equipment. Findings include:

Per observation on 3/15/22 at 12:50 PM, a Registered Nurse (RN) began cleaning a scope that was used to perform a colonoscopy (A procedure in which a flexible fiber-optic instrument is inserted through the anus to examine the colon.) in a treatment room. The RN finished cleaning the scope, removed his/her gloves and without sanitizing his/her hands, donned a new pair of gloves. The nurse left the treatment room with the soiled scope, brought it into the dirty utility area of central sterile supply, touched several areas in the dirty utility area and then removed his/her gloves and washed his/her hands. Per interview on 3/15/22 with the RN at that time, S/He confirmed that hand hygiene needs be done each time gloves are removed and prior to new gloves being donned.

Per interview on 3/15/22 at 3:55 PM with the Infection Preventionist, S/He also confirmed that hand hygiene must be done after gloves are removed.

Per review of the policy "Guidelines for Hand Hygiene"-approved 9/2020, it states "2. If hands are not visibly soiled, use alcohol-based hand rub for routinely decontaminating hands ...or alternatively wash hands with antimicrobial soap and water ...: a. Before having direct contact with patients. b. Before donning gloves ...g. after contact with inanimate objects (including medical equipment) h. After removing gloves"

ACTION PLAN

- Under the direction of the Porter Medical Center Infection Preventionist, organization wide education applicable
 to the role on the Porter Medical Centers Guidelines for Hand Hygiene will be completed. The education will
 focus on the need to perform hand hygiene after glove removal.
- Performance with compliance with the referenced policy will be monitored through a combination of monthly
 self-audits supported by Infection Prevention and Readiness Rounds under the direction of the Director of
 Quality, Safety, and Performance Improvement. Direct Performance feedback will be provided individually and to
 local leadership. Performance data will be shared with the Senior Leaders for action as appropriate.
- All actions will be completed by 5/3/2022.

D. W. deauste PV

C1260 COVID-19 VACCINATION OF FACILITY STAFF CFR(s): 485.640 (f)(1)-(3)-(x) COVID-19 Vaccination of Facility Staff CFR(s): 485.640 (f)(1)-(3)(i)-(x)

- § 485.640 Condition of participation: Infection prevention and control and antibiotic stewardship programs.
- (f) Standard: COVID-19 Vaccination of CAH staff. The CAH must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.
- (1) Regardless of clinical responsibility or patient contact, the policies and procedures must apply to the following CAH staff, who provide any care, treatment, or other services for the CAH and/or its patients:
 - i. CAH employees;
 - ii. Licensed practitioners;
 - iii. Students, trainees, and volunteers; and
 - iv. Individuals who provide care, treatment, or other services for the CAH and/or its patients, under contract or by other arrangement.
- (2) The policies and procedures of this section do not apply to the following CAH staff:
 - Staff who exclusively provide telehealth or telemedicine services outside of the CAH setting and who do not have any direct contact with patients and other staff specified in paragraph (f) of this section; and
 - ii. Staff who provide support services for the CAH that are performed exclusively outside of the CAH setting and who do not have any direct contact with patients and other staff specified in paragraph (f)(1) of this section.
- (3) The policies and procedures must include, at a minimum, the following components:
 - i. A process for ensuring all staff specified in paragraph (f)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the CAH and/or its patients
 - ii. A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;
 - iii. A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (f)(1) of this section;
 - A process for tracking and securely documenting the COVID-19 vaccination status of any staff who
 have obtained any booster doses as recommended by the CDC;
 - v. A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
 - vi. A process for tracking and securely documenting information provided by those staff who have requested, and for whom the CAH has granted, an exemption from the staff COVID-19 vaccination requirements based on recognized clinical contraindications or applicable Federal laws;
 - vii. A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains
- (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
- (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the CAH's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;

- (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to
 (C) COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and
- (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication:
 - ii. A process for ensuring that all staff specified in paragraph (f)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;

This STANDARD is not met as evidenced by: Based on interview and record review the CAH failed to develop policies and procedures that ensured the implementation of additional precautions and contingency plans intended to mitigate the transmission and spread of COVID-19 for all staff who were not fully vaccinated for COVID-19. Findings include:

Per review of the policy, "COVID-19 Vaccine Policy"-effective 11/12/21, it states, "Monitoring and Documentation. Employee Health or Human Resources will notify employees' leaders of approved reasonable accommodations, including weekly testing, as necessary. They will not share any additional information with the leader". There was no evidence of what the additional approved reasonable accommodations and contingency plans would be to mitigate the transmission and spread of COVID-19 for staff who are not fully vaccinated for COVID-19.

Per interview on 3/16/22 at approximately 9:30 AM with the Director of Quality, Safety, and Performance Improvement, S/He stated that the CAH had "other COVID-19" policies that guided the mitigation and contingency plans for unvaccinated staff. During an interview 3/16/22 at 1:29 PM, with the Director of Accreditation and Regulatory Affairs for the Jeffords Institute for Quality, S/He confirmed that the staff vaccination policies did not contain the required elements of the regulation Quality, S/He confirmed that the staff vaccination policies did not contain the required elements of the regulation.

ACTION PLAN

- Under the direction of Director of Quality, Safety, and Performance Improvement the COVID-19 policies have been updated to explicitly state the approved contingency plans to mitigate the transmission and spread of COVID-19 for staff who are not fully vaccinated. The contingency plans were in place but not directly referenced in the policy language.
- Going forward, policy content and review in accordance with law and regulation will be monitored by the Porter Medical Center Policy Review Steering Committee, chaired by the Director of Quality, Safety and Performance Improvement and supported by University of Vermont Health Network Accreditation and Regulatory Affairs Department.
- All actions will be completed by 5/3/2022.

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C1612FREEDOM FROM ABUSE, NEGLECT & EXPLOITATION C1612CFR(s): 485.645(d)(3) Freedom from abuse, neglect and exploitation (§483.12(a)(1), (a)(2), (a)(3)(i), (a)(3)(ii), (a)(4),(b)(1), (b)(2), (c)(1), (c)(2), (c)(3), and (c)(4) of this chapter).

§483.12(a)(1) Freedom from abuse, neglect, and exploitation. The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.(a) The facility must-(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;

§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. §483.12(a)(3) Not employ or otherwise engage individuals who-

i. Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law:

ii. Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property

§483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

§483.12(b) The facility must develop and implement written policies and procedures that:

(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,

(2) Establish policies and procedures to investigate any such allegations,

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

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Have evidence that all alleged violations are thoroughly investigated.

(2) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(3) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This STANDARD is not met as evidenced by: Based on interview and record review the CAH failed to develop comprehensive policies and procedures for Swing Bed residents that prohibit and prevent, abuse, neglect, exploitation, and misappropriation of property. Findings include:

Per review of the policy, "Identification and Reporting of Suspected Abuse (Domestic, Child, and Vulnerable Adult)"-approved 11/2020. There was no evidence that the policy and/or procedure contained the time frame in which allegations involving abuse, neglect, exploitation, or mistreatment, to include injuries of an unknown origin and misappropriation of residents' property were reported, and to the required officials. There was also no indication of the process in which these allegations were to be fully investigated and if substantiated the appropriate corrective action that would be taken.

Per interview on 3/16/22 at 1:52 PM with the Chief Medical Officer (CMO), S/He stated that the CAH policies govern the Swing Bed residents and confirmed that the above policy did not "align" with the regulations.

ACTION PLAN

- Under the direction of Chief Medical Officer, Identification and Reporting of Suspected Abuse (Domestic, Child, and Vulnerable Adult was updated in accordance with 483.12(c) Swing Bed requirements. Specifically, ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Reports will be made to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. All alleged violations will be thoroughly investigated and documented.
- Under the direction of Chief Medical Officer, organization wide education, applicable to the role, on Identification and Reporting of Suspected Abuse (Domestic, Child, and Vulnerable Adult)" will be completed.
- Compliance with the referenced policy will be monitored through review of any reports of abuse submitted
 through the event reporting system. The review is conducted by the Quality and Safety RN, and escalated as
 required to Leadership. All occurrences are reviewed weekly through Safety Adjudication Committee triage as
 well.
- Going forward, policy content and review in accordance with law and regulation for both Critical Access and Swing bed requirements will be monitored by the Porter Medical Center Policy Review Steering Committee, chaired by the Director of Quality, Safety and Performance Improvement and supported by University of Vermont Health Network Accreditation and Regulatory Affairs Department.
- All actions will be completed by 5/3/2022.

PSC accepted 9/13/22 D. Wideauda Ru