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
Assistant Director, Division of Licensing & Protection

cc: Carol Muzzy, UVM Health Network Regulatory Compliance

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

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 _____	03/16/2022

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

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C 000	INITIAL COMMENTS An unannounced 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.	C 000		
C1104	RECORDS SYSTEM 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 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 11/12/21, and the same order again entered into the system on 1/3/22.	C1104	See attached plan of correction C1104 POC accepted 4/13/22 P. Wisdeanuka RN	5/3/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] | TITLE: President/COO | (X6) DATE: 4/4/2022

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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C1104	Continued From page 1 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 'inactive' 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 Palliative 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 Palliative Physician notes reveals Patient #14 "understands that if he is very	C1104		

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C1104	Continued From page 2 sick he would want to be left alone to a peaceful 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 distress/failure: 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.	C1104		

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C1104	Continued From page 3 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.	C1104		
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:	C1120	See attached plan of correction C1120 POC accepted 4/13/22 DLW Standards	5/3/22

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C1120	Continued From page 4 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.	C1120		
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	C1206	See attached plan of correction C1206 POC accepted 4/13/22 D. Whitcomb RN	5/3/22

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C1206	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	C1206		

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C1206	Continued From page 6 equipment) ...h. After removing gloves".	C1206		
C1260	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: (i) 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)(1) of this section; and (ii) Staff who provide support services for the CAH that are performed exclusively outside of the	C1260	See attached plan of correction C1260 POC accepted 4/13/22 D. Wisecarver RN	5/3/22

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C1260	Continued From page 7 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; (iii) 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; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (f)(1) of this section; (v) 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; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) 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	C1260		

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C1260	Continued From page 8 vaccination requirements based on recognized clinical contraindications or applicable Federal laws; (viii) 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 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:	C1260		

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C1260	Continued From page 9 (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	C1260		

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C1260	Continued From page 10 Quality, S/He confirmed that the staff vaccination policies did not contain the required elements of the regulation.	C1260		
C1612	FREEDOM FROM ABUSE, NEGLECT & EXPLOITATION CFR(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;	C1612	See attached plan of correction C1612 POC accepted 4/13/22 D. Lindauer RN	5/3/22

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C1612	Continued From page 11 (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	C1612		

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(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
C1612	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 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.	C1612		

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

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 _____	03/16/2022

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
C1612	Continued From page 13 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.	C1612		
E 000	Initial Comments During an unannounced on-site re-certification survey, on 3/14/22 to 3/16/22, the Division of Licensing and Protection conducted a review of the Critical Access Hospital's (CAH's) Emergency Preparedness Program. The facility was found to be in substantial compliance with the Condition of Participation for CAH's at 485.625, Emergency Preparedness.	E 000		

THE
University of Vermont
HEALTH NETWORK
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 000 INITIAL COMMENTS
An unannounced 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.

C1104 RECORDS SYSTEM 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 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 11/12/21, and the same order again entered into the system on 1/3/22.

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 'inactive' 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 Palliative 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 Palliative Physician notes reveals Patient #14 "understands that if he is very sick he would want to be left alone to a peaceful 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 distress/failure: 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

POC accepted 4/13/22
D. Whitewater RN

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.

PoC accepted 4/13/22
D. Wideawake RN

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.

POC accepted 4.13.22
D. Underwood RN

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:

- *i. 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;*
- *iv. 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 Institutefor 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.

PSC accepts 4/13/22
DWildcreek RN

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.

POC accepted 4/13/22
D. Wideawake RN