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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Helen Porter Healthcare & Rehab	30 Porter Drive Middlebury, VT 05753

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29776 Based upon interview and record review, the facility failed to provide care and services according to accepted standards of clinical practice regarding Physician Orders and notification for 1 resident [Res.#83] of 35 sampled residents. Findings include: Per record review, after a stay in the hospital, Res. # 83 was admitted to the facility on [DATE] with acute back pain. The resident was placed on a post-hospitalization nursing unit, where resident's vital signs, including their blood pressure, are measured at least twice a day. Res. #83's blood pressure upon admission to the facility was recorded as 121/75. Physician Orders for Res.#83 upon admission included: Notify provider . for: Systolic Blood Pressure: less than 100 mmHg. Review of Nursing Notes for Res.#83 included the resident's vital signs, including blood pressures. If Res. #83's blood pressure is below 90 systolic [The first (upper) number] the number is preceded by a red !, which per the electronic medical record program indicates abnormal. The electronic medical record also includes a section where the Nursing Note can be routed to a physician to alert them of the content. Additionally, the facility's electronic medical record under Vitals [Vital signs including blood pressure, temperature, heart rate, and respirations] includes a section labeled Provider Notification. In this section, there are areas to record the name of the provider[s] notified, the method of communication, the reason for communication, and the provider's response. Per review of Res.#83's medical record, during the resident's stay on the post-hospitalization unit from 2/6/24 to 5/27/24, the resident's blood pressure was recorded below the Physician Orders' parameters 82 times. Of the 82 times the blood pressure was recorded below the parameters of less than 100, 38 times the blood pressure was highlighted as abnormal; being below 90. Of the 38 instances, eight different nurses recorded abnormal blood pressures. An interview was conducted with the Assistant Director of Nursing [ADON] and Res. #83's Unit Manager of the post-hospitalization unit on 6/4/24 at 2:11 PM. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the interview, the ADON and Unit Manager reviewed a Nursing Note, dated 5/24/24. The Nursing Note documented Res.#83's blood pressure recorded by a Staff LPN [Licensed Practical Nurse] as 66/43, preceded by a red !, which per the electronic medical record program indicates abnormal. The remainder of the note records the resident as 'alert' and 'oriented' and does not include any documentation that the resident's physician was alerted to the abnormal blood pressure reading. The section of the medical record where the Nursing Note can be routed to a physician to alert them of the content lists no routing history on file. Additionally, on 5/24/24 under Res.#83's record of vital signs, below the blood pressure recording of ! 66/43, all areas of the Provider Notification section are left blank. After reading the Nursing Note from 5/24/24, the Unit Manager stated I don't understand that. As a nurse, I would take a manual blood pressure and recheck and notify the doctor. The ADON stated h/her expectation would be to notify the physician any time the systolic blood pressure number was under 100. Both the ADON and Unit Manager confirmed that Physician Orders for Res. #83 included Notify provider . for: Systolic Blood Pressure: less than 100 mmHg. Both the ADON and Unit Manager confirmed per record review since Res.#83's admission on 2/6/24, the resident's blood pressure was recorded by Nursing as under 100 mmHg 82 times. The ADON and Unit Manager confirmed per record review, of the 82 times, there was a single documented incident, on 3/11/24, where Physician Orders were followed and a note recorded that 'abnormal' blood pressure was reported to provider. References: According to the Mayo Clinic: Blood pressure is determined by the amount of blood the heart pumps and the amount of resistance to blood flow in the arteries. A blood pressure measurement is given in millimeters of mercury (mm Hg). It has two numbers: Systolic pressure. The first (upper) number is the pressure in the arteries when the heart beats. Diastolic pressure. The second (bottom) number is the pressure in the arteries when the heart rests between beats. Low blood pressure is generally considered a blood pressure reading lower than 90 millimeters of mercury (mm Hg) for the top number (systolic) or 60 mm Hg for the bottom number (diastolic). The causes of low blood pressure range from dehydration to serious medical conditions. It's important to find out what's causing low blood pressure so that it can be treated, if necessary. Potential complications of low blood pressure (hypotension) include: Dizziness Weakness (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Fainting Injury from falls Severely low blood pressure can reduce the body's oxygen levels, which can lead to heart and brain damage. (https://www.mayoclinic.org/diseases-conditions/low-blood-pressure/symptoms-causes/syc-2) Per review of the Lippincott Manual of Nursing, Common Departures from the Standards of Nursing Care include: failure to follow physician orders, follow appropriate nursing measures, communicate information about the patient. [Lippincott Manual of Nursing Practice-11th Edition 2018]

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48017 Based on staff interviews and record reviews, the facility failed to ensure that residents who are trauma survivors receive trauma-informed care that mitigates triggers that may re-traumatize residents for 3 of 8 sampled residents (Resident #33, #71, and #34). Findings include: 1) Per record review, Resident #33 was admitted to the facility on [DATE] with a diagnosis of PTSD (post-traumatic stress disorder), anxiety, and depression. Resident #33's care plan includes a focus of alterations in mood related to the diagnosis of anxiety, PTSD, and depression, with manifestations that include negative verbalizations about others, tearfulness, sudden mood changes, anger, and self-harming behavior at times. A mental health clinician assessment note dated 1/26/24 mentions details of Resident #33's past trauma. Per review of Resident #33's record, no evidence was found that the resident was assessed for triggers that may re-traumatize the resident. No evidence was found in Resident 33's plan of care regarding the resident's triggers or how staff can provide care that avoids re-traumatizing the resident. Per interview on 6/4/20244 at approximately 11:45 AM, an LPN (Licensed Practical Nurse) with 4 years on that unit was unable to identify Resident # 33's specific triggers related to their trauma experience. Per interview on 6/5/24 at approximately 12:00 PM, the Unit Manager confirmed that Resident #33's trauma experience and associated triggers are not identified in the resident's record. 2. Per record review, Resident #71 was admitted to the facility on [DATE] with diagnoses of PTSD (post-traumatic stress disorder) and depression. Resident #72's care plan includes a focus of depression PTSD (post-traumatic stress disorder), manifested by statements of sadness and decreased participation in activities. The mental health assessment dated [DATE] mentions chronic post-traumatic stress disorder after military combat, with ongoing issues. There are no additional details about the trauma or associated triggers. Per interview on 6/5/24 at approximately 11:15 AM, an LNA was unable to identify Resident # 71's specific triggers related to their trauma experience. Per interview on 6/5/24 at approximately 12:00 PM, the Unit Manager confirmed that Resident #71's trauma-specific triggers have not been identified or care planned for a resident with a history of trauma. 3. Per record review, Resident #34 has resided at this facility since 10/10/2018 with diagnoses that include PTSD (post-traumatic stress disorder). Resident #34's care plan includes a focus of alteration in thought processes and in mood related to depression, anxiety, and PTSD but does not include identification of Resident #34's associated triggers about his/her trauma experience or how staff can provide care that avoids re-traumatizing resident. Per interview on 6/5/24 at approximately 12:00 PM, the Unit Manager confirmed that Resident #34's care plan does not contain identified triggers specific to their trauma.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50431 Based on observation, interview, and record review the facility failed to ensure that food was stored in accordance with professional standards for food safety by leaving a used ice scoop in the ice machine. The facility also failed to monitor the temperatures of refrigerators and freezers daily and report abnormal values for further intervention. Findings include: During the initial tour of the kitchen on 6/3/24 at 10:32 AM with the lead chef it was discovered that the ice scoop was found lying on the ice in the ice machine that is used for 3 out of 3 kitchenettes. Per facility policy of Storage of Food and Non-Food Items reads, Store scoop in storage bin .Do not store the provided ice scoop in the machine. The lead chef confirmed that the ice scoop was in the ice machine per interview at 10:35 AM and 11:06 AM. On 6/3/24 at 10:47 AM in the main dining room meal service area it was discovered that the refrigerator temperature log for 6/3/24 was documented as 44 [degrees] in the AM temperature log. The AM freezer log temperature was not documented. Per record review of the Recording and Maintaining Nutritional Services Logs policy states, Freezer temperature range is 0 degrees [Fahrenheit] and lower .Cooler and refrigerator ranges are 33-41 degrees . Any reading noted to be out of specified ranges shall be reported to a Nutrition Services Leader and recorded on the log sheet. Per interview on 6/3/24 at 10:55 AM the lead chef confirmed that the temperature was recorded as 44 [degrees] and was not reported to a Nutrition Specialist. S/he also confirmed that the AM freezer log for 6/3/24 was not documented. Review of the kitchen refrigerator and freezer temperature logs for the months of December 2023 through April 2024 shows five abnormally high freezer temperatures in December 2023, five abnormally elevated freezer temperatures in January 2024, and one abnormally high freezer temperature in February 2024. There is no documentation that the abnormal temperatures were addressed. In December 2023 there were 87 undocumented temperatures for the refrigerator and 91 undocumented temperatures for the freezer. In January 2024 there were 95 undocumented temperatures for the refrigerator and 91 undocumented temperatures for the freezer. Per interview on 6/3/24 at 12:32 PM the Nutrition Specialist confirmed that there is missing documentation in December 2023 and January 2024 temperature logs. Further record review of February 2024 temperature logs shows 29 undocumented temperatures for the refrigerator and 30 undocumented temperatures for the freezer. Temperature logs for the refrigerator and freezer for March 2024 shows 51 undocumented temperatures for the refrigerator and 25 undocumented temperatures for the freezer. There are 21 undocumented temperatures for the refrigerator and 18 undocumented temperatures for the freezer for April 2024.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135 Based on interview and record review, the facility failed to ensure that each eligible resident receives the COVID-19 vaccine for 2 of 5 sampled residents on the rehabilitation unit (Residents #39 and #60). Findings include: 1. Per record review, Resident #39 was admitted to the facility on [DATE] and has diagnoses that include cerebral palsy (disorder of movement that affects muscle tone, and posture, developed before birth), spinal bifida (failure of the spinal completely close), chronic stage 4 pressure ulcers (deep wounds that may expose bone, tendon or muscle), and osteomyelitis (infection of the bone), The Resident #39 is currently receiving negative pressure wound therapy to treat the stage 4 pressure ulcers. Resident # 39 is considered high risk for COVID-19 complications because of his/her diagnoses. Per record review, Resident #39's last COVID-19 vaccination was administered on 5/21/21 and was not provided the 2023-2024 seasonal COVID-19 immunization. There is no evidence in the record that Resident #36 was screened for eligibility, or s/he had a medical contraindication to not receive the vaccine, that Resident #36 or their representative were provided education regarding the benefits or side effects of the immunization, or that Resident #36 or representative had signed consent to receive or not receive the immunization. A 1/8/24 nursing note reveals that Resident #39 tested positive for COVID-19. Per interview with Resident #39 and their Representative on 06/05/2024 at 1:30 PM, both indicated that Resident #39 was not offered the COVID-19 vaccine this year and would have accepted it if it was. Resident #39 explained that s/he had gotten COVID this winter and was sick with flu-like symptoms. Per interview with the Advanced Practice Registered Nurse (APRN) on 6/5/2024 at 1:40 PM, s/he explained that Resident # 39 is eligible for COVID-19 vaccine and should have been offered the 2023-2024 season COVID-19 vaccine. The APRN stated that there is not a consistent process for screening and identifying residents that need the COVID-19 vaccine on the rehab unit. 2. Per record review, Resident # 60, who is [AGE] years old, was admitted to the facility on [DATE] with diagnoses that include hip fracture with surgical repair, Alzheimer's and hypertension. Resident #60 is considered high risk for COVID-19 complications because of his/her diagnoses and age. Per record review, Resident # 60's last COVID-19 vaccination was administered on 10/3/23 and was not provided a second 2023-2024 seasonal COVID-19 immunization. There is no evidence in the record that Resident #60 was screened for eligibility, or s/he had a medical contraindication to not receive the vaccine, that Resident #60 or their representative were provided education regarding the benefits or side effects of the immunization, or that Resident #60 or representative had signed consent to receive or not receive the immunization. Per interview with the APRN on 6/5/2024 at 1:40 PM, s/he explained that Resident # 60 is eligible for a COVID-19 vaccine and should have been offered his/her second 2023-2024 season COVID-19 vaccine. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per interview with the Director of Nursing on 6/5/2024 at 2:46 PM, he/she revealed there is no written procedure for staff to follow for identifying residents who are not up-to-date with their COVID-19 immunizations. Per facility policy titled SNF COVID-19 Mitigation and care effective 06/19/2023 states COVID-19 vaccination will be offered to all residents not up-to-date, in which there are no medical contraindications, (unless the resident or legal representative refuses vaccination after education), per the CDC/ACIP's recommendation. Record vaccination or declination in the electronic health record. 50336