

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

September 16, 2014

Ms. Jennifer Combs-Wilber, Administrator
Green Mountain Nursing And Rehabilitation
475 Ethan Allen Avenue
Colchester, VT 05446-3312

Dear Ms. Combs-Wilber:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 11, 2014**. Please post this document in a prominent place in your facility.

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

Sincerely,



Pamela M. Cota, RN
Licensing Chief

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

PRINTED: 08/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/11/2014
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NAME OF PROVIDER OR SUPPLIER GREEN MOUNTAIN NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446
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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
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F 000

INITIAL COMMENTS

F 000

Assuming for the moment that the findings and the determination of the deficiency are accurate, without admitting or denying that they are, our proposed plan of correction is as follows:

F 164
SS=D

483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS

F 164

The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

It is the policy of this facility to ensure that residents have the right to personal privacy and confidentiality of his or her personal and clinical records.

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

All residents have the potential to be affected by the alleged deficient practice.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

To ensure that the alleged deficient practice does not occur policy review relating to personal privacy and confidentiality of medical records will be reviewed with staff.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

Staff will be reeducated on the importance of triple checking the information for the residents when information is sent to various appointments with residents to make sure the appropriate information is sent with the appropriate resident.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Janice Combs-Wilbey TITLE: NHA (X6) DATE: 9/4/14

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.

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

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OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/11/2014
NAME OF PROVIDER OR SUPPLIER GREEN MOUNTAIN NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446	

(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
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F 164 Continued From page 1

This REQUIREMENT is not met as evidenced by:
Based on a confidential family report and staff interview, the facility failed to maintain each resident's right to personal privacy and confidentiality of clinical records for 1 applicable resident (Resident #2).

Per a confidential report, a family member reported taking a relative who resides at Green Mountain Nursing Home and Rehab to a medical appointment in July 2014. Upon arrival, s/he discovered that the facility had provided medical information for another resident (Resident #2) to share with the clinic staff instead of that of his/her kin. S/he reported that the medical information included the other resident's first and last name, date of birth, list of medications and a total of 3 pages of health information.

Per 8/11/14 interview with a facility UM (Unit Manager), s/he stated that when residents have medical appointments, the facility places a face sheet (includes resident specific identifiers, name and date of birth, next of kin, and insurance information), medication record/current medical orders, and a problem list in an envelope to bring to the appointment. S/he reported uncertainty of how the above mix-up in records had occurred and stated that there was no policy that s/he was aware of regarding sending information to medical appointments.

On 8/11/14 at 1:20 PM, the ADNS (Assistant Director of Nursing) confirmed that medical information for Resident #2 was mistakenly given to another resident's family member to bring to a medical appointment; s/he confirmed that the information included a copy of Resident #2's MAR (medication administration record) and problem list (which would include the resident's

F 164

A quality Assurance evaluation has been implemented under the supervision of the QA committee, DON, and Administrator for three consecutive months then periodic audits thereafter. This evaluation will include a systematic review of information that is sent with each resident going on appointments.

Completion Date: 9/19/2014

Jew
9-4-14

R104 POC accepted 9/4/14 S Dennis APEN/PMC

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/11/2014
NAME OF PROVIDER OR SUPPLIER GREEN MOUNTAIN NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446		
(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	
F 164	Continued From page 2 medical diagnoses). S/he also confirmed that the facility's "Resident's Rights and Grievance Procedure" states that residents "...have the right to have all your medical and personal records kept confidential, except as required by law or regulation."	F 164			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, administrative and resident interviews and record review, the facility failed to ensure that the environment was free of accident hazards in a bathroom used by two residents residing in the adjoining room. (Resident #2 and Resident #4) Findings include: Per observation on 8/11/14 at 10:33 AM, the bathroom in room #115 had 4 floor tiles under and to the front of the sink and 2 additional tiles by the sink side of the toilet that were loose and lifting up. One tile directly in front of the sink was torn and curled up exposing the delaminating subfloor, creating a tripping hazard. Per record review on 8/11/14 of two of the residents using the bathroom in Room #115: Resident #2 has diagnosis of spondylosis (age related wear and tear of the spine) and difficulty walking; s/he has a care plan in place for	F 323	F323 <i>Assuming for the moment that the findings and the determination of the deficiency are accurate, without admitting or denying that they are, our proposed plan of correction is as follows:</i> It is the policy of this facility to ensure that the resident environment remains as free of accident hazards as is possible. All resident who access 115 bathroom have a potential to be affected by this alleged hazard.		

Jew
9-4-14

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 47504D	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/11/2014
NAME OF PROVIDER OR SUPPLIER GREEN MOUNTAIN NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446	

(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
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F 323

Continued From page 3
deconditioning and falls. His/her ADL (Activities of Daily Living) flow sheet lists that s/he ambulates with assistance and is continent of bladder. Resident #4 resides in the same room as Resident # 2. Both residents were observed ambulating with walkers and per interview on 8/11/14, both residents reported using the bathroom independently.
Per 8/11/14 at 10:33 AM interview, Resident #2 reported that a former roommate let water overflow from the sink and it got under the tiles and lifted them. S/he reported, "I try to be careful so I don't trip...I don't want to fall and break something."
On 8/11/14 at 10:50 AM, the facility administrator confirmed the condition of the loose floor tiles and the related tripping/fall hazard if a foot got caught under the tiles. S/he stated that staff are to notify and write a work order to maintenance when any safety issues are identified in the facility. The administrator contacted maintenance to repair the hazard after it was identified during the survey.

F 323

The alleged loose vinyl tiles underneath the sink in room 115 bathroom has been fixed temporarily to prevent any hazard. The complete bathroom floor will be retiled.

To ensure this alleged hazard does not affect residents. The alleged loose vinyl tiles underneath the sink in room 115 bathroom have been fixed temporarily to prevent any hazard. The complete bathroom floor will be retiled. Staff will be reeducated on the importance of completing written work orders for maintenance.

A quality Assurance evaluation has been implemented under the supervision of the QA committee, Administrator and maintenance director. Weekly environmental rounds will be completed and documented to identify any potential hazards. Work order follow up will be done to make sure potential hazards are fixed in a timely manner by a computerized tracking system.

Jew
9-4-14

F323 POC accepted 9/11/14 SDennis/APRN/jmc

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

AH
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475040	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	DATE SURVEY COMPLETE: 8/11/2014
NAME OF PROVIDER OR SUPPLIER GREEN MOUNTAIN NURSING AND REHABILITATI	STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 329

483.25(1) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to assure that 1 applicable resident's medication regimen had adequate monitoring for antipsychotic medication side effects (Resident #1). Findings include:

Per 8/11/14 record review, Resident #1 was admitted to the facility on 4/22/14 with diagnosis that included dementia with behavioral issues. S/he was prescribed Haloperidol 1 mg at 6 PM. Haloperidol is an antipsychotic medication that has risks for adverse side effects such as difficulty speaking, muscle spasms, restlessness, the need to keep moving, shuffling gait, stiffness of the arms and legs and other muscular symptoms that require monitoring to determine if the medication should be continued or dosage adjusted. Per 8/11/14 at 1:26 PM interview with the facility UM (Unit Manager), an AIMS (Abnormal Involuntary Movement Scale, used to monitor for antipsychotic medication side effects) was not conducted for Resident #1 on admission to the facility until identified by the consultant pharmacist on 6/9/14; the facility completed the AIMS on 6/16/14, almost 8 weeks after admission. The UM confirmed that AIMS screening should have been done on admission to the facility to establish a baseline.

<http://www.mayoclinic.org/drugs-supplements/haloperidol-oral-route/side-effects/drg-20064173>
*This is an "A" level citation.

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The above (isolated deficiencies pose an actual harm to the residents