

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

February 17, 2016

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 **January 13, 2016**. 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

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 01/13/2016
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)

F 000 INITIAL COMMENTS

F 000

An unannounced on-site investigation of 2 complaints concerning care and services was conducted by the Division of Licensing and Protection on 1/13/16. The following regulatory violations were identified:

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET SS=D PROFESSIONAL STANDARDS

F 281

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and record review, the facility failed to provide services that meet professional standards of quality by not following physician's order to complete weekly head to toe skin assessments for 1 of 3 residents (Resident #1) Findings include:

Per 1/13/16 record review. Resident #1 had physician orders for a "weekly head to toe skin assessment" from 9/1/15 through the date of the survey. The resident had been identified as having a risk for alteration in skin integrity related to his/her limited mobility and incontinence of bowel and bladder. The resident also had a history of a significant contracture of the left hand with nails digging into his/her palm. Nursing progress notes dated 9/15/15 document that the resident refused to allow a protective gauze to be removed and to have his/her left hand washed; however, the note continued that with nursing education and reassurance, the resident followed instructions to wash the hand and removed the gauze with nursing direction on that date Per

This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. Without admitting or denying that they are our proposed plan of correction to meet requirements established by state and federal law is as follows:

It is the policy of Green Mountain Nursing & Rehab to ensure that services provided or arranged by our facility meet the professional standards of quality and follow physicians' orders.

Resident #1 continuously refuses treatment to said hand, this concern has been addressed since 9/2015 with multiple conversations with physician and caregivers due to the refusal of treatment, an order was obtained from physician on 12/20/15 to send to ER for eval and treat of said hand. Resident #1 received treatment of hand at hospital under sedation due to agitated behaviors. A medication management plan was ordered by physician to help alleviate pain symptoms causing resistive behavior during care specifically related to hand.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X5) DATE

Janice Combs Walber *Adm* *2/2/16*

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

PRINTED: 01/21/2016
FORM APPROVED
OMS NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X 1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475040	X 2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	X 3) DATE SURVEY COMPLETED C 01/13/2016
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			(X 5) COMPLETION DATE

F 281 Continued From page 1

review of the TAR (Treatment Administration Record), the resident is recorded as refusing weekly skin assessments on all 4 attempts 1n October and November and on attempts during the first 2 weeks in December; there was no documentation on the TAR or weekly skin assessment sheet that a head to toe skin assessment was attempted or completed in January. After 10/8/15 there is no documentation in the nursing progress notes until 12/ 19/15 The 12/19/15 nursing progress note documented that the resident refused care to his/her left hand and that the resident's fingernails were pressed into the palm of the hand and redness was noted. The physician was contacted and after refusing care the resident was sent to the ED (Emergency Department) and admitted to the hospital overnight for treatment of cellulitis of the left hand.

On 1/13/16 at 11 25 AM, the Unit Manager (UM) confirmed the above information and that the physician orders were not followed for completing weekly head to toe skin assessments The UM confirmed that the resident, though resistant to allowing his/her left hand to be manipulated, allowed showers, check and changes for incontinence care and morning and night time care at which time his/her skin could be assessed. S/he further added that it would be an expectation that if a resident was refusing skin assessments, that the staff member would notify a supervisor or ask another nurse to reapproach and complete the assessment. The UM confirmed that the facility's policy for Pressure Ulcers/Skin Breakdown-Clinical Protocol (adopted 1/2015) states under the section "Reporting," that staff are to "i Notify the supervisor if the resident refuses the procedure;" the UM confirmed that

F 281

To enhance currently compliant operations and assure this alleged practice does not occur for residents who are at risk, nursing staff will receive in-service training regarding completion of assessments and documentation for skin under the direction of the director of nurses.

Effective 1/13/2016, a quality-assurance program was implemented under the supervision of the director of nurses to review physicians orders and that documentation is being completed. The director of nurses or designated quality-assurance representative will perform the following systematic process: randomly checking, or weekly checking charts for documentation of skin assessments. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action.

02/4/2016

Opio 2/2/16

FBI POC accepted 2/18/16 S Dennis RN / PML

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 281 Continued From page 2

there is no evidence that staff had notified supervisory staff to arrange a different time approach or another staff member to provide the skin assessment. The UM also could not identify why there was no documentation in the nursing progress notes between 10/6/15- 12/18/15 (a 12/18/15 weekly skin integrity review identified that the resident's left hand was swollen-bruised-hand closed-nails long, refusing to cut). (Refer F282)

Reference: Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins.

F 282 483 .20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and record review, the facility failed to assure that services were provided in accordance with the residents' plan of care for 2 of 3 residents (Resident #1 and #3). Findings include:

1 Per 1/13/16 record review and staff interviews, Resident #1 had a care plan dated 9/16/15 for "Potential for Alteration in Skin Integrity R/T [related to] Limited Mobility and Incontinence of B&B [Bowel and Bladder]" The plan called for the "charge nurse to perform and document weekly skin check." Per review of the TAR (Treatment

F 281

F 282

This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. Without admitting or denying that they are our proposed plan of correction to meet requirements established by state and federal law is as follows:

It is the policy of Green Mountain Nursing & Rehabilitation Center to assure that services are provided in accordance with the residents' plan of care who are at risk for pressure ulcers and impaired skin integrity secondary to impaired mobility and urinary incontinence.

Jew 2/2/16

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F 282 Continued From page 3

Administration Record), the resident is recorded as refusing weekly skin assessments on all 4 attempts in October and November and on attempts during the first 2 weeks in December; there was no documentation on the TAR or weekly skin assessment sheet that a head to toe skin assessment was attempted or completed in January 2016.

During interviews throughout the day on 1/13/16, the Unit Manager (UM) confirmed the above information and that the care plan was not followed related to performing and documenting weekly skin checks. The UM confirmed that the Resident #1, though resistant to allowing his/her left hand to be manipulated, allowed showers, check and changes for incontinence care and morning and nighttime care at which time his/her skin could be assessed. S/he further added that it would be an expectation that if a resident was refusing skin assessments that the staff member could ask another nurse to reapproach and complete the assessment. The UM confirmed that the facility's policy for Pressure Ulcers/Skin Breakdown-Clinical Protocol (adopted 1/2015) states under the section "Reporting," that staff are to "1. Notify the supervisor if the resident refuses the procedure," the UM confirmed that staff had not notified supervisory staff to arrange a different time or approach or another staff member to provide the skin assessment.

2. Per 1/13/16 record review, Resident #3 also had a care plan (dated 12/11/15) for "risk for pressure ulcers and impaired skin integrity secondary to impaired mobility and urinary incontinence." The plan called for "weekly skin check to be performed and documented by charge nurse." Per review of the TAR and the

F 282

Residents #1&3 have had skin assessments completed.

To enhance currently compliant operations and assure this alleged practice does not occur for residents at risk for pressure ulcers and impaired skin integrity secondary to impaired mobility and urinary incontinence, the nursing staff will receive in-service training regarding completion of assessments and documentation for skin under the direction of the director of nurses.

Effective 1/13/2016, a quality-assurance program was implemented under the supervision of the director of nurses to review skin assessments and that documentation is being completed. The director of nurses or designated quality-assurance representative will perform the following systematic process: randomly checking, or weekly checking charts for documentation of skin assessments. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action.

02/4/2016

Jaw 2/2/16

FABR POC accepted 2/8/16 SDennis RN/pnu

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F 282	Continued From page 4 weekly skin integrity review sheet, skin assessments were performed on 12/11/15 and 12/18/15 for Resident #3; however, there is no evidence that another assessment was completed up to the date of the survey On 1/13/16 at 2:35 PM, the UM confirmed that the care plan was not followed and that skin assessments were not completed weekly for Resident # 1 and Resident #3. (Refer F281)	F 282		