

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

December 22, 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 **November 25, 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: 12/01/2014
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	1) PRODESUPPLIECLIA IDENTIFICATION NUMBER 475040	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED C 11/25/2014
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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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F 000 INITIAL COMMENTS

An unannounced on site entity self report investigation was completed by the Division of Licensing and Protection on 11/25/14. The following regulatory violations were identified:

F 279 483.20(d), 483.20(k)(1) DEVELOP SS=D COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:

Based on staff interview and record review, the facility failed to develop a comprehensive care plan for one of three residents (Resident #3). Findings include:

Per medical record review, Resident #3 was admitted to the facility on 11/12/14 following

F 000
F 279

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:

It is the policy of Green Mountain Nursing & Rehab to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

Resident # 3 has a care plan for anticoagulant medications in place.

All residents who are prescribed anticoagulants have the potential to be affected by the alleged deficient practices.

To ensure the alleged deficient practice does not occur, and procedure stays consistent we are taking the following measures:

All residents who are prescribed anticoagulant medications will have a care plan initiated that will include monitoring of labs as ordered by physician, signs and symptoms of bleeding, protection from injury and the administration of the anticoagulant medication. A quality improvement evaluation has been implemented under the supervision of the quality improvement team, DON and or designee for three consecutive months then ongoing thereafter to monitor accuracy and implementation of anticoagulant medication care plan.

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

TITLE

(DATE) DATE

Jennifer Combs-Wilber, NHA

12/12/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided 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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F 279 Continued From page 1

hospitalization. At the time of admission to the facility, Resident #3 had a new diagnosis of AF (Atrial fibrillation) and was started on Coumadin in the hospital as part of his/her treatment (Coumadin is an anticoagulant medication that increases risks for bleeding).

On 11/25/14 at 2:40 PM, the ADNS (Assistant Director of Nursing) reported that when residents are admitted to the facility a working care plan is developed within 48-72 hours. S/he reported that a typical care plan for a resident who was prescribed Coumadin would include monitoring of labs, signs and symptoms of bleeding, protection from injury and administration of medications as ordered. The ADNS confirmed that the facility "missed it" and did not develop a care plan for Resident #3 for his/her new diagnosis of AF with anticoagulant treatment.

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

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

This REQUIREMENT is not met as evidenced by:

Based on medical record review and staff interview, the facility failed to meet professional standards of practice by following a physician's order to monitor blood pressures prior to administering an antihypertensive medication for 1 applicable resident in the 3 resident sample (Resident #1). Findings include:

Per medical record review, Resident #1 had a diagnosis of hypertension (high blood pressure) and was prescribed Metoprolol 25 mg Yi tablet twice daily and Losartan 25 mg daily for its

F 279

Completed by: 1/2/2015

F279 POC accepted 12/22/14 SDennis RN/PMC

F 281

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:

It is the policy of Green Mountain Nursing & Rehab to meet professional standards of practice by following a physician's order to monitor blood pressures prior to administering an antihypertensive medication. According to staff, Resident #1's blood pressures were taken prior to administration of blood pressure medications. Resident # 1's documentation includes blood pressures taken prior to administration of medication

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F 281	Continued From page 2 treatment. Per 11/25/14 interview with the ADNS (Assistant Director of Nursing), the resident developed symptoms of hypotension (low blood pressure), worsening kidney function and had intermittent complaints of fatigue and weakness. On 10/2/14 his/her physician ordered the facility to "Hold Metoprolol for systolic BP (blood pressure) below 100" and the order continued for the month of November. Per 11/25/14 medical record review and confirmed by the ADNS, there is no evidence that Resident #1's BP was taken consistently prior to the administration of his/her twice daily antihypertensive medication particularly on the evening shift from the start of the order on 10/2/14 through 11/19/14. Per 11/25/14 review of the MAR (Medication Administration Record) and associated flow sheets that were copied by the ADNS at the time of the survey, there were approximately 33 opportunities where the staff did not document taking BP's during the time frame of the orders. On 11/20/14, the ADNS reported that s/he identified that staff were not consistently monitoring BPs and reeducated them about the orders. Starting on 11/20/14 Resident #1's BP was taken twice daily (prior to the administration of his/her Metoprolol) for 4 consistent days; however, there was insufficient evidence/time to ensure that the facility was fully compliant in following the physician orders at the time of the survey.	F 281	All residents have the potential to be affected by the alleged deficient practices of failure to document blood pressures taken. To ensure the alleged practice does not occur, and procedure stays consistent we are taking the following measures: All residents with orders to monitor blood pressures prior to administering an antihypertensive medication will be done as frequently as ordered by physician. A quality improvement evaluation has been implemented by the supervision of the quality improvement team, DON and or designee for three consecutive months then ongoing thereafter to evaluate that physicians' orders are being followed. Completed by: 1/2/2015 <i>F281 POC accepted 12/22/14 Dennis Arral Pmc</i>
F 431	483.60(b), (d), (e) DRUG RECORDS, SS=E LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431	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:

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F 431 Continued From page 3

accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:

Based on observation and staff interview, the facility failed to ensure that all drugs and biologicals were stored in locked compartments with access by authorized personnel only. This had the potential of affecting all residents residing on the Champlain East unit. Findings include: During a tour of the facility on 11/25/14 at 2 PM,

F 431

It is the policy of Green Mountain Nursing & Rehab to ensure that all drugs and biological were stored in locked compartments with access by authorized personnel only.

All staff have been reeducated on the alleged deficient practice of ensuring that all drugs and biological were stored in locked compartments with access by authorized personnel only when not in use.

To assure that this alleged deficient practice does not occur a quality improvement evaluation has been implemented by the supervision of the quality improvement team, DON and or designee for three consecutive months then ongoing thereafter to assure that all drugs and biologicals are stored in locked compartments with access by authorized personnel when not in use.

Completed by: 1/2/2015

F431 POC accepted 12/22/14 SDennis APPN/pml

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F 431 Continued From page 4

F 431

an open and uncovered clear plastic storage tote with prescribed topical creams and powders was observed unattended and propped on the railing in the common hall of the Champlain East unit. No nursing staff were observed in the area. At 2:30 PM, the facility ADNS (Assistant Director of Nursing) was brought to the Champlain unit and confirmed that the medication storage box was left open and unattended on the unit and accessible to residents, unlicensed staff and visitors.

On 11/25/14 at 2:35 PM, the Champlain unit nursing supervisor reported that the tote was the treatment box for the East wing and contained bags with multiple topical medications (up to 5 in each bag) used for treatments for 10 residents. The medications included Voltaren gel (a topical analgesic cream), Clobetasol propionate 0.5% cream (a high potency steroid cream), Clotrimazole (an antifungal cream), Nystatin 100,000 topical powder (antifungal powder), topical antibiotic creams and other treatments. The nursing supervisor reported that the box is typically locked in a room by the nurse's station but had been brought to the wing to administer treatments. S/he stated that there was no room to store the topical medications in the medication cart and the facility did not have a treatment cart to keep the medications secure while on the unit. S/he reported that staff would need to return to the nurse's station to retrieve medications for each treatment if the box was locked in the storage area. Per interview, the unit has residents with dementia and other long term care needs. Per 10/25/14 review, the facility policy Storage of Medications section 7 states that "Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in

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F 431	Continued From page 5 use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others." On 11/25/14, the facility ADNS confirmed that this is the current facility policy regarding medication storage and that the medications in the tote were improperly stored and accessible to others.	F 431		