

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 18, 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 **July 16, 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
 CENTER8 FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/04/2014
 FORM APPROVED
 OMB NO 0938-0391

RECEIVED
 Division of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	SEP 16 14 Licensing and Protection	(X3) DATE SURVEY COMPLETED 07/16/2014
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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

An unannounced on-site recertification survey and investigation of complaints and facility self-reports was conducted on 7/14-16/2014 by the Division of Licensing and Protection. The following regulatory deficiencies were identified during the survey:

F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:

Based on observation, resident and staff interviews, the facility failed to promote care for 4 of 14 residents in the Stage 2 sample in a manner and in an environment that maintains each resident's dignity. Findings include:

- On 7/14/14 at 5:25 PM during observations near the doorway to room 204, Resident #74 was in bed on the far side of the room. The privacy curtain was open enough to observe him/her waving at me and observed from the doorway that Resident #74 was uncovered/unclotted. On 7/16/14 at 12:45 PM, a resident was observed in the TV area between rooms 203 and 204 and s/he then passed through room 204, where Resident #74 was in bed resting with the curtain drawn back. After exiting through the far door of room 204 (where 4 residents reside) and walking the hallways, going in and out of room 201 (where 4 residents reside), the ambulating resident once

F241

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 to meet requirements established by state and federal law is as follows:

An Informal Dispute Resolution (IDR) has been submitted relating to this alleged deficient practice relating to inaccurately identified information.

It is the policy of Green Mountain Nursing & Rehab to provide care to the residents in a manner and environment that maintains resident dignity.

Resident #74 will have the curtain pulled around him when he is in an undignified situation.

Residents and staff will not use room 204 as a pass through to the current sitting area.

Physical therapy services will not be provided on residents who are eating or in the close proximity of other residents eating during meal times.

Privacy curtains will be pulled on resident #67 when providing all care.

Resident #65 will have clean splint applied.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Janet Cond-Welby, NHA

9/9/14

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.

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F 241 Continued From page 1

again passed through room 204 and re-entered the TV area. At that time an LNA was responding to a call light in room 203 and confirmed that this resident is unable to engage the door codes to exit the TV area, so routinely passes through room 204 to go back to his/her room (205) and the general Maple Heights unit. When asked about his/her going into room 201, the LNA stated that this resident often uses the bathroom in room 201.

2). Per observation on 7/14/14 at 12:15 PM in the Champlain Unit East wing common area, two residents were being fed by staff. A third resident (resident #37) was seated in the area with her lunchtray, partially consumed. A Physical Therapist (PT) was actively working with the resident, performing lower extremity exercises in the common area. In an interview on 7/14/14 at 12:30 PM the PT explained that the resident stated she was done eating. When asked if it was usual to perform therapy in the dining area during a meal she stated, "The PT gym is under construction now and so we are doing therapy on the units. The resident stated that she was done eating. She has a wound vac and taking her back to her room would involve clamping that off and moving all her equipment. Also if she returned to her room she would probably see her bed and want to get in it." In an interview on 7/14/14 at 12:50 PM, the Unit Manager confirmed that therapy should not be performed in a public area where other residents are eating. S/he stated that the PT should have requested that staff move the resident to a private area.

3.) Per observation and staff interviews, Resident #71 is in a room with 3 other roommates. During

F 241

LNA's will knock on resident doors upon entry. Staff will explain any procedures or care being provided to residents.

All residents have the potential to be affected by the alleged deficient practices

Staff will be reeducated on

- Residents' curtains pulled around them when s/ he are in an undignified situation.
- Residents and staff not using room 204 as a pass through to the current sitting area.
- Physical therapy services will not be provided on residents who are eating or in the close proximity of other residents eating during meal times.
- Privacy curtains will be pulled on residents when providing all care.
- LNA's will knock on resident doors upon entry.
- Staff will explain any procedures or care being provided to residents.
- All splinting devices will be cleaned routinely and monitored for soiled condition.

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

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. This evaluation will include audits of staff practices on the above dignity concerns.

Completion Date 8/8/2014



F241 POC accepted 9/17/14 mcaicarn

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F 241 Continued From page 2

F241

observation of Resident #71 on 7/15/14 at 3:24 PM, a Licensed Nursing Assistant (LNA) entered the resident room without knocking or announcing him/herself at the doorway. The LNA confirmed that s/he had not knocked on the door or announced themselves before entering the room.

4.) On 7/16/14 at 10:10 AM an observation was made of the room that Resident #71 resides in the door was closed and when it opened an LNA left with one of the residents and left the door open. A Licensed Practical Nurse (LPN) was observed doing a glucose finger stick on Resident #71 and the privacy curtains were not pulled. The LPN made a comment that the door was open and h/she should close the curtain and attempted to do so and only succeeded in pulling it part way around the resident. At this time there were still two other residents in the room, one of them directly across from Resident #71. The LPN confirmed at the end of the procedure, that h/she had not pulled the curtain and should have.

5.) Per observation and staff interviews, Resident # 67 is in a room with 3 other roommates. The room has two openings, one for entering through the hall the other opens onto a small dining/television area, which connects to another 4-bed room. On 7/14/14 during the initial tour, it was observed that the LNA's had walked through the resident's room to enter the other 4-bed room, instead of using the access door that was reported by the LPN to be the acceptable access and not through the rooms.

6.) Per observation on 7/14/14, the LPN was observed to irrigate Resident #67's g-tube (feeding tube) and not pull the privacy curtains

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F 241 Continued From page 3 F 241

the door was open to the hall way and the Resident was easily observed by anyone passing. The LPN confirmed at time of incident that h/she had not closed the door.

7.) Per observation at 11:35 AM during tracheostomy (trach) care for Resident #67, the LPN prepared for the procedure by placing the required supplies, which included 4X4 split gauze for gtube dressing and one for trach site dressing and sterile scissors, on the resident's abdomen and chest. The LPN cut the ties to the trach and replaced with a new tie, placing the old trach tie and the scissors on the resident's chest and abdomen. H/she then proceeded to remove the old dressing to the gtube site and replace it with the clean one and then proceeded to change the inner trach cannula without changing gloves or practicing hand hygiene. The LPN then filled the nebulizer bottle without performing any form of hand hygiene between. After task completed, the LPN removed the materials, but left the old trach tie on the resident's chest. S/he did not explain the procedure to the resident prior to or during the process. After the LPN had completed the treatments, s/he verified that hand hygiene and glove changing had not occurred and that the scissors were left on the resident's chest. S/he also stated that if it were them, they would not have liked being used as a table to put supplies on. (See also F441)

8. During observation of the 7/14/14 lunch meal, at 11:45 AM, LNAs were transporting lunch trays to residents in the dining/television room and to the other 4-bed room by entering the room of Resident #67 instead of going through the hallway/stairway door, and at 12:30 PM they were returning the trays to the cart by using Resident



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<p>F 241 Continued From page 4</p> <p>#67's room as a corridor. The LNAs stated that they are supposed to use the stairway door to access the dining/television room and the other 4-bed room and not "cut through".</p> <p>9. On 7/15/14 at 8 AM it was observed from the hall, that an LPN was flushing the feeding tube for Resident #67 and the privacy curtain was not pulled. The LPN confirmed that the curtain is should be pulled during a procedure</p> <p>10.) In a family interview for Resident #67, on 7/16/14 at 11:30 AM, the family member stated that s/he has come into the room and has seen one of his roommates sitting in a chair with only a "diaper" on and it bothers him/her and makes the family concerned as to whether this is occurring with their family member.</p> <p>11). Per medical record review, Resident #65 admitted on 11/18/10 with diagnosis to include Cerebral Vascular Accident with Left Hemiplegia, Atrial Fibrillation, Chronic Obstructive Pulmonary Disease and Depression. Per observation on 7/15/14 Resident #65 attended the restorative feeding program for breakfast with a soiled palm guard in place. Per interview with LNA on 7/15/14 at 8:16 AM, confirmation was made that Resident #65 had the soiled palm guard in place during the breakfast meal and the palm guard should not have been applied while in the soiled condition noted.</p>	<p>F 241</p>
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F 279 Continued From page 5

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 observation, record review, and staff interview the facility failed to assure that the results of the assessment were used to develop a comprehensive plan of care for 1 resident, Resident #19 in a Stage 2 sample of 14. Findings include:

Per observations 7/14-16/14 Resident #19 (R #19) has a seat belt restraint in place when out of bed in a chair. Per observation on 7/16/14 the resident also has a scoop mattress on her bed. Per anonymous interview during the survey it was

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 to meet requirements established by state and federal law is as follows:

It is the policy of Green Mountain Nursing & Rehab to assure that the results of the assessments are used to develop a comprehensive plan of care.

The seat belt and scoop mattress utilized for resident #19 is used for the symptoms of the documented diagnosed disease process to enhance the quality of life of said resident.

Per extensive investigation and staff interviews, Resident # 19 did not slide out of her chair with the seat belt on.

The seat belt and scoop mattress will be care planned and documented according to usage, positioning and safety, Resident #19 will continue to be care planned for the tilt and space wheel chair, resident will continue to be monitored when up in tilt and space wheel chair.

All residents who need a seat belt for their medical symptoms to enhance their quality of life have the potential to be affected by this alleged deficient practice.

Seat belts and scoop mattresses will be care planned and documented according to usage, positioning, and safety.



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F 279 Continued From page 6

reported that R #19 had slid out of her chair and been caught by her seat belt. During investigation of that report the nurse on duty on the Maple Heights unit acknowledged that R #19 uses a seat belt when out of bed in her chair. Per interviews on 7/14/14 both the Director of Nursing Services (DNS) and the Assistant Director of Nursing Services (ADNS) confirmed that R#19 uses a seat belt restraint for medical reasons. Per interview on 7/16/14 the Unit Manager on Maple Heights confirmed that R #19 has a scoop mattress on his/her bed because s/he is able to roll and the mattress prevents the resident from rolling and falling out of bed.

In record review on 7/14-16 reveals a Physician's order stating "Resident may be in w/c [wheelchair] with seatbelt to prevent injury from spastic movements from medical condition of Huntington's Disease. Seatbelt to be released Q2 Hrs [every 2 hours] for 15 min duration." There is a form titled Consent for Use of Physical Restraint dated 5/4/2009 signed by the resident's husband. The form states that the PT (Physical Therapist) had recommended use of a Broda chair but that the spouse doesn't like the use of a Broda chair because it interferes with his ability to participate in (his/her) care. A restraint Release Flowsheet for the seat belt is in the record and reviewed. The care plan contains a section (0047) dated 3/27/14 and titled "At risk for injury due to falls r/t dx of Huntington's Disease m/b spastic movements of both upper and lower extremities" which states "Belt in w/c at all times due to spastic movements and MD order." A section (0203) titled "'R' has Huntington's Disease with severe spasms despite scoop mattress, high low bed and mat on floor 'R' has spasms causing her to come out of bed, landing on

F 279

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

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, this evaluation will include audits of documentation and visual reviews of positioning, usage and safety.

Completion Date 8/8/2014

F279 POC accepted 9/17/14 PMA:RPN



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F 279 Continued From page 7

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[his/her) mat." The interventions in this section include "Scoop mattress on bed" and "(2) body pillows on either side of resident while resident is in bed." There is no care plan found during record review for physical restraints in bed which includes any information regarding evaluation of the restraint, release of the restraint when applicable, attempts to use the least restrictive device, re-evaluation of the continued use of the restraint, or attempts to discontinue the restraint. There is no care plan regarding devices used in bed to prevent the resident from rolling and falling out of bed.

In an interview at 11:45 A on 7/16/14 the ADNS confirmed that there was no other documentation with the above information available.

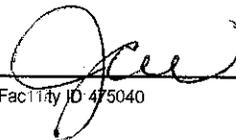
F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO SS=D PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

F280

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

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 to meet requirements established by state and federal law is as follows:



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F 280 Continued From page 8

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to assure that the plan of care was periodically reviewed and revised with changes in care/equipment for 1 of 14 residents Resident #19. Findings include:

1). Per observations on 7/14-16/14 Resident # 19 (R #19) has a seat belt restraint in place when seated in his/her chair. Per observation on 7/16/14 the resident also has a scoop mattress on his/her bed. Per interview, the nurse on duty on the Maple Heights unit acknowledged that R #19 uses a seat belt when out of bed in his/her chair. Per interviews on 7/14/14 both the Director of Nursing Services (DNS) and the Assistant Director of Nursing Services (ADNS) confirmed that R#19 uses a seat belt restraint for medical reasons. Additionally the DNS stated that the resident has had several different chairs attempted including a Broda chair.

In record reviews on 7/14-16/14 the record reveals that the current care plan contains a section (0047) dated 3/27/14 and titled "At risk for injury due to falls r/t dx of Huntington's Disease m/b spastic movements of both upper and lower extremities" which states "Belt in w/c [wheelchair] at all times due to spastic movements and MD order." In a review of previous care plans revised annually in May of 2010-2013, the care plan section 0047 was the section addressing the chair and contained only one intervention "Seat belt on when in w/c per MD order" but no

F 280

It is the policy of Green Mountain Nursing & Rehab to assure that residents plan of care is periodically reviewed and revised with changes in care/ equipment.

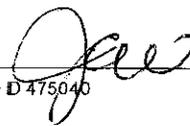
Resident # 19 is care planned according to usage, positioning, and safety of the tilt n space wheel chair, seat belt, and scoop mattress. Physical therapy reviews Resident #19 on a quarterly basis and as requested.

All residents who need a seat belt for their medical symptoms to enhance their quality of life have the potential to be affected by this alleged deficient practice. Residents will be care planned according to usage, positioning and safety of devices utilized to enhance their quality of life.

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

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 this evaluation will include audits of documentation and visual reviews of positioning, usage and safety.

Completion Date 8/8/2014



F280 POC accepted 7/17/14 Pmccarpen

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F 280 Continued From page 9
information about various changes in chairs, staff monitoring resident's position and reaction to new seating, proper position in new chair and precautions or safety measures for chairs. In an interview at 11:45 AM on 7/16/14 the ADNS confirmed that there was no other care plan documentation with the above information available.

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 observation, record review and staff interview, the facility failed to provide services in accordance with each resident's written plan of care for 1 resident in a sample of 14 in Stage 2 Findings include

1. Per observation and staff interview on 7/15/14 at 2:45 PM, while attempting to engage him/her in an interview, Resident #74 was observed seated in a recliner beside his/her bed. When asked if s/he was comfortable, Resident #74 responded "I would like it better if I could move the chair". I asked if s/he needed assistance to get up, and s/he responded, "they say I should ask for help, but I can't". I then observed that the call device was attached to the bed rail on the far side of the bed. I summoned a Licensed Nurse Assistant (LNA) and asked if Resident #74 should have a call device within reach while in the recliner. The

F 280

F 282
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 to meet requirements established by state and federal law is as follows:

It is the policy of Green Mountain Nursing & Rehab to assure that residents are provided services in accordance with their care plans.
Resident # 74's call device was moved from assist rail on bed to recliner immediately.
All residents have the potential to be affected by the alleged deficient practice. Staff will be reminded and reeducated on making sure that call assist devices are within residents reach.

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 this evaluation will include audits of making sure call lights or call devices are in reach of residents.

Completion Date 8/8/2014

FABA POC accepted 9/17/14 Pmestuen

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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 282 Continued From page 10
LNA responded that s/he was not the one who had failed to provide the call device, but yes it should be available. and s/he dd make it available. Upon review of the written plan of care the care plan to prevent falls instructed staff to make the call device available.

F 353 483 30(a) SUFFICIENT 24-HR NURSING STAFF
SS=E PER CARE PLANS

The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident as determined by resident assessments and individual plans of care

The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.

Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

This REQUIREMENT is not met as evidenced by:

Based on observations, record review and interviews the facility failed to assure sufficient nursing staff to provide nursing and related services to attain or maintain the highest

F 282

F353

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 to meet requirements established by state and federal law is as follows:

An Informal Dispute Resolution (IDR) has been submitted relating to this alleged deficient practice relating to inaccurate information

It is the policy of Green Mountain Nursing & Rehab to assure there is sufficient nursing staff to provide nursing and related services to attain or maintain the highest emotional physical and psychosocial well-being of residents, as determined by the resident assessments and plans of care.

GMNH will continue to have sufficient staff to provide nursing and related services to attain maintain the highest emotional physical and psychosocial well-being of residents, as determined by the resident assessments and plans of care.

Residents who are unable to communicate their needs will not be left unattended in the TV area between rooms 203-204, residents who are able to communicate their needs will have access to devices that alert staff of needed assistance.

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F 353 Continued From page 11
emotional, physical, and psychosocial well-being of residents, as determined by the resident assessments and plans of care. Findings include:

1). On 7/14/14 at 5:25 PM during observations near the doorway to room 204. Resident #74 was in bed on the far side of the room. The privacy curtain was open enough to observe him/her waving at me and was able to see from the doorway that Resident #74 was uncovered/unclothed. Resident #74 was noted to have pulled off the brief and was lying uncovered and unclothed on the bed.

2). On 7/16/14 at 12:45 PM, Resident #90 was observed in the TV area between rooms 203 and 204. There were also 3 residents in wheelchairs and 2 residents seated in chairs at the table. None of the six residents were able to report their name or have a conversation with the surveyor. The TV was not on and there was no music or activity materials. One resident had a drink available. No staff were in the area between rooms 203 and 204, where the only access to the nurses station is through either two coded doors or through room 204. None of the residents had access to a call device. Resident #90 (who per observation and record review is independent for ambulation, and wanders) then rose and passed through room 204 (where 4 residents reside) and walked down the Maple Heights hallway, in and out of the shower/bathroom, then in and out of room 201 (where 4 residents reside). Resident #90 then once again passed through room 204 to re-enter the TV area. At that time (1:00 PM) an LNA was responding to a call light in room 203 and confirmed to me that this resident is unable to engage the door codes to exit the TV area, so routinely passes through room 204 to go back to

F 353
Door to room 204 from the sitting area will be closed and a sign placed stating "do not enter please respect residents privacy this is not to be used as a thruway to main hallway".

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

To assure that this alleged deficient practice does not occur there will continue to be sufficient staff to provide nursing and related services to attain maintain the highest emotional physical and psychosocial well-being of residents, as determined by the resident assessments and plans of care.

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 this evaluation will include audits of schedule, daily staffing sheets and acuity.

Completion Date 8/8/2014

F353 POC accepted 9/17/14 Pmcoturn



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F 353 Continued From page 12

F 353

his/her room (205) and the general Maple Heights unit. When asked about his/her going into room 201, the LNA stated that this resident often uses the bathroom in room 201. The LNA further confirmed that no staff are specifically assigned to supervise residents in the TV area.

3). Per observation of supper on Maple Heights unit 7/14/14, at 5:45 PM, the environmental aid (EA) was assisting the 4 residents in room 201. While the EA cut up food for one resident, a second resident rose and was pushing the overbed tray across the room, a third resident was eating cottage cheese and soup with fingers and a fourth resident had fallen asleep with food uneaten. As the EA went to assist the resident who was eating with fingers, the surveyor proceeded to room 204 where the Licensed Nurse Assistant (LNA) was feeding Resident #19 (who requires full assistance) while also needing to supervise Resident #80. Resident #80 has dementia with behavioral disturbance and has been involved in a series of resident to resident altercations on 5/4, 5/6, and 5/14/14. On 5/7/14 the written plan of care was revised to initiate 1:1 staff supervision to Resident #80 at all times while out of bed. At this time during the supper observation, the resident from room 201 who was pushing the overbed tray entered room 204, the EA had to leave the other 3 residents in room 201 to redirect this resident out of room 204 and back to room 201. During an interview with the Director of Nurses (DNS) on 7/16/14 at 10:00 AM, the surveyor asked the DNS to clarify the expectation regarding supervision of Resident #80. The DNS confirmed that the expectation is that staff will share supervision of residents, including 1:1 supervision of Resident #80; this included that the staff person who was feeding Resident #19 would

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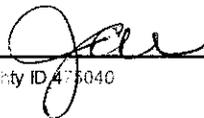
F 353 Continued From page 13

F 353

have been expected to intervene if Resident #80 had risen from bed and become agitated. It was further confirmed that no staff are specifically assigned to 1:1 supervision of Resident #80. On 7/16/14 at 11:20 AM, I was near the nurses' station on Maple Heights unit; no staff were in the area at the time. Resident #80 (who is independent to ambulate and has severe dementia with aggressive behaviors) came around the corner alone. I was able to engage him/her verbally for about 20 seconds without incident, then s/he walked into room 204 directly to his/her bed area. There were two residents in the room in their beds. Shortly thereafter, about 10 seconds, the EA appeared and stated, "There you are. I lost you".

4). Per interviews during Stage 1 of the survey, three families interviewed all answered the question "Is there enough staff available in this facility to make sure that residents get the care and assistance they need without having to wait a long time?" with a "No", citing the weekends and Holidays as the worst and citing aspects of care not completed.

5) Per review of information regarding care needs of residents requested from the Unit Manager of the Maple Heights Unit of the facility, the following issues were identified. Targeted staffing levels for the unit according to staff interview with the Unit Manager is 2-3 Licensed Nurses Aides (LNAs) and one Environmental Aide (EA) for the day shift and 2 LNAs and an EA on the evening shift. An EA may provide supervision and distraction but is



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F 353 Continued From page 14

F 353

not allowed to perform direct care or to feed the residents. In a review regarding the demographics of the unit there are 25 residents presently on the unit. Of the 25 residents 19 require a 2 assist transfer, 16 require total care and 9 of the 16 require 2 caregivers for care 11 need to be fed and a 12th requires a tube feeding, 10 residents have behaviors and 3 require 1:1 supervision (1 when awake, 1 when up and 1 when anxious). Assuming that residents receive the care and supervision required by assessments, there is not sufficient time in an eight hour shift for the usual number of staff to provide that care.

Per interview an anonymous staff member stated that additional staff were added to the staffing schedule beyond the daily usual numbers on both the day (7 A to 3 P) and evening (11 P to 7 A) shifts for the survey. The staff member stated that there were seldom 4 LNAs on the floor and that when there are only 3 one is tied up with 1:1 leaving only 2 caregivers for 25 residents with high care needs. The staff member stated that there was more staff on the unit because there was a survey in progress and extra staff had been sent to the unit.

6) Per conversation on 7/15/14 at 1045 AM between a Licensed Practical Nurse and family, Resident #32 would be taken to an activity that was going to be held involving children performing a music program. At 11 15 AM Resident #32 was being transported by Licensed Nursing Assistant (LNA) on to elevator to attend the activity. Activity care plan written 3/22/12 for Resident #32 presents that resident is to maintain current level of activity and participate in activities

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F 353 Continued From page 15

of choice 3-4 times a week. Observation of activity calendar in resident's room with blue dots next to some activities and the LNA explained that the blue dots indicated activities that the family and resident have chosen for him/her to attend. Per interview with the LNA at 11:30 AM that transported the resident to the activity, the activity had ended by the time the resident arrived and the resident did not participate in the program. When asked the LNA why h/she did not have the resident to the activity on time, h/she stated that h/she was directed to have Resident #32 up around 10:00 AM and they (the LNAs) were busy and h/she could not get to the Resident until 10:50 AM to get him/her up in time and that sometimes it is hard to get everything done, because there is not always enough people to help.

F 387 483.40(c)(1)-(2) FREQUENCY & TIMELINESS
SS=D OF PHYSICIAN VISIT

The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview, the facility failed to insure that 1 out of 14 residents in the Stage 2 sample Resident #32 was seen by a physician at least every 60 days, per required regulation. Findings include:

F 353

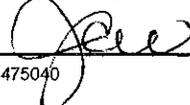
F 387

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 to meet requirements established by state and federal law is as follows:

It is the policy of Green Mountain Nursing & Rehab to assure that physician visits are completed according to regulatory guidelines.

Resident #71 and #32 physician visits are currently up to date.

Resident # 32 was seen on 7/2/14



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F 387 Continued From page 16

1.) Per record review on 7/16/14 at a 15AM for Resident #32, the progress notes by the primary care physician presented that the resident was seen on 1/18/14 and then not seen again until 5/14/14. The Licensed Practical Nurse reviewed the medical record and confirmed that there is no evidence that the physician visited as required by regulation.

F 431 483.60(b), (d), (e) DRUG RECORDS, SS=B LABEUSTORE 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 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

F 387

Missing physician visit for Resident #71 has already been addressed on 3/26/2014 during an investigative complaint survey in which an A level deficiency was cited.

All residents residing in this facility have a potential to be affected by this alleged deficient practice. The following procedure is in place:

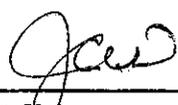
Nursing staff will call and send a fax reminder of impending visit.

If physician fails to meet visit requirement prior to due date Administrator will contact physician for notification. If physician does not meet visit requirement within the 10 day grace period Medical Director will attempt to contact physician for a courtesy call reminding him/her of visit requirements and visit resident.

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, this evaluation will consist of a review of physician visits and due dates.

Completion Date 8/8/2014

F387 POC accepted 9/17/14 Administrator



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F 431 Continued From page 17
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 observations and staff interviews the facility failed to store medications in a way to ensure expired medications were not kept on units, available for use. Findings include:

1) Per observation on 7/16/14 at 9:40 AM, the medication storage cabinet on the Maple Heights Unit contained the following expired medications

- Ferrous sulfate 325 milligrams (mg) - expired 4/14
- Ferrous sulfate 325 mg - expired 5/14
- One a day multi vitamin w/minerals - expired 6/14
- One a day multi vitamin w/minerals expired 4/14

The above was confirmed by the Unit nurse at 9:38 AM on 7/16/14.

2) Per observation on the Champlain Unit on 7/16/14 at 9:50 AM, the medication storage cabinet contained the following expired medications:

- Calcium Carbonate 500 mg - expired 12/13
- Aspirin 325 mg - expired 7/13
- Clotrimazole 1% cream - expired 12/12

The above was confirmed by the Unit Manager at 9:53 AM on 7/16/14.

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 to meet requirements established by state and federal law is as follows:

It is the policy of Green Mountain Nursing & Rehab to assure medications are stored in a way to ensure expired medications were not kept on units, available for use.

All medications found to be expired have been discarded.

All residents have the potential to be affected by this alleged deficient practice. To ensure that this alleged deficient practice does not occur, an ongoing inspection of medication dates will be completed at least monthly, any found with expiration date will be disposed of properly.

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, this evaluation will include audits of medication expiration dates.

Completion Date 8/8/2014

F431 POC accepted 9/17/14 Amataren



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F 431 Continued From page 18

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3). Per observation in the basement storage area on 7/16/14 at 10:45 AM, the following expired medications were identified:

- Miconazole 25 cream - expired 5/14
- Aspirin 325 mg - expired 3/14
- Hemorrhoid suppositories - expired 6/14

The Assistant Director of Nurses confirmed the above at the time of the observation.

F 441 483.65 INFECTION CONTROL, PREVENT SS=E SPREAD, LINENS

F 441

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection

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 to meet requirements established by state and federal law is as follows:

(a) Infection Control Program

- The facility must establish an Infection Control Program under which it -
- (1) Investigates, controls, and prevents infections in the facility;
 - (2) Decides what procedures, such as isolation, should be applied to an individual resident; and
 - (3) Maintains a record of incidents and corrective actions related to infections.

It is the policy of Green Mountain Nursing & Rehab to assure proper infection control techniques are used by direct care staff.

(b) Preventing Spread of Infection

- (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
- (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

Staff continues to be reeducated on the importance of infection control and proper procedures of hand hygiene relating to the treatment procedures of resident #67.

Thickening will be done using gelled thickener packets to eliminate utilizing a scoop therefore eliminating the chance of cross contamination.

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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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(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

Based on observations, record review, and staff interviews the facility failed to assure proper infection control techniques are used by direct care staff and failed to assure that a safe, sanitary environment was maintained for use of scoops in multi-dose containers for 2 of 14 residents in the Stage 2 sample. Findings include:

1) Per observation and staff interview on 7/7/14 at 11:35 AM during tracheostomy care for Resident #67, the LPN prepared for the procedure by placing the required supplies, which included 4X4 split gauze for feeding tube (gtube) dressing and one for trachea site dressing and sterile scissors, on the resident's abdomen and chest. The LPN cut the ties to the trachea and replaced with a new tie, placing the old trachea tie and the scissors on the resident's chest and abdomen. H/she then proceeded to remove the old dressing to the tube site and replace it with the clean one and then proceeded to change the inner trachea cannula without changing gloves or practicing hand hygiene. The LPN then filled the nebulizer bottle without performing any form of hand hygiene. After the task was completed, the

F 441

All residents have the potential to be affected by this alleged practice, to ensure that this alleged deficient practice does not occur staff will be reeducated on the importance of hand hygiene and infection control techniques.

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, this evaluation will include hand hygiene audits, treatment procedures and infection control techniques.

Completion Date 8/8/2014

F441 PIC accepted 9/11/14 Pmcoturn



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

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FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475040	X2) MULTIPLE CONSTRUCTION A B U I L D I N G — B W I N G _____	X3) DATE SUREY COMPLETED 07/16/2014
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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) D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	D 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 441

LPN removed the materials, but left the old trachea tie on the resident's chest. H/she did not explain the procedure to the resident prior to or during the process. After the LPN had completed the treatments, h/she verified that hand hygiene and glove changing had not occurred and that the scissors were left on the resident's chest. H/she also stated that if it were them, they would not have liked being used as a table to put supplies on

2.) Per observation at 12 Noon on July 7, 2014, an Licensed Nursing Assistant (LNA), prepared thickened liquids for a resident by using the scoop that was in the multi usage, house stock can of Thick It. H/she did not wash their hands prior to preparation and using the scoop, nor did they wear gloves. The LNA then replaced the scoop into the container. Immediate confirmation was made by the LNA that they had not worn gloves and that the container is used for many residents and h/she had touched the scoop with their bare hands and then placed it back into the container.

Per observation on 7/14/14 at 524 PM, a Registered Nurse (RN) was witnessed thickening liquids for Resident #45. The RN did not wash his/her hands prior to thickening the liquids, did not wear gloves during the process and thickened the liquids by utilizing the measuring scoop that had been stored in the multiple dose canister. Per interview with the RN, he/she confirmed that hand washing did not occur prior to thickening the liquids, that gloves were not applied and that the contaminated scoop was used for measuring the powder

Per interview with Director of Nurses (DNS) on



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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 07/16/2014
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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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7/15/14 at 12:08 PM confirmation is made that the dining room, restorative dining room, Champlain East and West, Cabot Cove and the Maple Unit on the second floor all utilize multiple dose canisters for thickening fluids with the measuring scoop is stored in the canister. DNS also confirms that she/he can not ensure that the thickening powder has not been contaminated nor that proper hand hygiene is utilized while thickening liquids.

F 441

F 465 483.70(h)
SS=E SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT

F 465

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

This REQUIREMENT is not met as evidenced by:

Based on observation and staff interview, the facility failed to provide a safe functional and sanitary environment for residents staff and visitors. Findings include:

1. Per observation on 7/14/14 at 12:20 PM, an oxygen (O2) tank was standing upright and unsecured on a loading dock near the main dining room, creating a potential accident hazard. This observation was confirmed by the facility Administrator at 12:28 PM.

2. Per observation on 7/15/14 at 9:46 AM, a wall mounted fan in that was operating was blowing across the top of room 115 in Cabot Cove was heavily soiled with dust. The 10-12 inches of wall

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 to meet requirements established by state and federal law is as follows:

It is the policy of Green Mountain Nursing & Rehab to assure that a safe, functional, and sanitary environment for residents, staff, and visitors occurs.

The oxygen tank standing outside of the oxygen tank rack on the loading dock was immediately put into the rack.

The wall mounted fan has been cleaned.

The sink faucet in room 205 has been repaired.

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in front of the fan was also soiled with dust. There were strands of dust attached to ceiling tiles. The overhead enclosed lights in the same hallway have visible dead insects and debris. This observation was confirmed by the Assistant Director of Nurses on 7/15/14 at 9:56 AM.

3. Per observation on 7/15/14 at 3:05 PM, the sink faucet in Maple Heights room 205 is loose and can be easily pulled away from the sink, creating a potential accident hazard. There is an ambulatory resident in the room. This observation was confirmed by the Maintenance Director at 8:44 AM on 7/16/14.

F 465

All residents, staff, and visitors have the potential to be affected by this alleged deficient practice, to ensure that this alleged deficient practice does not occur; facility environmental rounds will be done and documented.

All concerns will be documented on work orders and maintenance director, administrator, and or designee will do follow up for completion.

A quality improvement evaluation has been implemented under the supervision of the quality improvement team, maintenance director, and or designee will monitor for three consecutive months then ongoing thereafter, this evaluation will include audits documenting environmental rounds.

Completion Date 8/11/2014

F465 POC accepted 9/17/14 pmc/taew