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

March 28, 2018

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 **February 15, 2018.** 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475040	A. BUILDING _____ B. WING _____	C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN MOUNTAIN NURSING AND REHABILITATION	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
E 000	Initial Comments During an unannounced onsite re-certification survey 2/12-2/15/18, the facility was found in substantial regulatory compliance regarding emergency preparedness planning activities.	E 000		
F 000	INITIAL COMMENTS An unannounced on site recertification survey and investigation of two complaints was conducted by the Division of Licensing and Protection on 2/12 through 2/15/18. The findings include the following:	F 000	See attached document for all POC's.	
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed by staff interview, the facility failed to evaluate 1 applicable resident in the sample of 21, to determine if the practice to self-administer medication is appropriate (Resident #211). The findings include the following: Record review identifies, Resident #211 was admitted to the facility on 1/11/16 with a diagnosis to include, but not limited to Major Depression, Psychosis, Scleroderma, Neuropathy, Hypertensive Disorder and Diabetes. Medical Record identifies that the resident, has a physician order dated 10/3/17, for Sildenafil Citrate	F 554		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer Wilbur — TITLE: NHA — (X6) DATE: 03/08/2018

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 554	Continued From page 1 100 milligrams (mg.) by mouth (PO) daily for Raynaud's Disease. May keep at bedside to self-administer. Facility policy titled, Self-Administration of Medications dated 10/2017, identifies that the staff and practitioner will assess the resident's mental and physical abilities to determine whether a resident is capable of self-administering medication. The staff and practitioner will periodically re-evaluate a resident's ability to continue to self-administer medication. There is no evidence in the medical record identifying that an initial or follow-up evaluations have been conducted. The resident has been self-administering medication since 10/3/17. The Director of Nurses confirms on 2/13/18 at approximately 3:35 PM, that assessments can not be found.	F 554		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this	F 582		

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F 582	Continued From page 2 section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide 1 of 3	F 582		

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F 582	Continued From page 3 residents (#53) with proper notification for change or discontinuation of coverage, at the time of discharge. The specifics are detailed below: Per review of 3 closed medical records on 02/14/18 09:36 AM, Resident #53 was not issued an Advanced Beneficiary Notice (ABN). This is a Federally mandated notification, that alerts the resident that skilled services are being discontinued and the resident has an option to appeal. According to the medical record, Resident #53 was discharged from the facility on 2/6/2018. There is no documentation to support that the resident initiated the discharge as indicated by the facility. The facility was unable to provide verification that this resident requested the discharge. The Administrator confirms, during interview on 2/15/2018 at 10:00 AM that no ABN, was issued to the resident or to the resident's representative, Administrator stated that because the discharge came from the resident, it was not necessary to issue the notice.	F 582		
F 645 SS=E	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the	F 645		

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F 645	Continued From page 4 State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and	F 645		

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F 645	Continued From page 5 (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed by staff interview the facility failed to complete a preadmission screening for mental illness, mental Retardation or a related condition (PASARR) for 5 of 21 residents reviewed. Residents #9, 40, 41, 51, and 211 all have a length of stay that exceeds the 30-day exemption. The findings include the following: 1. Record review identifies that Resident #41 was admitted to the facility on 2/3/16 with diagnosis to include, but not limited to Adjustment Disorder, Anxiety and Depressed Mood. The resident currently resides in the facility. A PASARR screening was completed on a previous admission dated 9/15/14. There is no evidence in the medical record that identifies a screening was completed for the current admission. Confirmation was made by the Admission Coordinator on 2/13/18 that the PASARR screening has not been completed for Resident	F 645		

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F 645	Continued From page 6 #41's current admission. 2. Record review identifies, Resident #211 was admitted to the facility on 1/11/16 with a diagnosis to include, but not limited to Major Depression and Psychosis. The resident currently resides in the facility. A PASARR screening was completed on admission and identifies that if the resident is being admitted to the nursing facility for less than 30 days, then no further screening is necessary. The pre-admission screening also states, that if the resident's stay exceeds 30 days, the remaining assessment must be completed and if necessary the appropriate agency must be contacted. Confirmation was made by the Admission Coordinator on 2/13/18 that the PASARR screening has not completed as required for Resident #211. 3. Per record review Resident #40 was admitted to the facility on 12/27/17. Per review of PASARR form, the physician's signature on the form indicated that Resident #40 was PASARR exempt, likely with an expected stay of less than 30 days in the nursing home facility. As of 2/15/18, Resident #40 continued to reside at the facility and there was no evidence in the medical record that the resident had been screened for PASARR. Confirmation was made by the Admission	F 645		

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F 645	Continued From page 7 Coordinator on 2/13/18 that the PASARR screening has not completed as required for Resident #40. 4. Per record review, Resident #51 was admitted to the facility on 9/11/15 with a diagnoses to include, but not limited to Schizophrenia. Per review of the medical record, a step one PASARR was completed by the hospital before the resident transferred to the nursing home. There was no evidence that the facility reevaluated the resident after the admission extended past the 30 day window, to assess the need for further evaluation and potential services. Confirmation was made by the Admission Coordinator on 2/13/18 that the PASARR screening has not completed as required for Resident #51. 5. Per record review, Resident #9 was admitted to the facility on 2/23/17 from the hospital, with a diagnoses to include, but not limited to Depressive Disorder, Dementia, and Anxiety. The hospital had completed the step one PASARR screening, and checked off that the expected stay would be less than 30 days. The facility did not screen the resident again after they stay exceeded 30 days, as required. On 2/14/18 at 10:30 AM, the Admissions Coordinator confirmed that Residents # 9, did not have completed PASARR screenings.	F 645		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning	F 655		

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F 655	Continued From page 8 §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.	F 655		

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F 655	Continued From page 9 (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop and implement a baseline care plan within 48 hours of admission, for 5 applicable residents in a sample of 21, (Resident #12, 34, 40, 60 and 362). The findings are as follows: 1. Per medical review, Resident # 12, was admitted to the facility on 11/29/2017, was discharged to the hospital on 1/07/2018 and readmitted on 2/6/2018. A baseline care plan for this admission, dated 02/06/2018, does not contain initial goals, resident information, therapy services or social services that are to be provided for Resident # 12. There is also no indication to support that a copy of the baseline care plan was given to the resident's representative. The unit nurse confirms, during interview on 2/14/2018 at 2:57 PM, that the baseline care plan does not contain instructions to provide effective and person-centered care for residents that meet professional standards of quality care. 2. Per record review Resident #40 was admitted on 12/27/17, the baseline care plan was initiated; however, not all members of the interdisciplinary team (dietitian, nurse, licensed nursing assistant, physician, social worker) signed the care plan; and there was no evidence that the resident	F 655		

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F 655	Continued From page 10 and/or resident's representative had received a summary of the baseline care plan. Per interview on 2/15/18 at 2:11 PM with the Director of Nurses (DNS), s/he stated that baseline care plans were to be signed by all interdisciplinary team members involved and the resident and/or resident's representative. S/he stated that if the care plans were not signed and dated, therefor the care plans were not valid. 3. Per record review Resident #362 was admitted on 2/7/18, the baseline care plan was initiated; however, no members of the interdisciplinary team had signed the care plan and there was no evidence that the resident and/or the resident's representative had received a summary of the baseline care plan. Per interview on 2/15/18 at 2:11 PM with the Director of Nurses (DNS), s/he stated that baseline care plans were to be signed by all interdisciplinary team members involved and the resident and/or resident's representative. S/he stated that if the care plans were not signed and dated, therefore the care plans were not valid. 4. Per record review Resident #60 was admitted on 1/26/18, the baseline care plan was initiated; however, no members of the interdisciplinary team had signed the care plan and there was no evidence that the resident and/or resident's representative had received a summary of the baseline care plan. Per interview on 2/15/18 at 2:11 PM with the Director of Nurses (DNS), s/he stated that baseline care plans were to be signed by all interdisciplinary team members involved and the	F 655		

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F 655	Continued From page 11 resident and/or resident's representative. S/he stated that if the care plans were not signed and dated, therefor the care plans were not valid. 5. Per record review, Resident #34 was admitted on 1/29/18. Per review of the baseline care plan, there were sections that were not filled out with regards to medications prescribed, assistive equipment and discharge planning. The signature page had one signature on it, and there was no evidence that the baseline care plan was explained to the resident or were given a copy. Per interview on 2/15/18 at 10:05, the Director of Nursing (DNS) confirmed that the baseline care plan was incomplete for the sections listed above, and that there was no evidence that the interdisciplinary team had participated in the process. The DNS also confirmed that a copy of the care plan had not been given to the resident or their legal representative.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656		

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F 656	Continued From page 12	F 656		

required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and confirmed by staff interview the facility failed to develop a person-centered comprehensive care plans for 4 of 21 residents reviewed, (Residents #6, 40, 56, and 211). The plan is developed and implemented to meet the resident's preferences and goals and addresses the resident's medical, physical, mental and psychosocial needs, The findings include the following:

1. Record review identifies, Resident #56, weight

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475040	A. BUILDING _____ B. WING _____	C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN MOUNTAIN NURSING AND REHABILITATION	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 656	Continued From page 13 on 10/18/17 was documented as 143 pounds, on 11/17/17 weighed 143 pounds, on 1/22/18 weighed 143 pounds and on 2/9/18 weighed 135 pounds. The Minimum Data Set Assessment (MDS) identifies on 1/30/18 a weight of 144 pounds. This calculates to a nine (9) pound weight loss in 10 days or a 5.9% loss in one month. Care plan dated 2/6/18 identifies goals met ongoing and is able to feed self independently after set up. The care plan does not identify any weight loss as a problem. Per discussion with a Licenses Nurse Aide confirmation was made that the resident often refuses food and just wants to go to sleep. Director of Nurses confirms on 2/13/18 at approximately 9 AM, that s/he was unaware of the weight loss therefore a care plan problem was not developed. 2. Record review identifies, Resident #211, has a physician order dated 10/3/17, for Sildenafil Citrate 100 milligrams (mg.) by mouth (po) daily for Raynaud's Disease. May keep at bedside to self-administer. Care plan dated 1/18/18, does not identify that the resident is able to self-medicate any medication, that medications are kept at bedside and/or identifies the responsibility of the nursing staff in the management of the medication. Registered Nurse (RN) Unit Manager, confirms on 2/13/18, the care plan does not identify that the resident self medicates, does not identify the nursing staff's responsibilities in following the facility policy as well as the need to have the	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475040	A. BUILDING _____ B. WING _____	C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN MOUNTAIN NURSING AND REHABILITATION	475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446

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F 656	Continued From page 14 medication verified by the Registered Pharmacist since the medication is purchased outside of the United States. 3. Per record review Resident #6 was receiving Hospice services. In a review of the Electronic Medical Record (EMR) and the paper record, there is no Hospice care plan found. Additionally, the resident had a Stage II Pressure Ulcer identified on 9/28/2017 and coded in a Quarterly Minimum Data Set (MDS) assessment dated 11/22/17 as still present. There is no care plan for Hospice or End of Life Care in the record. The Unit Nurse confirmed that there are no care plans for these issues available. The Director of Nursing Services (DNS) stated that s/he was unaware that the resident had a pressure ulcer in an interview on 2/15/18 at 1 PM. 4. Per record review, Resident #40 has a nutritional evaluation was completed on 1/8/18. The Registered Dietitian wrote, "Taking protein three times a day and wound on leg reportedly healing well." A care plan was initiated on 1/12/18 and the care plan read, "Provide supplements and snacks throughout the day. Protein packs three times a day for wound healing." There was no evidence in the medical record that the resident had received protein packs three times a day for wound healing. Per interview on 2/15/18 at 11:05 AM with the Unit Manager, s/he confirmed that the resident did not receive protein packs three times a day as stated in the care plan and nutritional evaluation.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475040	A. BUILDING _____ B. WING _____	C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN MOUNTAIN NURSING AND REHABILITATION	475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446

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F 657	Continued From page 15 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed by staff interview, the facility failed to ensure that the care plan must be prepared by an interdisciplinary team for 5 of 21 residents reviewed, (Residents # 15, 22, 31, 54, and 56). The findings include the following: 1. Resident # 31 had a care plan review dated 1/10/18, the meeting attendance record identifies	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475040	A. BUILDING _____ B. WING _____	C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN MOUNTAIN NURSING AND REHABILITATION	475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446

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F 657	Continued From page 16 that there was no representation by the physician or the dietary department. 2. Resident # 54 had a care plan review dated 2/6/18, the meeting attendance record identifies that there was no physician representation nor is there any evidence that information about the resident was provided from the Licensed Nurse Aide (LNA). 3. Resident # 56 had a care plan review dated 11/8/17, the meeting attendance record identifies that there was no representative from the physician nor is there any evidence that information about the resident was provided by the physician and Licensed Nurse Aide (LNA). 4. Per resident interview on 02/13/18 03:46 PM, Resident # 22 reported that s/he can get all the fluids that s/he asks for, but that no drinks are offered except at meal times. Staff on the day shift, report during interview at 3:40 PM that no nourishments are offered other than what is provided at meals. Dietary notes reflect that Resident # 22 is on a regular diet but does not address fluid needs. Hydration, which is a resident preference, is not addressed in the care plan. 5. Per record review, Resident #15 is on a regular diet as directed in the Physician orders and the current plan of care. On 2/14/18 the survey Team Leader was notified by the Registered Dietitian (RD), that Resident #15 was one of 2 residents on a pureed diet. Per interview with the Speech Language Pathologist (SLP), s/he stated that the resident was, to his/her knowledge, on a mechanical soft	F 657		

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	475040	A. BUILDING _____ B. WING _____	C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN MOUNTAIN NURSING AND REHABILITATION	475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446

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F 657	Continued From page 17 diet. Per interview with the Unit Nurse, s/he stated that s/he was not aware of the resident being on a pureed diet. Per record review, the routine monthly physician orders for February 2018, are unsigned, and include a Regular diet with thin liquids. The physician signed orders for January 2018 and December 2018, identify a Regular diet. There is a signed clarification telephone order dated 11/27/17 and signed 11/30/17, for a Mechanical soft diet. Comfort Care orders signed 1/25/18 call for pleasure foods and liquids as tolerated. In an interview on 2/14/18, the Dietary Manager states that the resident is on and receives a pureed diet. The resident generally eats lunch in the restorative dining room. The Dietary Manager, states that the Registered Dietician (RD) instituted the diet and produced a yellow copy of a Diet Order & Communication Form. The Nutrition care plan for Resident #15 identifies, that the resident is on a regular diet. There are no care plan revisions to note the dietary changes indicated in the physician orders. The unit nurse, in interview stated that the nursing staff generally are notified of a diet change via the yellow copy of the diet order form but that s/he had not seen any form regarding a diet change for Resident #15.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475040	A. BUILDING _____ B. WING _____	C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN MOUNTAIN NURSING AND REHABILITATION	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 658	Continued From page 18	F 658		

by:
Based on interviews and record review the facility failed to assure that the services provided or arranged by the facility, as outlined by the comprehensive care plan, meet professional standards of quality for 2 of 21 residents reviewed (Residents #6, #34). Findings include:

1. Per record review, Resident #34 was admitted to the facility on 1/29/18 from the hospital, and had an unstageable pressure ulcer on his/her left heel at the time of admission. Although it was identified in the admission Minimum Data Set (MDS-tool used for the comprehensive assessment), and baseline care plan, there were no details in the nurse's notes to indicate that they were taking wound measurements or consistently documenting other characteristics of the wound such as any odor or drainage. The pressure ulcer was healing, and treatment orders were changed by the physician. However, the documentation was not clear as to the assessment details of the healing pressure ulcer.

Per interview on 2/15/18 at 9:40 AM, the nurse confirmed that the only measurement that they could locate was written on the back of a paper tape measure from 2/8/18. The nurse confirmed that there were no other measurements recorded, and the medical record did not have a weekly assessment sheet for monitoring wounds that was usually initiated for a pressure ulcer at this facility.

2. Per record review Resident #6, is coded on the facility matrix as having a facility acquired pressure ulcer. On the first day of survey, the resident stated during interview that s/he has no wounds or open areas on her buttocks. S/he was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475040	A. BUILDING _____ B. WING _____	C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN MOUNTAIN NURSING AND REHABILITATION	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 658	Continued From page 19	F 658		

admitted on 8/16/2017 and the admission Minimum Data Set (MDS), states there are no pressure ulcers on admission. The resident was discovered to have a Stage II pressure ulcer on his/her coccyx on 9/28/17. There is a Wound Pressure Ulcer Weekly Check, in the record with wound assessments documented on 9/28, 10/9, 10/24 and 11/8. There is no pressure ulcer staging documented on the 10/9 and 10/24 assessments. Each sheet contains 4 dates, there is only one sheet in the record. The assessment dated 11/8 lists the wound as a Stage II and states wound healing slowly. The Quarterly MDS dated 11/28/17, states that the resident has a Stage II pressure ulcer. The MDS Coordinator was is unavailable, during the survey for clarification. There are no nursing notes regarding the wound or any assessment in the record. The unit nurse, on the first day of survey, stated that there was no wound care to be observed. The unit nurse, on the second day of survey stated there were no pressure ulcers for any residents on the unit. The Director of Nurses (DNS) stated on 2/15 at 1 PM, that s/he was unaware that Resident #6 has or had a pressure ulcer. There is no documentation in the record regarding the resolution of the pressure ulcer.

According to the WOCN Society Position Paper: Avoidable versus Unavoidable Pressure Ulcers dated February 22, 2017 the following is found: "Accurate and thorough documentation is essential for effective prevention and management of pressure ulcers. Good documentation must be comprehensive, consistent, concise, chronological, continuing and also reasonably complete. (Ayello et al., 2009). According to Dahlstrom et al. (2011), initiation of appropriate treatment of pressure ulcers is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475040	A. BUILDING _____ B. WING _____	C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN MOUNTAIN NURSING AND REHABILITATION	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 658	Continued From page 20 dependent on the identification and complete documentation of the ulcer (i.e., location, stage, size), and ongoing measurements and descriptions are necessary to monitor the progression of the wound and effectiveness of interventions. However, based on a retrospective chart review, Dahlstrom et al. found documentation of the characteristics of pressure ulcers was frequently missing key descriptors, such as the stage, location, and size; and therefore, was not meeting quality guidelines. The investigators suggested that the first step to improving pressure ulcer care is to improve the identification and documentation of the ulcer, which is necessary for treatment, communication within the healthcare team, and reimbursement. Therefore, for a pressure ulcer to be deemed unavoidable, there must be clear, complete, and consistent documentation of the prevention and treatment interventions provided to the patient." Ref: WOCN Society Position Paper: Avoidable versus Unavoidable Pressure Ulcers (Injuries). Copyright 2017 Wound, Ostomy, Continence Nurses Society. February 22, 2017	F 658		
F 675 SS=D	Quality of Life CFR(s): 483.24 § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.	F 675		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475040	A. BUILDING _____ B. WING _____	C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN MOUNTAIN NURSING AND REHABILITATION	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 675	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation, record review and confirmed by staff interview the facility failed to provide 3 of 21 residents reviewed, with the care and services necessary to attain and maintain the highest practicable physical, mental, and psychosocial well-being, (Resident # 40, #211, and #362). The findings include the following: 1. Record review identifies, Resident #211 was admitted to the facility on 1/11/16, with a diagnosis to include, but not limited to Major Depression, Psychosis, Scleroderma, Neuropathy, Hypertensive Disorder and Diabetes. Medical Record identifies that the resident, has a physician order dated 10/3/17, for Sildenafil Citrate 100 milligrams (mg.) by mouth (PO) daily for Raynaud's Disease. May keep at bedside to self-administer. The Medical Record Administration Record (MAR) is initialed by the evening nurse, identifying that the medication has been administered every evening at 8 PM. Licensed Practical Nurse (LPN) confirms on 2/13/18 at approximately 4 PM, that s/he does not check the locked box to identify if the resident has taken the prescribed medication, but rather questions the resident who confirms or denies administration. However, interview with the resident on 2/13 and 2/14/18, confirms that the nurse does not routinely check with him/her, ensuring that the medication was taken. Further interview with the Registered Nurse (RN), confirms that staff have no knowledge, how many tablets the resident has in his/her possession, how many tabs s/he takes and when/where the	F 675		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475040	A. BUILDING _____ B. WING _____	C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN MOUNTAIN NURSING AND REHABILITATION	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 675	Continued From page 22	F 675		

tablets are purchased from. Medication flow-sheet kept at the bedside identifies that the medication has only been taken once on 2/13/18 at 9 PM. When asked for the January flow sheet, the resident confirms s/he does not know the location of the flow sheet and assumes it was discarded. Nor is there evidence of any previous medication flow sheets.

Confirmation is made by the Registered Pharmacist on 2/14/18 at approximately 4:30 PM, that the he/she was unaware that the resident was self-medicating as needed (PRN) rather than the following physician orders for daily administration, nor was s/he aware that the medication was being purchased from outside of the United States. Confirmation is made that the medication has not been verified by a pharmacist as required.

Facility policy titled, Self-Administration of Medications dated 10/2017, identifies that the staff and practitioner will assess the resident's mental and physical abilities to determine whether a resident is capable of self-administering medications. The staff and practitioner will periodically re-evaluate a resident's ability to continue to self-administer medications. There is no evidence in the medical record identifying that an initial or follow-up evaluations have been conducted. The resident has been self-administering medication since 10/3/17. The Director of Nurses confirms on 2/13/18 at approximately 3:35 PM, that any assessments can be found.

2. Per record review, Resident #40 has a nutritional evaluation completed on 1/8/18 and the Registered Dietitian wrote, "Taking protein three

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475040	A. BUILDING _____ B. WING _____	C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN MOUNTAIN NURSING AND REHABILITATION	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 675	Continued From page 23	F 675		

times a day and wound on leg reportedly healing well." A care plan was initiated on 1/12/18 and the care plan read, "Provide supplements and snacks throughout the day. Protein packs three times a day for wound healing." There was no evidence in the medical record that the resident had received protein packs three times a day for wound healing.

Per interview on 2/15/18 at 11:05 AM with the Unit Manager, s/he confirmed that the resident did not receive protein packs three times a day as stated in the care plan and nutritional evaluation.

3. Per record review Resident #362 was admitted on 2/7/18, with a diagnosis of a seizure (convulsion) disorder. Resident #362's medication order read, "Lamictal (lamotrigine-medication used to treat seizures) 200 milligrams (mg) by mouth at bedtime, 8:00 PM." Per review of the nurse's notes from the morning of 2/8/18, Resident #362 had seizure-like activity. The physician's progress notes from 2/9/18 read, "Patient with seizure-like activity morning following admission. Of note, s/he did miss PM dose of lamotrigine on 2/7 due to a pharmacy error ...Unclear whether missed dose is etiology of seizure-like activity." Per review of the pharmacist progress notes dated 2/8/18, there was no mention of the resident missing a dose of lamotrigine in his/her review.

Per interview on 2/15/18 with a Staff Nurse, s/he stated that the resident's medications were ordered on time.

Per interview on 2/15/18 at 1:32 PM with the Director of Nurses (DNS), s/he stated that an incident report was filed and that the physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475040	A. BUILDING _____ B. WING _____	C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN MOUNTAIN NURSING AND REHABILITATION	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 675	Continued From page 24 was aware of the missed dose. S/he stated that it was nursing's responsibility to notify the physician and make arrangements to obtain all medications so a resident does not miss a dose. Per interview on 2/15/18 at 2:01 PM with the Physician, s/he stated that s/he was aware that the resident had missed a dose of medication and that a process needed to be implemented to assure resident's get their medications. Per review of the policy Medication Orders and Receipt Record it read, "4. Medications should be ordered in advance, based on the dispensing pharmacy's required lead time. If medications unavailable the nurse should call pharmacist to have medication delivered as soon as possible. 4. Call physician to notify of unavailable medication."	F 675		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475040	A. BUILDING _____ B. WING _____	C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN MOUNTAIN NURSING AND REHABILITATION	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 686	Continued From page 25	F 686		

Based on record reviews and staff interviews the facility failed to assure that 2 applicable residents in a sample of 21, receive care consistent with professional standards of practice, to prevent pressure ulcers, prevent further injury/infection of existing ulcers and to promote healing. For Residents #6 and #34, they are to receive necessary treatment and services, consistent with professional standards of practice. The findings include the following:

1. Per record review, Resident #34 was admitted to the facility on 1/29/18 from the hospital, and had an unstageable pressure ulcer on her/his left heel at the time of admission. Although it was identified in the Minimum Data Set (MDS-tool used for the comprehensive assessment) and care plan, there were no details in the nurse's notes to indicate that they were taking wound measurements or consistently documenting other characteristics of the wound such as any odor or drainage. The pressure ulcer was healing, and treatment orders changed by the physician. However the documentation was not clear as to the assessment details of the healing pressure ulcer.

Per interview on 2/15/18 at 9:40 AM, the nurse confirmed that the only measurement that facility staff could locate was written on the back of a paper tape measure from 2/8/18. The nurse confirmed that there were no other measurements recorded. The medical record did not have a weekly assessment sheet for monitoring wounds that was usually initiated for a pressure ulcer at this facility.

2. Per record review, Resident #6 is coded on the facility matrix as having a facility acquired

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475040	A. BUILDING _____ B. WING _____	C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN MOUNTAIN NURSING AND REHABILITATION	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 686	Continued From page 26	F 686		

pressure ulcer. On the first day of survey, the resident stated, during interview, that s/he has no wounds or open areas on her buttocks. S/he was admitted on 8/16/2017. The Admission Minimum Data Set (Minimum Data Set (MDS-tool used for the comprehensive assessment), states there are no pressure ulcers on admission. The resident was discovered to have a Stage II pressure ulcer on his/her coccyx on 9/28/17. There is a Wound/Pressure Ulcer Weekly Check form in the record with wound assessments documented on 9/28, 10/9, 10/24 & 11/8. There is no pressure ulcer staging documented on the 10/9 and 10/24 assessments. Each sheet contains 4 dates, there is only one sheet in the record. The assessment dated 11/8 lists the wound as a Stage II and states wound healing slowly. The Quarterly MDS dated 11/28/17, states that the resident has a Stage II pressure ulcer. The MDS Coordinator was not available during the survey for clarification. There are no nursing notes regarding the wound or any assessment in the record. The nurse on the unit on the first day of survey stated that there was no wound care to be observed. The nurse on the unit on the second day of survey stated there were no pressure ulcers for any residents on the unit.

The Director of Nurses (DNS) stated on 2/15 at 1 PM that s/he was unaware that Resident #6 has or had a pressure ulcer. There is no documentation in the record regarding the resolution of the pressure ulcer.

According to the WOCN Society Position Paper: Avoidable versus Unavoidable Pressure Ulcers dated February 22, 2017 the following is found: "Accurate and thorough documentation is essential for effective prevention and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 686	Continued From page 27 management of pressure ulcers. Good documentation must be comprehensive, consistent, concise, chronological, continuing and also reasonably complete. (Ayello et al., 2009). According to Dahlstrom et al. (2011), initiation of appropriate treatment of pressure ulcers is dependent on the identification and complete documentation of the ulcer (i.e., location, stage, size), and ongoing measurements and descriptions are necessary to monitor the progression of the wound and effectiveness of interventions. However, based on a retrospective chart review, Dahlstrom et al. found documentation of the characteristics of pressure ulcers was frequently missing key descriptors, such as the stage, location, and size; and therefore, was not meeting quality guidelines. The investigators suggested that the first step to improving pressure ulcer care is to improve the identification and documentation of the ulcer, which is necessary for treatment, communication within the healthcare team, and reimbursement. Therefore, for a pressure ulcer to be deemed unavoidable, there must be clear, complete, and consistent documentation of the prevention and treatment interventions provided to the patient." Ref: WOCN Society Position Paper: Avoidable versus Unavoidable Pressure Ulcers (Injuries). Copyright 2017 Wound, Ostomy, Continence Nurses Society. February 22, 2017	F 686		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475040	A. BUILDING _____ B. WING _____	C 02/15/2018

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F 756	Continued From page 28	F 756		

licensed pharmacist.

§483.45(c)(2) This review must include a review of the resident's medical chart.

§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on record review and confirmed by staff interview the Registered Pharmacist failed to report any irregularities to the attending physician,

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	475040	A. BUILDING _____ B. WING _____	C 02/15/2018

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GREEN MOUNTAIN NURSING AND REHABILITATION	475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446

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F 756	Continued From page 29	F 756		

Medical Director and Director of Nurses that were identified on the monthly drug review for 2 of 21 residents reviewed, (Resident #211 and #362). The findings are as follows:

1. Record review identifies that Resident #211, has a physician order dated 10/3/17, for Sildenafil Citrate
100 milligrams (mg.) by mouth (PO) daily for Raynaud's Disease. May keep at bedside to self-administer.

Medical record review identifies that monthly Pharmacy consults are completed, but there is no notation related to medication, Sildenafil Citrate, as ordered for routine administration by the physician.

The Medical Record Administration Record (MAR) is initialed by the evening nurse, identifying that the medication has been administered every evening at 8 PM. Licensed Practical Nurse (LPN) confirms on 2/13/18 at approximately 4 PM that s/he does not check the locked box to identify if the resident has taken the prescribed medication, but rather questions the resident who confirms or denies administration. However, interview with the resident on 2/13 and 2/14/18, confirms that the nurse does not routinely check with the resident ensuring that the medication was taken. Further interview with the Registered Nurse (RN), confirms that staff have no knowledge how many tablets the resident has, how many tabs s/he takes and when/where the tablets are purchased from. Medication flow-sheet kept at the bedside identifies that the medication has only been taken once on 2/13/18 at
9 PM. When asked for the January flow sheet the resident confirms s/he does not know the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475040	A. BUILDING _____ B. WING _____	C 02/15/2018

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GREEN MOUNTAIN NURSING AND REHABILITATION	475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446

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F 756	Continued From page 30	F 756		

location of the flow sheet and assumes it was discarded. Nor is there evidence of any previous medication flow sheets.

Confirmation is made by the Registered Pharmacist on 2/14/18 at approximately 4:30 PM, that the medication has not been reviewed monthly nor is there any documentation on the consultation reports related to the medication. S/he also confirms that s/he was unaware that the resident was self-medicating as needed (PRN) rather than the following physician orders of daily, nor was s/he aware that the medication was being purchased from outside of the United States. Confirmation is made that the medication has not been verified by a pharmacist as required.

2. Per record review Resident #362 was admitted on 2/7/18 and has a diagnosis of a seizure (convulsion) disorder. Resident#362's medication order read, "Lamictal (lamotrigine-medication used to treat seizures) 200 milligrams (mg) by mouth at bedtime, 8:00 PM." Per review of the nurse's notes from the morning of 2/8/18, Resident #362 had seizure-like activity. The physician's progress notes from 2/9/18 read, "Patient with seizure-like activity morning following admission. Of note, s/he did miss PM dose of lamotrigine on 2/7 due to a pharmacy error ...Unclear whether missed dose is etiology of seizure-like activity." Per review of the pharmacist progress notes from 2/8/18, there

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	475040	A. BUILDING _____ B. WING _____	C 02/15/2018

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GREEN MOUNTAIN NURSING AND REHABILITATION	475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446

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F 756	Continued From page 31 was no mention of the resident missing a dose of lamotrigine in his/her review. Per interview on 2/15/18 with a Staff Nurse, s/he stated that the resident's medications were ordered on time. Per interview on 2/15/18 at 1:32 PM with the DNS, s/he stated that an incident report was filed and that the physician was aware of the missed dose. S/he stated that it was nursing's responsibility to notify the physician and make arrangements to obtain all medications so a resident does not miss a dose. Per interview on 2/15/18 at 2:01 PM with the Physician, s/he stated that s/he was aware that the resident had missed a dose of medication and that a process needed to be implemented to assure resident's get their medications. Per review of the policy Medication Orders and Receipt Record it read, "4. Medications should be ordered in advance, based on the dispensing pharmacy's required lead time. If medications unavailable the nurse should call pharmacist to have medication delivered as soon as possible. 4. Call physician to notify of unavailable medication."	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F 757		

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	475040	A. BUILDING _____ B. WING _____	C 02/15/2018

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GREEN MOUNTAIN NURSING AND REHABILITATION	475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446

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F 757	Continued From page 32 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the resident, pharmacist and the professional nurses, the facility failed to ensure that 1 of 21 residents reviewed has a drug regimen free from unnecessary medications. An unnecessary medication is any drug used without adequate monitoring, (Resident #211). The findings include the following: Record review identifies that Resident #211, has a physician order dated 10/3/17, for Sildenafil Citrate 100 milligrams (mg.) by mouth (PO) daily for Raynaud's Disease. May keep at bedside to self-administer. Medical record review identifies that monthly Pharmacy consults are completed, but there is no notation related to medication, Sildenafil Citrate, as ordered by the physician. The Medical Record Administration Record (MAR) is initialed by the evening nurse, identifying	F 757		

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F 757	Continued From page 33 that the medication has been administered every evening at 8 PM. Licensed Practical Nurse (LPN) confirms on 2/13/18 at approximately 4 PM that s/he does not check the locked box to identify if the resident has taken the prescribed medication, but rather questions the resident who confirms or denies administration. However, interview with the resident on 2/13 and 2/14/18, confirms that the nurse does not routinely check with the resident ensuring that the medication was taken. Further interview with the Registered Nurse (RN) confirms that staff have no knowledge how many tablets the resident has, how many tabs s/he takes and when the tablets are purchased. Medication flow sheet kept at the bedside identifies that the medication has only been taken once on 2/13/18 at 9 PM. When asked for the January flow sheet the resident confirms s/he does not know the location of the flow sheet and assumes it was discarded. Nor is there evidence of any previous medication flow sheets. Confirmation is made by the Registered Pharmacist on 2/14/18 at approximately 4:30 PM, that he s/he was unaware that the resident was self-medicating as needed (PRN) rather than the following physician orders of daily, nor was s/he aware that the medication was being purchased from outside of the United States. Confirmation is made that the medication has not been verified by a pharmacist as required.	F 757		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		

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	475040	A. BUILDING _____ B. WING _____	C 02/15/2018

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GREEN MOUNTAIN NURSING AND REHABILITATION	475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446

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F 812	Continued From page 34 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to store, prepare, distribute and serve food in accordance with professional standards of food service safety. Findings include: During the initial tour of the kitchen on 2/12/18 at 0953, an unlabeled quart size zip lock bag containing a brown substance dated 5/17 was located in one of the upright freezers in the kitchen; the second upright kitchen freezer contained an undated bag of frozen breaded chicken fingers and an undated bag of mixed vegetables. Located near the prep area on a top rack of clean dishes a roasting pan and a cookie sheet had chipped black matter on the outside of each of the pans. The test strips used to ensure clean and sanitized dishware and kitchen equipment had expired on 5/17. All of these findings were confirmed by the dietary manager at the time of the tour. Per observation during the kitchen tour on	F 812		

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	475040	A. BUILDING _____ B. WING _____	C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN MOUNTAIN NURSING AND REHABILITATION	475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446

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F 812	Continued From page 35 2/12/18 and throughout the time of survey, the dietary manager did not have a hair restraint on when s/he was in the kitchen. Per observation on 2/13/18 of the first floor nourishment room, the freezer contained the following undated and unlabeled items: a box of hot pockets, a box of frozen dinner-smart ones, a box of frozen vegetables, and a box of coconut water. The food cabinet in the nourishment room contained the following unlabeled and undated items: a sixteen ounce bottle of non-dairy creamer, a bag of granola, a box of tea, packets of instant grits, and a half loaf of bread. There was no way to discern if the items in the freezer and in the food cabinet belonged to patients and/or staff members. Per interview at 3:29 PM with the Unit Manager, s/he confirmed that the items in the freezer and in the food cabinet were not labeled with resident names and that staff food was present in the freezer used for residents. Per review of the policy Food Receiving and Storage, it read, "7. All foods stored in the refrigerator or freezer will be covered, labeled and dated "use by" date. 13. Food items and snacks kept on the nursing units must be maintained as indicated below: b. All foods belonging to residents must be labeled with the resident's name, the item must be dated when opened and discarded after three days."	F 812		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly.	F 814		

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	475040	A. BUILDING _____ B. WING _____	C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN MOUNTAIN NURSING AND REHABILITATION	475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446

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F 814	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to dispose of garbage and refuse properly. The findings include the following: Per observation on 2/14/18 at approximately 5:30 PM the dumpster located outside on the east side of the facility was uncovered with visible bags of trash. Per observation on 2/15/18 at 7:45 AM, upon entering the building the same dumpster was uncovered and overflowing with bags of trash. At that time, the maintenance director confirmed that the dumpster with the garbage should be covered.	F 814		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 37 conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 38	F 880		

infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation and interview the facility failed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 3 of 21 residents (Resident #9, Resident #27, and Resident #51) Findings include:

1. Per observation on 2/13/18 at 9:30 AM, a Licensed Nursing Assistant (LNA) donned gloves and then provided incontinence care for Resident #27. After performing the incontinence care, the LNA removed the soiled gloves and without sanitizing his/her hands touched the resident and multiple items in the resident's room. Per interview with the LNA at that time, s/he confirmed that s/he did not sanitize his/her hands after removing gloves.

Per review of the Handwashing/Hand Hygiene policy it read, "6. Hand hygiene is the final step after removing and disposing of personal protective equipment."

2. Per observation on 2/12/18 at 10:50 AM, Resident #9 was receiving oxygen therapy with a concentrator unit. The tape attached to the tubing and nasal cannula read 1/24/18, indicating the last time the tubing and water humidifier bottle were changed. Per interview on 2/12/18 at 11:05 AM, the nurse confirmed that the tubing was supposed to be changed weekly per MD orders,

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	475040	A. BUILDING _____ B. WING _____	C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN MOUNTAIN NURSING AND REHABILITATION	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 880	Continued From page 39 and that it had been almost two weeks since it was last replaced. 3. Per observation on 2/12/18 at 10:55 AM, Resident #51 had a CPAP machine by the bedside, and the mask and hose was left sitting on the bed by the pillow. Per interview on 2/12/18 at 11:10 AM, the nurse confirmed that the mask was left uncovered on the bed, and was supposed to be cleaned with special wipes, and then stored in a plastic bag after cleaning.	F 880		

Green Mountain Nursing & Rehabilitation Center LLC
2/15/2018 updated POC

The preparation and execution of this Plan of Correction does not constitute an admission or agreement by the Provider as to the truth or accuracy of the facts alleged or the conclusions set forth in the Statement of Deficiencies. This plan of correction is prepared and executed because it is required by federal and state regulations

F 554

It is the policy of GMNR to evaluate residents to determine if the practice to self-administer medication is appropriate.

Self-administrator evaluation was completed for resident #211.

All residents who have orders for self-administration of medications have a potential to be affected by this alleged deficient practice.

To ensure this alleged deficient practice does not occur the policy on self-administration of medications has been reviewed and/or updated.

Staff have been re-educated on the policy of resident self-administration.

Audits will be completed weekly on residents with self-administration of drugs orders x's 90 days then quarterly thereafter to ensure evaluations for self-administration of medications are completed according to facility policy and procedures.

Audits, policy review and education will be submitted to the QAPI team for review and recommendations.

Completion Date: 3/15/2018 F554 POC accepted 3/19/18 MBerhand RN | PMC

F 582

It is the policy of GMNR to provide residents with proper notification for change or discontinuation of coverage, at the time of discharge.

This should have been Resident #53 and daughter initiated discharge from the facility prior to facility completing skilled services.

All residents who are provided skilled services and are discharge have the potential to be affected by this alleged deficient practice.

To ensure this alleged deficient practice does not occur the facility will specifically document "resident or family initiated discharge on discharge summary form.

Discharge policy and procedure reviewed and or updated as needed.

Audits will be completed weekly on residents who discharge x's 90 days then quarterly thereafter to ensure documentation of initiated discharges are completed according to facility policy and procedures.

Green Mountain Nursing & Rehabilitation Center LLC
2/15/2018 updated POC

Audits, policy review and education will be submitted to the QAPI team for review and recommendations.

Completion Date: 3/15/2018 F582 POC accepted 3/19/18 MBertrand RN | PMC

F 645

It is the policy of GMNR to complete a preadmission screening for mental illness, mental Retardation or a related condition (PASARR) on residents who have a length of stay that exceeds the 30-day exemption.

PASARRs have been completed on residents #9, 40, 41, 51, and 211.

All residents who exceed the 30 day exemption have a potential to be affected by this alleged deficient practice.

To ensure this alleged deficient practice does not occur an education presented by the community PASARR coordinators will occur on 3/14/2018 @ 10am unless otherwise rescheduled.

PASARR policy and procedure reviewed and updated as needed.

Audits will be completed after the 30 day mark of resident stay to ensure PASSARS are completed on all who exceed the 30 day exemption.

Random audits, policy review and education will be submitted to the QAPI team for review and recommendations.

Completion Date: 3/15/2018 F645 POC accepted 3/19/18 MBertrand RN | PMC

F 655

It is the policy of GMNR to develop and implement a baseline care plan within 48 hours of admission.

Resident # 12 has a care plan in place signed by ID team and copy has been given to guardian.

Resident #34 care plan is in place, signed by ID team, copy provided to resident/family.

Resident #40 care plan signed by ID team, copy given to resident.

Resident #60 signed comprehensive care plan on 2/14 and signed by ID team, copy was given to resident.

Resident # 362 care plan completed on 2/16 signed by ID team, and reviewed by care giver from Allen brook on 2/21/18 in discharge planning meeting.

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

To ensure this alleged deficient practice does not occur flags have been set in the EMR system to remind staff every shift for 48 hrs to check and ensure care plan is being completed, a reminder is set in the EHR to flag a reminder to review and give a copy of the baseline care plan to resident and or family member and obtain signature of receipt.

The ID team have been reeducated on the baseline care plan policy and procedures.

Audits will be done weekly x's 90 days then quarterly thereafter.

Green Mountain Nursing & Rehabilitation Center LLC
2/15/2018 updated POC

Random audits, policy review and education will be submitted to the QAPI team for review and recommendations.

Completion Date: 3/15/2018 F655 POC accepted 3/19/18 MBertrandRN/PMC

F 656

It is the policy of GMNR to develop person-centered care plans to meet the resident's preferences and goals and addresses the resident's medical, physical, mental and psychosocial needs.

Resident # 56 care plan has been updated, and resident dietary needs assessed by dietician
Resident # 211 care plan has been updated relating to identified medication.
Resident #6 Bayada hospice care plan dated 9/11/2017 was in chart with facility care plan to accompany facility care plan, a updated care plan was added to the chart on 3/5/2018 from Bayada, pressure ulcer was resolved on 11/27/2017, evident by nurses note documented on 11/27/2017 stating stage II pressure ulcer resolved, resident #6 has no further pressure areas.
There is not a MDS on 11/28/2017 or due, MDS 11/22/2017 states stage II, MDS 2/20/2018 states no pressure ulcers.
Resident #40 care plan updated to reflect dietician recommendations to meet the goals of nutritional evaluation.

All residents who have special dietary needs, who self-administer medications, who have pressure ulcers or lose weight have a potential to be affected by this alleged deficient practice.

To ensure this alleged deficient practice does not occur nursing staff have been reeducated on care plan revisions according to the resident's needs and wishes.
Audits will be completed weekly x's 90 days and quarterly thereafter to identify care plans are updated appropriately.
Random audits, policy review and education will be submitted to the QAPI team for review and recommendations.

Completion Date: 3/15/2018 F656 POC accepted 3/19/18 MBertrandRN/PMC

F 657

It is the policy of GMNR to ensure that the care plan is prepared by an interdisciplinary team.

Residents # 15, 22, 31, 54, and 56

Resident #31 care plan has been updated by the ID team to include the physician and the dietary department.

Resident # 54 care plan has been updated to by the ID team to include the physician and a LNA.

Resident # 56 care plan has been updated by the ID team to include the physician and a LNA

Resident #22 care plan is updated to include hydration per his wishes, fluids and nutritional snacks continue to be readily available in the refrigerators/ cupboards on the units, fluids and snacks are offered to residents as well as available when asked.

Green Mountain Nursing & Rehabilitation Center LLC
2/15/2018 updated POC

Resident #15 care plan has been updated to reflect the accurate diet needs of resident.

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

To ensure this alleged deficient practice does not occur the ID team has been reeducated on expectations of attendance. Should attendance not be possible, a form will be completed by the absent ID team member to ensure input prior to the ID team meeting.

Should the physician not have availability to attend resident care plan meetings, physician will sign monthly orders that care plan as been reviewed and input is added.

Audits will be completed weekly x's 90 days and quarterly thereafter to identify care plans are prepared by the ID Team.

Random audits, policy review and education will be submitted to the QAPI team for review and recommendations.

Completion Date: 3/15/2018 F657 POC accepted 3|19|18 MBertrand RN|pmc

F 658

It is the policy of the facility to assure that the services provided or arranged by the facility, as outlined by the comprehensive care plan, meet professional standards of quality.

Resident #6 pressure ulcer was documented by evening nurse in a nursing note on 11/27/2017 as well as a care plan update dated 11/28/2017 as resolved. Resident has no further pressure areas. Plan of care updated.

There is not a MDS on 11/28/2017 or due, MDS 11/22/2017 states stage II, MDS 2/20/2018 states no pressure ulcers.
Resident #34's plan of care has been reviewed and updated as needed. Weekly assessment sheet for monitoring wounds

Residents who have a pressure area have the potential to be affected by this alleged deficient practice.

To ensure this alleged deficient practice does not occur staff have been reeducated on pressure ulcer documentation policy and procedures.

Audits of documentation will be completed weekly x's 90 days then quarterly thereafter.

Random audits, policy review and education will be submitted to the QAPI team for review and recommendations.

Completion Date: 3/15/2018 F658 POC accepted 3|19|18 MBertrand RN|pmc

F 675

It is the policy of the facility to provide care and services necessary to attain and maintain the highest practicable physical, mental, and psychosocial well-being.

Green Mountain Nursing & Rehabilitation Center LLC
2/15/2018 updated POC

Resident #211 now keeps medication in the medication cart and is administered by nurse on a routine basis. Pharmacist has reviewed Sildenafil, and will review upon each new delivery for irregularities.

Resident # 362 received medication Lamictal as soon as delivered.

Resident # 40 protein packets have been dc'd due to resident wishes, care plan updated to dc protein packets and increase protein by food choices.

All residents receiving medications from the pharmacy have a potential to be affected by this alleged deficient practice.

To ensure this alleged deficient practice does not occur staff have been reeducated on calling the pharmacy and the physician when a medication is not sent by pharmacy.

A meeting with pharmacy has been done on 3/5/2018 to express the seriousness of not sending a medication, and to develop a plan when a medication does not come with delivery.

Staff have been reeducated on the policy and procedure for self-administration of medications.

Staff have been reeducated on obtaining clarification of dietician recommendations and follow through with ensuring residents receive supplements according to recommendations.

Pharmacist will review out of country medications upon each new delivery for irregularities.

Random audits of care plans, self-administration medication documentation, pharmacy review of sildenafil and continuity of dietician and nursing recommendations will be completed weekly x's 90 days then quarterly thereafter.

Audits, policy review and education will be submitted to the QAPI team for review and recommendations.

Completion Date: 3/15/2018 F675 POC accepted 3/19/18 MBertrand RN | PMC

F 686

It is the policy of the facility to provide care consistent with professional standards of practice, to prevent pressure ulcers, prevent further injury/infection of existing ulcers and to promote healing

Resident #6 pressure ulcer was documented by evening nurse as resolved on 11/27/2017 as well as a care plan update on 11/28/2017. Resident has no further pressure areas.

There is not a MDS on 11/28/2017 or due, MDS 11/22/2017 states stage II, MDS 2/20/2018 states no pressure ulcers.
Resident #34's plan of care has been reviewed and updated as needed. Weekly assessment sheet for monitoring wounds

Residents who have a pressure area have the potential to be affected by this alleged deficient practice.

Green Mountain Nursing & Rehabilitation Center LLC
2/15/2018 updated POC

To ensure this alleged deficient practice does not occur staff have been reeducated on pressure ulcer documentation policy and procedures.

Audits of documentation will be completed weekly x's 90 days then quarterly thereafter.

Random audits, policy review and education will be submitted to the QAPI team for review and recommendations.

Completion Date: 3/15/2018 F686 POC accepted 3|19|18 MBertrand RN | PMA

F 756

It is the policy of the facility to ensure the Registered Pharmacist reports any irregularities to the attending physician, Medical Director and Director of Nurses that are identified on the monthly drug review.

Resident # 211 has been reviewed by the pharmacist, the medication is scheduled routinely and is on the medication cart for nursing administration as ordered.

Pharmacist will review medication upon each new delivery for irregularities.

Resident # 362 received medication Lamictal as soon as delivered.

All residents receiving medications have a potential to be affected by this alleged deficient practice.

To ensure this alleged deficient practice does not occur staff have been reeducated on calling the pharmacy and the physician when a medication is not sent by pharmacy.

Pharmacist has been reeducated on reporting irregularities immediately during monthly drug review.

A meeting with pharmacy has been done on 3/5/2018 to express the seriousness of not sending a medication, and to develop a plan when a medication does not come with delivery.

Staff have been reeducated on the policy and procedure for self-administration of medications and to notify the pharmacy and physician of unavailable medication.

Pharmacist will review of medications delivered from outside the country upon each new delivery for irregularities.

Random audits of care plans, pharmacy recommendations and self-administration medication documentation and audits of pharmacy sildenafil review will be completed weekly x's 90 days then quarterly thereafter.

Audits, policy review and education will be submitted to the QAPI team for review and recommendations.

Completion Date: 3/15/2018 F756 POC accepted 3|19|18 MBertrand RN | PMA

Green Mountain Nursing & Rehabilitation Center LLC
2/15/2018 updated POC

F 757

It is the policy of the facility to ensure residents are drug regimen free from unnecessary medications.

Resident # 211 has been reviewed by the pharmacist, the medication is scheduled routinely and is on the medication cart for nursing administration as ordered.

Sildenafil will be reviewed by pharmacist upon delivery for irregularities.

All residents who self-administrate medications have the potential to be affected by this alleged deficient practice.

To ensure this alleged deficient practice does not occur staff have been reeducated on adequate monitoring of self-administration of medications, policy reviewed and updated as needed.

Pharmacist will review out of country medications as delivered.

Audits of adequate monitoring are completed on residents who self-administer medications and of pharmacist reviews of delivery, weekly x's 90 days then quarterly thereafter.

Audits, policy review and education will be submitted to the QAPI team for review and recommendations.

Completion Date: 3/15/2018 F757 POC accepted 3/19/18 MBertrand RN/PMC

Green Mountain Nursing & Rehabilitation Center LLC
2/15/2018 updated POC

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F 812

It is the policy of the facility to store, prepare, distribute and serve food in accordance with professional standards of food service safety.

The quart size substance has been discarded.
The Vegetables and chicken fingers were labeled immediately then utilized.
Sanitizer test strips were brought to facility immediately after finding expired date.
Hair restraints will be worn according to recommended standards and guidelines.
Roasting pan and a cookie sheet identified as having chipped black matter on the outside of each of the pans have been resurfaced.
Items of residents not labeled has been labeled, items of employees have been discarded.

To ensure this alleged deficient practice does not occur, policies and procedures have been reviewed and updated as needed.
Staff have been reeducated on labeling open items, monitoring expiration dates of items and wearing a hair restraint.
Audits of unit refrigerators/freezers, kitchen refrigerators/freezers, nourishment centers for dated/labeled items, audits of dietary personnel for hair restraints and expired sanitation strips will be done weekly x's 90 days then quarterly thereafter.

Audits, policy review and education will be submitted to the QAPI team for review and recommendations.
Completion Date: 3/15/2018 F812 POC accepted 3/27/18 MBertrand RN/PMC

F 814

It is the policy of the facility to dispose of garbage and refuse properly.
The dumpster cover was closed immediately. No garbage impeded the closure of the cover.
To ensure this alleged deficient practice does not occur all staff have been reminded to close the dumpster cover when disposing trash.
The facility utilizes when warm weather is consistent a compactor for usage.
Ongoing audits will be done on a daily basis to ensure the cover is closed.
Audits, policy review and education will be submitted to the QAPI team for review and recommendations.
Completion Date: 3/15/2018 F814 POC accepted 3/27/18 MBertrand RN/PMC

F 880

It is the policy of the facility to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections
Staff are reeducated on hand washing and sanitizing practices, pocket hand sanitizers have been ordered to ensure hands are sanitized after gloves are taken off at all times.
All residents who require direct patient care have a potential to be affected by this alleged deficient practice.
Resident #9 oxygen tubing was changed immediately.
Resident # 51 CPAP mask was wiped down and put in a bag for storage.
All residents who utilize CPAP machines, oxygen have a potential to be affected by this alleged deficient practice.

Weekly audits for 90 days will be completed on oxygen equipment/cpap machines and random staff audits to ensure proper washing/sanitizing of hands
Audits, policy review and education will be submitted to the QAPI team for review and recommendations.
Completion Date: 3/15/2018 F880 POC accepted 3/27/18 MBertrand RN/PMC

Jennifer A. Wilson