AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

February 17, 2022

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

Dear Ms. Combs-Wilber:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 26, 2022.** 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

Pamela M. Cota, RN
Licensing Chief

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475040 | A. BUILDING ______ B. WING ______ | 01/26/2022 |

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

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| E 000 | Initial Comments<br><br>An unannounced onsite annual emergency preparedness review was conducted, in conjunction with the annual re-certification survey, by the Division of Licensing & Protection on 1/26/22. There were no regulatory deficiencies identified as a result of the review. | E 000 | **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 000 | INITIAL COMMENTS<br><br>An unannounced onsite re-certification survey was completed by the Division of Licensing and Protection from 1/24 - 1/26/2022. The following regulatory violations were identified. | F 000 | F 554<br>It is the policy of GMNR to evaluate residents to determine if the practice to self-administer medication is appropriate.<br><br>Self-administrator evaluation was completed for resident #29 | |
| F 554<br>SS=D | Resident Self-Admin Meds-Clinically Approp<br>CFR(s): 483.10(c)(7)<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Per observation, resident and staff interview, and record review the facility failed to ensure that 1of 16 residents in the sample were assessed for ability to self administer medications. Findings include:<br><br>During an interview with Resident # 29 on 1/25/2022 at 11:50 AM a plastic medication cup with a peach and blue colored capsule, and a box containing a bottle of Flonase were observed on the over bed table in front of the resident. When asked what was in the medication cup Resident #29 stated "oh, that's for my heart. I am supposed to take it before lunch but I like to take it after I eat so they leave it here for me." | F 554 | All residents who ask to have medications left for self administration have a potential to be affected by this alleged deficient practice.<br><br>To ensure this alleged deficient practice does not occur the policy on self-administration of medications has been reviewed and/or updated.<br><br>Staff have been re-educated on the policy of resident self-administration of medications.<br><br>The Director of Nursing and/or designee will complete random weekly audits for 60 days then quarterly there after to ensure evaluations for self-administration of medications are completed according to facility policy and procedures on those residents who ask for medications to be left at bedside.<br>Audits, policy review and education will be submitted to the QAPI team for review and further recommendations.<br>Completion Date: 02/18/2022<br>F554 POC accepted 2/16/22 LLovell RN/PML | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer Combs-Walker — TITLE: LNHA — (X6) DATE: 2/15/2022

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<br>Per record review Resident #29 has physicians orders for the two medications left on the over bed table as follows: Flonase Allergy Relief (fluticasone propionate) 1 spray each nostril twice daily, and Omeprazole (used to treat heartburn, ulcers, and Gastroesophageal reflux disease (GERD) ) 20 mg capsule, delayed release twice a day. There is no evidence of a self-administration assessment, care plan reflecting safe self-administration of medications, or a physicians order for self- administration in the resident's record.<br><br>The facility "Self-Administration of Medications" policy states:<br><br>"Residents in our facility who wish to self administer their medications may do so, if it is determined that they are capable of doing so. Under the section titled Interpretation and Implementation: # 2. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skills assessment, including (but not limited to) the resident's:<br>a. Ability to read and understand medication labels;<br>b. Comprehension of the purpose and proper dosage and administration time for his or her medications;"...<br><br>Per interview with the Unit Manager (UM) on 1/26/2022 at approximately 10:00 AM the medication in the cup on the over bed table was Omeprazole. Stated Resident #29 is having difficulty not having control over things. The resident often will not take her/his medication while the nurse stands there so s/he leaves it for her/him to take. The UM confirmed that the | F 554 | | |

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| F 554 | Continued From page 2<br>Omeprazole was left on Resident #29's over bed table. S/he also confirmed that the resident has not been assessed to self administer their medications.<br><br>Per interview with the Director of Nursing on 1/26/2022 at 10:50 AM s/he also confirmed that Resident #29 has not been assessed for safe self administration of medications, and the medications should not be left without an assessment. | F 554 | | |
| F 692 SS=D | Nutrition/Hydration Status Maintenance<br>CFR(s): 483.25(g)(1)-(3)<br><br>§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the | F 692 | It is the policy of GMNR to evaluate the needs of residents at risk for impaired nutrition.<br><br>Resident #24 weight has been obtained and documented, weight order has been clarified.<br><br>All residents who require monitoring of body weight have a potential to be affected by this alleged deficient practice.<br><br>The weight tracking tool has been updated and staff have been re educated on the tool as well as the policies and procedures relating to residents at risk for impaired nutrition.<br><br>The Director of Food Service and/or Dietician will complete weekly audits x's 60 days then quarterly thereafter to ensure residents weights are obtained according to the residents care plans and orders.<br>Weights ordered due to fluid restrictions will be monitored by Director of Nursing and/or designee.<br><br>Audits, policy review and education will be submitted to the QAPI team for review and further recommendations.<br><br>Completion Date: 02/18/2022<br>F692 POC accepted 2/16/22 LLovell, RN/PMC | |



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| F 692 | Continued From page 3 | F 692 | | |

facility failed to evaluate the needs of residents at risk for impaired nutrition for one of 16 sampled residents (Resident #24). Findings include:

1. Per record review, Resident #24 was admitted to the facility on 4/28/21. An order was placed on 5/7/21 that reads, "weekly weights once a day on Monday 6:00 AM." This order was still active at the time of investigation. Per review of Resident #24's care plan, Resident #24 had a care plan focus of "[Resident #24] has a diagnosis of adult failure to thrive. [They have] experienced some weight loss over the past month. Appetite is poor. Frequently consumes less than 50%. [They are] accepting supplements. At risk for further weight loss" added to their initial comprehensive care plan on 5/12/21. One of the interventions within this care plan focus, added on 5/12/21, states "weight weekly. Report any weight loss to MD (medical doctor)."

Per review of the facility's Weight Assessment and Intervention policy, under the section Weight Assessment the policy states, "1. The nursing staff will measure resident weights on admission, the next day, and weekly for two weeks thereafter unless the resident is in isolation or quarantine to protect themselves and/or other residents of infectious disease. Weights to be initiated after isolation/quarantine period. If no weight concerns are noted at this point, weights will be measures monthly thereafter."
Per observation of Resident #24's weight record in their chart, Resident #24 has the following weight entries since admission:

- 06/07/2021 12:49 PM Weight: 133.7 lbs
- 07/15/2021 02:04 PM Weight: 111 lbs
- 08/01/2021 01:29 PM Weight: 136.5 lbs

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| F 692 | Continued From page 4<br>- 11/01/2021 10:56 AM Weight: 100.1 lbs<br>- 11/08/2021 02:59 PM Weight: 124.3 lbs<br>- 01/03/2022 09:59 AM Weight: Not Taken (refused)<br><br>There were no weights entered into the record as having been taken, or offered and refused, during the months of April 2021, May 2021, September 2021, October 2021, and December 2021. During the months where weights were recorded as taken or offered and refused, there were no weekly entries.<br><br>Per interview on 1/25/22 at approximately 3:30 PM, the facility's RD (registered dietitian) confirmed that they have struggled with having to continually remind staff to document weights and/or refusals as expected. The RD stated that staff have informed her that Resident #24 often refuses, but that they are not documenting the refusals. It cannot verify that staff are attempting to obtain weights as expected. The RD also stated that they were under the impression that Resident #24 was ordered/care planned for monthly weights per facility policy and was not aware that they were ordered/care planned for weekly weights. | F 692 | | |
| F 726<br>SS=F | Competent Nursing Staff<br>CFR(s): 483.35(a)(3)(4)(c)<br><br>§483.35 Nursing Services<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care | F 726 | It is the policy of GMNR to ensure Licensed Nursing Assistant competencies are assessed relating to the skills and techniques needed to care for individual resident needs who reside within the facility. | |

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| F 726 | Continued From page 5<br>and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br><br>§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.<br><br>§483.35(c) Proficiency of nurse aides.<br>The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review the facility failed to assess competency of four (4) of five (5) sampled Licensed Nurse Assistants (LNAs) related to the skills and techniques needed to care for individual resident's needs.<br><br>Per review of resident records, facility assessment, and facility Census and Condition (A Centers for Medicare and Medicaid (CMS) form completed by the facility that represents the current condition of residents), the residents who reside in the facility have various care needs such as; catheter care, transfer assistance, mechanical Hoyer lift, dressing, toileting, and bathing assistance. | F 726 | | |

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| F 726 | Continued From page 6<br><br>Review of five LNAs employee and education files revealed no documentation that four of the five LNAs had been assessed for competency related to the skills needed to provide care to their assigned residents.<br><br>Per interview with the Director of Nursing Services (DNS) on 1/26/2022 at 2:21 PM the facility has a competency checklist that assesses LNA skills such as catheter care, transfers, and personal care. However, they have not been completed. The DNS confirmed that there was no evidence that skills competency have been assessed or that LNA competency assessments had been completed. | F 726 | Competence assessments have been completed on the four (4) LNA's who were missing them.<br><br>Ongoing completion of competencies will be done on LNA's upon hire, annually with performance evaluations and as needed.<br><br>To ensure competencies are completed, on going monitoring will be done by the HR director to ensure competencies are completed upon hire and/or in accordance with the employees annual evaluation and as needed.<br><br>The director of HR will report to the QAPI team monthly for 90 days and quarterly thereafter.<br><br>Completion Date: 02/18/2022<br>F726 POC accepted 2/16/22 ULovellRN/PMI | |
| F 880 SS=F | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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 | F 880 | It is the policy of GMNR to 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.<br><br>The laundry personnel have been re educated on the facility policy relating to washing linens and not leaving items wet in the washing machine over night and the proper handling of linens within the laundry area in regards to infection control.<br><br>All residents have a potential to be affected by this alleged deficient practice. | |



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| F 880 | Continued From page 7<br>arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and | F 880 | The Laundry/Housekeeping supervisor and/or designee will do random documented washing machine audits at the end of the day to ensure the laundry personnel have not left wet laundry in the washing machine.<br><br>Audits will be completed weekly for 30 days, then monthly there after for 60 days then quarterly.<br><br>Audit reports will be submitted to the QAPI team on a monthly basis then quarterly after 90 days.<br><br>Completion Date: 2/18/2022<br>F880 POC accepted 2/16/22 LLevell RN/PMu | |



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| F 880 | Continued From page 8<br>transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and record review, the facility failed to provide an environment to help prevent the development and transmission of communicable diseases and infections as evidenced by the facility failing to follow transmission-based precautions and processing linens so as to prevent the spread of infection. Findings include:<br><br>1. Per interview on 1/25/22 at approximately 10:30 AM, the primary linen department employee stated that it is their daily practice to load the facility's two industrial washers with facility linens from the units that day and start the loads prior to the employee leaving for their shift. The employee confirmed that employees in the linen department work from approximately 5:00 AM to 1:00 PM daily and that the loads of laundry started before the end of their shift sit wet in the machines overnight from the time the cycle completes until approximately 5:00 AM the next morning. The employee also confirmed that there is no one in the facility who is expected to process linens between 1:00 PM and 5:00 AM the following morning.<br><br>Per interview on 1/26/22 at approximately 10:30 AM, the Director of Nursing and the Assistant Director of nursing confirmed that they understood the information relayed from the linen department employee in regard to leaving wet | F 880 | | |

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| F 880 | Continued From page 9<br>linens to sit in the washing machines overnight on a daily basis.<br><br>Leaving wet linens for long periods of time (or overnight) in washing machines without any ventilation creates the risk for the growth of mold and other microorganisms which may not all be killed by the dryer cycle. Since the reprocessed linens effected are used for every resident throughout the facility, this practice has the potential to impact all residents.<br><br>2. Per observation on 1/24/22 at approximately 1:30 PM, Room #109 on Champlain East unit did not have any posted signage on the door or at the entrance to the room designating any level of transmission-based precautions required to enter the room. Observation also did not show any posted signage at the entrance to the Champlain East unit regarding any transmission-based precautions for that unit.<br><br>Per interview on 1/26/22 at approximately 10:30 AM, the DON (Director of Nursing) stated that all rooms on the Champlain East unit have required both contact and droplet transmission-based precautions since the week prior as the result of two residents on Champlain East who tested positive for COVID-19. The DON stated that the facility practice for proper transmission-based precaution signage would include either proper signage outside of every applicable resident room, or proper signage at the entrance to the unit with COVID-19 positive cases. The DON also confirmed that as of 1/26/22, one resident in room #109 had tested positive for COVID-19 as well. the DON confirmed via observation alongside this surveyor that Room #109 did not contain any signage to alert people entering the | F 880 | Donning and doffing PPE signs were near every resident door indicating what PPE usage was in effect as well as stock of required PPE to use.<br>A laminated sign was re added to the CE door. More transmission-based precaution signs were added to the unit until residents were out of quarantine status.<br><br>Currently no residents or units are on quarantine requiring full PPE due to positive covid. Current status is N95 and eye protection due to community based covid numbers. This status could change frequently.<br><br>All staff will be re educated on proper contact/ droplet precautions signage and adherence to facility policy regarding the droplet/contact signage.<br><br>Throughout the Covid Pandemic staff , providers and visitors continued to be reminded through frequent education, signs and text and voice all calls on the PPE requirements and quarantine process. The Director of Nursing, Infection Control Nurse and/or designee will monitor when precaution signage needs to be placed according to the policy of the facility. A folder with signs will remain on the units so staff can put them in place as directed. Staff and/or visitors will continue to be reminded of the the required PPE status. PPE audits will be done based on the status of PPE required weekly for 30 days then ongoing monthly for 60 days and quarterly there after.<br>The DON/ICN and/or designee will report PPE audit findings to the QAPI team monthly then quarterly thereafter.<br><br>Completion Date: 2/18/2022<br>F880 POC accepted 2/16/22 LLovell RN / Ame | |



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

| 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 ____ | 01/26/2022 |

| 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 10<br>room that any level of transmission-based precautions were required to enter the room, nor was their such signage at the entrance to the unit.<br><br>3. Per observation on Champlain East on 01/25/22 at 08:33 AM the LNA was seen entering residents rooms # 110 and #112 without a gown and gloves per protocol. On 1/25/2022 at 10:28 AM a Physician was observed in room # 110 at the foot of the resident's bed examining her/his toe with no gown on.<br><br>Per interview with the Unit Manager on 1/25/2022 at 10:35 AM staff should be donning gowns and gloves when entering each resident room. | F 880 | | |
| F 947 SS=C | Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4)<br><br>§483.95(g) Required in-service training for nurse aides.<br>In-service training must-<br><br>§483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.<br><br>§483.95(g)(2) Include dementia management training and resident abuse prevention training.<br><br>§483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.<br><br>§483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. | F 947 | | |

| 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 ______ | 01/26/2022 |

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

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|---|---|---|---|---|
| F 947 | Continued From page 11<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review the facility failed to ensure that four of five nurse aides in the sample completed required dementia and abuse training. Findings include:<br><br>Review of five nurse aide's training files revealed that four of the five nurse aides did not have documented annual dementia management or abuse prevention training.<br><br>During interview with the facility Administrator on 1/26/2022 at approximately 2:15 PM s/he confirmed that the education tracking that was provided did not have evidence of required training. The Administrator reported that the facility has implemented a computer based training and tracking program to help ensure that required staff training is completed. However, on 1/28/2022 s/he did confirm that staff have completed them. | F 947 | It is the policy of GMNR to ensure that staff have completed the required dementia and abuse training.<br><br>The five LNAs identified have completed the required trainings.<br><br>All residents have the potential to be affected by this alleged deficient practice.<br><br>The facility has adopted a on line software training system that was instituted October of 2021 to help meet the education requirements of the facility and be more accessible to the staff.<br>Staff are reminded daily by receiving a email from the on line education company that they have courses due as well as frequent reminders by administration to complete the required education by the all texting system.<br>The directors of the departments will continue to include education requirements in the performance evaluations of their staff, the HR director will monitor the hours and requirements of the staff education. Through the on line education software. This will be on going and reported to the QAPI team on a monthly basis.<br><br>Completion date: 2/18/2022<br><br>F947 POC accepted 2/16/22 LLovell, RN/PMu | |

# QAPI REPORT

DEPARTMENT: Green Mountain Nursing and Rehabilitation Center DATE: 2/15/2022

REPORTING TIME FRAME: Annually Semi-Annually Quarterly Monthly x

Directed Plan of Correction F 880 Survey Date 1/26/2022

| NO: | TOPIC: | FINDINGS AND CONCLUSIONS | ACTIONS | FOLLOW-UP |
|---|---|---|---|---|
| F 880 | Infection Control concern in the laundry room | Linens being left in the washer over night potentially exposing linens to infections organisms<br>This was said common practice by laundry staff<br>Conclusion that laundry will not be left in the washing machine over night. | Re education, review of policy with laundry staff, relating to infection control.<br>Documented weekly audits to ensure laundry is not left in the washing machine for 30 days monthly for 60 days then quarterly thereafter. | Ongoing, reported to the QAPI team |
| | Missing contact/droplet precaution signage in resident areas.<br>Staff, and providers failure to follow facility policy relating to proper PPE usage | Staff member and physician were identified as not wearing full PPE when full PPE policy was in effect.<br>Proper signage not installed in all areas of the building where it would be warrented. | All staff and provider are re educated on facility policy and guidance on proper PPE usage, when it is warranted and re education on the reasons for diligent PPE usage.<br>Folders will be at each unit with copies of signs readily available for when staff need to implement them when warranted.<br>A text/all call notice will be sent to staff as PPE requirements are implemented.<br>Audits will be completed weekly for 30 days then monthly for 60 days and quarterly there after. | Ongoing, reported to the QAPI team |

Jennifer Conboleikee
SNHA