

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

May 21, 2024

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 recertification survey conducted on **March 28, 2024.** 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,

Famila McotaRN Pamela M. Cota, RN Licensing Chief

Enclosure

PRINTED: 05/15/2024 FORM APPROVED OMB NO. 0938-0391

MME OF PROVIDER OR SUPPLIER GREEN MOUNTAIN NURSING AND REHABILITATION SIMMARY STATEMENT OF DEPICIENCY SIZE (EACH DEPICENCY NURS IT OF DEPICIENCY SIZE (EACH DEPICENCY AUDIT OF PROVIDER OR PROPERTY STATE (PROVIDER OF TAX) TAG E 000 Initial Comments The Division of Licensing and Protection conducted an onsite, unannounced survey of the facility's emergency preparedness program on 3/27/2024 through 3/28/2024 during a recetification survey. The following deficiencies were identificat. E 004 Develop EP Plan, Review and Update Annually \$485.54/2(a), \$485.54		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ATS ETHAN ALLEN AVENUE COLCHESTER, VT 05446			475040	B. WNG		03/28/2024
PREFIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION) E 000 Initial Comments The Division of Licensing and Protection conducted an onsite, unannounced survey of the facility's emergency preparedness program on 32772024 through 3728/2024 during a recertification survey. The following deficiencies were identified: E 004 Develop EP Plan, Review and Update Annually CFR(s): 483.73(a), \$483.475(a), \$481.54(a), \$418.113(a), \$441.184(a), \$400.84(a), \$482.15(a), \$483.73(a), \$483.475(a), \$484.102(a), \$485.52(a), \$485.52(a)			REHABILITATION		475 ETHAN ALLEN AVENUE	
The Division of Licensing and Protection conducted an onsite, unannounced survey of the facility's emergency preparedness program on 3/27/2024 through 3/28/2024 during a recertification survey. The following deficiencies were identified. E 004 SS=F CFR(s): 489.73(a) E 004 SS=F CFR(s): 489.73(a) \$403.748(a), \$416.54(a), \$418.113(a), \$441.184(a), \$485.642(a), \$485.625(a), \$485.727(a), \$485.642(a), \$486.362(a), \$485.625(a), \$485.727(a), \$485.82(a), \$486.362(a), \$486.36	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETION
SS=F CFR(s): 483.73(a) \$403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.562(a), §485.522(a), §485.522(a), §485.525(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that addresses emerging infectious diseases. No residents and/or staff were affected by this alleged deficient practice. All residents/and/or staff have the potential to be affected by this alleged deficient practice. The facility does have a EP Plan evidenced by; The EP plan for infectious diseases is not located in the Red Emergency Binder developed by our Maintenance Supervisor. It is located in the P & P binder as noted below. The Red Emergency Binder is not the sole contents of documentation of our EP program/Jean. The Red Emergency Binder is not the sole contents of documentation of our EP program/Jean. The Red binder contains procedures for staff. Further EP policies and procedures are located in the facility Operational policies & procedures (OP&P). The full EP OP&P to include The Red binder was reviewed 12/2023, annual approval of adoption on January 17th 2024 by QAPI committee. If policies stand as read, no changes are made.		The Division of Licer conducted an onsite, facility's emergency p 3/27/2024 through 3/2 recertification survey. were identified:	unannounced survey of the reparedness program on 28/2024 during a The following deficiencies		Correction does not constitute an admission of agreement by the prothe truth of the facts alleged or the correctness of the conclusions set the statement of deficiencies. The Correction is prepared and submit	vider of forth in Plan of ted
develop and maintain a comprehensive		S403.748(a), §416.54 §441.184(a), §460.84 §483.475(a), §484.10 §485.542(a), §485.62 §485.920(a), §486.36 §494.62(a). The [facility] must correderal, State and loor preparedness required develop establish and emergency prepared requirements of this spreparedness program limited to, the following: (a) Emergency Plan. and maintain an emethat must be [reviewed every 2 years. The phollowing: * [For hospitals at §48§485.625(a):] Emergency Plan. and maintain an emethat must be [reviewed every 2 years. The phollowing:	e(a), §418.113(a), (a), §482.15(a), §483.73(a), (a), §485.68(a), (a), §485.727(a), (a), §491.12(a), §491.1	EOC	and federal laws. E004 It is the policy of Green Mountain Nursing Rehabilitation to develop and maintain an emergency preparedness plan that address emerging infectious diseases. No residents and/or staff were affected by alleged deficient practice. All residents/and/or staff have the potentia affected by this alleged deficient practice. The facility does have a EP Plan evidenced EP plan for infectious diseases is not locate Red Emergency Binder developed by our Maintenance Supervisor. It is located in the P binder as noted below. The Red Emerge Binder is not the sole contents of documer our EP program/plan. The Red binder con procedures for staff. Further EP policies ar procedures are located in the facility Oper policies & procedures (OP&P). The full EP OP&P to The Red binder was reviewed 12/2023, annual approval of adoption on 1 17th 2024 by QAPI committee. If policies	g & es this al to be by; The ed in the e OP & ncy ntation of tains nd ational include anuary
						000 0475

Any deficiency statement ending with an astetisk (*) 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 net 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.

04/29/2024

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		475040	B. WING _			03/2	28/2024
	ROVIDER OR SUPPLIER OUNTAIN NURSING AN	D REHABILITATION		47	REET ADDRESS, CITY, STATE, ZIP CODE S ETHAN ALLEN AVENUE	•	
				C(OLCHESTER, VT 05446		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 004	requirements of this all-hazards approach * [For LTC Facilities Plan. The LTC facilities an emergency prepareviewed, and updat * [For ESRD Facilities Plan. The ESRD facilitie	dness program that meets the section, utilizing an in. at §483.73(a):] Emergency y must develop and maintain aredness plan that must be led at least annually. as at §494.62(a):] Emergency lility must develop and incy preparedness plan that and updated at least every 2 T is not met as evidenced and record review, the facility dimaintain an emergency hat addressed emerging. This deficient practice could. Findings include: cility's emergency last reviewed in 12/2023, with pervisor on 3/28/24 at 10:55 learner y management plan reds related to emerging such as influenza, COVID-19, lus diseases. The visor confirmed that the ment plan did not address diseases. This finding was diministrator on 3/28/2024 at was unable to provide mergency management plan	EO		Infectious diseases is specified in the OP & I under Disaster & Emergency Response pgs and Disaster & Emergency Preparedness pg with further information in the infection co and prevention operational policy & proced binder. Information beyond The Red Emer Binder was not allowed to be utilized during interview as evidence of plan/program, as in previous survey visits. Per CMS Pub 100-07 State Operations Manidated 4/16/2021, Surveyors should also consthe volume of documentation provided by the facility and working with the facility when reviewing the Emergency Preparedness Profacilities have the flexibility to determine hother format the documentation of their program. It is recommended, but are not refacilities to develop a crosswalk as applicable where their documents are located. For instantiating the following identify where these are located. Administration in the surveyors. If there are policies and procedures to specific standards/requirement identify where these are located. Administration include computer. To ensure this alleged deficient practice does occur, and procedure stays consistent with fadopted policies we are taking the following measures: For convenience of reviewing and access, the policies and procedures will be consolidated A QAPI evaluation /plan has been implement under the supervision of the Administrator, team and/or designee to analyze and investi processes to ensure procedures, protocols at practices are in place. QAPI team will contine review and approve policies and procedures annually and as needed.	63-65 s 45-47 ntrol ure gency s ual sider he gram as w to quiring, e for ance, if specify nts, ator did rent s not facility e EP l. nted QAPI gate nd best nue to	
	emerging infectious reviewed with the Ac 12:45 PM and s/he vevidence that the en addressed emerging	diseases. This finding was dministrator on 3/28/2024 at was unable to provide			practices are in place. QAPI team will continue review and approve policies and procedures	nue to	

PRINTED: 05/15/2024 FORM APPROVED OMB NO. 0938-0391

OFILER	OT OIL MEDIONINE OF	WEDIONID CERTICES					
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		475040	B. WNG_			03/	28/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
					75 ETHAN ALLEN AVENUE		
GREEN M	OUNTAIN NURSING AND	REHABILITATION					
		·			OLCHESTER, VT 05446		
(X4) ID		ATEMENT OF DEFICIENCIES	iD		PROVIDER'S PLAN OF CORRECTION	_	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
IAG	NEODEMONT ON		'^3		DEFICIENCY)		
,							
E 004	Continued From page	2	F	004	Tag E 004 POC accepted on 5/20/24 to S. Stem/P. Cota	у	
	that evening.	_			5. Stem/P. Cota		
E 015	•	or Stoff and Patients		015	It is the policy of Green Mountain Nursing 8	Ն	
		or Stair and Patients	"	כוט	Rehabilitation to ensure emergency	^	
SS=C	CFR(s): 483.73(b)(1)				preparedness policies and procedures address	:e	
	C400 740/b\/4\ C440	440/5\(0\(\);;\\ \$444.404/5\			all requirements for the provision of subsiste		
		.113(b)(6)(iii), §441.184(b)			needs for staff and residents, whether they		
		82.15(b)(1), §483.73(b)(1),			evacuate or shelter in place.		
	9483.475(D)(1), 9485	.542(b)(1), §485.625(b)(1)			•		
	(/h) Delicies and pres	advess (Facilities) must			The facility EP Plan/ program does include		
		edures. [Facilities] must ent emergency preparedness			OP&P that addressed the following provision	ns	
	•	res, based on the emergency			of substance needs for staff and residents if		
					they were to evacuate or shelter in place in a		
		graph (a) of this section, risk			emergency: food, water for staff, medical and	ì	
	• •	raph (a)(1) of this section,			pharmaceutical supplies, temperatures to		
		on plan at paragraph (c) of			protect resident health and safety and for the	2	
	•	cies and procedures must			safe and sanitary storage of provisions; and	_	
		ated every 2 years [annually			sewage and waste disposal. Evidenced by Th Red book pages pgs 84-91 extreme weather t		
	procedures must add	a minimum, the policies and			include but not limited to hypothermia tx ar		
	procedures must add	ress the following.			heat stroke tx, Pharmaceutical EP plan	iu	
	(1) The provision of s	ubsistence needs for staff			developed by Health Direct Pharmacy, adop	ted	
		they evacuate or shelter in			and added to The Red book by facility on		
		e not limited to the following:			3/15/2024 prior to 3/25/2024 survey date.		
	•	cal and pharmaceutical			Sewage/Waste disposal policy located in OP	&P	
	supplies				Disaster and Emergency Preparedness page		
	• •	of energy to maintain the			Safe storage of food and provisions policy is		
	following:				in Food Storage Operations Policy & Proced	ure as	
	•	protect patient health and			well as Emergency Supplies Planning in the		
		e and sanitary storage of			Emergency Disaster and Preparedness O P&		
	provisions.	o and canna, clorage of			23 Information beyond The Red Emergency		
	(B) Emergency lighting	ıa.			developed by maintenance supervisor was no		
		tinguishing, and alarm			allowed to be utilized during interview as evi		
	systems.	. Jg,			of plan/program as in previous survey visits.		
	(D) Sewage and was	te disposal.					
,	*[For Inpatient Hospic	ce at §418.113(b)(6)(iii):]					
ı	Policies and procedu						
		additional requirements for					
		atient care facilities only.					

Facility ID: 475040

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/15/2024 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				<u>OMB NO</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE	
		475040	B. WING			03/2	28/2024
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
				4	75 ETHAN ALLEN AVENUE		
GREEN M	OUNTAIN NURSING AN	D REHABILITATION		C	OLCHESTER, VT 05446		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 015	The policies and profollowing: (iii) The provision of shospice employees a evacuate or shelter in limited to the followin (A) Food, water, med supplies. (B) Alternate sources following: (1) Temperatures to safety and for the sarprovisions. (2) Emergency lightin (3) Fire detection, exsystems. (C) Sewage and was This REQUIREMENT by: Based on record revialled to ensure eme and procedures addithe provision of substresidents, whether the place. This deficient occupants. Findings Per review of the fact management plan, lathe Maintenance Sup AM, the facility's emedid not include policial addressed the follow needs for staff and revacuate or shelter if food, water for staff, supplies, temperature.	subsistence needs for and patients, whether they in place, include, but are not ig: dical, and pharmaceutical is of energy to maintain the protect patient health and fe and sanitary storage of its not met as evidenced its	E	015	Per CMS Pub 100-07 State Operations Manual dated 4/16/2021, Surveyors should also consider volume of documentation provided by the facility working with the facility when reviewing the Emergency Preparedness Program as facilities ha the flexibility to determine how to format the documentation of their program. It is recommen but are not requiring, facilities to develop a cross as applicable for where their documents are locat For instance, if their emergency plan is located in binder, specify this for surveyors. If there are poli and procedures to specific standards/requirement identify where these are located. Administrator didentify policies and procedures are in different at include computer. No residents and/or staff were affected by the alleged deficient practice. All residents and staff on duty have a potent affected by this alleged deficient practice. To ensure this alleged deficient practice dococur, and procedure stays consistent with adopted policies we are taking the following measures: For convenience of reviewing and access, the policies and procedures will be consolidated A QAPI evaluation /plan has been implement under the supervision of the Administrator team and/or designee to analyze and investignocesses to ensure procedures, protocols a practices are in place. QAPI team will continue review and approve EP policies and procedurally and as needed. Completion Date: 5/11/2024 Tag E 015 POC accepted on 5/20/24 S. Stem/P. Cota	y and ve ded, walk ed. a cicies ts, id reas nis tial to be es not facility g te EP d. chted QAPI igate nd best nue to ures	

of provisions; and sewage and waste disposal.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		TRUCTION	(X3) DATE COMP	
		475040	B. WNG _			03/2	28/2024
	ROVIDER OR SUPPLIER OUNTAIN NURSING ANI	D REHABILITATION		475 ETH	ADDRESS, CITY, STATE, ZIP CODE HAN ALLEN AVENUE HESTER, VT 05446		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 015	The Maintenance Surfacility had a plan for written down. S/He comanagement plan did provisions. This findin Administrator on 3/26 was unable to provide emergency management requirements for the needs for staff and reconference approxime evening. Procedures for Track CFR(s): 483.73(b)(2) §403.748(b)(2), §416 and (v), §441.184(b)(§482.15(b)(2), §485.542(b)(2), §485.542(b)(2), §485.542(b)(2), §485.5486.360(b)(1), §494 [(b) Policies and procedure plan set forth in paragassessment at paragand the communication this section. The policies and procedure policies and procedure following:] [(2) or (1)] A system to on-duty staff and she [facility's] care during staff and sheltered paragand sheltered paragang staff and sheltered staff staff staff staff staff staff staff staff staff	pervisor stated that the the above but did not have it onfirmed that the emergency of not address the above ag was reviewed with the 1/2024 at 12:45 PM and s/he are evidence that the ment plan addressed all the provision of subsistence sidents prior to the exit ately 6 hours later that sing of Staff and Patients 1.54(b)(1), §418.113(b)(6)(ii) 2), §460.84(b)(2), (73(b)(2), §483.475(b)(2), (625(b)(2), §485.920(b)(1), (62(b)(1)). The edures. The [facilities] must ent emergency preparedness res, based on the emergency graph (a) of this section, on plan at paragraph (c) of cies and procedures must be did at least every 2 years lities]. At a minimum, the res must address the	EO	It is track paties No r alleg All r by the first the lithe for the results to na are to the results to result	the policy of the facility to develop a system the location of on-duty staff and shelterents in the facility's care during an emeroresidents and/or staff were affected by the deficient practice. The sesidents and staff could potentially be a mis alleged deficient practice. The facility does have a tracking mechanism ocation of on-duty staff and sheltered practicient of on-duty staff and sheltered practicients is located under Planning for exactions in the EP of pages 32-36, Resident tracking is with the property of tracking is identified in Accushield Stor facility tracking log in program as well on the facility tracking log in program as well on the facility tracking log in program as well on the facility tracking log in program as well on the facility tracking log in program as well on the facility tracking log in program as well on the facility tracking log in program as well on the facility tracking log in program as well on the facility tracking log in program as well on the facility tracking to the facility tracking the following sures: The facility tracking the facility tracking the following sures: The facility tracking the	ered gency. dis ffected a to track atients in thin the EHR is ang. Staff/ taff/ ell as ot be able ly staff emented as was s not acility e EP l. The ation a will	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		CONSTRUCTION	(X3) DATE	
		475040	B. WNG _			03/:	28/2024
	ROVIDER OR SUPPLIER OUNTAIN NURSING AND	REHABILITATION		47	REET ADDRESS, CITY, STATE, ZIP CODE 5 ETHAN ALLEN AVENUE OLCHESTER, VT 05446		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 018	specific name and loc or other location. *[For PRTFs at §441. ICF/IIDs at §483.475(Policies and procedur location of on-duty stathe [PRTF's, LTC, ICF and after an emergen sheltered residents are emergency, the [PRT must document the space that receiving facility of the receiving facilities; transpevacuation location(s)	ation of the receiving facility 184(b), LTC at §483.73(b), b), PACE at §460.84(b):] res. (2) A system to track the aff and sheltered residents in F/IID or PACE] care during cy. If on-duty staff and re relocated during the F's, LTC, ICF/IID or PACE] pecific name and location of rother location. The at §418.113(b)(6):] res. The common the hospice, which is of care and treatment traff responsibilities; cation of evacuation ry and alternate means of external sources of the location of hospice and sheltered patients in the an emergency. If the resheltered patients are emergency, the hospice pecific name and location of rother location. 1.920(b):] Policies and evacuation from the CMHC, leration of care and	EO	18	A QAPI evaluation /plan has been implement under the supervision of the Administrator team and/or designee to analyze and invest processes to ensure procedures, protocols a practices are in place. QAPI team will contine review and approve EP policies and proced annually and as needed. Completion Date: 5/11/2024 Tag E 018 POC accepted on 5/20/24 S. Stem/P. Cota	, QAPI igate nd best nue to ures	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		475040	B. WING_			03/	28/2024
	ROVIDER OR SUPPLIER OUNTAIN NURSING AND	REHABILITATION		47	TREET ADDRESS, CITY, STATE, ZIP CODE '5 ETHAN ALLEN AVENUE OLCHESTER, VT 05446		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 018	assistance. *[For OPOs at § 486. procedures. (2) A system documentation that procedures and maintain of the procedures and maintain of the procedures. (2) Safe facility, which includes needs of the patients. This REQUIREMENT by: Based on interview a failed to develop a syon-duty staff and she care during an emergent of the patients.	360(b):] Policies and tem of medical reserves potential and actual otects confidentiality of tenor information, and s the availability of records. 62(b):] Policies and evacuation from the dialysis is staff responsibilities, and	E	018			
	the Administrator on 3 plan had contradicting residents during an exthat tracking would be electronic medical reciplan, it explained that using a census list that nursing station. The Aduring an emergency tracked using the electronic medical reciplan, it explained that using a census list that nursing station. The Aduring an emergency tracked using the electronic medical properties and the plant of the pl	ast reviewed in 12/2023, with 8/28/2024 at 9:04 AM, the g procedures for tracking mergency. The plan stated a managed through the cord system. Later in the tracking would be done by at is posted daily at each administrator confirmed that a residents should be ctronic medical record.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		475040	B. WNG		03/28/2024	1
	ROVIDER OR SUPPLIER OUNTAIN NURSING AND	REHABILITATION	4	TREET ADDRESS, CITY, STATE, ZIP CODE 75 ETHAN ALLEN AVENUE COLCHESTER, VT 05446		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	0.75	ON
E 020	§441.184(b)(3), §460. §483.73(b)(3), §483.4 §485.542(b)(3), §485. §485.920(b)(2), §491. [(b) Policies and procedure policies and procedure plan set forth in paragrament at paragrament at paragrament at paragrament and updated [annually for LTC facility] policies and procedure following:] [(3) or (1), (2), (6)] Sa [facility], which include treatment needs of expressionsibilities; transpersed evacuation location(simeans of communications) assistance. *[For RNHCls at §403 §416.54(b)(2) and RE Safe evacuation from REHs] which includes	Primary/Alt. Comm. 54(b)(2), §418.113(b)(6)(ii), 84(b)(3), §482.15(b)(3), .75(b)(3), §485.68(b)(1), 625(b)(3), §485.727(b)(1), .12(b)(1), §494.62(b)(2) edures. The [facilities] must not emergency preparedness es, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must be diat least every 2 years lities]. At a minimum, the es must address the fe evacuation from the es consideration of care and racuees; staff portation; identification of care and racuees; identification of care and racuees; identification of care and racuees; i		It is the policy of the facility to develop policy procedures regarding safe evacuation from that includes transportation. No residents and/or staff were affected by the deficient practice. All residents and staff have a potential to be by this alleged deficiency. The facility does have procedures regarding evacuation from the facility that includes transportation. Located in The Red EP book Transportation for facility-wide evacuations disaster, this plan includes two Phases, Phat transport of ambulatory and lower acuity re and Phase 2 higher acuity residents, local cowith phone numbers are included in plan. A located in facility OP&P Disaster & Emerger Preparedness page 32. Information beyond The Red Emergency Bid eveloped by maintenance supervisor was nallowed to be utilized during interview as evplan/program as in previous survey visits. Per CMS Pub 100-07 State Operations Man 4/16/2021, Surveyors should also consider twolume of documentation provided by the fworking with the facility when reviewing the Emergency Preparedness Program as facilities the flexibility to determine how to format the documentation of their program. It is recombut are not requiring, facilities to develop a as applicable for where their documents are For instance, if their emergency plan is locabinder, specify this for surveyors. If there are and procedures to specific standards/requiridentify where these are located. Administratidentify policies and procedures are in differential differential policies and procedures are in differential policies.	he facility is alleged affected safe pg 63 due to se 1 sidents inpanies lso incy inder ot idence of all dated ine es have c immended, crosswalk located. ied in a e policies ements, tor did	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE COMP	
		475040	B. WNG			03/2	28/2024
	ROVIDER OR SUPPLIER OUNTAIN NURSING AND SUMMARY STA	REHABILITATION	ID	STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446 PROVIDER'S PLAN OF COR			(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)			COMPLETION DATE
E 020	Therapy and Speech-Services; and ESRD staff responsibilities, at a [For RHCs/FQHCs at evacuation from the Fappropriate placement responsibilities and not this REQUIREMENT by: Based on interview a failed to develop policities and regarding safe evacuation includes transportation could affect all occupations of the facility and the Maintenance Sup AM, the facility's emedid not include policities addressed transportation during the Maintenance Sup emergency management plan, last the Maintenance Sup addressed transportation during the was reviewed with the at 12:45 PM and s/he evidence that the emedian expension in the series of the series o	external sources of i.68(b)(1), Clinics, es, OPT/Speech at ESRD Facilities at the [CORF; Clinics, es, and Public Health s of Outpatient Physical -Language Pathology Facilities], which includes and needs of the patients. at §491.12(b)(1):] Safe RHC/FQHC, which includes at of exit signs; staff eeds of the patients. is not met as evidenced and record review, the facility sies and procedures ation from the facility that n. This deficient practice ants. Findings include:	E 02	To ensure this alleged deficient pra occur, and procedure stays consiste adopted policies we are taking the fineasures: For convenience of reviewing and a policies and procedures will be con A QAPI evaluation /plan has been it the supervision of the Administrate or designee to analyze and investigatensure procedures, protocols and b in place. QAPI team will continue to approve EP policies and procedures needed. Completion Date: 05/11/2024 Tag E 020 POC accepted or S. Stem/P. Cota	ent with factoring access, the solidated. implementor, QAPI to ate process practic to review a sannually	cility EP ted unde- eam and, ses to es are and and as	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMP	
		475040	B. WNG_			03/2	28/2024
	ROVIDER OR SUPPLIER OUNTAIN NURSING AND) REHABILITATION		47	TREET ADDRESS, CITY, STATE, ZIP CODE 75 ETHAN ALLEN AVENUE OLCHESTER, VT 05446		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 020 E 022 SS=C	later that evening. Policies/Procedures f CFR(s): 483.73(b)(4) §403.748(b)(4), §416 §441.184(b)(4), §460 §483.73(b)(4), §483.4 §485.542(b)(4), §485 §485.920(b)(3), §491 (b) Policies and procedure policies and procedure plan set forth in paragand the communication this section. The policies and procedure policies and procedure policies and procedure following:] [(4) or (2),(3),(5),(6)] for patients, staff, and the [facility]. *[For Inpatient Hospid and procedures. (6) The following are hospice-operated inpolicies and procedures. (6) The following: (i) A means to shelter hospice employees we have the same and the communication of the policies and procedures. (6) The following are hospice-operated inpolicies and procedures. (6) The following are hospice employees we have the same and the communication of the policies and procedures. (6) The following are hospice-operated inpolicies and procedures. (6) The following are hospice-operated inpolicies and procedures.	rence approximately 6 hours for Sheltering in Place .54(b)(3), §418.113(b)(6)(i), .84(b)(5), §482.15(b)(4), .175(b)(4), §485.68(b)(2), .625(b)(4), §485.727(b)(2), .12(b)(2), §494.62(b)(3). .edures. The [facilities] must ent emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must ated at least every 2 years lities]. At a minimum, the		020	It is the policy of the facility to develop policiprocedures for staff to shelter in place during emergency. No residents and/or staff were affected by the deficient practice. All residents and/or staff have the potential affected by this alleged deficient practice. The facility does have Disaster and Emergen Preparedness OP&P that include addressing when sheltering in place. This is addressed use Emergency Supplies and Planning pg 23, Disand Emergency Response OP&P Emergency Procedure Shelter in Place pg 26-30. Information beyond The Red Emergency Bid developed by maintenance supervisor was nallowed to be utilized during interview as evelan/program as in previous survey visits. Per CMS Pub 100-07 State Operations Manual and 44/16/2021, Surveyors should also considered 4/16/2021, Surveyors should a	is alleged to be cy staff nder saster ot idence of	
	•	and record review, the facility					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FUR MEDICARE &	WEDICAID SERVICES				OMB MC). <u>0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		475040	B. WNG			03/	28/2024
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
ODEEN M	CUNTAIN NUIDCING AND	DELIABILITATION		4	75 ETHAN ALLEN AVENUE		
GREEN W	OUNTAIN NURSING AND	O REHABILITATION		_ c	COLCHESTER, VT 05446		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
					To ensure this alleged deficient practice does		
E 022	Continued From page	2 10	E	022	occur, and procedure stays consistent with fa		
		cies and procedures for staff			adopted policies we are taking the following		
		ing an emergency. This			measures: For convenience of reviewing and access, the	. ED	
		ld affect all occupants.			policies and procedures will be consolidated	; EF	
	Findings include:				A QAPI evaluation /plan has been implement		r.
		Pa. 1			the supervision of the Administrator, QAPI		
	Per review of the facil	• •			or designee to analyze and investigate proces		
		st reviewed in 12/2023, with ervisor on 3/28/24 at 10:55			ensure procedures, protocols and best practi		
	1	rgency management plan			in place. QAPI team will continue to review		
		es and procedures that			approve EP policies and procedures annually needed.	y and as	
	· ·	in place during emergencies			lileeded.		
		ance Supervisor confirmed			Completion Date: 5/11/2024		
		nanagement plan did not				C Cto	m/D Coto
	address sheltering in	place during emergencies			Tag E 022 POC accepted on 5/20/24 b	y S. Ste	II/P. Cola
		was reviewed with the			E 036		
		/2024 at 12:45 PM and s/he					
	was unable to provide				It is the policy of the facility to develop a	1: .:	
	emergency managem				emergency management plan that includes and procedures that address the facility's	policies	
		ring emergencies for staff			emergency preparation training and testing	program	
	later that evening.	rence approximately 6 hours			and review annually.	P 8	
F 036	EP Training and Testi	na	F	036	·		
	_	9		000	No residents and/or staff were affected by the alleged deficient practice.	ıis	
	§403.748(d), §416.54	(d), §418.113(d),			All residents and staff have a potential to be	affected	
		(d), §482.15(d), §483.73(d),			by this alleged deficient practice.	anecteu	
	§483.475(d), §484.10	2(d), §485.68(d),			-, g		
	§485.542(d), §485.62	5(d), §485.727(d),			The facility does have a policy and procedu	re that	
	§485.920(d), §486.36	0(d), §491.12(d),			addresses emergency preparation training a		
	§494.62(d).				testing that is reviewed annually. This is loc the Facility Assessment list of trainings revi		
	*IFOr PNCUIs at \$403	2 748 ASCs at 8416 54			annually most recently Dec 20th 2023. The		
		3.748, ASCs at §416.54, PRTFs at §441.184, PACE			policies section Disaster & Emergency	∵. ∽.	
	at §460.84, Hospitals				Preparedness pgs 14,36,47 address training.		
		§485.68, REHs at §485.542,			Information beyond The Red Emergency B		
	CAHs at §486.625, "C				developed by maintenance supervisor was r		
	485.727, CMHCs at §				allowed to be utilized during interview as ev		
	§486.360, and RHC/F				of plan/program as in previous survey visits	i.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		475040	B. WNG		03/	28/2024
	ROVIDER OR SUPPLIER OUNTAIN NURSING AND	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 036	and maintain an emetraining and testing pemergency plan set if section, risk assessment is section, policies at (b) of this section, policies at (b) of this section program must least every 2 years. *[For LTC facilities at and testing. The LTC maintain an emergen and testing program temergency plan set if section, risk assessment is section, policies at (b) of this section, policies at (b) of this section, and paragraph (c) of this testing program must least annually. *[For ICF/IIDs at §483 testing. The ICF/IID in an emergency preparates and procedure section, and the comparagraph (c) of this section.	The [facility] must develop regency preparedness rogram that is based on the orth in paragraph (a) of this lent at paragraph (a)(1) of and procedures at paragraph do the communication plan at section. The training and lobe reviewed and updated at section is based on the orth in paragraph (a) of this lent at paragraph (a) of this lent at paragraph (a)(1) of lend procedures at paragraph do the communication plan at lent at paragraph (a)(1) of lend procedures at paragraph do the communication plan at lent lent lent lent lent lent lent len	E 03	Per CMS Pub 100-07 State Operation dated 4/16/2021, Surveyors should als the volume of documentation provide facility and working with the facility of the Emergency Preparedness Program have the flexibility to determine how documentation of their program. It is recommended, but are not requiring, develop a crosswalk as applicable for documents are located. For instance, emergency plan is located in a binder for surveyors. If there are policies and to specific standards/requirements, id these are located. Administrator did i policies and procedures are in different include computer. To ensure this alleged deficient practic occur, and procedure stays consistent adopted policies we are taking the followneasures: For convenience of reviewing and accopolicies and procedures will be conso A QAPI evaluation /plan has been im under the supervision of the Administ team and/or designee to analyze and processes to ensure procedures, prote best practices are in place. QAPI team continue to review and approve EP procedures annually and as needed. Completion Date: 5/11/2024 Tag E 036 POC accepted on 56 S. Stem/P. Cota	so consider ed by the when reviewing n as facilities to format the facilities to where their if their , specify this I procedures dentify where dentify nt areas to ice does not t with facility lowing ress, the EP lidated. plemented strator, QAPI investigate pools and n will olicies and	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		475040	B. WNG			03/28/2024	
	ROVIDER OR SUPPLIER OUNTAIN NURSING ANI	D REHABILITATION		STREET ADDRESS, CITY, STA 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446	:		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRI EFICIENCY)	_	(X5) COMPLETION DATE
E 036	develop and maintain preparedness training orientation program to emergency plan set of section, risk assessmenthis section, policies (b) of this section, an paragraph (c) of this and orientation progrupdated at every 2 years. Based on interview of failed to develop and program training and based on all required management plan, in and communication program training and communication program traini	on. The dialysis facility must an emergency g, testing and patient hat is based on the forth in paragraph (a) of this ment at paragraph (a)(1) of and procedures at paragraph d the communication plan at section. The training, testing am must be evaluated and ears. The is not met as evidenced and record review, the facility maintain an emergency testing program that that is elements of the emergency cluding the risk assessment plan, or ensure it was his deficient practice could Findings include:	E	036			
	the Maintenance Sup AM, the facility's eme did not include policie addressed the facility training and testing p Supervisor confirmed about the facility's co the facility does not h Lastly, s/he indicated itself is not reviewed	ast reviewed in 12/2023, with pervisor on 3/28/24 at 10:55 argency management plan as and procedures that be seen and procedures that be seen argency preparation argument. The Maintenance of that there is no training mmunication plan because have a communication plan. It that the training program annually. This finding was					
	12:45 PM and s/he we evidence that the emincluded policies and	ministrator on 3/28/2024 at vas unable to provide ergency management plan procedures that addressed acy preparation training and					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		475040	B. WNG_			03/:	28/2024
	ROVIDER OR SUPPLIER OUNTAIN NURSING AND) REHABILITATION		47	TREET ADDRESS, CITY, STATE, ZIP CODE 75 ETHAN ALLEN AVENUE OLCHESTER, VT 05446		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
	testing program prior approximately 6 hours EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416 §441.184(d)(1), §460 §483.73(d)(1), §485. §485.68(d)(1), §485. §485.727(d)(1), §485. §491.12(d)(1). *[For RNCHIs at §403.45 Hospitals at §482.15, at §484.102, REHs at under §485.727, OPC RHC/FQHCs at §491 (1) Training program the following: (i) Initial training in en policies and procedur staff, individuals provarrangement, and volexpected roles. (ii) Provide emergency exact every 2 years. (iii) Maintain docume preparedness training (iv) Demonstrate staff procedures. (v) If the emergency procedures are signif must conduct training	to the exit conference is later that evening. .54(d)(1), §418.113(d)(1), .84(d)(1), §482.15(d)(1), .975(d)(1), §484.102(d)(1), .920(d)(1), §485.625(d)(1), .920(d)(1), §486.360(d)(1), .920(d)(1), .920(d		037	E 037 It is the facilities policy to develop an enmanagement plan that includes policies procedures that addresses the facility's e preparation training and testing program. No residents and/or staff were affected to deficient practice. All residents and staff have a potential to by this alleged deficient practice. The facility does have a policy and proceaddresses emergency preparation training testing that is reviewed annually. This is the Facility Assessment list of trainings annually most recently Dec 20th 2023. It policies section Disaster & Emergency Figs 14,36,47 address training. Staff are trained annually on EP within the evidenced attendance sheets of those where the salleged deficient practice occur, and procedure stays consistent wadopted policies we are taking the follow measures: New staff/volunteers will be greminded of emergency preparation trath HR will monitor attendance to verify trabeen completed.	and mergeno m. by this al be be affect edure that ng and clocated reviewed the OP& prepared the facility to attend does note ith facility ing given/ ining.	eged ted at in P hess
	hospice must do all o	I8.113(d):] (1) Training. The f the following: nergency preparedness					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES	OMB NO. 0938-0					
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		475040	B. WING			03/:	28/2024	
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE			
CDEEN M	CHAITAIN NI IDRING AND	DELIA DII ITATION		4	75 ETHAN ALLEN AVENUE			
GREEN W	OUNTAIN NURSING AND	REHABILITATION		0	COLCHESTER, VT 05446			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG			(EACH CORRECTIVE ACTION SHOULD BE COMPLETION CROSS-REFERENCED TO THE APPROPRIATE		
E 037	policies and procedur hospice employees, a services under arrange expected roles. (ii) Demonstrate staff procedures. (iii) Provide emergency least every 2 years. (iv) Periodically review emergency prepared employees (including special emphasis place procedures necessary others. (v) Maintain document preparedness training (vi) If the emergency procedures are signiff must conduct training procedures. *[For PRTFs at §441. program. The PRTF or (i) Initial training in empolicies and procedur staff, individuals proviarrangement, and volex expected roles. (ii) After initial training preparedness training (iii) Demonstrate staff procedures. (iv) Maintain document preparedness training (v) If the emergency procedures are significations are significations and procedures are significations are significations.	es to all new and existing and individuals providing gement, consistent with their knowledge of emergency by preparedness training at and rehearse its ness plan with hospice nonemployee staff), with ead on carrying out the y to protect patients and station of all emergency preparedness policies and cantly updated, the hospice on the updated policies and station of all of the following: nergency preparedness es to all new and existing ding services under unteers, consistent with their provide emergency gevery 2 years. It knowledge of emergency intation of all emergency	E	037	A QAPI evaluation has been initiated usupervision of Administrator and HR I evaluate attendance of new staff/volunt to emergency preparation training. HR report findings to the QAPI team mont three months and then quarterly therease. Completion Date: 5/11/2024 Tag E 037 POC accepted on 5/20/24 S. Stem/P. Cota	Director to teers related to the control of the con	ting will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		475040	B. WNG			03/28/2024	
		D REHABILITATION		4	STREET ADDRESS, CITY, STATE, ZIP CODE 175 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 037	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		E	037			
	CORF must do all of (i) Provide initial train						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	IPLE CONSTRUCTION	(X3	COMPLETED		
	475040	B. WNG _			03/28/2024		
NAME OF PROVIDER OR SUPPLIER GREEN MOUNTAIN NURSING AND	REHABILITATION		STREET ADDRESS, CITY, STATE, 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446	ZIP CODE			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE		
	and procedures to all new	EC	037				
and existing staff, indivunder arrangement, at with their expected rol (ii) Provide emergency least every 2 years. (iii) Maintain documen (iv) Demonstrate staff procedures. All new pand assigned specific the CORF's emergency their first workday. The include instruction in the alarm systems and signequipment. (v) If the emergency procedures are significant to conduct training procedures. *[For CAHs at §485.62 The CAH must do all of (i) Initial training in empolicies and procedure reporting and extinguis and where necessary, personnel, and guests cooperation with firefigauthorities, to all newindividuals providing sand volunteers, consistences. (ii) Provide emergency least every 2 years. (iii) Maintain documen (iv) Demonstrate staff procedures.	viduals providing services and volunteers, consistent es. y preparedness training at tation of the training. knowledge of emergency ersonnel must be oriented responsibilities regarding by plan within 2 weeks of e training program must the location and use of gnals and firefighting preparedness policies and cantly updated, the CORF on the updated policies and cantly updated policies and can						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		475040	B. WNG_		03/28/2024
	ROVIDER OR SUPPLIER OUNTAIN NURSING ANI	D REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP 0 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		TION SHOULD BE COMPLETION THE APPROPRIATE
E 037	Continued From page	e 17	E	037	
		icantly updated, the CAH g on the updated policies and			
	*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop and maintain an emergency program training that ensured all new staff and volunteers received initial training in emergency preparedness policies and procedures. This deficient practice could affect all occupants. Findings include:				
	the Maintenance Sup AM, the facility's eme did not include policie addressed the facility training and testing p Supervisor explained regularly on emerger explained that there v new staff or voluntee with the Administrato	st reviewed in 12/2023, with pervisor on 3/28/24 at 10:55 ergency management plan es and procedures that o's emergency preparation program. The Maintenance of that s/he did test staff from management policies but was not initial training for all res. This finding was reviewed or on 3/28/2024 at 12:45 PM to provide evidence that the			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1''	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		475040	B. WNG_			03/	28/2024
	ROVIDER OR SUPPLIER OUNTAIN NURSING AND	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 037 E 039 SS=C	and procedures that a emergency preparation program prior to the emproximately 6 hours. EP Testing Requirems CFR(s): 483.73(d)(2) \$416.54(d)(2), \$482.1 \$460.84(d)(2), \$482.1 \$483.475(d)(2), \$484.5.542(d)(2), \$485.542(d)(2), \$485.542(d)(2), \$485.542(d)(2), \$485.542(d)(2), \$485.542(d)(2), \$485.542(d)(2), \$485.727, CMHCs at \$485.542, OPO, "O \$485.727, CMHCs at \$491.12, and ESRD for the emergency must do all of the following the emergency must do all of the following the emergency accessible, conduct a exercise every 2 year (B) If the [facility] natural or man-made activation of the emerexempt from engagin community-based or functional exercise for actual event.	addressed the facility's on training and testing exit conference is later that evening. and testing exit is later that evening. and testing exit is later that exit is later that is later that is later that is later that exit is later that is later that exit is later that is later that is later that is later that exit is later that is later that is later that is later that exit is later that is later tha		037	It is the facilities policy to conduct exe the emergency plan annually to includ the facility's response to an actual emergency and an actual emergency and actual emergency actually actuall	e an ana rgency. by this a sal gas lead le facility was led le Dept) incommers or due to rior) and ges, or nge an ility was	ysis of alleged ffected also by a luded es a set
		ear the full-scale or nder paragraph (d)(2)(i) of ted, that may include, but is					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		475040	B. WING			03/	28/2024
	ROVIDER OR SUPPLIER OUNTAIN NURSING AND	REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	not limited to the follo (A) A second full-scal community-based or functional exercise; o (B) A mock disaster of (C) A tabletop exercise a facilitator and include a narrated, clinically-scenario, and a set of directed messages, of designed to challenge (iii) Analyze the [facility maintain documentatic exercises, and emergifacility's] emergency *[For Hospices at 418 (2) Testing for hospic patient's home. The exercises to test the exanually. The hospic (i) Participate in a full community based ever (A) When a community community based ever (B) If the hospice expirational exercise expiration of the emergency plant, and the emergency plant is next recommunity-based exercise function onset of the emergency plant is next recommunity-based exercise under paraging in its next recommunity-based exercise under paraging in exercise under paraging in exercise under paraging in exercise under paraging exercise under paraging in exercise under paraging in exercise exercise exercise under paraging in exercise e	wing: e exercise that is individual, facility-based r rill; or e or workshop that is led by les a group discussion using elevant emergency f problem statements, r prepared questions an emergency plan. ly's] response to and on of all drills, tabletop ency events, and revise the plan, as needed. 3.113(d):] les that provide care in the hospice must conduct emergency plan at least e must do the following: l-scale exercise that is ery 2 years; or ty based exercise is not an individual facility based very 2 years; or eriences a natural or y that requires activation of the hospital is exempt from equired full scale ercise or individual lal exercise following the	E	039	To ensure this alleged deficient practice occur, and procedure stays consistent wadopted policies and procedures we are following measures: The facility will partesting drills and provide further analyse exercises utilized to test the emergency testing exercises will occur at a minimum months. An ongoing QAPI review will be compl supervision of the Administrator, Main supervisor and/or designee to ensure farmeeting EP testing and analysis guidelind documentation will be reviewed by QACOmpletion Date: 5/11/2024 Tag E 039 POC accepted on 5/20/24 S. Stem/P. Cota	rith facili taking the ticipate is to the plan. EP m every eted und tenance cility is nes, anali PI team.	ty ne in 6

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		475040	B. WNG	B. WING			28/2024	
	ROVIDER OR SUPPLIER OUNTAIN NURSING AND	REHABILITATION		4	STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 039	exercise; or (B) A mock disaster of (C) A tabletop exercise a facilitator and include a narrated, clinically-rescenario, and a set of directed messages, of designed to challenge (3) Testing for hospical care directly. The hose exercises to test the expear. The hospice mid (i) Participate in an a is community-based; (A) When a community accessible, conduct a facility-based function (B) If the hospice expearment emergency plan, the emergency plan, the emergency plan, the based or facility-base following the onset of (ii) Conduct an additi may include, but is not (A) A second full-sca community-based or a exercise; or (B) A mock disaster of (C) A tabletop exercise facilitator that include narrated, clinically-rel and a set of problem	le exercise that is a facility based functional drill; or se or workshop that is led by les a group discussion using selevant emergency for problem statements, or prepared questions an emergency plan. Les that provide inpatient spice must conduct emergency plan twice per ust do the following: Innual full-scale exercise that for the hospice is exempt from equired full-scale community defunctional exercise that of the hospice is exempt from equired full-scale community defunctional exercise that of the initial exercise that of the initial exercise that of the emergency event. In annual exercise that of the emergency event. In annual exercise that of the emergency event. In annual exercise that of the exercise that is a facility based functional drill; or se or workshop led by a se a group discussion using a evant emergency scenario, statements, directed end questions designed to	E	039				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		475040	B. WNG	B. WING		03/28/2024	
	ROVIDER OR SUPPLIER DUNTAIN NURSING AND	D REHABILITATION		47	FREET ADDRESS, CITY, STATE, ZIP CODE 75 ETHAN ALLEN AVENUE OLCHESTER, VT 05446		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	maintain documentati exercises, and emerginospice's emergency *[For PRFTs at §441. §482.15(d), CAHs at (2) Testing. The [PRT conduct exercises to twice per year. The [do the following: (i) Participate in an a is community-based; (A) When a communi accessible, conduct a facility-based function (B) If the [PRTF, Hos actual natural or man requires activation of [facility] is exempt fro required full-scale confacility-based function onset of the emergen (ii) Conduct an [and that may include, following: (A) A second full-scale community-based or functional exercise; of (B) A mock of (C) A tabletop exeled by a facilitator and discussion, using a nate mergency scenario, statements, directed of questions designed to	sice's response to and ion of all drills, tabletop gency events and revise the plan, as needed. 184(d), Hospitals at §485.625(d):] F, Hospital, CAH] must test the emergency plan PRTF, Hospital, CAH] must mual full-scale exercise that or ty-based exercise is not an annual individual, hal exercise; or pital, CAH] experiences an emergency that the emergency plan, the mengaging in its next munity based or individual, hal exercise following the cy event. additional] annual exercise or but is not limited to the disaster drill; or tercise or workshop that is dincludes a group arrated, clinically-relevant	E	039			
	plan.						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			UCTION	(X3) DATE SURVEY COMPLETED	
		475040	B. WNG	B. WNG			28/2024
	ROVIDER OR SUPPLIER OUNTAIN NURSING ANI	D REHABILITATION		475 ETHA	DDRESS, CITY, STATE, ZIP CODE N ALLEN AVENUE STER, VT 05446	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	maintain documentate exercises, and emerg [facility's] emergency *[For PACE at §460.8 (2) Testing. The PAC exercises to test the annually. The PACE following: (i) Participate in an a is community-based; (A) When a community accessible, conduct a facility-based function (B) If the PACE experman-made emergency plan, engaging in its next robased or individual, frexercise following the event. (ii) Conduct an anyears opposite the years opposite years opposite years of functional exercise; of the years opposite years opposite years opposite years of functional exercise; of the years opposite ye	facility's] response to and ion of all drills, tabletop gency events and revise the plan, as needed. 84(d):] E organization must conduct emergency plan at least organization must do the annual full-scale exercise that or ity-based exercise is not an annual individual, nal exercise; or riences an actual natural or ey that requires activation of the PACE is exempt from equired full-scale community acility-based functional exercise every 2 ear the full-scale or functional raph (d)(2)(i) of this section y include, but is not limited to alle exercise that is individual, a facility based or drill; or se or workshop that is led by des a group discussion, ically-relevant emergency f problem statements, or prepared questions e an emergency plan.	E	39			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION		DATE SURVEY COMPLETED
		475040	B. WNG_			03/28/2024
	ROVIDER OR SUPPLIER OUNTAIN NURSING AND	D REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
E 039	maintain documentate exercises, and emerge PACE's emergency possible. The [LTC facilities at (2) The [LTC facility] test the emergency procedure [CF/IID] must do the (i) Participate in an at is community-based; (A) When a community accessible, conduct a facility-based function (B) If the [LTC facility actual natural or man requires activation of LTC facility is exemple required a full-scale of individual, facility-based following the onset of (ii) Conduct an additionary include, but is not (A) A second full-scale community-based or functional exercise; of (B) A mock disaster (C) A tabletop exercial facilitator includes a narrated, clinically-related a set of problem messages, or prepare challenge an emerge (iii) Analyze the [LTC and maintain docume exercises, and emergence (content of the content of the c	ion of all drills, tabletop gency events and revise the lan, as needed. It §483.73(d):] must conduct exercises to lan at least twice per year, ed staff drills using the less. The [LTC facility, following: Innual full-scale exercise that or ty-based exercise is not an annual individual, hal exercise. If facility experiences an emade emergency that the emergency plan, the from engaging its next community-based or led functional exercise is the emergency event. In all exercise that the emergency event in annual exercise that of limited to the following: le exercise that is an individual, facility based or drill; or se or workshop that is led by a group discussion, using a levant emergency scenario, statements, directed ed questions designed to	EO	39		

AND DI AN OF CORRECTION IDENTIFICATION AN IMPER-		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		475040	B. WNG_			03/28/2024
	ROVIDER OR SUPPLIER OUNTAIN NURSING AND	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIAT	
E 039	Continued From page	e 24	EO	039		
	to test the emergency The ICF/IID must do (i) Participate in an aris community-based; (A) When a community accessible, conduct a facility-based function (B) If the ICF/IID experimental emergency plan, engaging in its next recommunity-based or functional exercise for emergency event. (ii) Conduct an additional include, but is not (A) A second full-scal community-based or functional exercise; of (B) A mock disaster of (C) A tabletop exercise a facilitator and include using a narrated, cliniscenario, and a set of directed messages, of designed to challenge (iii) Analyze the ICF/III maintain documentati exercises, and emerging ICF/IID's emergency *[For HHAs at §484.1 (d)(2) Testing. The HI to test the emergency	ID must conduct exercises or plan at least twice per year. The following: Innual full-scale exercise that or ty-based exercise is not an annual individual, and exercise; or. In exercise; or. In exercise an actual natural or ty that requires activation of the ICF/IID is exempt from equired full-scale individual, facility-based flowing the onset of the individual, facility-based for individual, facility-based or individual,				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		475040	B. MNG	B. WING			28/2024
	OVIDER OR SUPPLIER DUNTAIN NURSING AND) REHABILITATION		₄	STREET ADDRESS, CITY, STATE, ZIP CODE 175 ETHAN ALLEN AVENUE COLCHESTER, VT 05446		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 039	community-based; or (A) When a comitaccessible, conduct a facility-based function or. (B) If the HHA et or man-made emerged of the emergency platengaging in its next recommunity-based or functional exercise for emergency event. (ii) Conduct an addition opposite the year the exercise under parage is conducted, that limited to the following (A) A second full community-based or functional exercise; or (B) A mock disass (C) A tabletop extended by a facilitator and discussion, using a net emergency scenario, statements, directed questions designed to plan. (iii) Analyze the HHA documentation of all demergency events, and emergency plan, as in a figure of the control of the	munity-based exercise is not in annual individual, hal exercise every 2 years; experiences an actual natural ency that requires activation in, the HHA is exempt from equired full-scale individual, facility based illowing the onset of the onal exercise every 2 years, full-scale or functional raph (d)(2)(i) of this section it may include, but is not g: -scale exercise that is an individual, facility-based or ercise or workshop that is dincludes a group earrated, clinically-relevant and a set of problem messages, or prepared or challenge an emergency is response to and maintain drills, tabletop exercises, and and revise the HHA's leeded.	E	039			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		475040	B. WNG		03/28/2024		
	ROVIDER OR SUPPLIER OUNTAIN NURSING AN	ID REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLÉTIC		
E 039	Continued From pag	ne 26	E 03	9			
	workshop at least ar led by a facilitator ar discussion, using a remergency scenario statements, directed questions designed plan. If the OPO expman-made emergen the emergency plan, engaging in its next following the onset of (ii) Analyze the OPO documentation of all	narrated, clinically relevant , and a set of problem messages, or prepared to challenge an emergency veriences an actual natural or cy that requires activation of the OPO is exempt from required testing exercise of the emergency event. Ver's response to and maintain tabletop exercises, and and revise the [RNHCI's and					
	must do the following (i) Conduct a paper- least annually. A tab discussion led by a f clinically-relevant en of problem statemen prepared questions emergency plan. (ii) Analyze the RNH maintain documenta and emergency ever emergency plan, as This REQUIREMEN by: Based on interview failed to conduct exe plan annually and fa response to an actual	emergency plan. The RNHCI g: based, tabletop exercise at letop exercise is a group acilitator, using a narrated, nergency scenario, and a set ats, directed messages, or designed to challenge an ICI's response to and tion of all tabletop exercises, nts, and revise the RNHCI's					

AND DI AN OF CORRECTION INTERPRETATION NI IMPER-		1 ' '	DING			(X3) DATE SURVEY COMPLETED	
		475040	B. WING			03/28/2024	
	ROVIDER OR SUPPLIER	D REHABILITATION		•			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	Maintenance Supervino evidence could be exercise to test the exercise to the Maintenance Sufacility did not do any in the past year on to the facility had to act due to a potential gathere was no analysis the facility following finding was reviewed 3/28/2024 at 12:45 Fiprovide evidence the management plan the second annual exercise plan had been conditions.	cility's emergency esting documentation, with the risor on 3/28/24 at 10:55 AM, er found that a second annual emergency plan had been ecumentation that the facility er to an actual emergency. Expervisor explained that the explained that is of the response done by the potential gas leak. This is divith the Administrator on PM and s/he was unable to	E	039			
F 000		rs later that evening.	F	000			
F 584 SS=E	conducted an unann survey from 3/25/202 determine compliand requirements for Lor following deficiencies Safe/Clean/Comforts CFR(s): 483.10(i)(1)	able/Homelike Environment -(7)	F	584			
	§483.10(i) Safe Envi The resident has a re						İ

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

AND DEAN OF CORRECTION IDENTIFICATION AND IMPER-			JILTIPLE CONSTRUCTION (X3) DATE S COMPL				
		475040	B. WNG_			03/	28/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CDEEN M	OUNTAIN NURSING AND	DEHABII ITATION		4	75 ETHAN ALLEN AVENUE		
GREEN W	OUNTAIN NURSING AND	REHABILITATION		C	OLCHESTER, VT 05446		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 584	comfortable and home but not limited to recessupports for daily living. The facility must prov §483.10(i)(1) A safe, whomelike environment use his or her personates possible. (i) This includes ensureceive care and serve physical layout of the	elike environment, including iving treatment and g safely.	F 5	584	It is the policy of the facility to provide with a home-like environment during No residents were negatively affected I deficient practice. All residents have the potential to be a alleged deficient practice. Effective 3/25/2024 plates were brough kitchen for staff to utilize for resident boxes of china are stored in the basem Paper products are to be utilized only	meals. by this alle ffected by at to the meals, ext ent storag as part of	ged this a z.
	(ii) The facility shall exthe protection of the ror theft. §483.10(i)(2) Housek services necessary to and comfortable interior	eeping and maintenance maintain a sanitary, orderly,			infection prevention procedures and/orplan of care. To ensure that the alleged deficient proposed to occur, dietary staff are reminded to basement storage area to look for supplies are out of stock staff must order vendor immediately to prevent paper to the procedure of the prevent paper of the paper	actice doe o go to the lies, if er from	; :
	in good condition; §483.10(i)(4) Private resident room, as specified to the specified to th				A QAPI evaluation has been initiated under the supervision of Dietitian and dietary supervisor to evaluate, audit and report findings to the QAPI (monthly for the first three months and then quathereafter. Audits to be submitted to QAPI team review. Compliance date: 5/11/2024 Tag F 584 POC accepted on 5/20/24 by S. Stem/P. Cota		o team rterly

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		475040	B. WING _	B. WNG		03/28/2024	
	ROVIDER OR SUPPLIER DUNTAIN NURSING AND) REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CO 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 584	Continued From page	2 9	F 5	84			
	failed to provide the r	n and interview the facility esidents with a home-like neals. Findings include:					
	lunch meal in the mai revealed 6 of 12 resid delivered on paper pl residents who had pu food that is blended to consistency. Regardin pureed diet, the plate appearing as the liquithe plate soft, effecting	ates, this included 2 free diets, a puree diet is o a soft almost liquid like ng the residents that had the s were noted to be wet id from the food was making ng the strength of the plate. the other residents in the					
	Registered Dietitian (has had a shortage o	24 at 12:30 pm with the RD) revealed that the facility f plates for about a month nave been using paper e.					
F 623 SS=F	administrator reveale into the storage area cases of regular plate facility had been usin month and the plates today. Notice Requirements	24 at 4:40pm with the facility d that the administrator went that morning and found 2 es. S/he confirmed that the g paper plates for the past had not been found until Before Transfer/Discharge -(6)(8)	F 6	23			
	§483.15(c)(3) Notice Before a facility trans resident, the facility n (i) Notify the resident representative(s) of the	fers or discharges a nust-					

CLIVILIN	STOR MILDICARL &	VILDICAID SLIVVICES				CIVID IVC	7. 0930-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		475040	B. WNG			_03/	28/2024	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		_	
ODEEN M	OUNTAIN NUIDCING AND	DELIA DIL ITATIONI		47	75 ETHAN ALLEN AVENUE			
GREEN W	OUNTAIN NURSING AND	REPABILITATION		С	COLCHESTER, VT 05446			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 623	the reasons for the manage and manner facility must send a correpresentative of the Long-Term Care Ombigiin Record the reasond discharge in the residuaccordance with para and (iii) Include in the notion paragraph (c)(5) of the §483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, discharge required urmade by the facility at resident is transferred (ii) Notice must be materially be endangered under this section; (B) The health of individual be endangered, under this section; (C) The resident's health of individual this section; (C) The resident has not days. §483.15(c)(5) Contention (C)(5) Contention (C)(5) Contention (C)(6) (C)(6) (C)(7) (C)(ove in writing and in a rethey understand. The opy of the notice to a Office of the State oudsman. It is for the transfer or ent's medical record in graph (c)(2) of this section; or the items described in its section. Of the notice. If in paragraphs (c)(4)(ii) and the notice of transfer or or inder this section must be at least 30 days before the or discharged. If it is a soon as practicable charge when-viduals in the facility would be paragraph (c)(1)(i)(C) of or inderstand in the facility would be paragraph (c)(1)(i)(D) of one of the interest or discharge, in the section; in serior or discharge is ent's urgent medical needs, in the facility for 30 of the soft the notice. The written is of the notice. The written	F	623	discharge notices to residents and/or the representatives at the time a resident is to the hospital. Resident #21,39,52,167 were readmitted acute hospital stay. All residents who transfer/discharge to potential to be affected by this alleged of the transfer of the potential to be affected by this alleged of the transfer of the tran	transferred to facil the ER heleficient ives are aff nurse esident a firmedically state to follow e and RF in the formula of t	ty following ave a practice. will nd/ al table am. up SC	
		ragraph (c)(3) of this section			Tag F 623 POC accepted on 5/20/24 S. Stem/P. Cota	by		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		475040	B. WNG		0	3/28/2024	
	ROVIDER OR SUPPLIER OUNTAIN NURSING AND	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 623	(iii) The location to what transferred or dischar (iv) A statement of the including the name, a and telephone number receives such request to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of Long-Term Care Ombe (vi) For nursing facility and developmental didisabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities and telephone or related disemail address and telephone or	nsfer or discharge; of transfer or discharge; nich the resident is ged; e resident's appeal rights, ddress (mailing and email), or of the entity which ts; and information on how orm and assistance in and submitting the appeal so (mailing and email) and the Office of the State budsman; or residents with intellectual sabilities or related grand email address and the agency responsible for evocacy of individuals with lities established under Part and Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and the protection and les with a mental disorder errotection and Advocacy unals Act.	F 62	3			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FUR MEDICARE &	MEDICAID SERVICES				OWR NO).	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
·		475040	B. WNG			03/28/2024		
NAME OF PI	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE			
0055N M	OUNTAIN NUIDOING AND	DELIADU MATION		4	75 ETHAN ALLEN AVENUE			
GREEN W	OUNTAIN NURSING AND	REHABILITATION		•	COLCHESTER, VT 05446			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRI PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE AP DEFICIENCY)		ULD BE COMPLETION		
F 623	In the case of facility the administrator of the written notification pri to the State Survey A State Long-Term Care the facility, and the rewell as the plan for the relocation of the residus. 70(I). This REQUIREMENT by: Based on observation review the facility failed resident representative hospital and the reast in writing for 4 of 27 mt 21, Resident #39, Rt #167). Findings included the facility facility failed resident representative discharged to the facility facility failed resident failed resident failed resident failed failed resident failed	in advance of facility closure closure, the individual who is ne facility must provide or to the impending closure gency, the Office of the e Ombudsman, residents of sident representatives, as e transfer and adequate lents, as required at § is not met as evidenced in, interview, and record ed to notify the resident and we of a transfer to the on for transfer to the hospital esidents sampled (Resident esident #52, and Resident de: Resident #21 was applied in 12/5/23 and was lity on 12/21/23. S/he was ne hospital on 1/29/24 and in the hospital on 1/29	F	623				
	the hospital on 3/24/2							

	OF DEFICIENCIES CORRECTION	X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED	
		475040	B. WNG_	B. WNG		03/28/2024
	ROVIDER OR SUPPLIER OUNTAIN NURSING AND	O REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 623	treatment due to sudd no documentation in record or the paper m #39 or his/her repress transfer/discharge no Per an interview on 3 PM the Registered Ni (UM) confirmed that that supports that the transfer to the hospita or the resident repress 3. Per record review the hospital on 12/28 treatment due to a fall documentation in the the paper medical rechis/her representative transfer/discharge no Per interview on 3/27 PM the Registered Ni (UM) confirmed that the	den onset of pain. There is the electronic medical nedical record that Resident entative was provided a tice. //27/24 at approximately 2:15 urse (RN) Unit Manager here is no documentation written notification of al was given to Resident #39 sentative. Resident #52 was sent to //23 for evaluation and II. There is no electronic medical record or cord that Resident #52 or e was given tice. //24 at approximately 2:15 urse (RN) Unit Manager here is no documentation ischarge/transfer notice was	F 62	23		
	PM, Resident #167 st transferred to the hos admission to the facil not recall ever having	25/24 at approximately 1:30 tated that they have been spital twice since their initial ity on 2/8/2024, and they do been given a notice of fer or discussing one with				

VIDER OR SUPPLIER	475040		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
VIDER OR SUPPLIER		B. WING	B. WING		03/28/2024	
INTAIN NURSING ANI	D REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP COL 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE	
Per record review, Reme hospital for evaluation 2/28/24 and 3/15/20 ospital admissions. The record that a transported to Resident atterview on 3/26/24 and 2/26/24	esident #167 transferred to ation of medical symptoms 24. Both transfers resulted in There was no evidence in sfer notice was ever #167 for either transfer. Per at approximately 12:45 PM, ated that nurses are ransfer notices to the ve prior to transfer. Per at approximately 1:00 PM, e confirmed that they also evidence of a transfer notice either of Resident #167's icility. 1/24 at approximately 1:10 or stated that there are blank ices in every resident's the event of a transfer. Upon ik transfer notices, it was dministrator's signature is ne copies. The Unit Manager the case, even though the ne person who is responsible ing the transfer notices with	F 62	23			
M, the Administrato urrent practice for transet the regulation. lotice of Bed Hold P:FR(s): 483.15(d)(1)	r confirmed that the facility's ansfer notices does not olicy Before/Upon Trnsfr (2) bed-hold policy and return-	F 6:	25			
	SUMMARY ST. (EACH DEFICIENCE REGULATORY OR IT continued From page or record review, Rese hospital for evaluation and a serior of the terview on 3/26/24 are social Worker states of the sident/representative terview on 3/26/24 are sident/representative	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ontinued From page 34 er record review, Resident #167 transferred to e hospital for evaluation of medical symptoms in 2/28/24 and 3/15/24. Both transfers resulted in despital admissions. There was no evidence in er record that a transfer notice was ever devided to Resident #167 for either transfer. Per exterview on 3/26/24 at approximately 12:45 PM, er Social Worker stated that nurses are expected to provide transfer notices to the esident/representative prior to transfer. Per exterview on 3/26/24 at approximately 1:00 PM, esident #167's nurse confirmed that they also dealing completed for either of Resident #167's earsfers out of the facility. er interview on 3/26/24 at approximately 1:10 M, the Unit Manager stated that there are blank depies of transfer notices in every resident's earsers of transfer notices in every resident's eaper chart to use in the event of a transfer. Upon espection of the blank transfer notices, it was espection of the the expension who is responsible er providing/discussing the transfer notices with er resident/representative. er interview on 3/26/24 at approximately 1:30 M, the Administrator confirmed that the facility's errent practice for transfer notices does not	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TOTAL PROPERTY TAG TOTAL PROPERTY TAG TOTAL PROPERTY TAG F 67 TAG TOTAL PROPERTY TAG TAG F 67 TAG TAG F 67 TAG TAG F 67 TAG TAG TAG F 67 TAG F 67 TAG TAG TAG TAG TAG TAG TAG TA	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ontinued From page 34 er record review, Resident #167 transferred to e hospital for evaluation of medical symptoms in 2/28/24 and 3/15/24. Both transfers resulted in spital admissions. There was no evidence in e record that a transfer notice was ever evoided to Resident #167 for either transfer. Per terview on 3/28/24 at approximately 12:45 PM, e Social Worker stated that nurses are expected to provide transfer notices to the sident/representative prior to transfer. Per terview on 3/28/24 at approximately 1:00 PM, esident #167's nurse confirmed that they also build not locate any evidence of a transfer notice sing completed for either of Resident #167's ansfers out of the facility. er interview on 3/28/24 at approximately 1:10 M, the Unit Manager stated that there are blank spies of transfer notices in every resident's aper chart to use in the event of a transfer. Upon spection of the blank transfer notices, it was scovered that the Administrator's signature is re-signed on all of the copies. The Unit Manager infirmed that this is the case, even though the dministrator is not the person who is responsible ry providing/discussing the transfer notices with er eresident/representative. er interview on 3/26/24 at approximately 1:30 M, the Administrator confirmed that the facility's irrent practice for transfer notices does not eet the regulation. otice of Bed Hold Policy Before/Upon Tmsfr FR(s): 483.15(d)(1)(2) Also, Notice of bed-hold policy and return-	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ontinued From page 34 er record review, Resident #167 transferred to e hospital for evaluation of medical symptoms 12/28/24 and 3/15/24. Both transfers resulted in spital admissions. There was no evidence in e record that a transfer notice was ever rovided to Resident #167 for either transfer. Per terview on 3/26/24 at approximately 12-45 PM, e Social Worker stated that nurses are quected to provide transfer notices to the isident/representative prior to transfer. Per terview on 3/26/24 at approximately 1:00 PM, esigned the for subject of the facility or interview on 3/26/24 at approximately 1:00 PM, esigned the facility or interview on 3/26/24 at approximately 1:10 M, the Unit Manager stated that there are blank pipes of transfer notices in every resident's apper chart to use in the event of a transfer. Upon spection of the blank transfer notices, it was scovered that the Administrator's signature is resigned on all of the copies. The Unit Manager onfirmed that this is the case, even though the diministrator is not the person who is responsible ry providing/discussing the transfer notices with e resident/representative. er interview on 3/26/24 at approximately 1:30 M, the Administrator confirmed that the facility's interview of the person who is responsible to the regulation. M, the Administrator confirmed that the facility surrent practice for transfer notices does not eet the regulation. M, the Administrator confirmed that the facility surrent practice for transfer notices does not eet the regulation. M, the Administrator confirmed that the facility surrent practice for transfer notices does not eet the regulation.	

l''		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		475040	B. WNG			03/2	28/2024
	ROVIDER OR SUPPLIER OUNTAIN NURSING AND	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 625	nursing facility transfethe resident goes on nursing facility must puthe resident or reside specifies- (i) The duration of the any, during which the return and resume refacility; (ii) The reserve bed pplan, under § 447.40 (iii) The nursing facility bed-hold periods, whi paragraph (e)(1) of the resident to return; and (iv) The information sof this section. §483.15(d)(2) Bed-hold the time of transfer of hospitalization or their facility must provide the resident representative specifies the duration described in paragraph This REQUIREMENT by: Based on interview a failed to ensure that representatives received in paragraph (e)(1) of the second paragraph (e)(2) Bed-hold policy the hospital for 4 of 2 (Resident #21, Resident #167). Find 1. Per record review (discharged to the hospital for 4 of 2 (Resident #167). Find 1.	ers a resident to a hospital or therapeutic leave, the provide written information to ant representative that e state bed-hold policy, if a resident is permitted to sidence in the nursing the state of this chapter, if any; the state of the section, permitting a dispectified in paragraph (e)(1) full notice upon transfer. At if a resident for repetite leave, a nursing to the resident and the very written notice which is not met as evidenced and record review, the facility the sidents or resident wed written notification of the vent written notification of the vent written sampled. ent #39, Resident #52, and ings include:	F	625	It is the policy of the facility to issue bed he to residents and/or their representatives at resident is transferred to the hospital. Resident #21,39,52,167 were readmitted to following acute hospital stay. All residents who discharge to the hospital potential to be affected by this alleged deficipractice. To ensure residents and/or representatives notified of bed hold, staff nurse will review notice with resident and/or representative signature if medical condition permits. If not medically stable, notice must be sent to resident/EMS team. Resident Family Servi Coordinator to follow up with resident repstaff nurse and RFSC will document in product of Administrator, DNS and Refamily Services Coordinator. Audits to be weekly for 30 days, then monthly for 30 day quarterly on going. Audits to be submitted team for review Completion Date: 5/11/2024 Tag F 625 POC accepted on 5/20/24 S. Stem/P. Cota	facility have a cient are bed hold and obtainesident is pER with ces resentative gress note are the sident completed ys then to QAPI	e,

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1, ,	PLE CONSTRUCTION G		COMPLETED		
		475040	B. WNG _		0	3/28/2024	
	ROVIDER OR SUPPLIER OUNTAIN NURSING A	ND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446			
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 625	the paper medical r was given to the re representative.	724. There is no ne electronic medical record or record that the bed hold policy sident or the resident's	F 6	25			
	Registered Nurse (confirms that there supports that the w hold policy was give	3/26/24 at 12:43 pm with the RN) Unit Manager (UM) is no documentation that ritten notification of the bed en to Resident # 21 or the ative on either of the two ospital.					
	the hospital on 3/24 treatment due to su no documentation i record or the paper	w Resident #39 was sent to #24 for evaluation and adden onset of pain. There is in the electronic medical medical record that a bed en to Resident #39 or their					
	PM the Registered (UM) confirmed that that supports that the	27/24 at approximately 2:15 Nurse (RN) Unit Manager It there is no documentation the written notification of the s given to Resident #39 or their					
	the hospital on 12/2 treatment due to a documentation in the	ne electronic medical record or record that a bed hold policy					
		27/24 at approximately 2:15 Nurse (RN) Unit Manager					

	IND PLAN OF CORRECTION IDENTIFICATION NI IMPER		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		475040	B. WNG_		03/28/2024		
	ROVIDER OR SUPPLIER DUNTAIN NURSING AND) REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 656 SS=D	bed hold policy was nor their representive. 4. Per interview on 3/PM, Resident #167 st transferred to the hos admission to the facili not recall ever having notice prior to transfe staff. They said that he them upon return was Per record review, Rethe hospital for evalua on 2/28/24 and 3/15/2 hospital admissions. The record that a bed Resident #167 for eith on 3/26/24 at approxi Worker stated that nuprovide bed hold notice sident/representation interview on 3/26/24 at Resident #167's nurs could not locate any enotice being complete #167's transfers out of Per interview on 3/26 PM, the Administrator current practice for be meet the regulation.	the written notification of the not provided to Resident #52 25/24 at approximately 1:30 tated that they have been spital twice since their initial ity on 2/8/2024, and they do been given a bed hold or or discussing one with leaving their bed held for a salways a concern for them. 24. Both transferred to ation of medical symptoms 24. Both transfers resulted in There was no evidence in hold notice was provided to the transfer. Per interview mately 12:45 PM, the Social brases are expected to the very prior to transfer. Per at approximately 1:00 PM, the confirmed that they also evidence of a bed hold and for either of Resident of the facility. 24 at approximately 1:30 or confirmed that the facility's and hold notices does not comprehensive Care Plan (3)	F 6				
	§483.21(b)(1) The fac	cility must develop and					

A. BUILDING COMPLETED 475040 B. WING 03/28/20 NAME OF PROVIDER OR SUPPLIER GREEN MOUNTAIN NURSING AND REHABILITATION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED.) A. BUILDING 03/28/20 B. WING 03/28/20 STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446		TO I OIL WILDIONIL W	VIEDICAID SERVICES				CIVID INC	7. 0930 - 039 <u>1</u>	
NAME OF PROVIDER OR SUPPLIER GREEN MOUNTAIN NURSING AND REHABILITATION TAG STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446 COLCHESTER, VT 05446 CONTROL OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CONTROL OF CONTRO			1, ,	1 ' '	1			(X3) DATE SURVEY COMPLETED	
GREEN MOUNTAIN NURSING AND REHABILITATION 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE			475040	B. WNG			03/	28/2024	
COLCHESTER, VT 05446 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) COMPARISON OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	NAME OF PI	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE					4	75 ETHAN ALLEN AVENUE			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	GREEN M	MOUNTAIN NURSING AND	REHABILITATION		ا ا	OI CHESTER VT 05446			
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE		_				· · · · · · · · · · · · · · · · · · ·			
	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETION DATE	
implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at \$483.10(c)(3) 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 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; and (ii) Any services that would otherwise be required under \$483.10, including the right to refuse treatment 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's experience and potential for future discharge. Facilities must document whether the resident's experience and potential for future discharge. Facilities must document whether the resident's experience and potential for future discharge. Facilities must document whether the resident's experience and potential for future discharge. Facilities must document whether the resident's experience and potential for future d	F 656	implement a compreh care plan for each res resident rights set fort §483.10(c)(3), that incobjectives and timefra medical, nursing, and needs that are identificant assessment. The complement of the following (i) The services that a commination the reside physical, mental, and required under §483.2 (ii) Any services that a under §483.24, §483. provided due to the resunder §483.10, include treatment under §483 (iii) Any specialized some rehabilitative services provide as a result of recommendations. If a findings of the PASAF rationale in the resider (iv) In consultation with resident's representat (A) The resident's good desired outcomes. (B) The resident's prefuture discharge. Fact whether the resident's community was assessible cal contact agencies entities, for this purpor (C) Discharge plans in plan, as appropriate, requirements set forther the resident's requirements set forther the resident's purpor (C) Discharge plans in plan, as appropriate, requirements set forther the resident's set forther the	densive person-centered sident, consistent with the sident sident and sychosocial sided in the comprehensive aprehensive care plan must a prehensive care of sident's highest practicable psychosocial well-being as 24, \$483.25 or \$483.40; and would otherwise be required 25 or \$483.40 but are not asident's exercise of rights a sident's exercise of rights a sident	F	656	comprehensive care plan that is person cer and developed to meet the residents' preferences and goals. Resident #30 plan of care has been updated reflect the right to refuse care. All residents have the right to refuse care a have the potential to be affected by this alleged deficient practice. To ensure this alleged deficient practice do not occur the facility has taken the following steps; Staff are reminded to care plan residents for the right to refuse care and document steps to encourage participation. A QAPI evaluation has been initiated undesupervision of DNS, ADON and/or design Audits to be completed weekly for 30 days then monthly for 30 days then quarterly or going. Audits to be submitted to QAPI tear review. Completion Date: 4/25/2024 Tag F 656 POC accepted on 5/20/24	d to and es ang n. er the nee. n m for		

PRINTED: 05/15/2024 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING _ B. WNG 475040 03/28/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **475 ETHAN ALLEN AVENUE GREEN MOUNTAIN NURSING AND REHABILITATION** COLCHESTER, VT 05446 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID ID **PREFIX** COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC (DENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) F 656 Continued From page 39 F 656 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-(iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced Based on observations, interviews, and record reviews, the facility failed to develop a comprehensive care plan that is person-centered and developed to meet the residents' preferences and goals for 1 of 23 residents in the sample (Resident #30). Findings include: 1. Resident #30 was admitted to the facility on 2/14/24 with diagnoses that include depression, demoralization, and apathy. Per interview on 3/25/2024 at approximately 2:00 PM with a family member of Resident #3, they revealed that they are concerned about how often the resident refuses care. This includes refusing to have a dressing changed on a wound on top of their head. When Resident #30 was at home, the family would reapproach until they could provide care, change the dressing and assist with bathing and dressing. Per observation on 3/26/24 at approximately 9:40 AM, Resident #30 was sitting in a recliner in his/her room. A Licensed Nursing Assistant (LNA) asked Resident #30 if they could assist resident with morning care. Resident #30 did not respond to several requests and pushed the LNA's hand An interview with the LNA a few minutes later. she/he stated "we just know to reapproach at another time" and that this resident refuses most care daily; it often takes several attempts before care of any care is received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		475040	B. WNG			03/	/28/2024
	ROVIDER OR SUPPLIER OUNTAIN NURSING AND	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 656	Per observation on 3/10:00 AM, Resident # wound care practition his/her wound dressir stated "this is often the experience to come be some days it took three. A record review reveat plan does not contain regarding refusal of cresident later. A policy titled "Care Person-Centered" witt page 1, # 7 states, "Tereson-centered care a. Includes measuratimeframes. b. describes the set furnished to attain or highest practicable phesychosocial well-beic. (1) services that for the above but are resident exercising hiright to refuse treatment #13 on page 2 states to refuse to participate his/her care plan and Such refusals are door to the side of the set of th	27/24 at approximately 30 did not respond to the er requesting to change ng. The wound care nurse e case, and I know from ack later", explaining that ee or four attempts. als that Resident #30's care any goals or interventions are or reapproaching lans, Comprehensive th an "adoption date" of 3/21, the comprehensive, plan: able objectives and vices that are to be maintain the resident's nysical, mental, and ng, including: would otherwise be provided not provided due to the s or her rights, including the	F	656			
F 657 SS=E	approximately 3:20 P Resident #30's care p documentation addre	ssing his/her refusal of care.	F	657	7		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FUR MEDICARE &	MEDICAID SERVICES				<u>ONI DINO</u>	<u>. 0936-039 I</u>	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		475040	B. WNG			03/2	28/2024	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				4	75 ETHAN ALLEN AVENUE			
GREEN M	OUNTAIN NURSING AND	REHABILITATION		l c	OLCHESTER, VT 05446			
(VA) ID	SUMMARYST	ATEMENT OF DEFICIENCIES		—			(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 657	Continued From page	. 41		657	It is the policy of Green Mountain Nursing	Q.		
	, -		'	001	Rehabilitation to make every attempt to ensi			
CFR(s): 483.21(b)(2)(i)-(iii)		(1)-(111)			resident's care plans are reviewed and revise			
	§483.21(b) Comprehe	ansive Care Plans						
		prehensive care plan must			Residents # 1 & 6 plan of care has been upda	ted on		
	be-	storionor outo piur muot			the following.			
	1	days after completion of			Residents #6 plan of care was updated evide	nced		
	the comprehensive as	•			by updates 12/30/23 with fall & Tramadol order, 1/2/23 Tramadol change, 1	11.612.4		
	(ii) Prepared by an in	terdisciplinary team, that			with change in Tramadol, 1/18/24 with char			
	includes but is not lim				Tramadol, add Tylenol.	ige uc		
	(A) The attending phy				Approaches remained consistent with reside	ents on		
		e with responsibility for the			going goals of care therefore not changed.			
	resident.				Resident #1 does have paper care plans initia			
	(C) A nurse aide with	responsibility for the			Tube plan of care under Focus of new G-Tu			
	resident.				noting diagnosis for placement reason, goals			
		I and nutrition services staff.			interventions and tasks. Focus of potential f			
		cticable, the participation of resident's representative(s).			deficit r/t GT feeding ,a 9/11/23 goal target ongoing updates evidenced by changes note			
		be included in a resident's			8/19/23 for tube site tx for infection, 8/24/23			
		participation of the resident			site tx change, 9/13/23, 3/12/24 change to re			
		resentative is determined			flushes and nectar thick liquids a SLP plan o			
	not practicable for the				was initiated on 1/18/24 that outlines safety			
	resident's care plan.				considerations. Located in the paper chart o	f the		
		staff or professionals in			care plan section.			
	disciplines as determ	ined by the resident's needs			All most dants have the metantial to be affected	J L		
	or as requested by th				All residents have the potential to be affected this alleged deficient practice.	1 DA		
		ised by the interdisciplinary			uns anegeu dencient practice.			
		ssment, including both the			To ensure this alleged deficient practice doe	s not		
	comprehensive and o	juarterly review			occur, and procedure stays consistent with f			
	assessments.				adopted policies we are taking the following			
		is not met as evidenced			staff are reminded of the plan of care updati			
	by:	n intonuous and record			review of resident care plans are done when			
		n, interview, and record			changes occur in resident conditions to iden	tily if		
	review, the facility fail	vas reviewed and revised for			plan of care has been updated.	1	(
		ipled (Residents #6 and #1).						
	Findings include:	p.se (residente no dila n'i).						
	1 Por record review 5	Resident # 6 admitted to the						
		iagnoses that include heart						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		475040	B. WNG_			03/:	28/2024	
	ROVIDER OR SUPPLIER OUNTAIN NURSING AN	D REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 657	on 12/30/23 Resided his/her chest striking documentation complicense nurse noted side of chest with no orders on 12/30/202 Resident # 6 as bein related to fall. Per Green Mountain policy last reviewed Care Plan: "assessmongoing and comprerevised as informatic condition changes. If and updates the care reasons. A significant when the desired out the resident has been hospitalization". Review of Resident at the comprehensive or revised timely to addright rib pain, and not in the above policy wo for care until 01/23/20. An interview with the 3/28/24 at 138 PM or had not been update 01/23/24, 24 days at injury. The Director or residents comprehensive or residents comprehensive or residents comprehensive or residents comprehensive or residents comprehensive.	art disease, chronic ygen dependent, and ants. Int #6 fell onto the right side of it off the footboard. Post fall bleted on 12/30/23 by a a "small bruise to the right other injury". Physician 3 at 11:54 am identified in severe right rib pain Nursing and Rehabilitation of 1/2021 Comprehensive ents of residents are shensive care plans are on about the resident's interdisciplinary team reviews a plan for the following at change in resident status, atcome is not met, and when in readmitted after #6's care plan revealed that care plan was not updated or lifess the fall or the severe one of the interventions listed overe implemented in the plan	F	857	A QAPI evaluation has been initiated und supervision of DNS, ADON and/or desig to be completed weekly for 30 days, then a 30 days then quarterly on going. Audits to submitted to QAPI team for review. Completion Date: 5/11/2024 Tag F 657 POC accepted on 5/20/24 S. Stem/P. Cota	nee. Audit nonthly fo be		

AND DI AN OF CORRECTION IDENTIFICATION AN IMPER			PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		475040	B. WNG_		-	03/28/2024	
	ROVIDER OR SUPPLIER OUNTAIN NURSING ANI	D REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 657	to facility on 6/14/201 Gehrig's disease (AL aphasia (the lack of a voice), and dysphagidisease or other injur for all his/her care, ar his hands that limit us assistance for mobilit 05/25/2023 Resident hospital with an infect 06/05/2024. A Physician's Transiti 06/05/2023 reveals thadmitted to the Universide to the	Resident # 1 was admitted 2 with diagnoses of Lou S), paraplegia, expressive ability to communicate using a (difficulty swallowing due to y). Resident #1 is dependent and has contractures of both se. Resident #1 requires y and all transfers. On #1 was transferred to the tion and admitted until	F 6	<u> </u>			
	hospital stay a G-tube all medications and norders written on 06/0 medications and nutring-tube. Per Green Mountain policy last reviewed S Gastrostomy and jejuphysician order to cabe reviewed and upd the resident. Docume include, when care we resident tolerated car assessment of the arcare will be complete	e was inserted to be used for utrition. Hospital discharge 05/2024 reflect all ition to be given through the Nursing and Rehabilitation September 2022, inostomy sites will have a re for the site, care plan will ated for any special needs of entation of the g-tube site will as performed, how the					

AND BLAN OF CORRECTION IDENTIFICATION AND INCOME.		E CONSTRUCTION (X3) DATE SUR COMPLETI				
		475040	B. WNG		03/28/20	024
	ROVIDER OR SUPPLIER OUNTAIN NURSING AND	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446		_
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COM	(X5) APLETION DATE
F 661 SS=E	Care Plan last update residents are ongoing plans are revised as i resident's condition of team reviews and upofollowing reasons. As status, when the desiwhen the resident has hospitalization. Review of Resident#1 evidence that a comp developed for Reside the interventions liste implemented in the plant Director of Nursing comprehensive care put the time there is a characteristic plant of the discharge Summary CFR(s): 483.21(c)(2) Dischard When the facility antimust have a discharge but is not limited to, the comprehensive care put is not limited to, the comprehensive care put the time there is a characteristic plant of includes, but is not limited to, the comprehensive care put is not limited to, the comprehensive care put the time there is a characteristic plant of includes, but is not limited to, the comprehensive care put the time there is a characteristic plant of the discharge but is not limited to, the comprehensive care put the time of the discharge plant of the di	ty's policy Comprehensive and 01/2021 assessments of and comprehensive care information about the manges. Interdisciplinary dates the care plan for the significant change in resident and side been readmitted after. I's care plan revealed no rehensive plan was int #1's G-tube, and none of in the policies were an of care. Infirmed during interview on all Resident's plans should be updated at ange in resident's condition. I)-(iv) I'ge Summary cipates discharge, a resident e summary that includes, he following: Ithe resident's stay that intended to, diagnoses, course therapy, and pertinent lab, tation results. If the resident's status to graph (b)(1) of §483.20, at rege that is available for persons and agencies, with	F 65			
	representative.	nuent of residents				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		475040	B. WNG			03/:	28/2024
	ROVIDER OR SUPPLIER OUNTAIN NURSING AND	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CO 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 661	medications (both pre over-the-counter). (iv) A post-discharge developed with the part and, with the resident representative(s), whadjust to his or her ne post-discharge plans to the individual plans to that have been made care and any post-discharder and care for 1 applicable did not have a system discharge summary the elements for any resident's status and care for 1 applicable did not have a system discharge summary the elements for any residischarge at risk for resident's policy titled "Plan," adopted on 9/2 resident's discharge plan awill be developed, profiled in the resident's indicates that the discinclude a summary or	all pre-discharge resident's post-discharge secribed and plan of care that is articipation of the resident it's consent, the resident ich will assist the resident to ew living environment. The of care must indicate where or reside, any arrangements for the resident's follow up echarge medical and is not met as evidenced record review, and facility ed to prepare a discharge da final summary of the a post discharge plan of resident (Resident #64) and in place to prepare a hat included all the required dent with the potential for sidents with the potential for nore than minimal harm. Discharge Summary and except summary and except summary should if the resident's status at the including a description of the diagnosis; b. medical	F	661	It is the policy of the facility to prepare a dis summary that included a final summary of tresident's status and a post discharge plan. No residents who discharged were adversel affected by this alleged deficient practice. All residents who discharge have a potential affected by this alleged deficient practice. To ensure this alleged deficient practice doe occur staff will be reminded of the discharge summary process, the facility policy & proceed will be reviewed, discharge summary evaluated. Because of discharges. Paper copies may resuntil PCC has Green Mountain Discharge Summary activated. Copies of discharge summary evaluation wireviewed and given to discharging resident representative. A QAPI review will be completed under the supervision of the DON/ADON and/or desimonitor implemented practices. Audits to be completed weekly for 30 days, then monthly 90 days then quarterly on going. Audits to be submitted to QAPI team for review. Completion Date: 5/11/2024 Tag F 661 POC accepted on 5/20/24 S. Stem/P. Cota	to be s not edure tion in e main Il be and/or eignee to be y for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	, , , ,	(X3) DATE SURVEY COMPLETED	
		475040	B. WNG			03/28/2024	
	ROVIDER OR SUPPLIER OUNTAIN NURSING AN	D REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 661	and mental functional activities of daily living and grooming, toilet is speech, language, ar systems, and the abit make health care detactivities; sensory an nutritional status and weight and height, nutritional status and weight and preference procedures; mental adischarge potential; opotential, rehabilitations tatusc. The post distact a description of the regoals; the degree of availability, capacity arequired care; how the resident or represent post-discharge care; resident vulnerable to and how those factor.	gnostic test results; physical I status; ability to perform g including bathing, dressing use, eating, and using and other communication lity to form relationships, cisions, and participate in d physical impairments; requirements including atritional intake, and eating tes; special treatments or and psychosocial status; dental condition; activities on potential, and cognitive charge plan should include: "tesident's stated discharge caregiver/support person and capability to preform the IDT will support the ative in the transition to what factors make the operventable readmission; is get addressed."	F 66	·			
	A request was made Service Coordinator of provide this surveyor discharge summary a 3/27/2024 at approximand this surveyor rev "GMNH Discharge In Resident #64's paper	and post-discharge plan. On mately 2:00 PM, the RFSC iewed a document titled structions," located in chart, a progress note titled r," located in Resident #64's					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·			(X3) DATE SURVEY COMPLETED		
		475040	B. WNG_			03/28/2024		
	ROVIDER OR SUPPLIER	D REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 661	the Discharge Instruct dated as reviewed or most of the required summary and the post above are not included discharging resident discharge summary at RFSC explained that form is what a reside addition to a medicat resident a copy of the indicated that s/he has summary and discharge plan required share as S/He explained that form Resident #64 rerequired elements as S/He explained that form is what they use and confirmed that the required elements as Quality of Care CFR(s): 483.25 § 483.25 Quality of CQuality of care is a full treatment facility residents. Bas assessment of a resident received accordance with profipractice, the comprehence is REQUIREMENT.	and Plan" policy. Review of ctions form for Resident #64, in 12/31/2023, shows that elements of the discharge st-discharge plan listed ed. S/He stated that the does not receive a separate and post-discharge plan. The the Discharge Instructions int receives on discharge, in ion list; they do not give the elements of the discharge rige plan policy before and interest the Discharge Instructions elements of the Discharge Instructions into the Discharge Instructions elements of the Discharge Instructions elements of the Discharge Instructions in the Discharge Instruction in		684				
	by: Based on interview a	and record review the facility						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		475040	B. WNG_			03/:	28/2024
	ROVIDER OR SUPPLIER OUNTAIN NURSING AND SLIMMARY ST	O REHABILITATION ATEMENT OF DEFICIENCIES	ID	47	TREET ADDRESS, CITY, STATE, ZIP CODE 75 ETHAN ALLEN AVENUE OLCHESTER, VT 05446 PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 690 SS=D	(Resident #29) did not is listed in their medical allergy. Per record review Relisted as an allergy. A 3/23/2024 reflects Traby mouth every 8 hourelated to low back parts and a series of Tramadol 25rd 10 pain scale. Per interview on 3/28 of Nursing (DON) conhad an order for and with a listed known all Bowel/Bladder Incontral	of 23 residents sampled of recieve a medication that cal record as a known drug sident #29 has Tramadol a physicians order dated amadol 25 mg give 1 tablet urs as needed for pain ain. Review of Resident ninistration Record (MAR) 24 Resident #29 receaved a mg for pain rated as 5 on a way for pain rated as 5 on a way a saministered Tramadol lergy.		690	It is the policy of the facility to ensure that do not receive a medication that is listed in medical record as a known drug allergy. Resident # 29 had tramadol prescribed by particular care physician. Resident # 29 has been deer to have a allergy to tramadol by the physicial allergy has since been discontinued on EHI resident #29 physician. Documentation is presidents EHR record. No residents were adversely affected by this deficient practice. All residents who are identified with a aller potential to be affected by this alleged deficient practice do occur, review with nursing staff will be contained and documented on the importance of noting physicians of drug allergies and reporting a the physician with any newly prescribed or the importance of the physician with any newly prescribed or the importance of the physician with any newly prescribed or the importance of the physician with any newly prescribed or the importance of the physician with any newly prescribed or the physician with any newl	orimary med not an, R by noted in s alleged gy have a ciency. es not mpleted ifying lerts to ders.	
	resident who is continuadmission receives somaintain continence to condition is or become not possible to maintain \$483.25(e)(2)For a reincontinence, based of comprehensive assessensure that- (i) A resident who entindwelling catheter is	cility must ensure that sent of bladder and bowel on ervices and assistance to unless his or her clinical es such that continence is ain. esident with urinary on the resident's esment, the facility must ers the facility without an not catheterized unless the dition demonstrates that			supervision of the DON/ADON and/or des monitor implemented practices. Audits to la completed weekly for 30 days, then monthl days then quarterly on going. Audits to be to QAPI team for review. Completion Date: 5/11/2024 Tag F 684 POC accepted on 5/20/24 S. Stem/P. Cota	be ly for 90 submitted	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		CONSTRUCTION	(X3) DATE COMF	SURVEY
		475040	B. WNG			03/	 28/2024
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
GPEEN M	OUNTAIN NURSING A	ND REHABILITATION		47	75 ETHAN ALLEN AVENUE		
GKEEN IN	CONTAIN NURSING A	ND REPABILITATION		С	OLCHESTER, VT 05446		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 690	Continued From pa	=	F	690	it is the point, or the facility to chibare that		
		enters the facility with an			residents with urinary catheters received		
	indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder					ent	
					urinary tract infections.		
			S				
	` '	e treatment and services to			Resident # 14 Foley Catheter bags are anti		
		t infections and to restore			reflex to prevent back flow to the bladder s		
	continence to the ex				tubing be above residents bladder. Staff did	ļ	
		•			wear gloves during procedure.		
	§483.25(e)(3) For a	resident with fecal			All residents who have a urinary catheter h	21/0	
	incontinence, based	d on the resident's			the potential to be affected by this alleged	avc	
	comprehensive ass	essment, the facility must			deficient practice.		
		ent who is incontinent of bowel			T .		
	''''	e treatment and services to			To ensure this alleged deficient practice do	es not	
		rmal bowel function as			occur, review with nursing staff will be	_	
	possible.				completed and documented on catheter ca	re and	
		NT is not met as evidenced			infection control practices.		
	by:	A			A QAPI review will be completed under th	•	
		terview, and record review, ensure that residents with			supervision of the DON/ADON and/or des		
		ensure that residents with eceived appropriate treatment			to monitor implemented practices. Audits		
		vent urinary tract infections for			completed weekly for 30 days, then month		
		d residents (Resident #14).			90 days then quarterly on going. Audits to		
	Findings include:				submitted to QAPI team for review. Comp Date: 5/11/2024	letion	
	1. Per Record revie	ew on 3/26/24 reveals resident					
		is of Flaccid Neuropathic			Tag F 690 POC accepted on 5/20/24	by	
	_	en the bladder does not			S. Stem/P. Cota	ьыу	
		nd therefore requires a			J. J		
	catheter to empty th	ne bladder). Resident #14 has					
		eling foley catheter (an					
		heter is a tube that is					
		ladder to constantly drain					
		ed to a collection bag that					
		mptying. Per further review of					
	_	sis list s/he has diagnosis of					
	Urinary Tract infecti	ions and Infection and					1

	OF DEFICIENCIES CORRECTION						
		475040	B. WING			03/	28/2024
	ROVIDER OR SUPPLIER	REHABILITATION	•	4	TREET ADDRESS, CITY, STATE, ZIP CODE 75 ETHAN ALLEN AVENUE COLCHESTER, VT 05446	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 690	Continued From page	2 50	F	690			
	Inflammatory Reactio catheter.	n due to Indwelling Urethral					
	a Licensed Nurse Aid #14 foley bag (the bat while the resident is in drainage bag that is s while the resident is of adhere to infection co- below facility policy/pr	strapped to the resident's leg but of bed). The LNA failed to introl standards, and the					
	Procedure "2. Wash and dry you gloves. #3 Clean the alcohol wipe before d remove cover over co #8 Connect the cathe touching the terminal Further review of facil Collection Bag reveal	r hands. Apply Clean catheter/bag junction with isconnecting. #7 Carefully innection tip on the leg bag. ter to the leg bag with out end of the catheter tubing. "lity policy Emptying a Urinary Is under section General the collection bag below the					
F 692 SS=D	3/26/24 at 3:30 pm, s policies should be foll catheter care. Nutrition/Hydration St CFR(s): 483.25(g)(1)- §483.25(g) Assisted r (Includes naso-gastric	·(3) nutrition and hydration. c and gastrostomy tubes,	F	692			
	(Includes naso-gastri						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/15/2024 FORM APPROVED

STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING O3/28/2 STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE	ND P ENITOR O
GREEN MOUNTAIN NURSING AND REHABILITATION 475 ETHAN ALLEN AVENUE	
GREEN MOUNTAIN NURSING AND REHABILITATION	NAME OF PRO
GREEN MOON TAIN NORSING AND REPABLITATION COLCHESTER. VT 05446	CDEEN MO
	GREEN WIO
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX
F 692 Continued From page 51 percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident. §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; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered sufficient fluid intake to maintain proper hydration and health; Fassed on staff interview and record review, the facility failed to ensure that residents maintain acceptable parameters of nutritional status as evidenced by lack of weight monitoring tor one of four sampled residents (Resident #16) and a lack of follow up on a significant weight loss for one of four sampled residents (Resident #56). Findings include: 1. Per record review, Resident #16 has a diagnosis of Congestive Heart Failure (a condition in which the heart pumps blood less efficiently, which can lead to fluid overload in the body). Resident #16's record did not contain an order for regular weights. The last documentation will be completed on 5/20/24 by S. Stem/P. Cota weight so be obtain weights. Resident #16 was ordered for weights to be obtain weights to be obtain weights to be obtain weights. Resident will be offered weight monitoring monthly, documentation will be completed on the fired residents end to obtain weights. Resident #16 intuitional status. Resident #16 is frequently refuses to get out of bed to obtain weights skeident will be offered weight monitoring monthly for resident section to the fired weight monitoring monthly documentation will be completed on the right to refuse care. Resident #16 is frequently refuses to get out of bed to obtain weights such as usual body weight refuses to evidence the refuse and the president section to the fired weight for the facility	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		475040	B. WNG_			03/28/2024
	ROVIDER OR SUPPLIER OUNTAIN NURSING AND	REHABILITATION		STREETADDRESS, CITY, STATE, 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIAT CIENCY)	
F 692	provider regarding dis Resident #16. Per the Record, Resident #16 regularly. The reason Resident #16 does not have weights obtaine #16's care plan, a car has the interventions and "notify registered physician of significar initiated on 6/29/23. F#16 also has chewing motified textured diet. anywhere in the record facility to assess Resor explore ways to incompliance with obtain discontinuation. Addit code status of full code are. Per interview on 3/26 PM, the Dietitian conficonversation between provider regarding the but that this cannot be documentation in the that Resident #16 documentation of weights obtain discontinuation discontinuation discontinuation discontinuation discontinuation discont	PM, the note states, and discontinuation of coring due to resident documentation from any scontinuation of weights for a Treatment Administration of refused monthly weights given for refusals is that not want to get out of bed to d. Per review of Resident re plan focus for nutrition "obtain weights as ordered" dietitian, family, and not weight changes", both Per the care plan, Resident repland difficulties requiring a state of any efforts by the dietitian and the second of any efforts by the dietitian state of the and is not on comfort weights, resident #16's record. The dietitian stated resident will be discontinuation of weights, and the they are not aware of anterventions done to explore ident #16's compliance with	F	692		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFIC	ENCIES						
AND PLAN OF CORREC	CTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		475040	B. WNG			03/	28/2024
NAME OF PROVIDER		REHABILITATION		47	TREET ADDRESS, CITY, STATE, ZIP CODE 75 ETHAN ALLEN AVENUE COLCHESTER, VT 05446	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
supple weigh supple	nt loss, as the fa	e 53 sident's diet in the event of mily has refused meal Resident #16 in the past.	F	692			
facility diagnocondit either diseas Further entries his/he 9/7/20 10/23/11/1/2 1/2/20 2/3/20 3/10/2 3/26/2 Further 3/26/2 Changenters intake Mighty maints The e (RD). of weekl A revidocum monito	y since 11/25/22 oses: metabolic tion in which bra temporarily or p ses or toxins in ter record review s: an 18-lb. weiger weight in the I 023 - 122.7 Lb 1/2023- 113.6 Lbs 024 - 109.9 Lbs 024 - 104.5 Lbs 024 - 104.5 Lbs 024 - 99.6 Lbs 0204 - 99.6 Lbs er record review 24 in the medica ge Warning." Av ed, and states, " e is often less the y Shake (a dieta aining weight ar entry is signed by A nursing note ight decline and ly." iew of Resident mentation of wei or and prevent i	os is. is. is. is. is. is. is. is. is. is					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		475040	B. WNG				03/28/2024
	ROVIDER OR SUPPLIER	ND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP (475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	I	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	
F 692	under #5 states: "Trunplanned and under based on the following weight loss is significated by the loss or impaired nuteffort and includes the dietitian, consultant individualized care pextent possible, the loss, goals and benefiting frames and pair reassessment." Per observation 3/2 AM resident #56 was up with an untouche Per an interview with aproximately 11AM, tray and offered a modern of the resident #56's cart administration. She Nursing (DON) runs [him/her] if we notice Per interview with the approximately 10:20 weight loss team con RD, and both are as S/he confirmed Resweight loss, a nutrition.	n "adoption date" of 9/22 ne threshold for significant esired weight loss will be ing criteria: 6 months-10% cant; greater than 10% is	F	692			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FUR MEDICARE &	MEDICAID SERVICES			UIVID IN	<u>J. 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	1, ,	E SURVEY PLETED
		475040	B. WNG_		03	128/2024
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ODEEN M	OUNTAIN NUIDOING AND			475 ETHAN ALLEN AVENUE		
GREEN M	OUNTAIN NURSING AND	REHABILITATION		COLCHESTER, VT 05446		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	contain interventions Tube Feeding Mgmt/l	for weight loss. Restore Eating Skills	'	It is the policy of Green Mountain Rehabilitation to provide care and gastrostomy tube (g-tube; a tube in into the stomach that can deliver n hydration, and/or medications) con	treatment of a serted directly utrition,	
	CFR(s): 483.25(g)(4)(s) §483.25(g)(4)-(5) Enter (Includes naso-gastric both percutaneous error percutaneous endoscenteral fluids). Based comprehensive assessensure that a resident §483.25(g)(4) A reside eat enough alone or venteral methods unleaded condition demonstrate clinically indicated an resident; and §483.25(g)(5) A resident means receives the asservices to restore, if and to prevent compliance to prevent compliance including but not limited diarrhea, vomiting, deabnormalities, and nathis REQUIREMENT by: Based on interview a failed to provide care gastrostomy tube (g-tinto the stomach that hydration, and/or med professional standard sample (Resident #1) Findings include:	eral Nutrition c and gastrostomy tubes, idoscopic gastrostomy and opic jejunostomy, and on a resident's isment, the facility must dent who has been able to with assistance is not fed by is the resident's clinical es that enteral feeding was d consented to by the ent who is fed by enteral peropriate treatment and possible, oral eating skills cations of enteral feeding ed to aspiration pneumonia, chydration, metabolic sal-pharyngeal ulcers. is not met as evidenced and record review the facility and treatment of a ube; a tube inserted directly can deliver nutrition, lications) consistent with s for 1 of 24 residents in the		professional standards Resident #1 does have paper care pinitiated, G-Tube plan of care und G-Tube noting diagnosis for place goals, interventions and tasks. For fluid deficit r/t GT feeding, a 9/11/date and ongoing updates evidence noted 8/19/23 for tube site tx for it tube site tx change, 9/13/23, 3/12/2 receiving flushes and nectar thick plan of care was initiated on 1/18/2 safety considerations. Located in the paper chart of the control of the paper chart of the paper chart of the control of the paper chart	plans er Focus of new ment reason, cus of potential (23 goal target ed by changes infection, 8/24/23 (24 change to liquids a SLP (24 that outlines are plan section. have the potential ent practice. ment obtained on 3/25/2024. have the potential ent practice. actice does not will be completed of a gastrostomy under the ind/or designee to ments. Audits to hen monthly for hudits to be w.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		475040	B. WNG			03/	28/2024	
	ROVIDER OR SUPPLIER OUNTAIN NURSING AND	REHABILITATION		4	TREET ADDRESS, CITY, STATE, ZIP CODE 75 ETHAN ALLEN AVENUE OLCHESTER, VT 05446			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 693	note dated 6/05/2023 returned to the facility hospital stay that requig-tube. Per review of Resider Resident #1 did not hight guide site care, physiste, documentation of	reveals that Resident #1 on 6/5/2023 following a uired the placement of a ht #1's medical record, ave a care plan related to ician orders to care for the	F	693				
	documentation of how over 9 months (6/5/20). Per facility policy "Ga Site Care" last review states "the purpose o promote cleanliness a gastronomy of jejunos breakdown and infect is required "physician care plan will be revies special needs of the return the g-tube site will incorperformed, how the resite, and assessment	v s/he tolerated site care for D23 through 3/25/2024). strostomy and Jejunostomy ed in September 2022, if this policy/procedure are to and to protect the stomy site from irritation, ion". Per policy the following order to care for the site, ewed and updated for any resident. Documentation of stude, when care was esident tolerated care of the of the area. Documentation inpleted by the license						
	#1 suffered complicate breaking during media	sing progress note, Resident ions related to the g-tube cation administration and gency room for g-tube						
	11/19/23 with the repart evidence that the faci	narge summary dated #1 returned to the facility on aired G-tube. There is no lity contacted the provider to to the care and monitoring						

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` '		NSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		475040	B. WNG_			03/	28/2024
	ROVIDER OR SUPPLIER OUNTAIN NURSING AND) REHABILITATION		475 E	ET ADDRESS, CITY, STATE, ZIP CODE ETHAN ALLEN AVENUE CHESTER, VT 05446		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 693	of the g-tube after reti 11/19/23. Per interview on 3/27	um from the hospital on /2024 at 2:00 pm a Licensed	F€	93			
F 757 SS=D	did not have physicial to 3/26/2024. The LPN documentation and er on the treatment adm Confirmation was main place at start of car Orders to include eva g-tube site and area. would be to contact p Resident # 1's care o evidence that the faci obtain orders prior to	lity contacted provider to 03/26/2024. e from Unnecessary Drugs	F 7	757			
	unnecessary drugs. Adrug when used-	regimen must be free from An unnecessary drug is any essive dose (including					
	§483.45(d)(2) For exc	cessive duration; or					
	§483.45(d)(3) Withou	t adequate monitoring; or					
	§483.45(d)(4) Withou use; or	t adequate indications for its					
	§483.45(d)(5) In the p consequences which reduced or discontinu	indicate the dose should be					

PRINTED: 05/15/2024 FORM APPROVED OMB NO. 0938-0391

CLIVILIN	OT OIL MILDIOANL &	WILDICAID SERVICES				CIVID IVC	7. 0930-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		475040	B. WNG			03/	28/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
005511.11	O			4	75 ETHAN ALLEN AVENUE		
GREEN M	OUNTAIN NURSING AND	REHABILITATION		Ιc	OLCHESTER, VT 05446		
(X4) ID	SI IMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
					It is the policy of the facility to ensure that		
F 757	Continued From page 58			757	monthly pharmacist drug regimen reviews,		
			'		recommendations, and attending physician		
	8483 45(d)(6) Apv co	mbinations of the reasons			responses are completed and documented i		
		(d)(1) through (5) of this			the resident record.		
	section.	(d)(1) tillough (5) of this					
		is not met as evidenced			Resident #6 pharmacy review relating to		
		is not met as evidenced			digoxin level was ordered by physician and		
	by:	and record review, the facility			completed on 12/20/2023.		
		nonthly pharmacist drug			All residents who pharmacy submits drug		
	regimen reviews, reco	• •			regimen review have a potential to be		
		esponses are completed and			affected by this alleged deficient practice.		
	• • •	sident record for 1 of 5					
	sampled residents. Fi				December of 2023 it was identified by DON		
	Sampled residents. 11	nangs molade.			that some pharmacy reviews may have been		
	Per record review a r	pharmacy recommendation			overlooked and the process at that time manned not be working.	7	
		esident #6 states "Obtain lab			not be working.		
		ery 6 months most recent			To ensure this alleged deficient practice do	•¢	
	per record 3/09/2023.				not occur a review with nursing staff will b		
	po. 1000.u 0/00.2020.				completed and documented, physicians are		
	Per review of Resider	nt #6's medical record, there			reminded of the process, the pharmacy		
		evidence in the record that			recommendations are received by DON and	1/	
		ed the 10/24/23 Pharmacy			or designee, reviewed with physicians.		
	Recommendations fo	•					
		Digoxin can become toxic,			Recommendations will be addressed with		
	which will be evident	_			appropriate plan of care physician deems		
					necessary according to residents condition.		
	During an interview of	n 3/28/24 at 2:00 pm the			Plan of care deemed by physician to be carr out by physician order.	ica	
	Director of Nursing (D	OON) confirmed that there			out by physician order.		
		the physician reviewed or			A QAPI review will be completed under th	e	
	addressed the recom	mendations. The DON			supervision of the DON/ADON and/or	-	
		ood work was not done until			designee to monitor pharmacy		
	12/20/23 for Resident	t #6.			recommendations. Audits to be completed		
F 758	_	chotropic Meds/PRN Use	F	758		rs	
SS=D	CFR(s): 483.45(c)(3)	(e)(1)-(5)			then quarterly on going. Audits to be		
					submitted to QAPI team for review.		
	§483.45(e) Psychotro	•			Completion Date: 5/11/2024		
		hotropic drug is any drug that					
		associated with mental			Tag F 757 POC accepted on 5/20/24	by	
	processes and behav	ior. These drugs include,			S. Stem/P. Cota	-	

Facility ID: 475040

PRINTED: 05/15/2024 FORM APPROVED

OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					
		475040	B. WNG_			03/2	28/2024
	ROVIDER OR SUPPLIER	REHABILITATION		47	REET ADDRESS, CITY, STATE, ZIP CODE 5 ETHAN ALLEN AVENUE OLCHESTER, VT 05446		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 758	but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehresident, the facility not seed on the facility of seed on the clinical record; \$483.45(e)(1) Resided psychotropic drugs a unless the medication specific condition as in the clinical record; \$483.45(e)(2) Resided drugs receive gradual behavioral intervention contraindicated, in and drugs; \$483.45(e)(3) Resided psychotropic drugs punless that medication diagnosed specific coin the clinical record; \$483.45(e)(4) PRN of are limited to 14 days \$483.45(e)(5), if the apprescribing practition appropriate for the Ploeyond 14 days, he crationale in the reside indicate the duration	ensive assessment of a nust ensure that— ents who have not used re not given these drugs in is necessary to treat a diagnosed and documented ents who use psychotropic I dose reductions, and ons, unless clinically in effort to discontinue these ents do not receive ursuant to a PRN order in is necessary to treat a condition that is documented and enter for psychotropic drugs is. Except as provided in attending physician or er believes that it is RN order to be extended or she should document their ent's medical record and	F7	758	It is the policy of the facility ensure that residents who use psychotropic drugs receigradual dose reductions. Resident #6 pharmacy review relating to Gwas reviewed on 12/15/2023. All residents who have a order for psychodrugs have a potential to be affected by thi alleged deficient practice. In December of 2023 it was identified by Ethat some pharmacy reviews may have bee overlooked and the process at that time manot be working. To ensure this alleged deficient practice do occur review with nursing staff will be completed and documented, physicians ar reminded of the process, the pharmacy recommendations are received by DON and designee, reviewed with physicians. Recommendations will be addressed with appropriate plan of care physician deems necessary according to residents condition of care deemed by physician to be carried physician order. A QAPI review will be completed under the supervision of the DON/ADON and/or deto monitor pharmacy recommendations. At the top the process of the physician order. A QAPI review will be completed under the supervision of the DON/ADON and/or deto monitor pharmacy recommendations. At the physician physician to be carried by the physician order. A QAPI review will be completed under the supervision of the DON/ADON and/or deto monitor pharmacy recommendations. At the physician physician to be carried to be completed weekly for 30 days, then monthly for 90 days then quarterly on goin Audits to be submitted to QAPI team for a Completion Date: 5/11/2024 Tag F 758 POC accepted on 5/20/24 S. Stem/P. Cota	DR cropic	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		475040	B. WNG			03/28/2024		
	ROVIDER OR SUPPLIER	D REHABILITATION		47	REET ADDRESS, CITY, STATE, ZIP CODE 5 ETHAN ALLEN AVENUE DLCHESTER, VT 05446			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 758	drugs are limited to 1 renewed unless the a prescribing practition the appropriateness of This REQUIREMENT by: Based on interview a failed to ensure that a psychotropic drugs rereductions (GDR), uncontraindicated, for 1 (Resident #6). Findin Per record review, Reof depression with the Citalopram 40 miligragiven by mouth., writis a psychotropic med depression). Per record review, or medication regimen in for Citalopram, from evidence that a physipharmacist recomme or that a GDR was at provided clinical ration not attempted prior to Review of Resident #Administration Recorreceived Citalopram through 12/15/2023. Per interview on 3/28 Director of Nursing cont review the pharm	A days and cannot be attending physician or er evaluates the resident for of that medication. T is not met as evidenced and record review, the facility residents who use eceive gradual dose aless clinically of 5 sampled residents gs include: esident # 6 has a diagnosis e following Physician order. It is a diagnosis e following physician diagnosis. It is a diagnosis e following to a diagnosis e following physician order. It is a diagnosis e following to a d	F	758				

	3 FOR WEDICARE &	VIEDICAID SERVICES				CIVID IVC	7. 0830-0381	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		475040	B. WNG			03/	28/2024	
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
CDEEN M	OUNTAIN NURSING AND	DELIABILITATION		47	75 ETHAN ALLEN AVENUE			
GREEN IN		REMADILITATION		С	OLCHESTER, VT 05446			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
	CFR(s): 483.60(i)(1)(3) §483.60(i) Food safet		F	812				
	The facility must - §483.60(i)(1) - Procur approved or consider state or local authoriti (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using p gardens, subject to co safe growing and food (iii) This provision doe from consuming food §483.60(i)(2) - Store, serve food in accorda standards for food se This REQUIREMENT by: Based on observation record review, the fact store food in accorda standards for food se include. On 3/25/24 at 11:05 a facility kitchen was co Manager and Registe present during this to During an observation the kitchen, the follow 1. A package of donu	re food from sources red satisfactory by federal, ries. rood items obtained directly subject to applicable State ulations. res not prohibit or prevent roduce grown in facility rompliance with applicable d-handling practices. res not preclude residents res not preclude residents res not procured by the facility. In prepare, distribute and rice with professional rice safety. The is not met as evidenced rice with professional rice safety. The indings rice safety. Findings rice safety. Findings						

CENTER	OT OIL MEDIONIL G	MEDICAID SERVICES			OND 140, 0930-0391		
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		475040	B. WING			03/	28/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CDEEN M	OUNTAIN NUIDEING AND	DELIABILITATION		4	75 ETHAN ALLEN AVENUE		
GREEN W	OUNTAIN NURSING AND	DREHABILITATION		c	COLCHESTER, VT 05446		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
					DEFICIENCY)		
F 812	, ,		F	812			
		hat appeared to be mixed					
		with no date and no label on					
	the container.	be 4 baked cake layers,					
	frozen with no dates,						
	•	vith what appeared to be					
		I no label and no date.					
	6. A plastic bag of wh	at appeared to be pepperoni					
	with no date and no la						
		with no label and no date					
	that appeared to be fi						
		d with tin foil that had a tear					
		e food in the container, the					
		teriyaki no date was noted.					
	white substance in th	ng-size containers with a					
		Mayonnaise there were no					
	dates or labels on the	•					
		of what appeared to be					
	pickles with no date of	• •					
	11. In a different freez	zer unit, there was a metal					
		mni foil labeled "kielbasa					
	•	a break in the foil that					
		d another metal pan was					
	underneath, with the	foil that was covering the					
		ed down, exposing the food					
	to the bottom of the to	op pan.					
	12. In a dry food stor	age area there was a large					
		cake mix" that had no date					
	, ,	s opened. When asked					
		en date, the dietary manager					
		it, and s/he was asked if the					
		ed today s/he stated "I don't					
		ened". The top of the					
	opened bag was fold	ed down but was not					
	secured shut.						
					1		

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		475040	B. WNG_			03/:	28/2024
	ROVIDER OR SUPPLIER OUNTAIN NURSING AND	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	Ţ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	racks of what appear with plastic wrap, both On 3/28/24, a review revealed the following 1. In August 2023, at 50 degrees (F) on 8/6. 2. During November recorded temperature and 80 degrees (F) fro November 21st On 03/28/24 at 12:26 kitchen manager revein August and Novem was out of the accept milk was removed an refrigerator". S/he fur refrigerator that is kep the basement, however revealed that when the refrigerator that the temperature was not taken at any being stored there in An interview on 3/28/25 Supervisor reveals the times the milk coot that the milk was take brought to the refrigerator.	rage area there were 2 red to be muffins covered in with no label or dates. of refrigerator temperatures g: the milk cooler was recorded 8/1, 8/2, 8/3, 8/4, 8/5 and er 2023 the Milk cooler has es between 60 degrees (F) om November 5th through of PM interview with the eals that during the episodes ber when the milk cooler able temperature range, the distored in "the cave ther explained that this is a bot unplugged and empty in er, the dietary manager the milk was put in this terature of the refrigerator time while the milk was August or November. 24 with the Maintenance at s/he does recall both of older was down, s/he reveals en out of the milk cooler and rator in the basement the of service and was fixed by		312	It is the policy of the facility to consistently food in accordance with professional stands for food service safety. All foods have been dated and labeled. Back up refrigerator is no longer in use as milk cooler is fixed. No residents were adversely affected by this alleged deficient practice. All residents have the potential to be affected by this alleged deficient practice. To ensure this alleged deficient practice do occur review with staff will be completed and documented of the policy and procedure for food storage and labeling. Staff will put temp log on back up refrigerate when in use should it need to be utilized agreeminders posted on refrigerators. A QAPI review will be completed under the supervision of the Dietitian and Dietary Supervisor. Audits to be completed 2 x weef for 30 days, then weekly on going. Audit resubmitted to QAPI team on a monthly basif 6 months, then Quarterly. Completion Date: 5/11/2024 Tag F 812 POC accepted on 5/20/24 S. Stem/P. Cota	ards	
	CFR(s): 483.20(f)(5),			, - -			

PRINTED: 05/15/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		475040	B. WING		03/28	B/2024	
	ROVIDER OR SUPPLIER OUNTAIN NURSING AND	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 842	§483.20(f)(5) Resider (i) A facility may not reresident-identifiable to (ii) The facility may reresident-identifiable to accordance with a colagrees not to use or of except to the extent to to do so. §483.70(i) Medical reresidents areas and and must maintain medicate that areas areas areas areas (ii) Complete; (iii) Accurately docume (iii) Readily accessible (iv) Systematically org §483.70(i)(2) The fact all information contain regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, pay operations, as permit with 45 CFR 164.506 (iv) For public health a neglect, or domestic of activities, judicial and law enforcement purp purposes, research p medical examiners, fi	nt-identifiable information. elease information that is to the public. lease information that is to an agent only in intract under which the agent disclose the information ine facility itself is permitted cords. dance with accepted is and practices, the facility al records on each resident ented; e; and ganized dility must keep confidential ined in the resident's records, in or storage method of the release is- ir their resident permitted by applicable law; yment, or health care ted by and in compliance	F 84	It is the policy of the facility to ensure tha records are complete, accurately document readily accessible, and systematically organized related to physician. The facility has a hybrid medical record system, it is the practice of the facility to the PCC for EHR, physician notes, x rays and labs are documented in UVMMC Epic software. As reasonably practicable facilities that will print and scan documents in PCC this was implemented in or about Jan/Deccession progress notes, x rays, and labs in paper chart. The facility has been working on a consolidation and processes of EHR since implementation of PCC 4/1/2023. Resident #63 physician visit notes and x-results are documented in UVMMC, facil staff could have accessed them for survey upon request. There is a physician note dated 1/12/2024 relating to death that is import from our on call after hours physicians from our on call after hours physician, dated 9/11, 9/12, 9/13, 9/21, 10/20.10/21, 10/26, 11/9, 11/15, 11/20, 11/24, 11/29, 12/2, 12/27, 12/29/23, 1/3, 1/1/19, 2/21, 2/27, and 3/5/24 notes are scar into the misc tab of PCC.	ay ity team ed om l 11/7,		

Facility ID: 475040

AND DI AN OF CORRECTION IN INFER		1`'	(X2) MULTIPLE CONSTRUCTION A. BUILDING		X3) DATE SURVEY COMPLETED		
		475040	B. WING_			03/2	28/2024
	ROVIDER OR SUPPLIER OUNTAIN NURSING ANI	D REHABILITATION		47	TREET ADDRESS, CITY, STATE, ZIP CODE 75 ETHAN ALLEN AVENUE OLCHESTER, VT 05446		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 842	by and in compliance §483.70(i)(3) The factorecord information agunauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requirement (iii) For a minor, 3 yealegal age under State §483.70(i)(5) The medical formation of the results of any and resident review of determinations conductively Physician's, nurse professional's progretical years are this REQUIREMENT by: Based on interview of failed to ensure that accurately document systematically organinotes for 2 of 23 sam #63, #56), laboratory residents (Resident #1 of 5 sampled residents)	with 45 CFR 164.512. dility must safeguard medical painst loss, destruction, or a records must be retained required by State law; or see date of discharge when ent in State law; or ars after a resident reaches a law. dical record must containation to identify the resident; sident's assessments; ive plan of care and services by preadmission screening evaluations and sucted by the State; b's, and other licensed as notes; and logy and other diagnostic equired under §483.50. To is not met as evidenced and record review, the facility records are complete, ed, readily accessible, and ized related to physician apled residents (Residents y results for 1 of 23 sampled (Resident #35), and tes for 3 of 23 sampled	F	342	Resident #52's care plan was reviewed and updated by IDT team on January 18th 2024 of significant change in residents condition not February 2024. Evidenced by updated care plwith January 18th date. Resident #39,care plan had been reviewed an revised by the IDT. Evidenced by Social Servicare plan reviewed note and dates of update of the written care plan, Resident #35 care plan meeting was completed January 24th 2024 not February 2024 with ID due to a significant change, Evidenced by parchart documentation of signature sheet, updacare plan. Resident # 35 pharmacy medication regimen review recommendations were reprinted and provided to surveyor. To ensure this alleged deficient practice does occur physician notes and pharmacy recommendations will be monitored for com and scanned into PCC for easier accessibility Review with nursing staff will be completed documented. Care plan sign sheets will be ket the residents medical record with written car until full EHR care plan transition occurs. A QAPI review will be completed under the supervision of the DON/ADON to monitor pharmacy recommendations, Resident Famil Service coordinator to monitor care plan sign sheets. Audits to be completed weekly for 30 then monthly for 90 days then quarterly on gaudits to be submitted to QAPI team for rev Completion Date: 5/11/2024 Tag F 842 POC accepted on 5/20/24 to S. Stem/P. Cota	lan id ice on ed on of per ated in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		475040	B. WING			03/	28/2024
	ROVIDER OR SUPPLIER OUNTAIN NURSING A	ND REHABILITATION		4	TREET ADDRESS, CITY, STATE, ZIP CODE 75 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 PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE
F 842	1. Per review of 1/1 notes, Resident #6: symptoms on 1/11// physician. Resident that day and confirr RSV and ordered a 1/12/2024 nursing p Resident #63 passe review of both Resi record and the pap- 1/11/2024 physician x-ray results. On 3/27/2024 at 11 confirmed that the the 1/12/2024 x-ray #63's medical record 2. Per record review the facility since 11 electronic medical r #56's paper chart in provider visits after Per an interview wi 3/26/24 at approxim the facility had been the paper charts to (EMR) since April 2 there was time, s/h #56's provider note place them in the p how the facility was	1/2024 nursing progress 3 was showing respiratory 2024 and staff notified the t #63 was seen by a physician med him/her to be positive for chest x-ray to be complete. A progress note reveals that ed away the following day. A dent #63's electronic medical er chart does not contain the n visit note or the 1/12/2024 AM, the Administrator 1/11/2024 physician note and results were not in Resident	F	842			
	provider information	w, 25 documents containing n, dated 9/11, 9/12, 9/13, 9/21, , 11/7, 11/9, 11/15, 11/20,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		475040	B. WNG_		ļ	03/28/2024	
	ROVIDER OR SUPPLIER OUNTAIN NURSING AN	D REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CO 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 842	2/21, 2/27, and 3/5/2 paper chart and the E Per interview on 3/26 Licensed Practical Ni evening charge nurse access to Prism, previous accessible. Per interview on 3/27 PM, the Unit Manage was not maintaining in systemically organize accessible. Per record review Consultant Pharmaci Review recommenda October of 2023 were record. During an interview of 3:00 PM the Director that the September at Pharmacist's Medica recommendations we medical record. The recommendations we medical record. The recommendations du provided them to this 4. Per record review plan meeting docume Care Plan / Review - reflects that member team (IDT) met to rev plan on 11/1/23. The evidence in the record	2/27,12/29/23,1/3, 1/11, 1/19, 24 were missing from both the EMR. 6/24 at approximately 3 PM, a urse (LPN) functioning as the ereported s/he did not have venting access to Resident 7/24 at approximately 1:00 er confirmed that the facility medical records in a ed manner that was readily Resident #35's monthly ist's Medication Regimen ations for September and ernot available in the medical ernot available in the medical ernot available in the DON printed the uring this interview and a surveyor. Resident #52 last had a care ented on 11/1/23. A Resident ented on 11/1/23. A Resident ented on 11/1/23. A Resident ented on 11/1/23 care ented en	F8	42			

	IT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONST OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			CTION (X3) DATE SURVEY COMPLETED		
		475040	B. WNG			3/28/2024
	ROVIDER OR SUPPLIER OUNTAIN NURSING AND) REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446	Ē	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 842	plan meeting documed Care Plan / Review - reflects that members team (IDT) met to reviplan on 11/8/23. Therevidence in the recomplan had been review February 2024 as recomplan meeting documed Care Plan / Review - reflects that members team (IDT) met to reviplan on 11/8/23. Therevidence in the recomplant is to revidence in the recomplant of the recomplant is to revidence in the recomplant in the recomplant is to revidence in the recomplant i	sident #39 last had a care ented on 11/8/23. A Resident Sign Sheet dated 11/8/2023 of the Interdisciplinary iew Resident #39's care e was no documented d that Resident #39's care red and revised by the IDT in quired. sident #35 last had a care ented on 11/8/23. A Resident Sign Sheet dated 11/8/2023 of the Interdisciplinary iew Resident #35's care e was no documented d that Resident #35's care ed and revised by the IDT in	F 84	2		
F 880 SS=D	Director of Nursing (Director	(2)(4)(e)(f) ntrol blish and maintain an nd control program	F 88	0		

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		475040	B. WNG			03/:	28/2024
	ROVIDER OR SUPPLIER OUNTAIN NURSING AND) REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORI PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)			(X5) COMPLETION DATE
F 880	diseases and infection in program. The facility must estal and control program (a minimum, the follows §483.80(a)(1) A system reporting, investigating and communicable distaff, volunteers, visite providing services underrangement based unconducted according accepted national states §483.80(a)(2) Written procedures for the probut are not limited to: (i) A system of surveil possible communicable disease infections before they persons in the facility; (ii) When and to whom communicable disease reported; (iii) Standard and trant to be followed to preven (iv) When and how is considered; including but (A) The type and durated pending upon the individual consideration of the province of the provi	prevention and control blish an infection prevention (IPCP) that must include, at ving elements: Immorphy for preventing, identifying, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards; I standards, policies, and ogram, which must include, include, include diseases or a can spread to other include of the preventions should be used for a troot limited to:	F	880	It is the policy of the facility for staff to mai proper procedures and techniques to ensur infection prevention was maintained during catheter care. Resident #14 catheter bag has an anti back flow system to ensure urine does not reent the bladder. Resident #14 leg bag has a cap on the spout applied, connection ends are being cleaned when performing catheter changes, barrier is utilized on the floor who staff are performing catheter changes. Resident #14 is offered hand hygiene when assisting in his/her changing of catheter bag. All residents who have a foley catheter have the potential to be affected by this alleged deficient practice. To ensure catheter care and infection preveduring catheter care is followed a review winursing staff will be completed and documented, competencies reviewed relating catheter care and infection prevention procedures during catheter care. A QAPI review will be completed under the supervision of the DON/ADON and/or desto review catheter care and infection prevention gatheter care. Audits to be completed weekly for 30 days, then monthly for 90 day then quarterly on going. Audits to be subm to QAPI team for review. Completion Date 5/11/2024 Tag F 880 POC accepted on 5/20/24 S. Stem/P. Cota	e g g g g g g g g g g g g g g g g g g g	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		475040	B. WNG				03/28/2024	
	ROVIDER OR SUPPLIER OUNTAIN NURSING AND	REHABILITATION		475 ETI	FADDRESS, CITY, STATE, ZIP CODE HAN ALLEN AVENUE HESTER, VT 05446	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 880	must prohibit employed disease or infected sk contact with residents contact will transmit the (vi)The hand hygiene by staff involved in direction of the staff involved in direction. Staff involved in direction of the staff involved in direction of the staff involved in direction of the staff involved in the staff involved i	ees with a communicable cin lesions from direct sor their food, if direct ne disease; and procedures to be followed rect resident contact. In for recording incidents incility's IPCP and the en by the facility. It is, store, process, and to prevent the spread of the program, as necessary. It is not met as evidenced on, interviews and recorded to ensure that staff ocedures and techniques to the ention was maintained for 1 of 27 residents that a secondary is Resident #14 has a secondary in the record that a secondary is resident #14 has a secondary in the record that a secondary is resident #14 has a secondary in the record that a secondary is resident #14 has a secondary in the record that a secondary is resident #14 has a secondary in the record that a secondary is resident #14 has a secondary in the record that a secondary is resident #14 has a secondary in the record that a secondary is record to the record to the record that a secondary is record to the record	F	380				
	therefore requires a c bladder). Resident #1 catheter (a foley cathe maintained in the blad	4 has orders for a foley eter is a tube that is dder to constantly drain to a collection bag that otying.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		475040	B. WNG_			03/	28/2024	
	ROVIDER OR SUPPLIER OUNTAIN NURSING AND	REHABILITATION		47	REET ADDRESS, CITY, STATE, ZIP CODE 5 ETHAN ALLEN AVENUE OLCHESTER, VT 05446			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 880	Licensed Nurse Aide #14's foley bag [the b while the resident is is drainage bag that is swhile the resident is of following. 1. Before the start of noted to be two leg be on a rail, the bags we neither bag was label had residual urine in to on the spout that empronnector that connec. 2. Resident #14 was side while in bed, bef emptied. The foley ballifted up over the resident the other side. [Lifting bladder can cause the backflow into the blad risk for infection] 3. The LNA placed a to where the foley ban ot place a barrier be container, and s/he ovalve to release the uwas noted to spray or places, this was not mot cleaned up. 4. When the LNA was connection from the f Resident #14 took ho connection site and p then bent the end of thand and held the care.	(LNA) changing resident ag used to drain the bladder in bed] to a leg bag [a strapped to the resident's leg but of bed] revealed the the procedure there were ags in the bathroom hanging are exposed with no cover, ed or dated and both bags them. They both had no cap bities the bags or on the cts the bag to the catheter. assisted to roll to his/her fore the foley bag was ag that had urine in it was dent and the bag was placed of the bed. This was done a ce resident was rolled back to get the foley bag above the entire that is in the tube to lider putting the resident at container on the floor next g was hanging. The LNA did tween the floor and the portion of the container, Urine into the container, Urine into the floor in multiple noted by the LNA, and was seready to disconnect the foley bag and the catheter, and of the tubing at the fulled the tubes apart. S/he the catheter over in his/her theter there. The resident	F	880				
	then bent the end of the hand and held the car	he catheter over in his/her						

A75040 NAME OF PROVIDER OR SUPPLIER GREEN MOUNTAIN NURSING AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446 [X4) ID PROVIDER'S PLAN OF CORRECTION (X5)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475040		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER GREEN MOUNTAIN NURSING AND REHABILITATION O(4) ID PRETRY TYX F 880 Continued From page 72 5. The LNA then asked the resident for the end of the catheter ob before connecting the two tubes. The resident was not offered hand sanitizer after releasing the catheter tube. Per an interview with the LNA on 3/26/24 at 2:15 pm s/he confirmed that there should have been a barrier on the floor and that she should have been a barrier of with alcohol when she reconnected the bag but stated that there was not anything she could treatheter should have been a spandule bekept at bladder level and not lifted higher. When asked about the resident separating the tubing and holding the catheter end folded over in his hand she stated there was not anything she could obout that but confirmed have deaned the catheter of his hand she stated there was not anything she could obout that but confirmed have resident separating the resident sanitize his/her hands and or put gloves on would be a good idea. A review of the facility policy Urinary Leg Drainage Bags reveals under section Steps in the Proceedure "2. Wash and dry your hands. Apply Clean gloves. #2 Clean the catheter roth leg bag. #8 Connect the catheter to the leg bag.								
(A) DESIGNATION NURSING AND REHABILITATION (A) DEPARTMENT TO ESPICIENCES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 880 Continued From page 72 5. The LNA then asked the resident for the end of the catheter so he/she could connect it to the leg bag. The LNA did not clean the end of either tube with alcohol before connecting the two tubes. The resident was not offered hand sanitizer after releasing the catheter tube. Per an interview with the LNA on 3/26/24 at 2:15 pm s/he confirmed that there should have been a barrier on the floor and that s/he should have been a barrier on the floor and that s/he should have cleaned the catheter off with alcohol when s/he reconnected the bag but stated that there was no alcohol handy to do that. S/he confirmed that the foley bag should be kept at bladder level and not lifted higher. When asked about the resident separating the tubing and holding the catheter end folded over in his hand s/he stated there was not anything she could do about that but confirmed having the resident sanitize his/her hands and or put gloves on would be a good idea. A review of the facility policy Urinary Leg Drainage Bags reveals under section Steps in the Proceedure "2. Wash and dry your hands. Apply Clean gloves. #3 Clean the catheter/bag junction with alcohol wipe before disconnecting. #7 Carefully remove cover over connection tip on the leg bag. #8 Connect the catheter to the leg bad with outh				13:	==	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	28/2024
FREGIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION) F 880 Continued From page 72 5. The LNA then asked the resident for the end of the catheter so he/she could connect it to the leg bag. The LNA did not clean the end of either tube with alcohol before connecting the two tubes. The resident was not offered hand sanitizer after releasing the catheter tube. Per an interview with the LNA on 3/26/24 at 2:15 pm s/he confirmed that there should have been a barrier on the floor and that s/he did not notice the urine that sprayed on the floor. S/he confirmed that she should have cleaned the catheter off with alcohol when s/he reconnected the bag but stated that there was no alcohol handy to do that. S/he confirmed that the foley bag should be kept at bladder level and not lifted higher. When asked about the resident separating the tubing and holding the catheter end folded over in his hand s/he stated there was not anything she could do about that but confirmed having the resident sanitize his/her hands and or put gloves on would be a good idea. A review of the facility policy Urinary Leg Drainage Bags reveals under section Steps in the Proceedure "2. Wash and dry your hands. Apply Clean gloves. #3 Clean the catheter/bag junction with alcohol wipe before disconnecting, #7 Carefully remove cover over connection tip on the leg bag. #8 Connect the catheter to the leg bad.	GREEN MOUNTAIN NURSING AND REHABILITATION				l			
5. The LNA then asked the resident for the end of the catheter so he/she could connect it to the leg bag. The LNA did not clean the end of either tube with alcohol before connecting the two tubes. The resident was not offered hand sanitizer after releasing the catheter tube. Per an interview with the LNA on 3/26/24 at 2:15 pm s/he confirmed that there should have been a barrier on the floor and that s/he did not notice the urine that sprayed on the floor. S/he confirmed that s/he should have cleaned the catheter off with alcohol when s/he reconnected the bag but stated that there was no alcohol handy to do that. S/he confirmed that the foley bag should be kept at bladder level and not lifted higher. When asked about the resident separating the tubing and holding the catheter end folded over in his hand s/he stated there was not anything she could do about that but confirmed having the resident sanitize his/her hands and or put gloves on would be a good idea. A review of the facility policy Urinary Leg Drainage Bags reveals under section Steps in the Proceedure "2. Wash and dry your hands. Apply Clean gloves. #3 Clean the catheter/bag junction with alcohol wipe before disconnecting. #7 Carefully remove cover over connection tip on the leg bag. #8 Connect the catheter to the leg bad with outh	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREF	PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP			COMPLETION
Further review of facility policy Emptying a Urinary Collection Bag reveals under section General Guidlines "#8 Keep the collection bag below the level of the residents bladder." Per an interview with the Director of Nursing on 3/26/24 at 3:30 pm, s/he indicated that the	F 880	5. The LNA then ask of the catheter so he leg bag. The LNA did tube with alcohol before tubes. The resident was an intizer after releasing the confirmed the barrier on the floor are the urine that sprayed confirmed that she is catheter off with alcohol the bag but stated the bag but stated the bag but stated the handy to do that. She bag should be kept a higher. When asked a separating the tubing end folded over in his not anything she could confirmed having the hands and or put glow. A review of the facility Bags reveals under seproceedure "2. Wash and dry you gloves. #3 Clean the alcohol wipe before of the remove cover over compared the catheter touching the terminal further review of facility collection Bag reveals Guidlines "#8 Keep the level of the residents."	ded the resident for the end as the could connect it to the not clean the end of either ore connecting the two was not offered handing the catheter tube. The LNA on 3/26/24 at 2:15 at there should have been a and that s/he did not notice do not the floor. S/he hould have cleaned the holl when s/he reconnected at there was no alcohol the confirmed that the foley about the resident and holding the catheter shand s/he stated there was all do about that but resident sanitize his/her was on would be a good idea. The policy Urinary Leg Drainage the ection Steps in the serior of the leg bag. The end of the catheter tubing. The end of the catheter tubing. The end of the catheter tubing. The policy Emptying a Urinary als under section General the collection bag below the bladder."	. ·	880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
475040			B. WING_			03/28/	/2024
NAME OF PROVIDER OR SUPPLIER GREEN MOUNTAIN NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CO 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446	DE		
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD B HE APPROPRIA	_	(X5) COMPLETION DATE
F 880 F 940 SS=F	policy and confirmed bags would be rinsed and the bags should should have a clean they are taken off. The LNA should use a container and the floc S/he confirmed that the cleansed with an alco connection and that the	for staff to follow facility that the unused catheter leg , the ends would be capped, be labeled, dated, and begovering them when the DON also confirmed that the barrier between the for when emptying the bag, the connector should be sholl sponge prior to the resident should have glove to assist with his/her		380			
	§483.95 Training Red A facility must develo an effective training p existing staff; individu a contractual arrange consistent with their e must determine the a necessary based on a specified at § 483.70 include but are not lin This REQUIREMENT by: Based on interview, facility assessment, fa onboarding training, t implement and mainta program for all new a QAPI (quality assurar improvement), comm preparedness, for 10 staff, and failed to imp	p, implement, and maintain program for all new and pals providing services under parent; and volunteers, expected roles. A facility mount and types of training a facility assessment as (e). Training topics must noted to- is not met as evidenced employee record review, acility policy, and facility he facility failed to ain an effective training and existing staff related to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
475040 B			B. WNG	B. WNG			03/28/2024	
NAME OF PROVIDER OR SUPPLIER GREEN MOUNTAIN NURSING AND REHABILITATION				4	STREET ADDRESS, CITY, STATE, ZIP CODE 175 ETHAN ALLEN AVENUE COLCHESTER, VT 05446			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
F 940	include: Per facility policy titled Staff," last revised 8/2 participate in initial or in-service training For the purpose of thinew and existing person services under contravolunteers Required training topia. effective communic d. elements and goals program Training requirements providing services to necessary based on the Completed training is development coordinated includes: the date topic of the training, the asummary of the contraining of the hours of training of the hours of training of the hours of training of the contraining of the facility has determined an extensive list of all facility has determined complete in order to pand care for the residence of the residence of the residence of the communication of the communication of the contraining	d "In-Service Training, All 2022 states. "All staff must dentation and annual so policy, "staff" means all connel, individuals providing ctual agreement, and cs include the following: cation	F	940	It is the policy of the facility to develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. All residents have the potential to be affected this alleged deficiency. Ongoing training is provided to staff to includu the limited to QAPI, Emergency Preparedness and communication. To ensure new staff are trained in accordance with facility policy, new hires will be given education packets on their first assigned shiftstaff will receive ongoing education and train throughout employment on a scheduled base make every attempt for staff to complete required education. HR director will monitor staff attendance, correction of test staff submit will be completely the department in which the training was initiated from. A QAPI review will be completed under the supervision of the Administrator, DON/AD HR Director and Maintenance Supervisor are or designee to review training programs. Auto be completed weekly for 30 days, then monthly for 90 days then quarterly on going Audits to be submitted to QAPI team for recompletion Date May 10th 2024 Tag F 940 POC accepted on 5/20/24 S. Stem/P. Cota	d by ude ee ft. ning is to eted only dits view.		

NAME OF PROVIDER OR SUPPLIER GREEN MOUNTAIN NURSING AND REHABILITATION (XA) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REQUIATORY OR LSC IDENTIFYING INFORMATION) F 940 Continued From page 75 sampled were hired within the past year. These 3 staff did not have evidence of onboarding education in their files [Licensed Nursing Assistant #1 (LNA), LNA#2, and Registered Nurse #1 (RN)]. Per interview on 3/28/24 at 3:15 PM, the Staff Educator, whom is also the Director of Nursing, explained that onboarding education to the materials, and return the quiz to Human Resources, who keeps track of training. S/He explains that she is not responsible for emergency preparedness and QAPI training and is unsure when these trainings are completed and how they are tracked. The Educator confirmed that contracted staff are supposed to do the education as well. Per interview on 3/28/2024 at 4:20 PM, the Human Resources specialist explained that new employees are given new hire folders that contain handouts, that seve as the required trainings, and follow up quizzes to these handouts. S/He explained that the explained that the keeps records of the quizzes but is unsure that the quizzes are reviewed for correction. S/He explained that there is no system in place to follow up with employees that have not returned the onboarding quizzes.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED	
CAI) D SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES GEACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PROFIDER \$1.4M OF CORRECTION (EACH OPERCITIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DOT! CONTENT TAG PROFIDER \$1.4M OF CORRECTION (EACH OPERCITIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DOT! CONTENT TAG PROFIDER \$1.4M OF CORRECTION (EACH OPERCITIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DOT! CONTENT TAG PROFIDER \$1.4M OF CORRECTION (EACH OPERCITIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DOT! CONTENT TAG F 940 Continued From page 75 Sampled were hired within the past year. These 3 staff did not have evidence of onboarding education in their files [Licensed Nursing Assistant #1 (LIVA), LIVA #2, and Registered Nurse #1 (RIVI). Per interview on 3/28/24 at 3:15 PM, the Staff Educator, whom is also the Director of Nursing, explained that onboarding education consists of the new staff member reading handouts that are included in their new hire packets. Staff are to read the materials, and return the quiz to Human Resources, who keeps track of training. SH-le indicated that there is no communication training. SH-e explains that she is not responsible for emergency preparedness and QAPI training and is unsure when these trainings are completed and how they are tracked. The Educator confirmed that contracted staff are supposed to do the education as well. Per interview on 3/28/2024 at 4:20 PM, the Human Resources Specialist explained that have were the keeps records of the quizzes but is unsure that the quizzes are reviewed for correction. S/He explained that she keeps records of the quizzes but is unsure that the quizzes are reviewed for correction. S/He explained that she have not returned the onboarding quizzes			475040	B. WNG_			03/28/2024	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 940 Continued From page 75 sampled were hired within the past year. These 3 staff did not have evidence of onboarding education in their files [Licensed Nursing Assistant #1 (LNA), LNA #2, and Registered Nurse #1 (RN)]. Per interview on 3/28/24 at 3:15 PM, the Staff Educator, whom is also the Director of Nursing, explained that onboarding education consists of the new staff member reading handouts that are included in their new hire packets. Staff are to read the materials, take a quiz on the materials, and return the quiz to Human Resources, who keeps track of training. S'He indicated that there is no communication training. S'He indicated that there is no remains are completed and how they are tracked. The Educator confirmed that contracted staff are supposed to do the education as well. Per interview on 3/28/2024 at 4:20 PM, the Human Resource Specialist explained that hew employees are given new hire folders that contain handouts, that serve as the required trainings, and follow up quizzes to these handouts. S'He explained that the keeps incords of the quizzes but is unsure that the quizzes are reviewed for correction. S'He keeps incords of the quizzes but is unsure that the quizzes are reviewed for correction. S'He keeps incords of the quizzes but have not returned the onboarding quizzes that the returned the onboarding quizzes that the province of the quizzes that the quizzes that the province of the quizzes that the province of the	NAME OF PROVIDER OR SUPPLIER				475 ETHAN ALLEN AVENUE	E		
sampled were hired within the past year. These 3 staff did not have evidence of onboarding education in their files [Licensed Nursing Assistant #1 (LNA), LNA #2, and Registered Nurse #1 (RN)]. Per interview on 3/28/24 at 3:15 PM, the Staff Educator, whom is also the Director of Nursing, explained that onboarding education consists of the new staff member reading handouts that are included in their new hire packets. Staff are to read the materials, take a quiz on the materials, and return the quiz to Human Resources, who keeps track of training. S/He indicated that there is no communication training. S/He explains that s/he is not responsible for emergency preparedness and QAPI training and is unsure when these trainings are completed and how they are tracked. The Educator confirmed that contracted staff are supposed to do the education as well. Per interview on 3/28/2024 at 4:20 PM, the Human Resource Specialist explained that new employees are given new hire folders that contain handouts, that serve as the required trainings, and follow up quizzes to these handouts. S/He explained that s/he keeps records of the quizzes but is unsure that the quizzes are reviewed for correction. S/He explained that contracted staff do not return quizzes. S/He indicated that there is no system in place to follow up with employees that have not returned the onboarding quizzes to that have not returned the onboarding quizzes	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
and employees can work their assignments without having evidence of training completed. The Human Resource Specialist confirmed that s/he did not have evidence that LNA #1, LNA #2, or RN#1 had completed any onboarding education and confirmed that they worked	F 940	sampled were hired wat staff did not have evice education in their files. Assistant #1 (LNA), Lassistant #1 (LNA), Lassistant #1 (RN)]. Per interview on 3/28 Educator, whom is all explained that onboat the new staff member included in their new read the materials, tare and return the quiz to keeps track of training is no communication s/he is not responsibly preparedness and Q/when these trainings are tracked. The Educontracted staff are seas well. Per interview on 3/28 Human Resource Spemployees are given handouts, that serve and follow up quizzes explained that s/he kebut is unsure that the correction. S/He expless do not return quizzes no system in place to that have not returne and employees can without having evider. The Human Resource s/he did not have evidor RN#1 had completed.	within the past year. These 3 dence of onboarding is [Licensed Nursing .NA #2, and Registered	F9	940			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NC	0.0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475040				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		B. WNG			03/	28/2024	
NAME OF PROVIDER OR SUPPLIER GREEN MOUNTAIN NURSING AND REHABILITATION				4	STREET ADDRESS, CITY, STATE, ZIP CODE 175 ETHAN ALLEN AVENUE COLCHESTER, VT 05446		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 940	assignments without I completed. Per review of an employed and employ	having this education loyee onboarding packet, of communication training, ergency preparedness	F	940			