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

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

November 19, 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 complaint investigation conducted on **October 22, 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,

Pamela M Cota RN
Pamela M. Cota, RN, BS
Assistant Division Director
State Survey Agency Director

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475040	A. BUILDING ______ B. WING ______	C 10/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced, on-site complaint investigation #23352 was conducted by the Division of Licensing and Protection on 10/8/24 through 10/22/24 at Green Mountain Nursing Home to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory violations were identified:	F 000	***Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists.*** ***This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.***	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 609	Resident #1 was sent to the hospital on 9/29 at the request of family prior to full evaluation and investigation by nurse and facility could be completed. All residents have the potential to be affected by this alleged deficient practice. An in-service education program was conducted by the DON/ADON and/or designee with direct care staff addressing circumstances that require reporting including appropriate timeframes. The DON/ADON and/or designee, will conduct a random audit of five (5) residents weekly for four (4) consecutive weeks. These residents will be assessed and interviewed to ensure that any injuries are identified, properly investigated and reported to the appropriate people. This plan of correction will be reported monthly at Quality Assurance meeting until such time consistent substantial compliance has been met. Completion Date: 11/18/2024 **Tag F 609 POC accepted on 11/19/24 by C. Howard/P. Cota**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	NHA	11/18/24

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 609	Continued From page 1 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to report an injury of unknown origin to the state licensing agency as required for one resident (Resident #1) of three sampled residents. Findings include: Per interview with Resident #1's family representative on 10/8/24 at 10:00 AM, on 9/29/24 s/he noticed a bruise on Resident #1's face. Resident #1 stated s/he fell out of bed but did not his/her head. Resident #1 was unaware of how the bruise occurred on his/her face. A telephone interview was conducted with LPN [Licensed Practical Nurse] #1 on 10/8/24 at 5:46 PM. LPN#1 stated three staff members were needed to assist Resident #1 back into bed after Resident #1 "slid out of bed" on 9/29/24 at approximately 6:00 AM. LPN#1 stated that this incident was never reported to the oncoming nurse during shift change that occurred at approximately 7:00 AM, or to the nursing supervisor. Per record review, the injury was not noted by staff until 10:57 AM on 9/29/24 when his/her family representative called the facility and requested Resident #1 be sent to the hospital for the reported fall and the bruise of unknown origin. Per record review of Resident #1's ED [Emergency Department] records dated 9/29/24, Resident #1 "has severe posterior thigh pain on the right [side of his/her body] extending to the knee joint. It does appear that [Resident #1] hit his head ... does have an abrasion on the right side of his/her forehead which his family confirms	F 609	Please note that noted statement from LPN #1 in 2567 is not consistent with statements obtained during facility investigation from LPN #1 and LPN # 2, LNA's and roommate relating to the families accusation of resident #1 falling out of bed to the floor. Review of facility camera footage reveals that at no time did three different staff members pass by camera to Resident #1 room supporting the accusation " it took three staff to assist resident back to bed" Statements from nursing staff are consistent that there was not a fall as defined by an unintentional change in position that results in someone landing on the ground, floor, or a lower surface. Family requested resident to be transported to the hospital during a visit to the resident on 9/29 between 14:30 and 15:10.	

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F 609	Continued From page 2	F 609		

is new ...Patient will be admitted [to the hospital] for further management ..."

Per record review of the facility's "Reporting Abuse to Facility Management" policy, "The following definitions of abuse are provided: ...g. Injury of unknown source is defined as an injury that meets both of the following conditions: (1) the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and (2) the injury is suspicious because of: a) The extent of the injury; or b) The location of the injury ... c) The number of injuries observed at one particular point in time;[sic] or d) the incidence of injuries over time ...5.) Any individual observing an incident of resident abuse or suspected resident abuse must immediately report such incident to the administrator, director of nursing services, or charged nurse. The following information should be reported: a. The name(s) of the resident(s) to which the abuse or suspected abuse occurred;
b. The date and time that the incident occurred
c. Where the incident took place;
d. The name(s) of the person(s) allegedly committing the incident, if known;
e. The names(s) of any witnesses to the incident;
f. The type of abuse that was committed ...
g. Any other information that may be requested by management.

8.) The administrator or director of nursing services must be immediately notified of suspected abuse or incidents of abuse...9. When an incident of resident abuse is suspected or confirmed the incident must be immediately reported to facility management regardless of the time lapse since the incident occurred. Reporting procedures should be followed as outlined in this

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F 609	Continued From page 3 policy." Per record review of the facility's "Accidents and Incidents-Investigation and Reporting" policy, "All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises...shall be investigated and reported to the administrator...The following data, as applicable, shall be included on the "Report of Incident/Accident form: the nature of the injury/illness...the circumstances surrounding the accident or incident ...The date/time injured person's family was notified and by whom ...the condition of the injured person, including his or her vital signs ... the nurse supervisor show complete a report of incident and submit the original office of the director of nursing services within 24 hours of the incident or accident." Per the facility's "Abuse Investigation and Reporting" policy, "Suspected abuse, neglect, exploitation, or mistreatment will be reported within two hours ... Alleged abuse, neglect, exploitation or mistreatment will be reported within two hours if the alleged events have resulted in serious bodily injury." Despite there being a reported fall by the resident to the family, and in turn the family reporting to the facility, the clinical record did not contain evidence that this resident was asked about a fall or the cause of the facial bruise, or assessed after there was a report of a fall. The record contains no documentation of the incident that occurred as reported by LPN#1 on the morning on 9/29/24 where the resident had to be assisted back into bed by three staff. The facility Administrator confirmed on 10/8/24 at 11:47 AM that the facility did not complete an internal	F 609		

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F 609	Continued From page 4 incident report for this unknown injury. The administrator also confirmed the facility did not inform the state agency of the injury of unknown source within the specified time frame stated in the facility's policy for reporting accidents and incidents. Per interview with RN [Registered Nurse] #1 on 10/8/24 at 2:53 PM, RN #1 confirmed s/he was unaware of the bruise or reported fall until the afternoon when the family arrived and made it known to him/her. RN#1 confirmed there was no investigation initiated into the bruise of unknown origin and the injury was not reported to Administrator or to the State Agency as required.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 610		

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F 610	Continued From page 5 Based upon interviews and record review, the facility failed to ensure that allegations of abuse, neglect, exploitation, misappropriation of resident property, and mistreatment, including injuries of unknown source were thoroughly investigated for 1 resident (Resident #1) of three sampled residents. Findings include: Per record review of the facility's "Reporting Abuse to Facility Management" policy, "The following definitions of abuse are provided: g. Injury of unknown source is defined as an injury that meets both of the following conditions: (1) the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and (2) the injury is suspicious because of: a) The extent of the injury; or b) The location of the injury ... c) The number of injuries observed at one particular point in time;[sic] or d) the incidence of injuries over time." Per record review of the facility's "Reporting Abuse to Facility Management" policy, " ...The following definitions of abuse are provided: g. Injury of unknown source is defined as an injury that meets both of the following conditions: (1) the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and (2) the injury is suspicious because of: a) The extent of the injury; or b) The location of the injury ... c) The number of injuries observed at one particular point in time;[sic] or d) the incidence of injuries over time ...5.) Any individual observing an incident of resident abuse or suspected resident abuse must immediately report such incident to the administrator, director of nursing services, or charged nurse. The following information should	F 610	It is the practice of the facility to thoroughly investigate injuries of unknown sources. Resident #1 was sent to the hospital on 9/29 at the request of family prior to full evaluation and investigation by nurse and facility could be completed. All residents have the potential to be affected by this alleged deficient practice. An in-service education program was conducted by the DON/ADON and/or designeee with direct care staff addressing circumstances that require reporting for timely investigations, and their responsibilities related to investigations. The DON/ADON and/or designee, will conduct a random audit of five (5) residents weekly for four (4) consecutive weeks. These residents will be assessed and interviewed to ensure that any injuries are identified, properly investigated and reported to the appropriate people. This plan of correction will be reported monthly at Quality Assurance meeting until such time consistent substantial compliance has been met. Completion Date: 11/18/2024 Tag F 610 POC accepted on 11/19/24 by C. Howard/P. Cota	

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F 610	Continued From page 6 be reported: a. The name(s) of the resident(s) to which the abuse or suspected abuse occurred;[sic] b. The date and time that the incident occurred c. Where the incident took place; d. The name(s) of the person(s) allegedly committing the incident, if known; e. The names(s) of any witnesses to the incident; f. The type of abuse that was committed ... g. Any other information that may be requested by management. 8.) The administrator or director of nursing services must be immediately notified of suspected abuse or incidents of abuse...9. When an incident of resident abuse is suspected or confirmed the incident must be immediately reported to facility management regardless of the time lapse since the incident occurred. Reporting procedures should be followed as outlined in this policy." Per interview with Res.#1's family representative on 10/8/24 at 10:00 AM, on 9/29/24 s/he noticed a bruise on Resident #1's face. Resident #1 stated s/he fell out of bed but did not his/her head. Resident #1 was unaware of how the bruise occurred on his/her face. A telephone interview was conducted with LPN [Licensed Practical Nurse] #1 on 10/8/24 at 5:46 PM. LPN#1 stated three staff members were needed to assist Resident #1 back into bed after Res #1 "slid out of bed" on 9/29/24 at approximately 6:00 AM. LPN#1 stated that this incident was never reported to the oncoming nurse during shift change that occurred at approximately 7:00 AM, or to the nursing supervisor.	F 610	Please note that noted statement from LPN #1 in 2567 is not consistent with statements obtained during facility investigation from LPN #1 and LPN # 2, LNA's and roommate relating to the families accusation of resident #1 falling out of bed to the floor. Review of facility camera footage reveals that at no time did three different staff members pass by camera to Resident #1 room supporting the accusation " it took three staff to assist resident back to bed" Statements from nursing staff are consistent that there was not a fall as defined by an unintentional change in position that results in someone landing on the ground, floor, or a lower surface. Family requested resident to be transported to the hospital during a visit to the resident on 9/29 between 14:30 and 15:10.	

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F 610	Continued From page 7 Per record review, the injury was not noted by staff until 10:57 AM on 9/29/24 when his/her family representative called the facility and requested Resident #1 be sent to the hospital for the reported fall and the bruise of unknown origin. Per record review of Resident #1's ED [Emergency Department] records dated 9/29/24, Resident #1 "has severe posterior thigh pain on the right [side of his/her body] extending to the knee joint. It does appear that [Resident #1] hit his head ... does have an abrasion on the right side of his/her forehead which his family confirms is new ...Patient will be admitted [to the hospital] for further management ..." Per interview with RN [Registered Nurse] #1 on 10/8/24 at 2:53 PM, RN #1 confirmed s/he was unaware of the bruise or reported fall until the afternoon when the family arrived and made it known to him/her. RN #1 confirmed s/he did not assess Resident #1, call the Director of Nursing Services or the Administrator, and confirmed there was no investigation initiated into the bruise of unknown origin.	F 610		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's	F 655	Resident #1 was sent to the hospital on 9/29 at the request of family prior to baseline careplan being completed by interdisciplinary team. All newly admitted residents have the potential to be affected by this alleged deficient practice. All interdisciplinary care plan team members responsible for writing baseline care plans will be re-educated on the facility's policy and procedure for developing Baseline Care Plans.	

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F 655	Continued From page 8 admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for one sampled resident	F 655	The DON/ADON and/or designee, will complete random weekly audits of baseline care plans for six (6) consecutive weeks. Random audits will be completed to ensure that baseline care plans are being completed within 48 hrs of admission. Audits will be reported to the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Completion Date: 11/18/2024 Tag F 655 POC accepted on 11/19/24 by C. Howard/P. Cota	

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F 655	Continued From page 9 (Residents #1) of three sampled residents. Findings include: Per record review, Resident #1 was admitted to facility on 9/26/24. Review of the resident's baseline care plan reveals the care plan was not signed or dated by the Resident or staff completing the baseline care plan. Per review, the resident's baseline care plan does not document the resident's admission goals, functional abilities, fall status, code status, initial/admission goals, educational needs, or social service needs. There is no documentation of Resident #1's status on eating, oral hygiene, transfers, ambulation, therapy goals, and social services on the baseline care plan. Further review reveals no documentation of the Resident #1's daily preferences including "Choosing clothes to wear, caring for personal belongings, receiving tub bath, receiving shower, family or significant other involvement in care discussions."	F 655		