

Division of Licensing and Protection  
103 South Main Street, Ladd Hall  
Waterbury, VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 871-3317  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 871-3318

January 15, 2014

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

Dear Ms. Combs-Wilber:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 6, 2013**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN  
Licensing Chief

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

PRINTED: 12/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/06/2013
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NAME OF PROVIDER OR SUPPLIER  GREEN MOUNTAIN NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to assure that the services provided or arranged by the facility were provided by qualified persons in accordance with each resident's written plan of care for 1 of 2 residents sampled (Resident #1). Findings include:  1. Per record review on 12/2-12/3/13, Resident #1 had a diagnosis of dementia. According to nursing and dietary notes, the resident had poor food and fluid intake and had lost significant amount of weight since admission, as well as a history of losing weight before they were admitted to the nursing facility. The resident also took a diuretic blood pressure medication that increased the possibility of dehydration. The plan of care for nutrition included the intervention of monitoring intake and output daily. Upon review of the documentation since the resident's admission, the daily logs of meal and fluid intake were sporadically filled out since the admission date of	F 282	<b>F282</b>  <i>Assuming for the moment that the findings and the determination of the deficiency are accurate, without admitting or denying that they are, our proposed plan of correction is as follows:</i>  It is the policy of this facility to assure that services provided or arranged by the facility are provided by qualified persons in accordance with each resident's written plan of care.  Resident #1 has been discharged to home on 9/21/2013.  To assure that this alleged deficient practice does not affect other residents, the plan of care for nutrition includes interventions and monitoring of intake and output daily.  To ensure the alleged practice does not occur, and procedure stays consistent we are taking the following measures:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Jungfer Lomb-Wilber*

The unit managers will audit the I&O and meal percentages daily. (X8) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may have used to determine 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.

PMW

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F 282	Continued From page 1 7/12/13. In the month of July 2013, there was blank meal percentage spaces on 7/12- 7/16, as well as 7/20, 7/21, 7/25, 7/26, 7/27, and 7/30/13. In August and September, the meal percentage documentation was also sporadic, with many days left blank for one or more meals. With regard to the fluid intake sheets, there were many blank spaces also, starting in July 2013 and going until the resident's discharge from the facility on 9/21/13. The plan of care for this resident stated to monitor intake and record on ADL flow sheets. Per interview on 12/3/13 at 11:30 AM, the Director of Nursing confirmed that Resident #1 had a care plan in place that included monitoring food and fluid intake, that documentation of the resident's intake of food and fluids was very inconsistent, and that staff were expected to record an accurate amount on both documents.	F 282	x's 3 months. Staff education on documentation relating to I&O's and meal percentages will be completed. A new written procedure for weight loss and I&O's has been developed and implemented.  <b>Completion Date: 01/10/2014</b>  A quality Assurance evaluation has been implemented under the supervision of the QA committee, DON, ADON, Dietary Supervisor and Administrator for three consecutive months then quarterly thereafter. This evaluation will include a systematic review of all I&O's, meal percentages and weight change evaluations and interventions, immediate action will be taken if warranted.		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assure that each resident received, and the facility provided, the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive	F 309	F302 POC accepted 1/14/14 Klampos/RW/PML  <b>F309</b> <i>Assuming for the moment that the findings and the determination of the deficiency are accurate, without admitting or denying that they are, our proposed plan of correction is as follows:</i>		

It is the policy of this facility to provide services that attain or

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F 309	<p>Continued From page 2 assessment and plan of care for 1 of 2 residents sampled (Resident #1). Findings include:</p> <p>Per record review on 12/3/13, Resident #1 was admitted to the facility on 7/12/13, after living at home with a family member. The resident has dementia. Upon admission, the resident was taking Quetiapine XR (sustained release) 150 mg. once daily, an anti-psychotic medication. A suggestion of dose reduction was made by the consultant Pharmacist during the July review, and the MD agreed to a dose reduction on 8/1/13, changing the order to Quetiapine XR 100 mg. once daily. The pharmacy received the order, however had a question regarding whether the order should be for the XR (extended release) or an instant release formula. Nursing staff started marking the Medication Administration Record (MAR) with circled initials, sometimes stating the medication was unavailable, however sometimes not explaining the circled initials at all.</p> <p>The resident did not receive any of this prescribed medication for 11 days. According to manufacturers' warnings, stopping this anti-psychotic medication suddenly may cause side effects. One nurse was putting their initials down without circling them, although the medication was unavailable, and when the DNS followed up with that nurse, they stated that they indeed did not give the medication or circle their initials. The staff did not follow up with the pharmacy, nor did the pharmacy follow up with the facility until finally on 8/12/13, the medication was sent to the facility and it was administered to the resident as ordered by the Physician. Per interview on 12/3/13 at 11:45 AM, the DNS confirmed that there was a lack of follow up by</p>	F 309	<p>maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care.</p> <p>Resident #1 has been discharged to home on 9/21/2013.</p> <p>To assure that this alleged deficient practice does not affect other residents a procedure for new orders and unavailable medications and treatments have been implemented and staff will be educated.</p> <p>"Any nurse receiving a new order for medication or treatment will fax order to pharmacy then call pharmacy to confirm that they have received the order. All pink copies of telephone order will be placed in DON's box on DON office door for follow up.</p> <p>Unit managers are accountable to check new orders daily to ensure that medication/treatment has arrived from pharmacy. Evening charge nurses are responsible for following up that pharmacy has delivered any new</p>	
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medications/treatments received on day shift. On weekends the charge nurse is responsible for ensuring

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F 309	Continued From page 3 staff with the pharmacy to inquire about the medication, and that the resident did not receive the scheduled prescribed medication for 11 days due to the oversight.  Reference: <a href="http://www.seroquelxr.com/bipolar-disorder/seroquel-xr-side-effects.aspx">http://www.seroquelxr.com/bipolar-disorder/seroquel-xr-side-effects.aspx</a>	F 309	that any new orders have been received from pharmacy. When a medication or treatment has not been delivered from pharmacy the nurse is responsible for calling and checking on where the medication is. If the medication/treatment is unavailable the nurse must then call the physician and notify of the unavailable medication/treatment and await further orders.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH  The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.  The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide pharmaceutical services (including procedures that assure the accurate	F 425	<b>Completion Date: 01/10/2014</b>  A quality Assurance evaluation has been implemented under the supervision of the QA committee, DON, ADON, Unit Managers, Pharmacy and Administrator for three consecutive months then quarterly thereafter. This evaluation will include a systematic review of all medication and treatment orders as well as delivery of orders and documentation of MAR's. Interventions, immediate action will be taken if warranted.  <i>F309 POC accepted 1/14/14 Klompes RN/PML</i>	

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F 425	<p>Continued From page 4</p> <p>acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 2 residents sampled (Resident #1) Findings include:</p> <p>Per record review on 12/3/13, Resident #1 was admitted to the facility on 7/12/13, after living at home with a family member. The resident has dementia. Upon admission, the resident was taking Quetiapine XR (sustained release) 150 mg. once daily, an anti-psychotic medication. A suggestion of dose reduction was made by the consultant Pharmacist during the July review, and the MD agreed to a dose reduction on 8/1/13, changing the order to Quetiapine XR 100 mg. once daily. The pharmacy received the order, however had a question regarding whether the order should be for the XR (extended release) or an instant release formula. Nursing staff started marking the Medication Administration Record (MAR) with circled initials, sometimes stating the medication was unavailable, however sometimes not explaining the circled initials at all.</p> <p>The resident did not receive any of this prescribed medication for 11 days. One nurse was putting their initials down without circling them, although the medication was unavailable, and when the DNS followed up with that nurse, they stated that they indeed did not give the med or circle their initials. The staff did not follow up with the pharmacy, nor did the pharmacy follow up with the facility until finally on 8/12/13, the medication was sent to the facility and it was administered to the resident as ordered by the Physician. Per interview on 12/3/13 at 11:45 AM, the DNS confirmed that there was a lack of follow up by staff with the pharmacy to inquire about the</p>	F 425	<p><b>F425</b></p> <p><i>Assuming for the moment that the findings and the determination of the deficiency are accurate, without admitting or denying that they are, our proposed plan of correction is as follows:</i></p> <p>It is the policies of this facility to provide routine and emergency drugs and biological to its residents.</p> <p>Resident #1 has been discharged to home on 9/21/2013</p> <p>To assure that this alleged deficient practice does not affect other residents a procedure for new orders and unavailable medications and treatments have been implemented and staff will be educated.</p> <p>“Any nurse receiving a new order for medication or treatment will fax order to pharmacy then call pharmacy to confirm that they have received the order. All pink copies of telephone order will be placed in DON’s box on DON office door for follow up.</p> <p>Unit managers are accountable to check new orders daily to ensure that medication/treatment has</p>	
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F 425	Continued From page 5 medication, and that Resident #1 did not receive the scheduled prescribed medication for 11 days due to the oversight.	F 425	arrived from pharmacy. Evening charge nurses are responsible for following up that pharmacy has delivered any new medications/treatments received on day shift. On weekends the charge nurse is responsible for ensuring that any new orders have been received from pharmacy. When a medication or treatment has not been delivered from pharmacy the nurse is responsible for calling and checking on where the medication is. If the medication/treatment is unavailable the nurse must then call the physician and notify of the unavailable medication/treatment and await further orders.	
F 514 SS=D	Refer also to F309. 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. Findings include:  1. Per record review on 12/2-12/3/13, Resident #1 had a diagnosis of dementia. According to nursing and dietary notes, the resident had poor food and fluid intake and had lost significant amount of weight since admission, as well as a	F 514		Completion Date: 01/10/2014  A quality Assurance evaluation has been implemented under the supervision of the QA committee, DON, ADON, Unit Managers, Pharmacy and Administrator for three consecutive months then quarterly thereafter. This evaluation will include a systematic review of all medication and treatment orders as well as delivery of orders and documentation of MAR's

Interventions, immediate action will be taken if warranted.

F425 POC accepted 1/14/14 klampson/pml

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F 514	Continued From page 6 history of losing weight before they were admitted to the nursing facility. The resident also took a diuretic blood pressure medication that increased the possibility of dehydration. The plan of care for nutrition included the intervention of monitoring intake and output daily. Upon review of the documentation since the resident's admission, the daily logs of meal and fluid intake were sporadically filled out since the admission date of 7/12/13. In the month of July 2013, there was blank meal percentage spaces on 7/12- 7/16, as well as 7/20, 7/21, 7/25, 7/26, 7/27, and 7/30/13. In August and September, the meal percentage documentation was also sporadic, with many days left blank for one or more meals. With regard to the fluid intake sheets, there were many blank spaces also, starting in July 2013 and going until the resident's discharge from the facility on 9/21/13. The plan of care for this resident stated to monitor intake and record on ADL flow sheets. Per interview on 12/3/13 at 11:30 AM, the Director of Nursing confirmed that Resident #1 had a care plan in place that included monitoring food and fluid intake, that documentation of the resident's intake of food and fluids was very inconsistent, and that staff were expected to record an accurate amount on both documents.	F 514	F 514  <i>Assuming for the moment that the findings and the determination of the deficiency are accurate, without admitting or denying that they are, our proposed plan of correction is as follows:</i>  It is the policies of this facility to assure that the clinical records on each resident is maintained in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized.  Resident # 1 was discharged to home on 9/21/2013.	
F9999	FINAL OBSERVATIONS  Per Vermont Licensing and Operating Rules for Nursing Homes:  3.14 (d) (e) Transfer and Discharge Notice before transfer or discharge. Before a facility transfers or discharges a resident, the facility must: (1) notify the resident, and if known, a family member, including a reciprocal beneficiary, or	F9999	To assure that this alleged deficient practice does not affect other residents the plan of care for nutrition includes interventions and monitoring of intake and output daily.  To ensure the alleged practice does not occur, and procedure stays consistent we are taking the following measures:	

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F9999	<p>Continued From page 7</p> <p>legal representative of the resident, of the proposed transfer or discharge and reasons for the move. The notice shall be in writing and in a language and manner they understand, and shall be given at least 72 hours before a transfer within the facility and 30 days before the discharge from the facility.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and interviews, the facility failed to provide written notice of a room change for 1 of 8 residents sampled (Resident #2). Findings include:</p> <p>Per record review on 12/3/13, Resident #2 had resided in a semi-private room without a roommate. Resident #2 is non-verbal and totally dependent on staff for all care, is a two person mechanical transfer, and has equipment that takes up significant space in the room, as well as personal effects like a large television. The resident is not able to communicate themselves, and has a family guardianship. The facility requested that the resident transfer to another room, giving a verbal notice 72 hours before the move to the legal guardian, including discussing the new room with the family, which had the advantage of more space and a sunnier location. Per interview with the Social Service Director, there was a discussion with the family first before other resident moves were planned to assure they were in agreement, however stated that they did not issue a written notice with the required elements such as the ombudsman's contact information and a stated right to appeal the transfer. Per interview on 12/3/13 at 2:25 PM, the Social Services Director confirmed that although</p>	F9999	<p>The unit managers will audit the I&amp;O and meal percentages daily. DON/ADON will monitor weekly x's 3 months. Staff education on documentation relating to I&amp;O's and meal percentages will be completed. A new written procedure for weight loss and I&amp;O's has been developed and implemented.</p> <p><b>Completion Date: 01/10/2014</b></p> <p>A quality Assurance evaluation has been implemented under the supervision of the QA committee, DON, ADON, Dietary Supervisor and Administrator for three consecutive months then quarterly thereafter. This evaluation will include a systematic review of all I&amp;O's, meal percentages and weight change evaluations and interventions, immediate action will be taken if warranted.</p> <p><i>F514 POC accepted 1/14/14 Klampowski RWP/MLC</i></p> <p><b>F9999</b> Transfer/Discharge</p> <p><i>Assuming for the moment that the</i></p>	
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*findings and the determination of the deficiency are accurate,*

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F9999	Continued From page 8 they had verbally discussed the move, there was no written notice provided to the family prior to relocating the resident.	F9999	<p><i>without admitting or denying that they are, our proposed plan of correction is as follows:</i></p> <p>It is the policy of this facility to follow Vermont Licensing and Operating Rules for Nursing Homes.</p> <p>Resident # 2 was transferred on July 12<sup>th</sup> 2013 after a verbal agreement between resident # 2's medical guardian. Documentation in medical file.</p> <p>On 9/25/2013 a Notice of Room Change letter was signed by Medical Guardian to reject and appeal transfer agreement. Letter was not submitted in a timely manor.</p> <p>All other room changes reviewed did have appropriate documentation and notice.</p> <p>All room changes will continue to be initiated by a conversation and a minimum of a 72 hour notice unless it is deemed an emergency according to the nursing home rules and regulations.</p> <p>Staff have been reeducated about</p>	
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the importance of documentation Page 9 of 9

and notification relating to resident  
room transfers and discharges.

**Completion date: 9/25/2013**

*F9999 POC accepted 1/14/14 Klampax Dr/PMU*

A handwritten signature in cursive script, appearing to read "Jee".