

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 5, 2016

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

Dear Ms. Combs-Wilber:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on April 6, 2016. 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: 04/13/2016
FORM APPROVED
OMB NO 0938-0391

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| 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 04/06/2016 |
| NAME OF PROVIDER OR SUPPLIER GREEN MOUNTAIN 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 PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS | F 000 1 | | |
| F 164 SS=E | 483.10(e), 483.75(1)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. | F 164 1 | 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 to meet requirements established by state and federal law is as follows: It is the policy of Green Mountain Nursing and Rehabilitation to make sure residents have the right to personal privacy and confidentiality of his or her personal and clinical records. The medical records in question were moved from the cave to another locked room that was recently cleared out. Access to this room is strictly limited. Employees must gain approval from the Administrator or Director of nursing and is accessed by authorized staff only. All residents have the potential to be affected by the alleged deficient practice. To ensure the alleged practice does not occur, and procedure stays consistent we are taking the following measures: Only the Administrator and Director of Nursing, and Medical Records clerk have a key to the overflow and discharge medical record rooms, any other authorized staff must get clearance from the Administrator or Director of Nursing to gain access. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Janice Combs-Walber, NHA* TITLE: _____ (X6) DATE: *4/19/16*

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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This REQUIREMENT is not met as evidenced by:

Based on observation and staff interview, the facility failed to ensure that all information contained in residents' medical records was stored in a manner that ensured that confidentiality of the information was maintained for closed records dated from 2010-2015. The findings include:

Per direct observation beginning on the morning of 4/4/16, approximately 78 cardboard boxes of closed medical records for former residents of the facility were observed stored in a room (called the Cave) without protection for confidentiality of the information. Per observation, not all of the boxes were covered and names of some of former residents were visible in these boxes. There were also medical records, including probate court correspondences, physician orders and nursing progress notes visible on top of some of the boxes that were not covered or secured; these records included resident names, birthdates, medications and diagnosis and other identifying information.

On 4/15/16 at 7:30 AM, two members of the contracted housekeeping service were observed alone in the "Cave" (with the stored records) sweeping the floor. At 7:38 AM, the contracted supervisor of housekeeping and laundry services reported that maintenance staff unlocks the door to the room so that housekeeping can sweep the floor, about every other day. S/he reported that the housekeeper is alone in the room doing the cleaning. S/he also reported that the Cave is used for staff meetings.

On 4/5/16 at 1:26 PM, the facility administrator reported that there had been a leaking pipe in the medical record room a "couple of months ago"

F 164,

A quality improvement evaluation has been implemented under the supervision of the quality improvement team, the Administrator and or designee to review the policy and procedures of:
Location and Storage of Medical Records

! Access to resident medical records will be limited to authorize staff and business associates.
An audit of cameras will be reviewed weekly for one month and monthly for 3 months and periodically after that to ensure that there is no unauthorized staff entering into medical record room.

Completion Date: 4/20/2016

F164 POC accepted 4/28/16 mthigarsRU/pmc



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and that the boxes of medical records were moved to the Cave. She confirmed the surveyor observations as listed above and that resident medical information was visible. The administrator confirmed that staff meetings are held in the room and that housekeeping staff are not authorized to have access to medical records. The following policies were reviewed and confirmed with the administrator at the time of the interview: 1. Location and Storage of Medical Records (from the Operational Policy and Procedure Manual; adoption date 5/2013) states under Policy Interpretation and Implementation, 2. Medical records are stored in a locked room and protected from fire, water damage, insects and theft." 2. The policy, Confidentiality of Information (Revised April 2014) states under the heading Policy Interpretation and Implementation, part 2. Access to resident medical records will be limited to authorized staff and business associates.

Per review of the policies with the Administrator, s/he confirmed that housekeeping staff are not authorized to have unsupervised access to the confidential resident medical records. On arrival to the facility on the morning of 4/6/16, the medical records had been moved from the Cave. (Refer 516)

F 253 483.15(h)(2) HOUSEKEEPING & SS=E MAINTENANCE SERVICES

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced

F 164

F 253

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 to meet requirements established by state and federal law is as follows:

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by:

Based on observation and staff interview the facility failed to provide maintenance services necessary to maintain a sanitary, orderly and comfortable environment. The findings include:

Per observation and tour with the facility's Director of Maintenance (OM) on 4/6/16 starting at 8:39 AM the following observations were made and confirmed at the time of the tour:

1. In the hallway by the Champlain nurses station, the baseboard molding was loose and lifting away from the wall on both sides of the hall creating a potential trip hazard for residents walking in the hall.
2. In room 102, there were 2 screw heads protruding upward from the threshold at the entrance to the bathroom creating a potential tripping hazard. The OM assigned a maintenance staff member to fix the hazard as soon as it was identified.
3. In the bathroom shared by rooms 101 and 102, a portable commode was missing all 4 rubber safety feet creating a potential slip hazard when used. The OM confirmed the observation and stated that the rubber feet would be replaced.
4. In room 119, a wallpaper patch was torn and lifting away from the wall. The OM reported this area had been repaired multiple times in the past.

Per observation and tour with the facility's supervisor of housekeeping and laundry (SH&L) on 4/6/16 beginning at 8:10 AM, the following observations were made and confirmed:

F 2531

It is the policy of Green Mountain Nursing and Rehabilitation to provide maintenance services necessary to maintain a sanitary, orderly and comfortable environment.

The baseboard molding has been adhered to the wall.

The 2 screw heads that were protruding were fixed immediately.

The rubber feet have been replaced on the commode.

Room 119 wall will be patched.

The tub has been cleaned and not used for storage.

Floor has been buffed.

103 Curtains have been re attached to the rod.

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

To ensure the alleged practice does not occur, and procedure stays consistent we are taking the following measures:

A review of baseboard molding has been done to identify any loose and lifting away and made sure that it is adhered to the wall.

A review of thresholds has been done to identify any screw heads sticking up.

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1. In the bathroom shared by room 101 and 102, the tub was soiled with dark stains, grit, and scraps of white tissue. Though not used for bathing, the tub is currently used to store equipment and visible to anyone using the bathroom. The SH&L confirmed the condition of the tub and reported that it should be cleaned twice per week or when soiled. The floor in the same bathroom was dull and gray soiled and with multiple black scuff marks. The SH&L reported that the floors are stripped and waxed yearly and maintained by buffing and confirmed that buffing/cleaning was needed.

2. In room 103, the curtains for 2 windows were dangling and not fully attached to the rod. The SH&L confirmed the observation and stated that housekeeping was responsible for fixing the curtains. S/he reported that s/he is in the process of reestablishing a cleaning schedule and routine since recently taking this position.

F 441 483.65 INFECTION CONTROL, PREVENT SS=D SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program

The facility must establish an Infection Control Program under which it -

- (1) Investigates, controls, and prevents infections in the facility;
- (2) Decides what procedures, such as isolation, should be applied to an individual resident; and
- (3) Maintains a record of incidents and corrective

F 253

F 253 Continue:

A review of commodes has been done to identify any missing rubber safety feet.

Maintenance is in the process of repairing areas that need to be patched. An audit to identify rooms and areas that need patching is being done.

All remaining tubs have been cleaned and will remain free of equipment, or other items.

Housekeeping is working on keeping floors buffed and stripped and waxed. An audit of rooms/floors needing to be buffed or waxed is being done to identify which ones are in need of immediate attention.

An audit of curtains has been done to identify which ones are in need of being attached to the rod.

Staff will be reminded of the work order process to ensure that housekeeping and maintenance are aware of situations that need attention. A quality improvement evaluation has been implemented under the supervision of the quality improvement team.

Weekly environmental audits will be completed for 30 days and then biweekly for 30 days and at least monthly thereafter to identify any situations relating to housekeeping and maintenance services that are necessary to maintain a sanitary, orderly and comfortable environment.

Completion Date: 4/22/2016

F253 POC accepted 4/28/16
M Higgins RN / PMU

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actions related to infections.

F 441

- (b) Preventing Spread of Infection
 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
 Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and policy review, the facility failed to implement proper infection control measures during a dressing change for one of two resident dressing change observations (Resident #55) and failed to ensure that hand-held nebulizer equipment was sanitized and stored or discarded per infection control standards for one applicable resident (Resident #80). Findings include:

1. Per observation of a wound dressing change for Resident #55 on 4/5/16 at 10:04 AM, the staff nurse failed to follow infection control measures during the procedure. At the time of the

It is the policy of Green Mountain Nursing and Rehabilitation establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

All residents have the potential to be affected by the alleged deficient practice. To ensure the alleged practice does not occur, and procedure stays consistent we are taking the following measures:

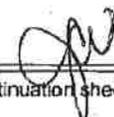
Nursing staff will be reeducated on the proper technique of wound dressing changes.

Nursing staff will be reeducated on the proper storage and cleaning of nebulizer treatment equipment.

A quality improvement evaluation has been implemented under the supervision of the quality improvement team.

Weekly audits of wound dressing changes and nebulizer equipment will be done by the DON and or designee to ensure proper procedure is being followed according to policy for 30 days, bi weekly for next 30 days and periodically thereafter as part of the Quality improvement program.

Completion Date: 4/22/2016



F441 POC accepted 4/28/16 mth/qms/rd/pnw

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F 441,

observation, the nurse failed to wash/sanitize his/her hands prior to starting the dressing change and applying gloves. After removing the old, soiled dressing and wound packing, the nurse did not wash or sanitize his/her hands prior to changing gloves and packing the wound and applying a clean dressing. Following the observation, the nurse confirmed the failure to sanitize hands.

Per 4/5/16 at 2:33 PM interview with the Infection Control Nurse (ICN) and facility Director of Nursing (DNS), the ICN reported that staff should wash their hands before all resident contacts, before a dressing change is started and after removing a soiled dressing. Per review, the facility policy Dressings, Dry/Clean (Adoption date 1/2013) under steps in the procedure, states that handwashing should be done prior to starting a dressing procedure (step 5) and after removing and discarding a soiled dressing (step 8).

2. Per 4/4/16 at 2:04 PM observation, a handheld nebulizer face mask and connected medication chamber and a nebulizer mouth piece and medication chamber for Resident #80 were not cleaned or stored in a manner consistent with infection control standards. Per observation, the face mask was spotted with dried white particles and had the imprint of a nose on the inner surface of the mask. The medication chamber had dried white spots; the mask was stored in direct contact with the surface of the resident's night stand without the protection of a clean barrier. A second oral nebulizer mouth piece was stored with the mouth piece in contact with the surface of the wall; its medication chamber was spotted with a dried white substance.

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On 4/5/16 at 2:48 PM, the facility ICN and DNS confirmed the above observations and that the nebulizer mask and mouthpiece were not cleaned or stored in a manner consistent with infection control practices. The DNS reported that the nebulizer equipment should have been separated and cleaned after use and placed on a clean paper towel (which is consistent with the facility policy, Administering Medications through a Small Volume (Handheld) Nebulizer, adoption date 1/2013). The equipment was discarded by the ICN after the observation.

F 516 483.75(1)(3), 483.20(f)(5) RELEASE RES INFO, SS=E : SAFEGUARD CLINICAL RECORDS

F 516

A facility may not release information that is resident-identifiable to the public.

The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

The facility must safeguard clinical record information against loss, destruction, or unauthorized use.

This REQUIREMENT is not met as evidenced by:

Based on observation and staff interview, the facility failed to store closed medical records, dated from 2010-2015, in a manner that ensures that they are protected against loss, destruction or unauthorized use. The findings include:

It is the policy of Green Mountain Nursing and Rehabilitation to ensure that closed medical records are protected against loss, destruction or unauthorized use.

The medical records in question were moved from the cave to another locked room that was recently cleared out. Access to this room is strictly limited and safe from water damage. Employees must gain approval from the Administrator or Director of nursing and is accessed by authorized staff only. Relating to the said quote by administrator stating "confirmed that the medical records are not protected from risk of water damage in their current location" This is a miss quote.

I stated that the medical records were not currently at risk of water damage when they were stored behind locked doors in the cave or in the current medical record room, moving them was to ensure there would be no more damage and was the primary reason they were moved to the cave.

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F 516

Per direct observation beginning on the morning of 4/4/16, approximately 78 cardboard boxes of closed medical records for former residents of the facility were observed stored in a room (called the Cave) in the basement directly on the floor and under an open ceiling with exposed piping and sprinklers, creating an opportunity for potential water damage. Per observation, some of the boxes were marked "flood damage." Not all of the boxes were covered and names of the former residents were visible on the file folders. There were also medical records, including probate court correspondences, physician orders and nursing progress notes visible on top of some of the boxes that were not secured; these records included resident names, birthdates, medications and diagnosis and other identifying information. On 4/15/16 at 7:30 AM, two members of the contracted housekeeping service were observed alone in the "Cave" (with the stored records) sweeping the floor. At 7:38 AM, the contracted supervisor of housekeeping and laundry services reported that maintenance staff unlocks the door to the room so that housekeeping can sweep the floor, about every other day. S/he reported that the housekeeper is alone in the room doing the cleaning. S/he also reported that the Cave is used for staff meetings. On 4/5/16 at 1:26 PM, the facility administrator reported that there had been a leaking pipe in the medical record room a "couple of months ago" and that the boxes of medical records were moved to the Cave. She confirmed the surveyor observations as listed above and that the records were not secure from risk of water damage in their current location and that resident medical information was visible. The administrator confirmed that staff meetings are held in the room and that housekeeping staff are not authorized to

All residents have the potential to be affected by the alleged deficient practice. To ensure the alleged practice does not occur, and procedure stays consistent we are taking the following measures:

The medical records will continue to be housed in a manner that ensures that they are protected against loss, destruction or unauthorized use.

Only the Administrator and Director of Nursing, and Medical Records clerk have a key to the overflow and discharge medical record rooms, any other authorized staff must get clearance from the Administrator or Director of Nursing to gain access.

A quality improvement evaluation has been implemented under the supervision of the quality improvement team, the Administrator and or designee to review the policy and procedures of:
Location and Storage of Medical Records

! Access to resident medical records will be limited to authorize staff and business associates. An audit of cameras will be reviewed weekly for one month and monthly for 3 months and periodically after that to ensure that there is no unauthorized staff entering into medical record room.

F516 POC accepted 4/28/16 M Higgins RN/PML

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have access to medical records.

The following policies were reviewed and confirmed with the administrator at the time of the interview: 1. Location and Storage of Medical Records (from the Operational Policy and Procedure Manual; adoption date 5/2013) states under Policy Interpretation and Implementation, 2. Medical records are stored in a locked room and protected from fire, water damage, insects and theft." 2. The policy, Confidentiality of Information (Revised April 2014) states under the heading Policy Interpretation and Implementation, part 2. Access to resident medical records will be limited to authorized staff and business associates.

Per review of the policies with the Administrator, s/he confirmed that the medical records are not protected from risk of water damage in their current location and that housekeeping staff are not authorized to have unsupervised access to the confidential resident medical records. On arrival to the facility on the morning of 4/6/16, the medical records had been moved from the Cave. (Refer 164)