

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  10/22/2024
NAME OF PROVIDER OR SUPPLIER  Green Mountain Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  475 Ethan Allen Avenue Colchester, VT 05446	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>50431</p> <p>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:</p> <p>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 hit his/her head. Resident #1 was unaware of how the bruise occurred on his/her face.</p> <p>A telephone interview was conducted with LPN [Licensed Practical Nurse] #1 on 10/8/24 at 5:46 PM.</p> <p>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.</p> <p>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.</p> <p>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 .</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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;</p> <p>b. The date and time that the incident occurred</p> <p>c. Where the incident took place;</p> <p>d. The name(s) of the person(s) allegedly committing the incident, if known;</p> <p>e. The names(s) of any witnesses to the incident;</p> <p>f. The type of abuse that was committed .</p> <p>g. Any other information that may be requested by management.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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 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.</p> <p>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.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>50431</p> <p>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.</p> <p>Findings include:</p> <p>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.</p> <p>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;[sic]</p> <p>b. The date and time that the incident occurred</p> <p>c. Where the incident took place;</p> <p>d. The name(s) of the person(s) allegedly committing the incident, if known;</p> <p>e. The names(s) of any witnesses to the incident;</p> <p>f. The type of abuse that was committed .</p> <p>g. Any other information that may be requested by management.</p> <p>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.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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 hit his/her head. Resident #1 was unaware of how the bruise occurred on his/her face.</p> <p>A telephone interview was conducted with LPN [Licensed Practical Nurse] #1 on 10/8/24 at 5:46 PM.</p> <p>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.</p> <p>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 .</p> <p>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.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>50431</p> <p>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 (Residents #1) of three sampled residents. Findings include:</p> <p>Per record review, Resident #1 was admitted to facility on 9/26/24.</p> <p>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.</p> <p>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.</p>