

Division of Licensing and Protection  
103 South Main Street, Ladd Hall  
Waterbury VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 241-2345  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 241-2358

January 3, 2011

Susan Laninfa, Administrator  
Pine Heights At Brattleboro Center  
187 Oak Grove Avenue  
Brattleboro, VT 05301

Provider ID #:475023

Dear Ms.. Laninfa:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on  
**December 8, 2010.**

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,



Pamela M. Cota, RN  
Licensing Chief

PC:jl

Enclosure



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

PRINTED: 12/16/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/08/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PINE HEIGHTS AT BRATTLEBORO CENTER FOR NURSING &amp; R</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>187 OAK GROVE AVENUE BRATTLEBORO, VT 05301</b>
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F 000	INITIAL COMMENTS	F 000		
F 279 SS=D	<p>An unannounced recertification survey was conducted by the Division of Licensing and Protection from 12/06/2010 to 12/08/2010. The following regulatory deficiencies were identified:</p> <p><b>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</b></p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review, the facility failed to develop comprehensive care plans for 3 of 22 residents in the sample. (Resident #2, #15 and #16) Findings include:</p> <p>1. Per interview on 12/7/10 at 12:37 PM, the</p>	F 279	<p>F279 Care Plans</p> <p>R#15 has been assessed for any existing oral problems by the RN Unit Manager and has been scheduled for an annual dental exam. The care plan has been reviewed and revised as appropriate.</p> <p>R#2 has been assessed for any existing oral problems related to her 2 broken teeth and none was found. The Charge Nurse will exam the resident's mouth weekly and document on the treatment record. A dental care plan was developed and a dental consult was scheduled.</p> <p>R#16 has a care plan addressing her mood and it has been reviewed by the interdisciplinary team to ensure all her needs regarding the loss of her partner have been addresses.</p> <p>Residents with oral problems and residents who have suffered a loss of a loved one have the potential to be affected</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>ADMINISTRATOR</b>	(X6) DATE <b>12/27/10</b>
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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 279	Continued From page 1 responsible party for Resident #15 indicated this resident has a history of chronic, intermittent tongue pain / mouth sores. Per record review on 12/8/2010, there was no plan of care directing staff in routine dental assistance for Resident #15. During interview on 12/8/10 at 11:20 AM, the Unit Nursing Supervisor confirmed that there was no dental plan of care for this resident. Refer also to F411.  2. Per resident observation on 12/07/2010 at 10:44 AM, Resident #2 has broken and missing teeth. Per record review on 12/08/2010 at 9:30 AM, there is no individualized care plan to address dental issues for Resident #2. Dental assessments are present in the medical record and dental visits occurred on 02/05/2010, 02/19/2010 and 03/05/2010. None of the recommendations made during those visits were transferred to the care plan. It was confirmed during interview with the charge nurse at 9:55 AM on 12/08/2010, that the care plan for Resident #2 has not been developed to address specific dental health needs.  3. Per record review, Resident #16 had been roommates in the facility with a close friend and partner of many years. The friend passed away in July 2010, and per interview with the resident on 12/8/10, this was a significant loss and saddened the resident deeply. Per review of Resident #16's plan of care, there was no area to address the resident's psychosocial needs related to grief and loss. Per interview on 12/8/10 at 3:25 PM, the Social Worker confirmed that the resident experienced a significant loss, and that no care plan was developed to address this concern.	F 279	DNS has directed the review of all current dental consults to ensure care plans are updated.  The Social Worker has reviewed care plans of all residents who may have suffered a loss to ensure that the appropriate interventions are in place.  Nursing staff have been in- serviced on the proper way to follow-up on dental consults; Day Supervisor will review all consults and update care plans as needed  DNS will assign audits to management staff who will review care plans of residents who have been examined by the dentist or who may have suffered a loss. These audits will be done monthly for 3 months and negative results will be reported to DNS immediately for resolution and to the QA Committee. DNS will be responsible for compliance  <i>F279 POC Accepted 12/30/10 G. Coleman RN / PMCotURN</i>	1/15/2011	
F 353	483.30(a) SUFFICIENT 24-HR NURSING STAFF	F 353			

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F 353 SS=D	<p>Continued From page 2 <b>PER CARE PLANS</b></p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure adequate staffing was available to meet the needs of 1 applicable resident in the survey (Resident #90). Findings include:</p> <p>1. Per observation at 3:30 PM on 12/8/10, the call light for Resident #90 was ringing. This continued until 3:39 PM, when a family member informed staff that Resident #90 had been waiting to receive assistance to bed for the "past hour". At 3:42 PM 2 staff entered Resident #90s room with a Hoyer lift to assist the resident to bed.</p>	F 353	<p>F353 Staffing R#90 has had her care plan revised to reflect her out of bed schedule. This was discussed with the family who agreed.</p> <p>Residents who require assistance with transfers have the potential to be affected.</p> <p>Staff will be in-serviced on reporting off to each other regarding resident's needs and will do walking rounds at the end of each shift, so all residents needs will be met regardless of change of shift.</p> <p>DNS will assign random auditing of call bells to ensure that all needs are being met timely. Day supervisor has reviewed all LNA assignments to ensure all out of bed schedules are communicated accurately.</p> <p>Results of audits will be reported to DNS and QA committee monthly for 3 months. DNS will be responsible for compliance.</p> <p><i>F353 POC Accepted 12/30/10 G. Coleman RN   [Signature]</i></p>	1/15/2011	

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F 353	Continued From page 3 During interview following the transfer, the family member stated that Resident #90 had returned from a 2:00 PM therapy session and had rung the call bell for assistance to return to bed upon return to the unit. S/he stated that an LNA had responded to the light, turned off the light "at least 30 minutes ago" and agreed to return stating that change of shift was in process. During interview immediately following the family interview, a staff member confirmed that Resident #90 is transferred to bed following treatments, as the resident requires rest after activity, and that if this had occurred during change of shift the resident might have had a longer wait.	F 353			
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS  The facility must assist residents in obtaining routine and 24-hour emergency dental care.  A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assist 1 applicable resident (Resident #15) to obtain routine dental care. Findings include:	F 411	F411 Dental Service R#15 has been assessed for any existing oral problems by RN Unit Manager and has been scheduled for an annual dental exam. The care plan has been reviewed and revised to meet the resident's oral needs.  All residents with oral problems have the potential to be affected. DNS has directed the review of all current dental consults to ensure that the care plans are updated.  The Day Supervisor will keep a calendar of dental visits to ensure all residents will have annual dental exams and that if there are existing problems the resident will see the dentist timely.		

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F 411	Continued From page 4  1. Per interview on 12/7/10 at 12:36 PM, the responsible party for Resident #15 indicated this resident has a history of chronic, intermittent tongue pain / mouth sores. Per record review on 12/8/2010, there was no evidence that a professional dental exam had been completed during the prior year. Additionally, there was no instruction for professional routine dental evaluation indicated in the physician orders. During interview on 12/8/10 at 11:20 AM, the Unit Nursing Supervisor confirmed that there were no orders for professional dental care and that no professional dental care had been arranged / provided for this resident. Refer also to F279.	F 411	The DNS will assign random audits of dental visits for 3 months and results reported to QA committee. Day Supervisor to be responsible for compliance.  <i>F411 POC Accepted 12/30/10 G.Coleman RN / J.M. Coleman</i>	1/15/2011
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT 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 actions related to infections.  (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.	F 441	F441 Infection Control R#84 has been discharged to home. There were no negative outcomes from not having a precautions cart outside the resident's room.  All residents with communicable disease have the potential to be effected.  All residents with infections have been reviewed by the Infection Control nurse to ensure that all necessary precautions are in place.  Licensed staff have been in-serviced on facilities' policy and procedure for isolation precautions.	

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F 441	<p>Continued From page 5</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a safe, sanitary environment and to help prevent the transmission of infection for 1 of 22 residents in the sample (Resident #84). Findings include:</p> <p>Per interview with a family member of Resident #84 on 12/8/10 at 8:32 AM, facility staff have not been following precautions for Resident #84's Clostridium-Difficile (C-diff). Per record review on 12/8/10 at 9:00 AM, Resident #84 was diagnosed with C-diff on 11/27/10. Per observation during the first 2 days of survey, there was no contact precaution equipment near the Resident's door and no signage to "see nurse before entering" on the Resident's door. Per review of the facility policy regarding C-diff on 12/8/10 at 11:09 AM, it is the facility's policy to institute contact precautions for residents with known C-diff.</p> <p>During a 9:45 AM interview with the Unit Manager</p>	F 441	<p>Infection Control nurse will monitor during rounds to make sure all interventions are in place and will report findings to DNS and QA committee for 3 months.</p> <p>Infection Control Nurses will be responsible for compliance.</p> <p><i>F441 PDC Accepted 12/30/10 P. McArthur RN / G. Coleman RN</i></p>	1/15/2011

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F 441	Continued From page 6 (UM), s/he confirmed that Resident #84 has had C-diff since 11/27/10 and that contact precautions (gowns and gloves) should be in place. Per a 12/8/10 interview at 9:56 AM, a unit Licensed Nursing Assistant (LNA) stated that s/he was unaware of contact precautions for Resident #84. Per record review on 12/8/10 at 10:00 AM, the LNA daily care sheet and the care plan for C-diff did not indicate that Resident #84 was on contact precautions. During a 10:05 AM interview on 12/8/10, a Unit Nurse confirmed that Resident #84 has C-diff and that s/he did not utilize contact precautions while providing care on 12/6/10 and 12/7/10.	F 441			

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # <b>475023</b>	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: <b>12/8/2010</b>
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
<b>F 166</b>	<p><b>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</b></p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assure that a prompt, systematic response was provided to 1 of 22 applicable residents in the sample (Resident #15) regarding lost clothing items. Findings include:</p> <p>1. Per interview on 12/7/10 at 12:36 PM, the POA-HC (power of attorney for health care) for Resident #15 stated that a missing clothing item had been reported to staff more than 2-3 weeks ago and that the item has not been located or replaced. Per interview on 12/8/10 at 9:05 AM, the Social Services Director stated that s/he had not been notified by staff that Resident #15 was missing an article of clothing and that there is no systematic method / policy in place to track missing clothing items. Per interview on 12/8/10 at 8:15 AM, the Director of Nursing stated that s/he is unaware of this missing item, that s/he is unaware of a formalized tracking system for missing items, and that there is no specific 'missing items' policy and procedure.</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

The above isolated deficiencies pose no actual harm to the residents