



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

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

February 16, 2012

Mr. J. Michael Rivers, Administrator
Pine Heights At Brattleboro Center For Nursing & Rehab
187 Oak Grove Avenue
Brattleboro, VT 05301

Dear Mr. Rivers:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 24, 2012**. 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,

A handwritten signature in black ink that reads "Pamela M. Cota RN". The signature is fluid and cursive.

Pamela M. Cota, RN, MS
Licensing Chief

PC:jl



STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/24/2012
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NAME OF PROVIDER OR SUPPLIER PINE HEIGHTS AT BRATTLEBORO CENTER FOR NURSING & R	STREET ADDRESS, CITY, STATE, ZIP CODE 187 OAK GROVE AVENUE BRATTLEBORO, VT 05301
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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 An unannounced on-site complaint investigation was conducted on 01/24/12 by the Division of Licensing and Protection. The following are regulatory findings.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment, prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to revise the care plan to reflect a change in treatment for 1 applicable resident. (Resident #1) Findings include: 1. Per record review on 01/24/12, Resident #1	F 280	F 280 1. Resident #1 care plan has been reviewed and revised to reflect Foley catheter placed as per MD order. 2. All residents who require foley catheters may be affected by this alleged deficient practice. 3. Audits of all residents with foley catheters performed to ensure care plans are up to date and reflective of the MD order. 4. Random audits will be performed by DNS or designee weekly x4 then monthly x2 to ensure continued compliance. 5. Results to be reported out at CQI monthly x3 at which time committee will decide process for further surveillance. Complete by 2/20/2012	2/20/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Administrator</i>	(X6) DATE 2/13/12
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deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days within 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 participation.

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F 280	Continued From page 1 was sent to the hospital on 12/27/11 for concerns regarding a leaking Foley catheter. The Resident returned that evening with a placement of a new curved-type (Caude) catheter. The care plan dated 01/18/10 states "Foley cath 18FR 10cc balloon". There was no revision for this new type of catheter on the care plan. The Unit Nurse Manger confirmed at 12 noon that the care plan was not revised to reflect the new catheter.	F 280		
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 services were provided according to the resident's written plan of care regarding weighing of adult diapers and accurate I&O (Intake and Output) measurements for Resident #3 in the sample. Findings include: 1. Per review of the closed record for Resident #3, who was on comfort care, the physician ordered on 11/10/11 "weigh all adult diapers-total wt. per day and I&O x 1 week". Per review the I&O sheets, they show no oral intake documentation for the 3-11 and 11-7 shift on 11/10/11 and no records of the diaper weights between 11/10/11 and 11/12/11. The resident was sent to the hospital on 11/12/11. Per interview at 4:30 PM the DNS (Director of Nursing Services) confirmed that services were not	F 282	F 282 1. Resident #3 was on comfort care and has expired. 2. All residents who are on I+O may be affected by this alleged deficient practice. 3. Audits of all residents on I+O to be performed to: A. ensure completeness of I+O, B. review MD orders to ascertain residents who have orders to weigh adult diaper. 4. Nursing staff to be re-educated as to organizational policy for I+O. 5. Random audits will be performed by DNS or designee weekly x4 then monthly x2 to ensure continued compliance. 6. Results to be reported out at CQI monthly x3 at which time committee will decide process for further surveillance. Complete by 2/20/12	2/20/12

POC F282 accepted
2/15/12 Susan J. Sumner RN

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F 282	Continued From page 2 provided according to the plan of care.	F 282		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to provide sufficient fluid to maintain proper hydration for 1 applicable resident. (Resident #2) Finding include: 1. During the tour on 01/24/12 at approximately 12 PM of Unit 3, the floor nurse was attempting to place an intravenous (I.V.) catheter for Resident #2. The resident was observed sleeping, had dry skin and poor skin turgor. The floor nurse stated to the nurse surveyor at that time, the resident had been on antibiotic therapy, not taking fluids well and the labs (blood urea nitrogen and creatinine) results indicated dehydration. Per review of the resident's record, the physician ordered on 01/23/12 before 3:00 PM a hydration solution of D5W 1,000 ml every 10 hours. There was no information in the nursing notes on 01/23/12 as to why the I.V. was not started, if the physician was aware the I.V. was not started as ordered, or if family was aware of the change in treatment. Per interview at 12:15 PM, the acting unit manager stated that the nurse "was probably waiting for the solution and pump to come from the pharmacy" and also stated that "the night nurse is an LPN (Licensed Practical Nurse) and LPNs can't start I.V.". When asked if there was	F 327	F 327 1. Resident #2 was on comfort care and has expired. 2. All residents with MD orders for IV hydration may be affected by this alleged deficient practice. 3. Audit to be performed on all residents with orders for IV hydration to ensure timeliness of implementation. 4. Nursing staff to be re-educated on steps to ensure timeliness of implementation for IV hydration orders. 5. Random audits will be performed DNS or designee weekly x4 then monthly x2 to ensure continued compliance. 6. Results to be reported out at CQI monthly x3 at which time committee will decide process for further surveillance. Completed by 2/20/2012.	2/20/12

POC. F 327 accepted
2/15/12

Suzanne J. Emmerson RN

STATEMENT OF DEFICIENCIES
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F 327	Continued From page 3 any I.V. solution in the building or a R.N (Registered Nurse), the nurse surveyor was told that the 2nd floor unit had a R.N. and there might be solution in the 'back-up box'. Per observation of supplies and interview with the R.N manager at 12:32 PM, there was several types of I.V. solution, including D5W, and I.V. lines and supplies. The solution can be used until the replacement is sent from the pharmacy. The DNS confirmed at 4:30 PM that the resident did not receive the I.V fluid for nearly 20 hours after it was ordered.	F 327		
F 328 SS=D	Also see F157 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure that one applicable resident received proper treatment and care regarding enteral nutrition. (Resident #1) Findings include:	F 328	F 328 1. Resident # 1 evaluated and no negative outcome sustained as result of this alleged deficient practice. 2. All residents receiving enteral nutrition may be affected by this alleged deficient practice. 3. Audits to be performed for residents receiving enteral nutrition to ensure policy adherence to hourly checks. 4. Nursing staff to be re-educated as to the organizational policy for enteral nutrition. 4. Random audits will be performed by DNS or designee weekly x4 then monthly x2 to ensure continued compliance. 5. Results to be reported out at CQI monthly x3 at which time committee will decide process for further surveillance. Complete by 2/20/2012	2/20/12

POC F 328 accepted
2/15/12 Susan J. Emmons RN

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F 328	Continued From page 4 1. Per record review, Resident #1 has a physician's order to receive enteral nutrition for 18 hours per day, from 11 AM to 5 AM daily. Per review of the facility policy regarding enteral feedings, staff are to monitor the resident every hour and check the pump delivering the nutrition every hour. Per direct observation on 1/24/12 from 11:00 AM to 3:00 PM, staff were not observed checking the resident every hour. Per interview, at 4:30 PM the DNS confirmed staff did not act according to policies for enteral nutrition.	F 328		
F 441 SS=D	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. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441	F 441 1. Resident #1 evaluated. No negative outcome sustained as result of this alleged deficient practice. 2. Resident #2 was identified in error. 3. All residents with a foley catheter may be affected by this alleged deficient practice. 4. LNA's re-educated as covering of foley bags and the process for emptying. 5. Random audits will be performed by DNS or designee weekly x4 then monthly x2 to ensure continued compliance. 6. Results to be reported out at CQI monthly x3 at which time committee will decide process for further surveillance. Complete by 2/20/2012	2/20/12

POC F 441 accepted
2/15/12 Susan J. Emmons RN

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F 441	<p>Continued From page 5</p> <p>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 and interview, the facility failed to provide an environment to help prevent development of infection for 2 applicable residents. (Resident #1 & #2) Findings include:</p> <ol style="list-style-type: none"> 1. Per observation on 01/24/12 at 2:07 PM of the LNA emptying the urine drainage bag for Resident #2, the drainage spout was seen touching and resting against the collection container. The LNA wiped the end of the spout with alcohol, however, the spout re-touched the collection container without the LNA being aware and the spout was inserted into the holder. Per interview later that day the infection control nurse confirmed that the spout should not come into contact with anything. 2. During the initial tour at on 01/24/12 at 11:00 AM, Resident #1 was observed with a urine drainage bag, uncovered and hanging off the bed touching the underside of the bed and sheets. Per interview with LNA staff at 1:00 PM 	F 441		

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F 441	Continued From page 6 who were in the residents room stated "we don't know where the cover went but it should be covered, we'll use the one that is on the wheelchair". Per interview later that day the Infection control nurse confirmed that the urine drainage bag should be covered at all times to prevent possible infection.	F 441		
F 498 SS=D	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that 3 applicable Licensed Nurse Aides (LNAs) demonstrated competency skills and techniques necessary to care for residents needs; Findings include: 1. Per review of inservice files on the afternoon of 01/24/12, the facility's staff development person was unable to provide evidence of competency reviews for 3 LNAs who had been employed for greater than 1 year. Per interview on 01/24/12 at 4:00 PM, the DNS stated the facility "is working on a system to do that" and confirmed the competencies were not demonstrated.	F 498	F 498 1. No individual residents affected by this alleged deficient practice. 2. All residents may be affected by this alleged deficient practice. 3. Audit of LNA educational records to be performed to ascertain need for annual update. 4. Complete competencies required as per organizational policy for LNA's 5. Random audits will be performed by DNS or designee weekly x4 then monthly x2 to ensure continued compliance. 6. Results to be reported out at CQI monthly x3 at which time committee will decide process for further surveillance. Complete by 2/20/2012.	2/20/12
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514	DOC. F-498 accepted 2/15/12 Susan J. Emmerson RN	

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F 514	<p>Continued From page 7</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to assure that 2 applicable residents' charts were complete, accurate and/or systematically organized. (Resident #1 & #3) Findings include:</p> <p>1. Per medical record review on 01/24/12, Resident #1, who is diagnosed with recurrent urinary tract infections as well as having a catheter, did not have a care plan in the medical record that addressed those needs. When asked by the nurse surveyor if there was a care plan for the above concerns the nurse stated "I think so, maybe it is in the thinned chart". The nurse then went into a locked back room and found the care plan stating "this should be in the main chart". The Unit Manager Nurse at 12 Noon confirmed that Resident #1's chart was not complete and had missing information.</p> <p>2. Per review of a closed record on 01/24/12 for Resident #3, the clinical record did not contain</p>	F 514	<p>F 514</p> <ol style="list-style-type: none"> 1. No individual residents were affected by this alleged deficient practice. 2. All residents may be affected by this alleged deficient practice. 3. Audit all active records and closed records from January 1, to present to ensure completeness, accessibility, accuracy and systematically organized. 4. Staff re-education as to open and closed chart maintenance. 5. Random audits will be performed by DNS or designee weekly x4 then monthly x2 to ensure continued compliance. 6. Results to be reported out at CQI monthly x3 at which time committee will decide process for further surveillance. Complete by 2/12/2012. <p><i>POC F 514 accepted 2/15/12 Susan J. Emmer RN</i></p>	2/20/12

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F 514	Continued From page 8 correct information, had missing information and was not systematically organized. The resident's records contained physician orders mixed in with nursing progress notes of varying dates, Medication Administration Records mixed in with therapy notes and scattered treatment records and admission information dispersed through out several folders. In addition, a physician order of 11/10/11 states d/c (discontinue) Foley, weigh all adult diapers, I&O (input & output) x1 week, but on 11/11/11 an order states to keep the Foley. There was missing information as to whether the Foley was removed on 11/10/11 per physician order, accurate I&O's for 11/10-11/12/11 and missing nursing notes on those days as to the outcome or treatments provided. Per interview at 4:30 PM, the DNS confirmed that the closed records were not systematically organized and did not contain complete and accurate information.	F 514		