

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

December 13, 2011

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

Provider #: 475023

Dear Mr. Rivers:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 16, 2011**. 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

PC:ne

Enclosure



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

PRINTED: 11/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2011
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	
(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 272 SS=D	<p>An unannounced on-site recertification survey was conducted by the Division of Licensing and Protection from 11/14/11 to 11/18/11. The following are regulatory violations.</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and</p>	F 272	<p>F 272</p> <ol style="list-style-type: none"> 1. Psychiatric consult obtained for Resident #39 Diagnosis for treatment obtained. 2. All residents who receive antipsychotic residents may be affected by this alleged deficit practice. 3. All resident who receive antipsychotic medications shall be checked to ensure proper diagnosis for treatment is obtained. 4. Random weekly audits will be performed x 4 then monthly x2 by DNS or designee to ensure continued compliance. 5. Results to be reported out at CQI monthly x3 at which time committee will decide process for further surveillance. <p><i>OK accept 12.12.11 R. Treubay / Luth</i></p>	12/16/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Mike Rivers* TITLE *Administrator* (X6) DATE *12/19/11*

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 those 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
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 476023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/16/2011	
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		
(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 272	<p>Continued From page 1</p> <p>Documentation of participation in assessment:</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to comprehensively assess 1 of 17 residents' mental and psychosocial needs to identify risks and determine the underlying causes of the resident's condition and the impact of the use of anti-psychotic medication on his/her function, mood and cognition. (Resident #39)</p> <p>Findings include:</p> <p>Per record review, physician orders written by the Nurse Practitioner (NP) on 10/14/11 stated the following: 'Please obtain med-psych records from [prior assisted living arrangement] & need psych assessment and diagnosis. Refer to psych [former psychiatric hospital where the resident had an inpatient stay].'</p> <p>Also, on 10/24/11 the NP wrote: 'Obtain med records from [psychiatric hospital] - need psych assessments and diagnosis', also 'need ger-psych evaluation.'</p> <p>On 11/15/11 at 2 PM the Unit Manager confirmed that a ger-psych consult had not been obtained for this resident and that the prior medical records were not obtained from the psychiatric hospital. In addition, the former assisted living home was unable to provide medical records related to the resident's psychiatric history and why s/he had</p>	F 272		

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

PRINTED: 11/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/16/2011
--	--	--	--

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
---	--

(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 272	Continued From page 2 been prescribed an anti-psychotic.	F 272		
F 278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment, or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p>	F 278	<p>F 278</p> <ol style="list-style-type: none"> 1. Correction to MDS assessment submitted for resident #100 to reflect antipsychotic use. 2. All residents who receive antipsychotic medication may be affected by this alleged deficient practice. 3. Audit of all MDS assessments for residents on antipsychotic performed, corrections made as needed. 4. Random weekly audits will be performed weekly x4 then monthly x2 by DNS or designee to ensure continued compliance. 5. Results to be reported out at CQI monthly x3 at which time committee will decide process for further surveillance. <p><i>Doc reports 12.12.11</i> <i>R. Treanby</i></p>	12/16/11

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

PRINTED: 11/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/16/2011
--	--	--	--

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
--	--

(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 278	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the clinical record, the Minimum Data Set (MDS) assessment and interview, the facility failed to ensure that MDS assessments accurately reflected the medication regimen of one Resident (#100). This affected one (#100) of 17 Stage II sampled Resident assessments reviewed. Findings include:</p> <p>Review of the clinical record for Resident #100 on 11/15/11 revealed a diagnosis of dementia secondary to alcohol abuse and a medication order dated 08/05/11, for Seroquel (an anti-psychotic medication) 12.5 milligrams (mg) by mouth twice daily. Review of the medication administration record for September 2011 revealed that Resident #100 had received the medication as ordered. The MDS assessment completed 09/14/11 for the reference period ending 09/07/11 did not indicate that anti-psychotic medication had been used during the assessment period.</p> <p>During interview on 11/16/11 at 10:15 A.M., the Registered Nurse Minimum Data Set assessment Coordinator confirmed that the assessment did not accurately reflect the medications administered to Resident #100 during the assessment period.</p>	F 278		
F 279 SS-D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p>	F 279		

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

PRINTED: 11/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/16/2011
--	--	--	--

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
--	--

(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 279	<p>Continued From page 4</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 clinical record review and interview, the facility failed to develop a comprehensive plan of care for the use of psychotropic medications for one Resident. This affected one (#100) of three applicable residents of the 17 Stage II Residents reviewed for psychotropic medication use. Findings include:</p> <p>Per clinical record review on 11/15/11, Resident #100 was admitted on 04/21/11, with diagnoses of altered mental status, dementia secondary to alcohol abuse and possible Wernicke-Korsakoff syndrome. The physician's orders dated 11/01/11 through 11/30/11 revealed the Resident received Seroquel (an anti-psychotic medication) 25 milligrams (mg) one half tablet (12.5 mg) by mouth twice daily ordered 08/05/11, bupropion</p>	F 279	<p>F 279</p> <ol style="list-style-type: none"> 1. Care plan psychotropic drug use has been developed for resident #100 2. All residents receiving antipsychotic medication may be affected by this alleged deficient practice. 3. Audit all care plans for residents who receive antipsychotic medication to ensure that they are in place. 4. Random audits will be performed 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. <p><i>Bo. airta 12.12.11</i> <i>R. Trumbly / Hert</i></p>	12/14/11
-------	--	-------	--	----------

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

PRINTED: 11/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/16/2011	
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 06301		
(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 279	Continued From page 5 (an anti-depressant medication) SR 150 mg by mouth twice daily ordered 07/19/11, and lorazepam (an anti-anxiety medication) 0.5 mg by mouth twice daily as needed for agitation ordered 08/24/11. No plan of care for the use of these medications was located in the clinical record. Interview of the Licensed Practical Nurse (LPN) Unit Manager on 11/15/11 at 4:30 P.M. and on 11/16/11 at 10:30 A.M. confirmed that no plan of care for the use of anti-anxiety or anti-psychotic medication had been developed. The unit manager stated that it was his/her responsibility to update the plan of care when new orders were received between comprehensive assessments.	F 279		
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.	F 280	F 280 1. Care plan meeting for resident #33 was conducted, resident invited to attend. 2. Care plan for resident #39 reviewed and revised to ensure accuracy. 3. All residents may be affected by this deficient practice as alleged with resident #33 4. All residents receiving antipsychotic medication may be affected by the deficient practice as alleged for resident #39. 5. An audit of all care conference records and an audit of care plans of all residents who receive antipsychotic medication performed.	12/14/11

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

PRINTED: 11/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/16/2011
--	--	--	--

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
--	--

(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 280	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, facility staff failed to revise 2 of 17 comprehensive care plans (Residents #33 & #39). The facility failed to provide the opportunity for Resident #33 to participate in his/her quarterly comprehensive care planning review(s) and for Resident #39, the facility failed to revise the care plan when they were unable to obtain a ger-psych evaluation. Findings include:</p> <p>1. Per Interview with Resident #33, on 11/15/11 at 09:40 AM, s/he indicated that s/he had not participated in meetings with facility staff to discuss his/her plan of care. Per record review on 11/16/11 at 10:00 AM, Resident #33 was admitted to the facility on 12/8/09. Review of the medical record shows the resident has some short term memory issues but is able to make own decisions. There were no nurses notes reflecting that Resident #33 had been involved in discussions regarding his/her care. Review of the signature sheet for the quarterly and annual care plan meetings showed there was no entry reflecting that Resident #33 had attended care planning meetings since the initial admission care plan meeting in December 2009. Per interview with the Minimal Data Set (MDS) Director on 11/16/11 at 11:10 A.M., s/he indicated that the facility protocol was to send a letter of invitation to residents informing them of the opportunity to attend the care plan meetings to discuss the plan of care with the resident. The MDS Director was unable to provide a copy of any invitation letters to the resident. Per interview with the Director of</p>	F 280	<p>6. Process to retain all invitations to care conference developed. 7. Weekly random audits to be performed x4 then monthly x2 by DNS or designee to ensure continued compliance. 8. Results to be reported out at CQI monthly x3 at which time committee will decide process for further surveillance.</p> <p><i>Doc audit 12-12-11</i> <i>R. Timby 15</i></p>	12/16/11
-------	---	-------	---	----------

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

PRINTED: 11/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/16/2011
--	--	--	--

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
---	--

(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 280	<p>Continued From page 7</p> <p>Nursing Services on 11/16/11 at 2:54 PM, s/he confirmed that there was no record that an invitation had been sent to Resident #33 to attend his/her comprehensive care plan meetings.</p> <p>2. Per review on 11/15/11 of the comprehensive care plan for the 'use of psychotropic medications,' Resident #39's care plan had the intervention(s) 'psych eval & follow-up' checked off as being a completed intervention. Per interview on 11/16/11 at 11 A.M., the Unit Manager confirmed that although a geri-psych evaluation had been ordered by the NP (on 10/14/11) it had not been completed because a geri-psychiatric professional was not available at the facility. In addition, s/he confirmed the care plan had not been revised to reflect this. On 11/15/11 at 2 P.M. the nurse practitioner (NP) confirmed that because the facility did not have a geri-psychiatric professional available the resident had not yet had a geri-psych evaluation and at this time there was no diagnosis to support the use of an anti-psychotic drug.</p>	F 280		
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide services by qualified person(s) and in accordance with the written plan of care for 2 of 17 residents in the stage 2</p>	F 282	<p>1. Psychiatric consult obtained for Resident #39, #100</p> <p>2. All residents who have orders for a psychiatric consultation may be affected by this alleged deficient practice.</p> <p>3. All resident who receive antipsychotic medications shall be checked to ensure proper diagnosis for treatment is obtained.</p>	12/16/11

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

PRINTED: 11/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/16/2011
--	--	--	--

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
--	--

(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 282	<p>Continued From page 8 sample. (Residents # 38 & 100) Findings include:</p> <p>1. Per record review on 11/15/11 Resident #39's care plan for 'use of psychotropic meds' documented the interventions 'Psych eval and follow-up' had been completed for this resident. Per interview with the Unit Manager on 11/15/11 at 11 AM, s/he confirmed that because a gerl-psych professional had not been available at the facility, the gerl-psych evaluation and/or follow-up had not been completed. In addition, per interview on 11/15/11 at 2 PM the nurse practitioner (NP) also confirmed that the gerl-psych evaluation, ordered on 10/14/11 had not been completed because the facility did not have a gerl-psych professional to complete the evaluation and there was no diagnosis that would indicate the need for use of the resident's anti-psychotic medication.</p> <p>2. Per review of Resident #100's clinical record on 11/15/11, the Advanced Practice Registered Nurse (APRN) had indicated on 06/24/11 on the June 2011 physician's orders to administer lorazepam (an anti-anxiety medication) 0.5 milligrams (mg) by mouth twice daily and set up a psychiatric consult to evaluate and make recommendations for the treatment of increasing intrusive and angry behaviors. The 06/24/11 orders were initiated and dated 06/25/11 by facility staff. On 08/05/11, the physician documented on the August 2011 physician's order sheet to administer the lorazepam as needed and not routinely, to start Seroquel (an anti-psychotic medication) 12.5 mg by mouth twice a day routinely and to please follow up on the request for a formal psychiatric evaluation dated 06/24/11. These orders were initiated and</p>	F 282	<p>4. Random weekly audits will be performed x4 then monthly x 2 by DNS or designee to ensure continued compliance.</p> <p>5. Results to be reported out at CQI monthly x3 at which time committee will decide process for further surveillance.</p> <p><i>Doc audit 12.12.11</i> <i>R. Turley</i></p>	12/16/11
-------	---	-------	--	----------

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

PRINTED: 11/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/16/2011
--	--	--	--

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
--	--

(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 282	<p>Continued From page 9.</p> <p>dated 08/06/11 by facility staff. Further review of the record revealed no evidence of a psychiatric evaluation. Interview with the fourth floor Licensed Practical Nurse (LPN) unit manager on 11/16/11 at 10:30 AM confirmed that she had been unable to locate documentation of a psychiatric evaluation for Resident #100.</p> <p>Interview of the Director of Nursing Services (DNS) on 11/16/11 at 1:10 P.M. revealed that the facility had not had contracted psychiatric services in house for several months. S/he revealed that a psychiatrist had come once several months prior and had not come back. S/he verified that Resident #100 had not been evaluated by psychiatric services as ordered on 06/24/11 and 08/05/11. Interview of the Administrator on 11/16/11 at 1:20 P.M. revealed that there had been no in house psychiatric services in the facility since s/he was employed in June 2011. S/he stated that s/he was unable to reach the prior service after multiple attempts and had begun the process of contracting a new service in October 2011. S/he verified that psychiatric services were not available in the facility between June 2011 and 11/16/11.</p>	F 282		
F 329 SS=D	<p>483.26(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p>	F 329	<p>F 329</p> <ol style="list-style-type: none"> 1. Psychiatric consult obtained for Resident #39, #100 appropriate diagnosis identified for use of medication. 2. All residents who receive antipsychotic medication may be affected by this alleged deficient practice. 	12/16/11

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

PRINTED: 11/30/2011

OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

475023

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

(X3) DATE SURVEY COMPLETED

11/16/2011

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

(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 328

Continued From page 10

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interviews, 2 of 10 Residents in the applicable sample failed to be free of unnecessary drugs. (Residents # 39, 100). Findings include:

1: Per review of the clinical record for Resident #100 on 11/15/11, an admission date of 04/21/11 and diagnoses of dementia secondary to alcohol abuse with ataxia, anterograde amnesia, and possible Wernicke-Korsikoff syndrome were noted. Physician's orders were noted for Seroquel (an anti-psychotic medication) 25 milligrams (mg) one half tablet (12.5 mg) by mouth twice daily ordered 08/05/11, and lorazepam (an anti-anxiety medication) 0.5 mg by mouth twice daily as needed for agitation ordered 06/24/11. Review of the nurses notes revealed on 06/24/11 at 1:00 P.M. the nurse practitioner was updated on the increase in intrusive

F 329

3. All resident who receive antipsychotic medications shall be checked to ensure proper diagnosis for treatment is obtained.
4. Nursing staff shall be re-educated to ensure understanding of their roles to document behaviors.
4. Random weekly audits will be performed x4 then monthly x 2 by DNS or designee to ensure continued compliance.
5. Results to be reported out at CQI monthly x3 at which time committee will decide process for further surveillance.

R. Tremblay / S. 12.12.11

12/16/11

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

PRINTED: 11/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2011
--	--	--	--

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
--	--

(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 329	<p>Continued From page 11</p> <p>behaviors and angry outbursts noted by staff. New orders were noted. The nurse's notes from 4/21/11 to 08/24/11 revealed no documentation of intrusive behaviors or angry outbursts. Further review of the nurse's notes from 08/24/11 through 11/01/11 revealed no indication of intrusive behaviors and anger. No documentation was made in the nurse's notes from 11/01/11 through the date of the record review on 11/15/11. No documentation was noted to indicate the symptoms displayed by Resident #100 to require the use of anti-anxiety or anti-psychotic medication.</p> <p>Review of the comprehensive plan of care for Resident #100 revealed no indication that s/he had any behaviors or symptoms to indicate a need to receive psychoactive or psychotropic medications, nor the indications for the use of the medications or non pharmacological interventions that may be effective to reduce the anxiety and agitation of Resident #100. Review of the behavior/intervention monthly flow record for October 2011 indicated no instances of anxiety, agitation, or depression. The flow record for September 2011 indicated one instance of agitation on 9/22/11 day shift. The agitation was not defined or described.</p> <p>Interview of the fourth floor Licensed Practical Nurse (LPN) unit manager on 11/18/11 at 10:30 A.M. confirmed that the clinical record of Resident #100 did not contain appropriate diagnoses for the use of anti-anxiety and anti-psychotic medication. S/he verified that there was no plan of care for the use of the medications and no documentation of the intrusive and angry behaviors that were</p>	F 329		
-------	---	-------	--	--

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

PRINTED: 11/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/16/2011
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	
(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 329	Continued From page 12 mentioned in the 06/24/11 nurse's note prompting the initiation of the medications. Interview of the DNS on 11/16/11 at 1:15 PM confirmed that appropriate diagnoses for the use of psychotropic medications were not located in the record of Resident #100.	F 329		
F 371 SS=E	483.35(f) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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

PRINTED: 11/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/16/2011
--	--	--	--

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
--	--

(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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 371	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to store, prepare, distribute and serve food under sanitary conditions in two of the facility's unit kitchenettes. The findings include:</p> <ol style="list-style-type: none"> Per observation on 11/14/11 at 11:58 AM in the kitchenette on the third floor, the output vent directly over clean coffee cups and coffee maker was coated with a thick gray substance resembling dirt and dust particles. Per observation at 12:01 PM on 11/14/11, there was a dead bug carcass in a drawer in the kitchenette that contained packets of salad dressing. The cabinet directly under the coffee maker contained dirt matter, dirty folded cloth covers, foam insulation, an ant trap and a large opening exposing the sheet rock behind the inner back wall of the cabinet. On 11/14/11 at 12:40 PM the Director of Nursing Services (DNS) observed and confirmed the output vent directly over clean coffee cups and coffee maker was coated with a thick gray substance resembling dirt and dust particles, the presence of a dead bug carcass in a drawer in the kitchenette containing packets of salad dressing and that the cabinet directly under the coffee maker contained dirt matter, dirty folded cloth covers, foam insulation, an ant trap and a large opening exposing sheet rock behind the inner back wall of the cabinet and that this was a cause for concern. The DNS confirmed that residents on the unit had independent access to this area unsupervised. The DNS agreed on 11/14/11 at 12:40 PM the facility would cease 	F 371	<p>F 371</p> <ol style="list-style-type: none"> Kitchenettes on 3rd and 4th floor thoroughly cleaned. Ant traps removed and plumbing covered. All residents may be affected by these alleged deficient practices. All Kitchenettes have been cleaned. A process developed for scheduled cleaning. Housekeeping has been re-educated in relation to this process. Staff reeducated not to enter kitchenette while food is being served without a hairnet. Random weekly audits will be performed x4 then monthly x2 by Administrator or designee to ensure compliance. Results to be reported out at CQI monthly x3 at which time committee will decide process for further surveillance. <p><i>PC audit 12.12.11</i> <i>R. Trubly</i></p>	12/14/11
-------	--	-------	---	----------

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

PRINTED: 11/30/2011
FORM APPROVED
OMB NO. 0938-0397

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2011
--	--	--	--

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
--	--

(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 371	<p>Continued From page 14</p> <p>usage of items contained in the kitchenette until area was cleaned.</p> <p>2. During observation of the noon meal service on the fourth floor on 11/14/11 from 12:00 P.M. through 12:30 P.M., food was served from a steam table located in the center of the small kitchenette adjacent to the dining room. There was enough room to walk completely around the steam table. A coffee machine was located in the back, left corner of the room and a refrigerator in the front, left corner of the room. Condiments and beverages were located on the counter at the front, right corner of the steam table. Food was plated by a single Dietary staff person and passed through a small window to the nursing staff in the dining room for service to Residents. The single Dietary staff member plated the food wearing a hair covering and gloves. Throughout the meal service, three nursing staff members serving in the dining room were observed to frequently enter the kitchenette to access the coffee machine, the refrigerator and the condiments and beverages on the counter top as the food was uncovered and being served. No nursing staff was observed to apply a head covering before entering the kitchenette. Observation during the meal service revealed a vent above the steam table at the back of the kitchenette to be soiled with a dust like build up. The back wall inside the cabinet beneath the sink was observed to have two large holes approximately eight inches tall by 15 inches wide, exposing the plumbing.</p> <p>Review of the resident council meeting minutes dated 08/15/11 and 09/19/11 revealed that Residents suggested staff with long hair should</p>	F 371		
-------	--	-------	--	--

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

PRINTED: 11/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/16/2011
--	--	--	--

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
--	--

(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 371	Continued From page 15 tie it back when serving meals. One Resident complained that hair was observed in the food. Interview of the Dietary staff serving the fourth floor on 11/14/11 at 12:30 P.M. revealed that nursing staff frequently enter the kitchenette to get things and they do not put on a hair covering. Interview of the fourth floor Licensed Practical Nurse (LPN) unit manager at 12:45 P.M. confirmed that nursing staff enter the kitchen frequently to access supplies and they do not wear hair nets. The fourth floor LPN unit manager verified that staff walked around the uncovered food on the steam table multiple times during the food service with their hair uncovered. The LPN unit manager verified at that time that the exhaust fan vent above the steam table was heavily soiled with dust and the wall inside the cabinet beneath the sink contained two large holes exposing the plumbing.	F 371		
F 428 SS=D	483.80(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on review of pharmacy medication regimen reviews and recommendations and	F 428	F 428 1. Psychiatric consult obtained for resident #100 diagnoses for use of antidepressant, anti anxiety and antipsychotic drug obtained. 2. All residents who receive antidepressants, anti anxiety or antipsychotic medication are at risk related to this alleged deficient practice. 3. All residents who receive antidepressants, anti psychotics or anti anxiety medications have been have been audited to ensure proper diagnosis for use of these medication is in place.	12/16/11

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

PRINTED: 11/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/16/2011
--	--	--	--

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
--	--

(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 428	<p>Continued From page 18</p> <p>interview, the facility failed to act on a pharmacy recommendation to obtain an appropriate diagnosis for the use of anti-anxiety and anti-depressant medications and failed to obtain an appropriate diagnosis for the use of anti-psychotic medication identified on the medication review documented in the clinical record. This affected one (#100) of three sampled Residents reviewed for the use of psychotropic medications. Findings include:</p> <p>Per clinical record review on 11/15/11, Resident #100 was admitted on 04/21/11, with diagnoses of altered mental status, dementia secondary to alcohol abuse and possible Wernicke-Korsakoff syndrome. The physician's orders dated 11/01/11 through 11/30/11 revealed the Resident received Seroquel (an anti-psychotic medication) 12.5 mg by mouth twice daily ordered 08/05/11, bupropion (an anti-depressant medication) SR 150 mg by mouth twice daily ordered 07/19/11, and lorazepam (an anti-anxiety medication) 0.5 mg by mouth twice daily as needed for agitation ordered 06/24/11. The pharmacy medication regimen review documented in the record acknowledged on 07/22/11 the use of anti-depressant and anti-anxiety medication. The box next to no new suggestions was checked. The notes indicate no diagnosis was noted. The review dated 08/16/11 acknowledged the new order for anti-psychotic medication obtained 08/05/11. No recommendations were specified, the box indicating no new suggestions was blank. The notes indicated no diagnosis was noted.</p> <p>Interview of the Director of Nursing Services (DNS) on 11/16/11 at 1:15 P.M. revealed that the pharmacy had submitted a separate</p>	F 428	<p>4. Memo to MD's informing them of the need for acceptable diagnosis for use of anti depressants, antianxiety and antipsychotic medication.</p> <p>5. Staff re-educated as to acceptable diagnosis for treatment for residents receiving anti depressants, anti psychics and anti anxiety medication.</p> <p>6. Random weekly audits will be performed x4 then monthly x2 by DNS or designee to ensure compliance.</p> <p>7. Results to be reported out at CQI monthly x3 at which time committee will decide process for further surveillance.</p> <p>POC aunts 12.12.11. R. Ferby. <i>[Signature]</i></p>	12/16/11
-------	---	-------	---	----------

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

PRINTED: 11/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/16/2011
--	--	--	--

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
--	--

(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 428	Continued From page 17 recommendation form to the facility on 07/22/11 requesting a diagnosis to support the use of anti-anxiety and anti-depressant medications. The DNS indicated that follow up was done on 7/27/11 but was unable to locate documentation of supporting diagnoses in the record. The DNS did not produce a pharmacy recommendation form for the 8/19/11 visit or an appropriate diagnosis in the clinical record to support the use of the anti-psychotic medication ordered on 08/05/11.	F 428		
F 431 SS-E	483.80(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431	F 431 1. Outdated medication removed from the 2 nd and 4 th floor. All employee food items were removed from 2 nd floor medication refrigerator. 2. All residents who receive medication can be affected by this alleged deficient practice. 3. An audit of all medication storage areas was performed. All outdated medication was removed. All employee food was removed. 4. A process for routine monitoring for outdated medication has been put in place. 5. Nursing staff have been re-educated on the need to remove outdated medications as per this process and the proper places to store employee food.	12/16/11

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

PRINTED: 11/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/16/2011
--	--	--	--

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
--	--

(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 431	<p>Continued From page 18</p> <p>controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly store and dispose of expired medications. Findings include:</p> <p>1. Per observation on 11/14/11 at 6:50 A.M., there were expired medications in the second floor medication room and staff food stored in the medication refrigerator. A bottle of Ibuprofen oral suspension had expired 11/10 and a bottle of Vitamin D 400 International Units had expired 10/11. The 2 expired medications were opened and were located in the medication room cupboard. Additionally, there were two wrapped food items identified by the Unit Nurse as staff lunches in the medication refrigerator placed on top of medications. The Unit Charge Nurse confirmed these observations at 6:55 A.M. on 11/14/11 and stated s/he knew the food items should not be stored in the medication refrigerator.</p> <p>2. Per observation on 11/14/11 at 7:20 A.M. there were medications that were to be disposed of 28.</p>	F 431	<p>6. Random weekly audits performed x4 then monthly x2 by DNS or designee to ensure compliance.</p> <p>7. Results to be reported out at CQI monthly x3 at which time committee will decide process for further surveillance.</p> <p><i>PC met 12.12.11</i> <i>R. Trish</i></p>	12/16/11
-------	--	-------	---	----------

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

PRINTED: 11/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 478023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/16/2011
--	--	--	--

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

(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 431 Continued From page 19
days after opening on the 4th floor medication carts that were past the date of disposal. A vial of Novolog insulin opened 9/19/11 and a vial of Novolin R insulin opened 10/3/11 were found on the unit's medication carts. Per interview with the Unit Manager on 11/14/11 at 8:00 A.M. it is the facility policy to dispose of vials of insulin 28 days after opening. The Unit Manager confirmed both vials of insulin were past their disposal date and should have been removed from the carts.

F 431

Compliance date for
aforementioned plan of correction. 12/16/11
PDC *unt* *R. Hensby*
12.12.11 *SH*