

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 10, 2010

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
November 2, 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

RECEIVED
Division of
DEC 8 6 10

PRINTED: 11/16/2010
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 _____	Licensing and Protection (X3) DATE SURVEY COMPLETED C 11/22/2010
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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
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F 000	INITIAL COMMENTS	F 000		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to revise each plan of care to meet the resident's current needs for 1 resident in the targeted sample. (Resident #2) Findings include:</p> <p>1. Per interview and record review, staff failed to revise Resident #2's care plan to assure appropriate monitoring and treatment of an</p>	F 280	<p>F 280</p> <p>1. Resident #2's care plan has been reviewed, specialist recommendations fully implemented. No negative outcome</p> <p>2. All residents who receives consultative services have the potential to be effected by this alleged deficient practice</p> <p>3. Resident consults reviewed with MD orders obtained as needed.</p> <p>4. Nurses re-educated regarding process for informing MD and implementation of consult reports.</p> <p>5. A random weekly audit shall be performed by DNS or designee to ensure compliance with plan of correction. Results shall be reported to QAA committee monthly x3 months then frequency will by determined by committee</p> <p>F280 POC Accepted 12/10/10 RMCARN</p>	12/30/10 12/30/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE ADMINISTRATOR _____ (X6) DATE 12/3/10

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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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	Continued From page 1 exacerbation of a chronic medical condition. On 10/20/10, Resident #2 saw a specialist for the chronic medical condition, at which time specific recommendations were made regarding treatment for the condition. Per review of the plan of care for Resident #2 around the chronic condition, the plan of care was not revised to include any of the recommendations made by the specialist. Per interview with a Unit Nurse on 11/2/10 at 2:40 PM, staff was still awaiting clarifications of the recommendations from the specialist. Per review of the documentation from the visit on 10/20/10, not all recommendations require clarification, and some could have been implemented immediately. Per interview with Resident #2 on 11/2/10 at 10:50 AM, the recommendations voiced by the specialist during the 10/20/10 visit had not been implemented by the facility staff and s/he is experiencing difficulty with ambulation and experiencing discomfort as a result of the exacerbated chronic condition.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, staff failed to meet professional standards of quality regarding implementation of physician's orders and/or specialist recommendations for 2 of 4 residents in the targeted sample (Resident #3, #2). Findings include: 1. Per record review on 11/2/10 at 11:30 AM, staff	F 281	F 281 1. Resident #2 and 3's MD orders and Specialist recommendations have been reviewed implemented as needed. No negative outcome. 2. All residents have the potential to be effected by this alleged deficient practice. 3. Resident MD orders and consults reviewed. New MD orders obtained as 12/30/10 needed. 4. Nurses re-educated regarding process for implementation of MD orders, as well	

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NAME OF PROVIDER OR SUPPLIER PINE HEIGHTS AT BRATTLEBORO CENTER FOR NURSING & R			STREET ADDRESS, CITY, STATE, ZIP CODE 137 OAK GROVE AVENUE BRATTLEBORO, VT 05301		
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F 281	Continued From page 2 failed to follow a physician's order by leaving Resident #3 unsupervised in his/her room. The order, dated 9/30/10 read " Do not leave in room in wheelchair unsupervised". Per staff interview on 11/2/10 at 10:50 AM, Resident #3, who requires assistance of 2 staff for transfers, moved him/herself from his/her wheelchair to the bed. Per interview with Resident #3, who is alert and oriented, on 11/2/10 at 12:00 PM, s/he stated that s/he used the call bell but no one came to help and stated that s/he "waits a long time a lot" for assistance from staff. At 12:05 PM on 11/2/10, a Unit Nurse confirmed that the physician's order was not followed and that the Resident was left unsupervised in his/her room. 2. Per interview and record review, staff failed to implement recommendations regarding a exacerbation of a chronic medical condition for Resident #2. On 10/20/10, Resident #2 had a specialist for the chronic medical condition, at which time specific recommendations were made regarding treatment for the condition. Per review of the treatment sheet and plan of care for Resident #2 around the chronic condition, the recommendations have not been implemented. Per interview with a Unit Nurse on 11/2/10 at 2:40 PM, staff was still awaiting clarifications of the recommendations from the specialist. Per review of the documentation from the visit on 10/20/10, not all recommendations require clarification, and some could have been implemented immediately. Per interview with Resident #2 on 11/2/10 at 10:50 AM, the recommendations voiced by the specialist during the 10/20/10 visit had not been implemented by the facility staff, and s/he is experiencing difficulty with ambulation and experiencing discomfort as a result of the exacerbated chronic condition.	F 281	as informing MD and implementation of consult reports. 5. A random weekly audit shall be performed by DNS or designee to ensure compliance with plan of correction. Results shall be reported to QAA committee monthly x3 months then frequency will by determined by committee. <i>F281 POC Accepted 12/10/10 P. Mettern</i>	12/30/10 12/30/10	

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F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each resident receives adequate supervision and assistance devices to prevent accidents for 2 Residents in the targeted sample. (Resident #1, #4) Findings include:</p> <p>1. Based on interview and record review, the facility failed to provide the recommended constant supervision to Resident #1 to prevent accidents. Per record review, Resident #1 was heard calling for help and found on the floor in his/her room at 9:15 PM on 10/12/10. The resident was assessed and a new skin tear was observed on the left elbow, for which treatment was ordered. Per Nurses' Notes (NN) at 7 AM and 8:30 AM that same day, staff documented that the resident was requiring 1:1 monitoring due to anxiety. Per NN dated 10/8/10, the resident is anxious and agitated and required 1:1 monitoring until his/her spouse arrived. The NN states "Advised management...and requested 1:1 for pt through the night for pt safety and floor safety until medication effectiveness assessed." Per staff interview on 11/2/10 at 3:30 PM and 3:35 PM with 2 different nurses, the "management" identified in the note refers to the current</p>	F 323	<p>F 323</p> <p>1. Resident #1 and 4's Plan of care has been evaluated, recommendations implemented as needed. No negative outcome.</p> <p>2. Resident #4 call light in reach. Resident re-educated to call staff with call light so that they may assist her.</p> <p>3. All residents have the potential to be effected by this alleged deficient practice.</p> <p>4. Review of resident's plans of care will be performed to ensure full implementation 12/30/10</p> <p>5. Nursing staff re-educated for their role to ensure care plan is implemented as recommended. Nursing staff also re-educated as to their role in the process of proper placement and timely response to call lights. 12/30/10</p> <p>6. Random weekly audits to be completed by DNS or designee to ensure compliance with this plan of correction. Results to be reported out at CQI monthly x3 at which time committee will decide process for further surveillance. 12/30/10</p> <p><i>F323 POC Accepted 12/10/10 Amoturn</i></p>		

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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		
(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 323	Continued From page 4 administrator and a former supervisor. During the same interview, the staff members stated, respectively, that the fall could have been avoided if staff for 1:1 was provided, that management was informed about the need for 1:1 for this resident, and that there was no additional staff provided to assist with 1:1 supervision for the resident's safety. 2. Per interview and record review on 11/2/10, Resident #4 fell on 11/1/10, sustaining facial injuries due to lack of staff to provide timely assistance. Per interview with Resident #4 on 11/2/10 at 11:05 AM, the Resident stated that s/he stated that s/he had dropped something on the floor and could not reach the call bell to call for help. S/he also stated that s/he yelled for help but no one came. The Resident stated that h/she doesn't like to bother staff because they are understaffed, and attempted to _____, _____, _____ independently, at which time the fall occurred. This was confirmed by a Licensed Nursing Assistant (LNA) and by a Staff Nurse on 11/2/10 at 10:35 AM and 10:50 AM respectively.	F 323			
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 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. 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:	F 353	Resident #1,2,3and 4's Plan of care has been evaluated MD orders reviewed, recommendations implemented as needed. No negative outcome. All residents have the potential to be effected by this alleged deficient practice. Staffing patterns assessed by DNS and Administator		

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F 353	<p>Continued From page 5</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 family, staff and resident interviews and record review, the facility failed to assure 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 (including Resident #1, #2, #3, #4). Findings include:</p> <p>1. Per resident interview on 11/2/10 at 10:50 AM, Resident #2, who is alert and oriented, reported that there is not enough staff to meet his/her needs in a timely manner. Resident #2, who is dependent on assistance from staff to transfer to the toilet, reported that in the past week, s/he rang the call bell to request assistance to use the toilet, had to wait for around 15 minutes for staff to arrive, and as a result was incontinent of urine. S/he stated that this same thing has happened "a couple of times" since admission to the facility within the past 2 months. When the resident was asked how this made them feel, s/he responded "embarrassed." Per medical record review, no type of urinary incontinence is listed in the medical diagnoses.</p> <p>2. Per interview and record review, the facility</p>	F 353	<p>changes made as needed. Completed by 12/3/10 Staffing coordinator re-educated as to role to follow recommended staffing levels, and process for communication when these levels are not met. Completed by 12/3/10 DNS and Administator have developed a process whereby the communication will be improved between the staff, residents and families of the facility. Family communication will be improved by forming a Family Council that will meet quarterly with the DNS and Administrator, creating a family monthly news letter and re-educating families and residents on the grievance process which will encourage all parties to communicate to the facility administration when there are concerns. Staff communication will be improved by DNS rounds on all shifts to improve communication between</p>	
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F 353	Continued From page 6 failed to assure adequate staff to provide necessary and recommended care and services for Resident #1 to prevent accidents. Per record review, Resident #1 was heard calling for help and found on the floor in his/her room at 9:15 PM on 10/12/10. The resident was assessed and a new skin tear was observed on the left elbow, for which treatment was ordered. Per Nurses' Notes (NN) at 7 AM and 8:30 AM that same day, staff documented that the resident was requiring 1:1 monitoring due to anxiety. Per NN dated 10/8/10, resident is anxious and agitated and required 1:1 monitoring until his/her spouse arrived. The NN states "Advised management...and requested 1:1 for pt through the night for pt safety and floor safety until medication effectiveness assessed." Per staff interview on 11/2/10 at 3:30 PM and 3:35 PM with 2 different nurses, the "management" identified in the note refers to the current administrator and a former supervisor. During the same interview, the staff members stated, respectively, that the fall could have been avoided if staff for 1:1 was provided, that management was informed about the need for 1:1 for this resident, and that there was no additional staff provided to assist with 1:1 supervision for the resident's safety. 3. Per interview and record review on 11/2/10, Resident #4 fell on 11/1/10, sustaining facial injuries due to lack of staff to provide timely assistance. Per interview with Resident #4 on 11/2/10 at 11:05 AM, the Resident stated that s/he stated that s/he had dropped something on the floor and could not reach the call bell to call for help. S/he also stated that s/he yelled for help but no one came. The Resident stated that h/she doesn't like to bother staff because they are understaffed, and attempted to retrieve the object	F 353	staff and nursing management. DNS will review staffing everyday and sign off to ensure there are the appropriate amounts of staff on every shift. DNS will educate staff on time management and signs of burnout focusing on the responsibilities of the supervisory staff to identify and resolve and issues. DNS has reviewed LNA assignments and is now working with the LNAs to ensure that they are reasonable and all residents will receive care timely. This review will continue monthly. DNS will continue to do monthly staff meetings to encourage staff to bring issues to the table so resolutions can be developed. DNS will continue to meet weekly with management staff to review actual staffing for the previous week and to determine if the LNA assignments are		

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F 353	Continued From page 7 independently, at which time the fall occurred. This was confirmed by a Licensed Nursing Assistant (LNA) and by a Staff Nurse on 11/2/10 at 10:35 AM and 10:50 AM respectively. 4. Per record review on 11/2/10 at 11:30 AM, the facility failed to provide adequate staff to provide physician ordered services for Resident #3. The physician's order, dated 9/30/10 read " Do not leave in room in wheelchair unsupervised". Per staff interview on 11/2/10 at 10:50 AM, Resident #3, who requires assistance of 2 staff for transfers, moved him/herself from his/her wheelchair to the bed in his/her room. Per interview with Resident #3, who is alert and oriented, on 11/2/10 at 12:00 PM, s/he stated that s/he used the call bell but no one came to help and stated that s/he "waits a long time a lot" for assistance from staff. At 10:05 PM on 11/2/10 a Unit Nurse confirmed that the physician's order was not followed and that the Resident was left unsupervised in his/her room. 5. Per interview with 7 LNAs and 3 Registered Nurses (RNs) on 11/2/10, staffing has been insufficient to provide safe care to residents on the 2nd, 3rd and 4th floors. There has been as few as 1 LNA staff on a floor with 25 residents, 15-16 who require mechanical lifts and/or assist of 2 staff for transfers or repositioning. During a 10:25 AM interview on 11/2/10, an LNA stated that during a fire drill on 10/29/10, there was only 1 LNA and 1 nurse on the 4th floor. All staff reported that there is insufficient staff to provide toileting and other Activities of Daily Living (ADL) care to residents in a timely manner. Interviews with 2 family members of 4th floor residents on 11/2/10 were consistent regarding the lack of sufficient staff to provide necessary care and	F 353	appropriate and resident satisfaction levels are being met. Resident communication will be improved by DNS attending Resident Council Meetings monthly by invitation. DNS will develop an interview process whereby Social Worker, Recreation and nursing staff will interview residents randomly to determine if the care given to them is timely. Reports of the above findings will be reviewed by the Administator and DNS weekly until compliance is established and reported to the QA committee monthly for 3 months.		12/30/10
			F353 POC Accepted 12/10/10 AMCoturn		

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F 353 Continued From page 8 services. Both family members felt that residents were suffering as a result.

F 353

6. Per staff interview prior to the investigation date, a staff member reported that there was an unsafe staffing situation during the night shift that began on 10/21/10. Per review of the actual staffing sheets, provided by the facility and confirmed that it reflected actual staff on duty for each shift, for 10/21-10/22/10, there was a total of 3 nurses (1 for each floor) and only 2 total LNA staff for the whole building from 2:00 AM to 6:00 AM on 10/22/10. The staff member stated during the interview that every floor has residents that require 2 assist for various ADL's and transfers and felt that the staffing situation was unsafe. The staff member further stated that Administration did not provide additional staff for this night shift and also denied overtime pay for an LNA that was willing to stay and work the night shift.

F 360 SS=D 483.35 PROVIDED DIET MEETS NEEDS OF EACH RESIDENT

F 360

F 360
1. Resident #2 wishes for treatment have been determined diet orders obtained, Diabetes assessed. recommendations implemented as needed. No negative outcome.
2. All residents who are Diabetics have the potential to be effected by this alleged deficient practice.
3. All residents with Diabetes will have diet reviewed, Diabetes reassessed. Orders obtained as needed.

The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and medical record review, the facility failed to provide each resident with a diet that meets the special dietary needs of the resident for 1 applicable resident in the targeted sample. (Resident #2) Findings include:

12/13/2010

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F 360

Continued From page 9

Per observation, interview, and record review, Resident #2, who has diagnoses including Diabetes Mellitus, is not receiving a diet that meets the special dietary needs of the resident. Per resident and family interview on 11/2/10 at 10:50 AM, Resident #2 is not receiving a diabetic diet at the facility. During the interview, the resident stated that due to not receiving the correct diet, s/he has had to have injections of insulin, which s/he did not have prior to the recent hospitalization and admission to this facility. The resident reported having blood glucose levels that averaged around 100 mg/dl (milligrams per deciliter) in the home setting with oral medication and strict diet. The resident reported receiving breaded oven-fried chicken for the evening meal the prior night, french toast with maple syrup and bacon for breakfast the morning on 11/2/10, and per observation of the noon meal on 11/2/10, the resident was served a large portion of macaroni and cheese, and also offered a regular (non-diabetic) dessert that was reported by staff to be chocolate mousse with whipped cream.

Per review of the current physician's orders, Resident #2 is on a Carbohydrate Controlled Diet. Per interview with the dietician on 11/2/10 at 2:35 PM, she stated that in a long-term care setting, they prefer to offer a liberal diet and treat high blood glucose levels with medications. When the dietician was informed that Resident #2 is at the facility for short-term rehab, the dietician stated that the resident would be assessed the next day. Per review of the nutrition assessment sheets, the resident did not express that s/he did not want to continue a diabetic diet. Per review of the insulin sliding scale flowsheet for October, 2010, Resident #2 had blood glucose levels above 150

F 360

- 4. IDT staff re-educated as to roles and responsibilities regarding meeting special dietary needs of our diabetic residents.
- 5. Random weekly audits to be completed by DNS or designee to ensure compliance with this plan of correction. Results to be reported out at CQI monthly x3 at which time committee will decide process for further surveillance.

12/30/10

12/30/10

*F360 POC Accepted 12/10/10
AmcaturN*

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

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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 C 11/02/2010
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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 360	Continued From page 10 mg/dl, which required insulin injection for 91 of 123 opportunities, with blood glucose levels as high as 293 mg/dl. Per interview with a Unit Nurse on 11/2/10, Resident #2's diet is not restrictive and s/he does receive injections of insulin frequently for elevated blood glucose levels.	F 360		