

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

October 30, 2012

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

Provider #: 475023

Dear Mr. Rivers:

Enclosed is a copy of your acceptable plans of correction for the srecertification survey conducted on **October 3, 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,



Pamela M. Cota, RN  
Licensing Chief

PC:ne

Enclosure



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

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Division of  
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PRINTED: 10/15/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____  Licensing and Protection	(X3) DATE SURVEY COMPLETED  <b>10/03/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PINE HEIGHTS AT BRATTLEBORO CENTER FOR NURSING &amp; R</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>187 OAK GROVE AVENUE BRATTLEBORO, VT 05301</b>
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F 000	INITIAL COMMENTS	F 000		
F 253 SS=E	<p>An unannounced, on-site recertification survey was conducted by the Division of Licensing and Protection between October 1 and 3, 2012. The following deficiencies were identified:</p> <p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide necessary maintenance services for resident rooms and common living areas frequented by 28 residents of the facility's 4th floor unit. Findings include:</p> <p>1. Per observation during the initial facility tour on 10/1/12 at 11:00 A.M. and confirmed by a Licensed Practical Nurse (LPN) from the facility's 4th floor during a repeat of the tour on 10/3/12 at 11:45 A.M., the facility's 4th floor resident unit exhibited missing baseboard molding (molding where the wall meets the floor) in approximately 3- 4 foot sections on the wall across from the nurse's station, in the hallway by the elevator, and in the hallway near the showers. Additionally, in resident room #409 between resident's beds the baseboard molding was curling and no longer attached to the wall. The LPN also confirmed in resident rooms #415 and #418 the paper liner of the wallboard behind the beds was shredded in large sections exposing the inner core of gypsum plaster. Per interview with a maintenance person</p>	F 253	<p>F253 1. Cover base in 4th Floor hall will be replaced. Cover base between beds will be reattached in Rm.409, wall damage in Rm.#415 &amp; Rm.#418 will be patched and painted and loose handles on closet doors in Rm.#404 &amp; Rm.#406 will be replaced.</p> <p>2. All resident areas could be affected by this alleged deficient practice.</p> <p>3. Staff will be reeducated on reporting environmental issues and environmental rounds will be conducted on a regular basis and all negative findings will be followed up on.</p> <p>4. Review of environmental round reports will be audited by Administrator or designee to ensure compliance and will be reported CQI monthly x3 at which time committee will decide process for further surveillance.</p> <p><i>F253 POC accepted 10/26/12 [Signature]</i></p>	11/3/12 11/3/12 11/3/12 11/3/12

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

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.

*PMC*

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F 253	Continued From page 1 in room #415 on 10/3/12 at 11:40 A.M., the damaged walls required repair and painting. Also confirmed by the staff LPN during the 10/3/12 tour were broken and loose handles on closet doors in resident rooms # 404 and #406.  Per interview with the facility's Head of Environmental Services (HES) at 11:25 A.M. on 10/3/12 the baseboard molding "has been missing for a year. I notice it everyday." The HES reported that there were plans to renovate the 4th floor of the facility, but there was no exact month as to when the renovations would begin. The HES stated there were no immediate plans to repair the baseboards, and that upcoming renovations were not a reason for not replacing the molding. H/she also reported that with the present furniture loose and damaged handles were "a constant problem", and that the furniture also would be replaced but did not have a timeline for when that would happen.	F 253		
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	F 280		

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F 280	Continued From page 2 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 for 1 of 24 residents in the stage 2 sample (Resident #88). Findings include:  Per record review on 10/2/12, Resident #88's care plan did not reflect his/her current needs. Per review of the Minimum Data Sets (MDS), the resident had a decline in activities of daily living (ADL's) from extensive assist to total dependence for eating, toileting, bed mobility and transfers in the last 2 MDS assessments (5/7/12 - 7/17/12). Per interview with the Unit Manager on 10/3/12 at 8:34 AM, h/she confirmed that the care plan, including the Licensed Nursing Assistant plan of care had not been revised to reflect resident's current needs regarding ADL's.	F 280	F280 1. Resident #88 was evaluated and no negative outcome sustained and his care plan was reviewed and revised to ensure accuracy. 2. All residents having a change in ADL's may be affected by this alleged deficient practice. 3. Nursing staff will be educated to care plan review and revisions. Audits will be conducted to ensure MDS and care plans are consistent. 4. Audits will be performed by DNS or designee weekly x4 then monthly x2 to ensure continued compliance and results to be reported at CQI monthly x3 at which time committee will decide process for further surveillance.  <i>FABO POC accepted 10/26/12 Eldemann/PML</i>	11/3/12 11/3/12 11/3/12 11/3/12
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract	F 315		

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F 315	Continued From page 3 infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide appropriate services to 1 of 2 residents (Resident #23) reviewed with an indwelling Foley catheter. The findings include:  1. Per record review, Resident #23 was admitted to the facility on 12/22/11 with diagnosis that included urinary retention and an indwelling Foley catheter was in place. Per review of the bladder training assessment dated 12/27/11, Resident #23 had the indwelling Foley catheter placed on 12/22/11 for urinary retention which was a new diagnosis and the urinary retention issue was noted on 12/11/11 during a hospital stay. The assessment indicated that the plan was to maintain the catheter as ordered/per policy. Per the bladder assessment dated 3/16/12, Resident #23 had the indwelling catheter removed on 1/9/12 and than reinserted on 1/9/12 for urinary retention, secondary to residents inability to void and discomfort. The assessment dated 3/16/12 also indicates that Resident #23 is prone to urinary tract infections (UTI) and had a diagnosis of a UTI on 1/6/12.  Per medical record review, the Nurse Practitioner (NP) documented on 1/18/12 that Resident #23 had urinary retention and will re-evaluate the need for a indwelling catheter after the results of scheduled CT scan are obtained. The NP also documented that Resident #23 would have a trial to see if catheter can be removed. Per review of	F 315	F315 1. Resident #23 has an appointment to be evaluated by a Urologist. 2. All residents with a Foley catheter may be affected by this alledged deficient practice. 3. All residents with Foley catheters will be audited to ensure a follow up with a Urologist if indicated. 4. Licensed Nursing staff will be educated to F315. 5. Audits will be performed by DNS or designee weekly x4 then monthly x2 to ensure continued compliance and results to be reported at CQI monthly x3 at which time committee will decide process for further surveillance.  <i>F315 POC accepted 10/26/12 G Coleman RN/PMC</i>	11/3/12 11/3/12 11/3/12 11/3/12 11/3/12	

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F 315	Continued From page 4 the NP notes dated 1/20/12, Resident had hematuria (blood in the urine) and there was a question of the resident having a UTI and cultures were obtained. On 1/25/12 the NP documents that Resident #23 has a diagnosis and being treated for a UTI and has hematuria. Per review of the NP documentation, Resident #23 was diagnosed and treated again for UTI's on 6/21/12, 8/13/12 and 9/4/12.  Per review of the CT report dated 1/25/12, the report indicates that Resident #23 has a Foley catheter in place and the scan when compared to one done on 12/15/11 there are noted changes and that further follow-up is recommended. Per review of the medical record there was no evidence that any follow up regarding the cause of Resident #23's urinary retention was documented.  Per interview with the Director of Nursing (DNS) and Nurse Practitioner (NP) on 10/3/12 they reviewed the medical record of Resident #23 and confirmed that Resident #23 had an indwelling Foley catheter from 12/22/11 to 10/3/12 with a diagnosis of urinary retention. The DNS and NP confirmed that Resident #23 had failed two bladder training evaluations for removing the catheter and had several diagnosed UTI's from 1/20/12 to 9/4/12. The DNS and NP also confirmed on 10/3/12 after reviewing the medical record that there was no evidence that Resident #23 had any follow up per the recommendations on the CT scan dated 1/25/12 and that urology had not been contacted regarding Resident #23's on going urinary retention since admission on 12/22/11.	F 315			
F 318	483.25(e)(2) INCREASE/PREVENT DECREASE	F 318			

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F 318 SS=D	Continued From page 5 IN RANGE OF MOTION  Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 2 residents in the stage 2 sample (Resident #1) received appropriate care and services to increase range of motion and/or prevent further loss of range of motion. Findings include:  Per record review on 10/2/12 at 3:00 P.M., the facility failed to provide a physical therapy (PT) evaluation and treatment as ordered by the physician for Resident #1. There is an MD order dated 9/9/12 for a PT evaluation and treatment to address Resident #1's bilateral lower extremity contractures. A contracture is defined as abnormal shortening of muscle tissue, rendering the muscle highly resistant to passive stretching. During a 10/3/12, 9:52 A.M. interview with the Therapy Manager, h/she confirmed that the PT evaluation and treatment had not been done as ordered by the physician.	F 318	F318 1. Resident #1 was evaluated & assessed to have no negative outcome sustained and has been evaluated by Physical Therapy for bilateral lower extremity contractures. 2. Residents with contractures with MD orders for therapy evaluations may be affected by this alleged deficient practice. 3. Residents with contractures will be audited to ensure MD orders and therapy screens have been carried out. 4. Random audits will be performed by <del>DNS</del> or designee weekly x4 then monthly x2 to ensure continued compliance and results to be reported at CQI monthly x3 at which time committee will decide process for further surveillance.  <i>F318 POC accepted 10/26/12 G Coleman/PWC</i>	11/3/12  11/3/12 11/3/12 11/3/12