

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

PRINTED: 12/15/2009  
FORM APPROVED  
OMB NO. 0938-0391

JAN 14 2010



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  12/16/09
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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

An unannounced, on-site recertification survey was completed on 12-16-2009

F 152 483.10(a)(3)&(4) EXERCISE OF RIGHTS  
SS=D

In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf.

In the case of a resident who has not been judged incompetent by the State court, any legal surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law.

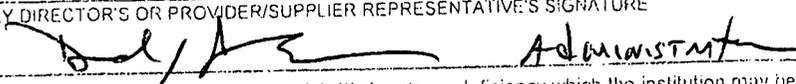
This REQUIREMENT is not met as evidenced by:  
Based on observations, interview and record review, the facility failed to ensure resident rights were protected and promoted in regards to the use of artificial nutrition for 1 of 5 applicable residents. (Resident #12) Findings include:

1. Per review on 12/15/09 of Advanced Directives, Resident #12 had stated over 13 years ago their wishes were to ".....decline all treatment including artificial nutrition". Per observation, Resident #12 presently has a feeding tube and is receiving nutritional feedings artificially due to dysphagia (difficult swallowing) after experiencing a CVA (Cerebral Vascular Accident). Per nursing notes, for 10/23/09, 11/7/09 and 11/30/09, the resident has disconnected him/herself from the feeding tube, has repeatedly requested to be given oral nourishment and was found on 7/16/09 drinking his/her roommates soda. In addition, the

This plan of correction is the facility's credible allegation of compliance. The filing of this plan does not constitute an admission that the deficiencies alleged did in fact exist. This plan of correction is filed and executed as evidence of the facility's desire to comply with the provisions of federal and state law, and to continue to provide quality care and services.

F152

F152 Resident # 12 has been evaluated by speech therapy and a MBS has been completed. ST is currently seeing him to evaluate ability to tolerate oral feedings. A Meeting has been set up with his family and physician for January 14<sup>th</sup>. All the residents that have MD orders for tube feedings have the ability to be affected. The DNS will review all Advanced Directives of residents with tube feedings to ensure residents rights are being followed. All Licensed Staff will be inserviced on Resident Rights. The Social Worker will audit all Advance Directives quarterly during the quarterly Inter-disciplinary Team Meeting to ensure compliance. She will report any

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 1-13-10
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 152 Continued From page 1  
resident has attempted ingestion of non-food items on 9/20/09 and 10/26/09. On 12/14/09 the resident was visited by his/her physician and again requested to receive oral intake. Subsequently, the physician ordered "A full liquid lunch at noon starting on 12/15/09". Per interview on the morning of 12/16/09, the Director of Nurses (DNS) confirmed prior Social Service documentation dated in 1996, Resident #12 had consented to a feeding tube while hospitalized. However the DNS concurred since that time, recent behaviors and actions by Resident #12 may indicate nonacceptance of the artificial feedings and despite having a health care agent acting on Resident #12's behalf regarding health care decisions, the facility has not presently ensured the decision rights of the resident are protected and promoted as they pertain to the continuation of artificial feedings or to have the opportunity to select from other health alternatives.

F 152  
negative findings immediately to the Administrator and DNS in order to ensure compliance. The Social Worker will be responsible for compliance.  
Date of Completion 1-25-10  
*Agreement per T.C. & Administrator on 1-14-10 to rec. DNS to report findings to CQI comm. for 3 months.*  
*POC Accepted & Agreement Doneg. Thonby, RN nurse supervisor*

F 157 483.10(b)(11) NOTIFICATION OF CHANGES  
SS=D  
A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in

F 157  
Resident # 12's MD was notified on 12/15 at 5 pm that the order for oral feeding was being held pending the Speech Evaluation. All residents may be affected when a physician writes an order that is unclear or deemed unsafe to follow. When the nurse identifies a physician order that cannot be followed the DNS will be notified immediately and the MD will be notified in a timely manner. The nurse will also document this on the 24 hour report and in the nurses notes.

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			(X5) COMPLETION DATE

F 157 Continued From page 2  
§483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:  
Based on interview and record review the facility failed to notify and consult with the physician when staff were unable to comply with an order received by the physician for 1 of 15 residents. (Resident #12) Findings include:

1. Per review on 12/15/09 of physician orders, Resident #12's attending physician had ordered on 12/14/09 "Full liquid lunch at noon starting on 12/15/09, reduce total volume of G-tube feed by 1/3, update MD on Friday 12/18/09". Due to circumstance regarding Resident #12's ability to tolerate "full liquids", nursing staff determined not to comply with the physician's order noting on the resident's care plan " Hold orders of 12/14/09 re: po intake due to aspiration risk". However, per interview on the morning of 12/16/09, the DNS confirmed staff had failed to contact the physician regarding their concerns and their inability to comply with the order without first obtaining consults from the Speech Language Pathologist

F 157

All licensed staff will be in serviced on this policy regarding MD Notification.

The Day Supervisor will audit the charts of residents noted to have physician orders that cannot be followed as written.

The DNS will be responsible for compliance.

The Date of Completion will be 1-25-10.

*Amendment per T.C. on 1-14-10 to Admin. To read: "DNS to report findings at CQI meeting for 3 months". P.D.C. accepted with Amendment.*

*Wang, J. 12/16/09*

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F 157 Continued From page 3 and the Dietician.  
F 164 483.10(e), 483.75(l)(4) PRIVACY AND SS=D CONFIDENTIALITY

The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:  
Based on observation and interview, facility staff failed to provide privacy during a respiratory treatment for 1 applicable resident in the targeted sample. (Resident # 18) Findings include:

F 157

F 164 F164

The nurse involved with resident #18 is no longer employed. All residents who have orders for respiratory treatments may be affected. Residents currently requiring respiratory treatments are being provided with privacy. All licensed staff will be inserviced on the policy Regarding administration of respiratory treatments. The Day and Evening Supervisor will monitor for compliance on resident rounds. Negative findings will be reported to the DNS immediately for resolution. The DNS will report on findings at the CQI Meeting for three months.  
Date of Completion: 1-25-10.

*PDC accepted on 1-14-10*  
*Danny [Signature]*  
*[Signature]*

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F 164 Continued From page 4

F 164

1. Per observation on 12-14-09 at 4:25 PM, during a medication administration observation, the medication nurse failed to provide Resident # 18 privacy during the administration of a nebulizer treatment. This procedure was attempted in the small sitting area across from the nurses station, at a busy time of the day, prior to the evening meal being served. Numerous staff and other residents were observed passing by. Per interview, during the medication administration, the nurse stated that Resident # 18 was not compliant with the treatment and declined to finish it. Per interview on the afternoon of 12-15-09 the nurse confirmed the treatment should have been conducted in the privacy of Resident # 18's room.

F 226 483.13(c) STAFF TREATMENT OF RESIDENTS  
SS=D

F 226

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:

Based on observation and staff interview, the facility failed to complete a Vermont Crime Information Center (VCIC) check on 1 of 5 new employees and failed to request a waiver for an individual whose background check revealed a misdemeanor charge. Findings include:

1. Per review of employee records for new hires on 12/15/09 at 11:14 am, the facility failed to conduct a VCIC background check for 1 of 5 employee records that were reviewed. This was confirmed during staff interview with the Director

F 226

A waiver will be requested for the new hire with a misdemeanor charge that was revealed on the Vermont Crime Information Center (VCIC) check.

No residents were affected.

A review was conducted of all new hires in the past six months and no conditions occurred where a waiver would be required.

In the future, the Human Resource Manager will give the Administrator the new hire folder with completed contents. The Administrator will check it for VCIC completeness prior to the new hires' first day of work.

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F 226 Continued From page 5 of Human Resources on 12/15/09 at 11:40 am. F 226

2. Per review of employee records for new hires on 12/15/09 @ 11:14 am, the facility failed to obtain a waiver from the Division of Licensing and Protection (DLP) to offer employment to an individual whose VCIC background check revealed a misdemeanor charge. This was confirmed during staff interview with the Director of Human Resources on 12/15/09.

Should a waiver be necessary, the request will be made. The Administrator will monitor for compliance. Date of Completion: 1-25-10

*POC accepted on 1-14-10  
Dana Tremblay RN  
Nurse Surveyor*

F 246 483.15(e)(1) ACCOMMODATION OF NEEDS SS=D F 246

A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

F 246 Resident # 9's call bell is now being placed on both sides of the bed for resident convenience. The LNA was counseled on not following the policy for placement of call bells. Resident # 5's call bell is now placed within acceptable reach. All residents may be affected. Nursing staff will be inserviced on call bell placement. Supervisors will monitor during rounds to ensure compliance. Negative findings will be reported to CQI Committee monthly x 6 months. The DNS will be responsible for compliance. Date of Completion: 1-25-10

*POC accepted on 1-14-10  
Dana Tremblay RN  
Nurse Surveyor*

This REQUIREMENT is not met as evidenced by:  
Based on observation and confirmed through interview, facility staff failed to assure call bells were accessible for 2 of 19 Residents in the targeted sample. (Residents # 5 and # 9)  
Findings include:  
1. Per observation at 12:50 PM on 12/14/09, Resident # 9, with a diagnosis of dysphasia, was observed alone, in the bedroom, seated in the reclining chair with no call bell accessible. The Resident was banging on the side of the chair. Staff brought the resident a call bell, after the incident was brought to their attention by the Nurse Surveyor. On the following morning at 8:50 AM surveyor observed Resident # 9 in bed asleep, with the call bell wrapped around the left

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F 246	Continued From page 6 side rail of the resident's bed. Resident # 9 has left sided hemiparesis and would not be able to access the call bell. The staff repositioned the call bell to the resident's right hand after the Nurse Surveyor brought the issue to their awareness.  2. Per interview on 12/15/09 at 10:00 AM, Resident #5 stated earlier in the morning s/he was unable to call staff to request assistance with repositioning in their bed because the call bell was not left accessible to reach. Resident #5 stated s/he called to their roommate for help who used their call light to obtain the attention of staff for Resident #5.	F 246		
F 278 SS=B	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  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	F 278	F278 Resident #12's pummel cushion has been evaluated by rehab and has been discontinued. Resident # 4's pummel cushion has been evaluated by rehab and has been discontinued. All residents using pummel cushions in their chairs may be affected. The DNS has reviewed the evaluations and care plans of all residents with pummel cushions to ensure compliance. The MDS Coordinator will monitor and audit charts of residents using pummel cushions to ensure they are coded accurately. Date of Completion: 1-25-10	

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F 278 Continued From: page 7  
penalty of not more than \$5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:  
Based on record review and interview, the facility failed to accurately code for the use of a pommel cushion on the Minimum Data Set (MDS) assessment for 2 of 4 residents in the targeted sample. (Residents #4 and #12) Findings include:

F 278

*Response per T.C. on 1-14-10 to Admin. To read: "DWS To report findings at CQI meeting for 3 months." D.O.C. accepted with acknowledgment. Dany [Signature]*

1. During days of survey, both Resident #4 and #12 were observed sitting in wheelchairs on pommel cushions (a contoured cushion which can be used as a restraint to prevent a resident from rising from a wheelchair or to assist in positioning and reduce slipping out of the chair). The MDS coding for Resident # 4 (10/29/09 quarterly assessment) and for Resident # 12 (12/3/09 quarterly assessment) failed to accurately reflect for "Devices and Restraints" P4e "A chair that prevents rising". Per telephone interview on the morning of 12/16/09 the MDS coordinator confirmed by using the pommel cushion in the residents' wheelchairs it does create "a chair that prevents rising".

F 279 483.20(d), 483.20(k)(1) COMPREHENSIVE SS=D CARE PLANS

F 279

F 279  
Resident # 12's care plan has been reviewed and revised; staff caring for him have been in serviced on his plan of care which includes a coded locked drawer for his care

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care

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F 279 Continued From page 8

F 279

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.

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).

This REQUIREMENT is not met as evidenced by:

Based on staff interview and record review, the facility failed to developed and revise care plans to reflective measurable objectives and timetables to meet the needs of 2 of 15 residents in the total sample. (Residents # 11, 12) Findings include:

1. Per review on 12/15/09 of nursing notes, Resident #12 had an incident on 9/20/09 of ingesting periwash. Although the care plan dated 9/21/09 identified the problem of ingesting non-food items by Resident #12, it failed to include in the interventions a plan to keep periwash and other toiletries and non-food items in a location that was not accessible to the resident. Refer to Tag: F323

2. Per record review on 12/15/09 Resident #11's care plan did not address the current restorative needs as recommended by Physical Therapy

items. In addition, his roommate will also have a locked cupboard for care items. Residents who have been identified as having a potential to ingest non-food items may be affected. These residents have had their care plans and LNA assignments revised. Nursing staff have been inserviced on how to develop a plan of care to prevent and monitor residents who have the potential to ingest non-food items.

Charge nurses on each shift will audit rooms of residents identified and will document this on the MAR. The Day Supervisor will audit the MARs for compliance and randomly spot check rooms of identified residents. Negative findings will be reported to the DNS/designee immediately for resolution.

The DNS will report to CQI Committee monthly x 3.  
DNS will monitor for compliance.

Date of Completion: 1-25-10.

Resident # 11's Restorative program has been added to the care plan.

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F 279 Continued From page 9 dated 12/10/09. The mobility and transfer status, as well as goals and interventions, were not indicated on the care plan. Per interview on 12/16/09 at 8:45 AM the DNS confirmed that a Restorative Care Plan was not developed for Resident #11.

F 279

All residents in a restorative program may be affected. The Restorative Nurse will be responsible for ensuring careplans are accurate.

F 280 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE SS=D CARE PLANS

~~F 280~~

DNS will audit careplans of residents who are currently on restorative programs. The DNS is responsible for compliance.

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.

Date of Completion: 1-25-20

*not accepted on 1-14-10*  
*[Signature]*

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 Resident # 2's care plan has been updated. Residents who have had changes in the plan of care may be affected. All resident care plans will be audited to ensure accuracy. The DNS has developed a policy whereby the MDS Coordinators receive all Telephone order slips and transcribe new orders onto the care plans. In addition, the Day Supervisor will review all MD orders and care plans after MD visits to ensure care plans are updated timely. DNS will monitor compliance by auditing 10% of care plans and report to CQI quarterly. Date of Completion: 1-25-10

This REQUIREMENT is not met as evidenced by:  
Based on staff interview and record review, the facility failed to revise the care plan to reflect each resident's current needs/status for 1 applicable residents in the sample. (Resident #2) Findings include:

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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)

F 280 Continued From page 10

Per record review on 12/14/2009, Resident # 2's care plan stated that the resident is to have passive range of motion (PROM) exercises to the upper and lower extremities as well as chest physical therapy (chest P-T). Upon review of the orders dated 11/05/09, a discontinuation of the PROM and chest P-T was ordered. During an interview on 12/16/09 at 8:45 AM the Director of Nursing/Unit manager (DNS) confirmed that the current care plan had not been revised to reflect the current status of the Resident.

F 281 483.20(k)(3)(i) COMPREHENSIVE CARE PLANS SS=D

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:  
Based on observations, interviews and record review, the facility failed to ensure professional standards of quality were met as they pertain to following physician orders, the delivery of enteral feedings and the administration of medications with potential interaction 2 of 3 applicable residents. (Residents #1, 2, 12) Findings include:

1. Per review of the Medication Administration Record (MAR) for Resident #12, Dilantin 300 mg (liquid form) via g-tube was administered each evening while the resident was receiving a enteral feeding of Glucerna. Per telephone interview at 11:15 AM on 12/16/09, the facility pharmacist confirmed nursing staff should wait at least 1 hour before and after the administration of Dilantin before initiating enteral feedings due to potential interaction between the medication and the formula. The error was confirmed by the DNS on 12/16/09 at 11:16 AM.

F 280

*POC accepted on 1-14-10*  
*David [Signature]*  
*Unit Supervisor*

F 281

Resident # 12's Dilantin is now Administered at a time that does not interfere with his tube feeding.

All residents who have tube feedings and Dilantin may be affected. Licensed staff will be educated regarding the policy of administering Dilantin with a tube feeding.  
The Consultant Pharmacist will monitor compliance during the monthly visits. Negative findings will be reported to the DNS for immediate resolution and to the CQI Quarterly Meeting.

F 281

Residents #1's MD was Notified that total dose of Sertraline was not given. There was no negative outcome. The nurse responsible has been counseled.

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F 281 Continued From page 11

F 281

2. Per record review on 12/14/09 the nurse failed to give Resident #1 the correct dose of an anti-depressant medication. The physician order was for Sertraline 150 mg (milligrams) PO (by mouth) QD (daily). As indicated on the Medication Administration Record (MAR) the dose was to be given as Sertraline one 100 mg tablet as part of the 150 mg dose and one Sertraline 50 mg tablet as part of the 150 mg dose. Per interview on 12/15/09 at 10:40 AM, the staff nurse confirmed that s/he administered Sertraline 100 mg and that s/he should have given the resident Sertraline 150 mg dose but the 50 mg tablet was not available on the unit. The nurse acknowledged that the facility procedure to obtain medication from an outside pharmacy was not implemented. Per interview on 12/15/09 at 10:50 AM the Director of Nursing Service confirmed that the correct dose of medication was not given and that the procedure to obtain a medication not available in the facility was not implemented.

3. Per record review and observation on 12/14/09, nursing staff failed to elevate the legs of Resident #1 as directed by a physician order dated 9/8/09 which stated "Elevate legs as tolerated when OOB (out of bed)" and a physician order dated 11-1-09 which stated "Elevate legs." The resident was observed on 12/14/09 sitting in a wheelchair next to the bed at 10:30 AM, 1:30 PM, 4:15 PM and 5:00 PM with feet flat on the floor. On 12/15/09 at 10:35 AM a staff nurse confirmed that the Care Plan for this resident stated "Elevate legs when OOB." and the legs were not elevated as ordered.

4. Per record review and observation nursing staff failed to follow Professional Standards of

All residents receiving medications may be affected. Nursing staff have been re-inserviced on the procedure to re-order and or obtain medications. The supervisor will be notified when a medication is unavailable. The Day Supervisor will audit the MARs to ensure all medications are given. Reports of audits will be reviewed by DNS and CQI Committee quarterly x 3 months.

Resident #1's order for "elevate legs when OOB" has been re-evaluated by the physician and it has been discontinued and the careplan has been revised. Residents with specific orders to elevate legs may be affected. Resident care plans and LNA Assignments have been audited to ensure all care plans are being followed. Supervisors/Charge Nurses will make rounds twice during the shift using the LNA Assignments to ensure all care plan interventions are

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F 281 Continued From page 12  
Practice by not checking the residual [amount] of Resident #2's N-G tube prior to a feeding and medication administration. Per review of the MAR [medication administration record] and the Facility's Policy, as well as an physicians's order, Nursing is directed to check placement and the residual of the N-G tube. Per observation on 12/14/09 at 2:15 PM, Nursing checked placement however, failed to check for any residual amount. In addition, per review of the MAR, there was no documentation on 12/10/09 and 12/11/09, day shift, and 12/12/09 and 12/13/09, evening shift, that placement and residuals were checked. Per interview on 12/15/09 at 2:05 PM, the nurse confirmed that the residual was not checked prior to administration of the feeding or medication.

F 282 483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS  
SS=D  
The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:  
Based on record review and observation the facility failed to implement the care plans for 2 of 18 residents in the targeted sample (Resident #1, #2). Findings include:

1. Per record review and observation on 12/14/09, the nursing staff failed to elevate the legs of Resident #1 when out of bed (OOB) as directed in the " Skin at Risk - Pressure Stasis " Care Plan section for the resident. The resident was observed on 12/14/09 sitting in a wheelchair next to the bed at 10:30 AM, 1:30 PM, 4:15 PM

F 281  
being followed. Negative findings will be resolved immediately and reported to the DNS for follow-up. Reports of audits will be reviewed at CQI Committee quarterly x 3 months.

Resident #2's NG tube is being checked for residual per facility policy and documented appropriately. Residents with feeding tubes may be affected. The DNS has reviewed all MARs of residents with tube feedings to ensure residual is being checked prior to administering medications. Licensed Nurses have been re-inserviced on policy regarding administering medications via feeding tube. The facility will check tube feeding competency of all nurses during orientation and annually. Day Supervisor and SDC will randomly check competencies and audit MARs for completeness. Audits with negative findings will be reviewed by DNS and CQI Committee for Appropriate interventions x 3 months.

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OMB NO. 0938-0391

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F 282 Continued From page 13  
and 5:00 PM with feet flat on the floor. On 12/15/09 at 10:35 AM a staff nurse confirmed that the legs were not elevated when the resident was out of bed.

F 281

SDC will monitor compliance.  
Date of Completion: 1-25-10

*PDC Accepted 02-1-10-10*  
*Dawn [Signature]*  
*Director of Nursing*

2. Per observation and record review the nursing staff failed to reposition and apply assistive devices as care planned for Resident #2. Per the medical record, the care plan directs staff to reposition every 2 hours and to apply bilateral hand rolls. Per observation on 12/14/09 at 2:00 PM until 5:45 PM, Resident #2 was lying continuously on his/her right side and without bilateral hand rolls. On 12/15/09 at 8:15 AM until 12 Noon, no hand rolls were observed. Per interview on 12/15/09 at 2:05 PM the Nurse confirmed the resident was not repositioned and devices applied as per the care plan.

F 282

Resident #1 has had the MD order to elevate legs discontinued. See 281 #3

Resident #2 has had a turning and repositioning evaluation assessment based on tissue perfusion which indicates the resident needs to be repositioned every three hours.

F 318 483.25(e)(2) RANGE OF MOTION  
SS=D

*282*

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.

The care plan reflects this need and the LNAs caring for the resident have been inserviced. All residents that need assist with turning and repositioning may be affected. The DNS has reviewed care plans of all residents that need assist with repositioning, revising if necessary.

This REQUIREMENT is not met as evidenced by:  
Based on interviews and record review, the facility failed to consistently provide Range of Motion (ROM) exercises for 1 of 19 residents in the targeted sample. (Resident #19) Findings include:

Nursing staff has been re-inserviced on facility policy regarding repositioning. Charge Nurses will make rounds to ensure identified residents are being turned per their individual schedule. Shift

1. Per interview on 12/15/09 at 8:15 AM, Resident #19, who is dependent on staff for stretching and Passive ROM exercises due to mobility issues,

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F 318 Continued From page 14  
stated that due to staffing issues, the exercises are not consistently performed by staff. Per interview on 12/15/09 at 12:05 PM, the Restorative LNA (Licensed Nursing Assistant) confirmed stretching exercises were added to the ROM program in October 2009 and that instructions were then delegated to the evening shift LNAs assigned to provide care to Resident #19. However, when discussing the schedule of upper and lower extremity ROM/Stretching exercises on the afternoon of 12/15/09, the evening nursing supervisor stated the day shift LNA staff are expected to do the leg stretching exercises for Resident #19 and the evening shift LNA staff is responsible for the upper extremity ROM exercises. Per record review of December 2009 LNA "Resident Care Flowsheet" for Resident #19, from 12/5/09 to 12/15/09 ROM exercises were not recorded on either the day or evening shift with the exception of evening shift on 12/8/09 and 12/9/09. The Resident reported when the ROM and new stretching exercises are not performed she/he notices a difference in the limited mobility of their extremities.

~~F 318~~  
F 282

supervisors will audit randomly to ensure compliance and will report negative findings to CQI Committee for further resolution.  
Staff development will monitor for compliance.  
Date of Completion: 1-25-10

*DOC ACCEPTED 02-1-14-10*  
F 318 *and [unclear]*

F 318

Resident # 19's Range of Motion has been reviewed by the Restorative Nurse in conjunction with the MD and PT. The Restorative LNA has been assigned to do these exercises daily and document on the flow sheet. The Social Worker will interview the resident daily to ensure he is satisfied with his care. All residents requiring ROM may be affected. The Restorative Nurse has identified all residents that need ROM/Stretching exercises and their care plan and LNA Assignments have been reviewed for accuracy. The LNAs assigned to these residents have been instructed on how to proceed with their care. The Restorative Nurse will audit the flow sheet documentation for

F 323 483.25(h) ACCIDENTS AND SUPERVISION  
SS=D

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.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview and record review, the facility failed to ensure the

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F 323 Continued From page 15

environment for 1 applicable resident was free of potential accident hazards. (Resident #12)  
Findings include:

1. Per review of nursing notes, on 9/20/09 Resident #12, who has dysphagia (difficult swallowing) and cognition issues was found "....spraying peri-wash in his/her mouth...." and on 10/26/09 "...toothpaste on lips, question if he/she eating it, moved to upper shelf, out of reach of resident.....". Per observation on 12/15/09 at 4:10 PM a bottle of peri-wash and a bottle of mouthwash were noted to be on the bedside stand next to Resident #12's bed. This observation was confirmed by a staff nurse at 4:25 PM who placed the peri-wash inside the bedside stand and shortly after staff removed the mouthwash. Per interview on the evening of 12/15/09 the Director of Nurses (DNS) confirmed although the care plan had identified the potential risk of injury to Resident #12 due to a history of ingesting non-food items, staff failed to remove potential hazards from the resident's immediate environment. Per interview on 12/16/09 at 8:15 AM an LNA stated "Sometimes we put the bucket (with toiletries items) away so he/she can't get at it...." however, throughout the 3 days of survey, the resident was observed moving freely within their room and able to access the bedside stand.

F 353 483.30(a) NURSING SERVICES - SUFFICIENT STAFF

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.

~~F318~~  
F318

residents needing ROM weekly to ensure compliance. Negative findings will be reported to DNS and CQI Committee x 3 months.  
Date of Completion: 1-25-10

*ROC accepted on 1-14-10.*  
F323 F323 *Dana Fleming*

Resident # 12 and his roommate now have locked cupboards for care items. Staff caring for them have been inserviced.

All residents who have been identified for being at risk to ingest non-food items may be affected. These residents have had their care plans and LNA Assignments reviewed and revised.

All staff have been inserviced on who is at risk for ingesting non-food items and have been instructed to remove any dangerous items if the resident has access to it.

The Charge Nurse on each shift will audit rooms of residents identified and will document on the MAR. Day Supervisor will audit MARs for compliance and randomly spot check rooms of identified residents. Negative findings will be reported to DNS/designee immediately

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F 353 Continued From page 16

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:

Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.

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.

This REQUIREMENT is not met as evidenced by:  
Based on observation and resident and staff interview, the facility failed to provide sufficient nursing staff to assure residents attain and/or maintain highest practicable physical, mental and psychosocial well-being; meeting the direct care needs of 5 of 15 Residents in the targeted sample. (Residents # 2, # 3, # 5, # 14 and #19)  
Findings include:

- Per interview on the afternoon of 12-14-09 and the morning of 12-15-09 Resident # 3 stated staff are not always able to answer the call light in a timely manner when s/he needed to urinate and as a result, the resident was incontinent of urine; "which is uncomfortable". "I know the staff are busy and will come when they can." Per interview, on the morning of 12-16-09, nursing staff confirmed that Resident # 3 is alert and oriented and knows when she needs to void. In addition, this resident has a history of urinary tract infections.

~~F323~~  
F323

F353

for a resolution. DNS will report to CQI Committee quarterly x 3.  
Day Supervisor to monitor compliance.  
Date of Completion: 1-25-10

*PDC accepted 01-14-10*  
*Don't think PDC*

F353  
A review of the Nursing Department staffing pattern was conducted to ensure there is a sufficient number of staff scheduled and on duty to meet the resident care needs. Resident #s 3 and 14 will have a bladder assessment/evaluation to determine their toileting needs, which will be care planned and added to the LNA assignments.  
Resident # 2 has been re-evaluated for turning and positioning needs based on tissue perfusion needs and pressure relief devices in use. Care plan and LNA Assignment have been updated to reflect current needs.  
Resident #19 has had his need for ROM reviewed with Restorative LNA who is now responsible to complete and document on flow sheet.  
Resident # 5's call bell on the night shift is being answered

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F 353 Continued From page 17

F 353

2. Per observation on 12/15/09 at 4:30 PM, resident # 14, seated by the nursing station, repeatedly requested of staff to; "go to the bathroom." H/she was told at 4:30, 4:33, 4:34 and at 4:38 PM that staff would be "right with back to help." At 4:40 PM h/she was observed trying to get out of the rocking chair, prompted by other residents who were stating that "You shouldn't have to wait when you have to go to the bathroom." Staff arrived to assist resident to the bathroom just after 4:40 PM.

3. Per interview on 12/15/09 at 8:15 AM, Resident #19 stated staff are often trying to "catch up" to complete what the previous staff did not have time to do as a result of insufficient staff. Specifically, for this resident, range of motion, (ROM) and stretching exercises are not being provided to he/she, due to staff not having available time to complete. (Refer to Tag F 318)

4. Per interview on 12/15/09 at 10:00 AM, Resident #5 stated the night shift (10 PM to 6 AM) is always short staffed and during this time if a resident uses the call bell "It takes awhile for them to come."

5. Per interview with a group from the Resident Counsel, conducted on 12-14-09 at 1:15 PM, numerous residents stated there are not enough staff. "This is a big problem." "You may wait 15 to 45 minutes with your light on; you may have an accident."

6. Per record review on 12/14/09 at 11:00 AM, Resident #2, needs total assist and has a care plan and physician's orders to be repositioned every 2 hours. On 12/14/09 from 2:00 PM to 5:45

timely. The LNA caring for her has been inserviced. Residents who need assist with toileting, repositioning or ROM may be affected. DNS has identified all residents who need assist with toileting, repositioning/ROM. Their care plans and assignments have been reviewed for accuracy. Nursing staff have been re-inserviced on meeting the needs of all residents and following assignments. Call bell audits will be done 3 times weekly covering all shifts by nursing, social service and weekend manager on duty. Administrator and DNS will review the results weekly and develop action plans as appropriate. Residents who need repositioning will be monitored by Charge Nurses/Supervisors during rounds and report results to DNS and CQI Committee x 3 months.

Date of Completion 1-25-10

*Approved per T.C. on 1-14-10 - Administrator to read. Administrator for DNS will monitor compliance.*

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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 353	Continued From page 18 PM Resident #2 was observed lying on his/her right side. Per interview and confirmed by 3 LNA staff on 12/14/09 at 6:00 PM Resident #2 was not repositioned for more than 3 1/2 hours "because there are only 3 LNA's today and quite a few resident's need 2 of us to assist them"	F 353	<i>P.O.C. accepted with addendum. Dana Fleming, RN course supervisor</i>
F 371 SS=E	483.35(i) SANITARY CONDITIONS  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  This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to maintain sanitary conditions in the food preparation area of the kitchen. Findings include:  1. Per observation during the kitchen tour on 12/14/09 at 10:30 AM, the ceiling tiles over the food preparation area and steam table had multiple sites of cracked, stained and broken tile pieces. In addition, the facility failed to consistently document proper sanitation testing of the 3 tub sink from 10/1/09 through 12/14/09 per the Daily Sanitizer Chart. Per interview, the Food Service Manager confirmed the observations at the time of the tour.	F 371	F371  The ceiling tiles have all been inspected and cleaning or replacement of any stained or cracked tiles have been made. No residents were affected. The ceiling tiles will be put on the Monthly Environmental Inspection Rounds to ensure a clean and secure surface. Any issues found at the time of inspection will be addressed immediately. The Director of Maintenance will be responsible for compliance.
F 441 SS=D	483.65(a) INFECTION CONTROL  The facility must establish and maintain an infection control program designed to provide a	F 441	The Daily Sanitizer Chart was reviewed and is now being used as directed. No residents were affected. The Food Service Director will check the sanitizer chart on a daily basis for completion for the next three months, and afterwards will be audited weekly. A new chart will be developed and all dietary staff will be in-

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

PRINTED: 12/16/2009  
FORM APPROVED  
OMB NO. 0938-0394

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  12/16/2009
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)

F 441 Continued From page 19

safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.

This REQUIREMENT is not met as evidenced by:  
Based on observation and confirmed through interview, the facility staff failed to assure a sanitary environment to prevent the development and transmission of infection for 5 of 22 residents in the targeted sample. (Res # 9, # 14, #20, # 21 and # 22). Findings include:

1. Per observation on the morning of 12-15-09, during the repositioning of Resident # 9, staff failed to remove from the resident's room a gastric tube syringe, used for medication administration, after the syringe fell on the floor. Per observation, the LNA picked the syringe up from the floor and placed it back on the residents' table. At 10:10 AM, the medication nurse, unaware that the syringe had been on the floor was about to administer medications with the contaminated syringe, until the incident was brought to the nurse's attention by the Nurse Surveyor. The medication nurse confirmed at the time of the observation that staff should have taken the contaminated syringe out of the resident's room and communicated the issue to the nurse.

2. Per observation during the evening meal at

~~F371~~  
F371

serviced on the importance of testing the sanitizer solution and documenting the results. The testing check sheets will be reviewed at the CQI Meeting monthly for the next three months.

The Food Service Director will monitor for compliance.  
Date of Completion: 1-25-10

*DOC accepted on 1-14-10*

F441

441  
*Don't know*  
Resident # 9 gastric tube syringe is being maintained in a clean environment. The LNA was counseled the day of the incident. All residents may be affected.

The nursing staff have been inserviced regarding the policy regarding disposing of dropped items/ equipment.

Infection Control Nurse will Monitor compliance.

Resident # 21 has been evaluated by IDT and it has been decided that she will use a portable table placed near the assisted diners' table.

Resident # 22 has been re-evaluated by IDT and her seating assignment has been reassigned. All residents may be affected.

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

PRINTED: 12/29/2009  
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  12/16/2009
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 441 Continued From page 20  
5:30 PM on 12-14-09, facility staff failed to replace Resident # 20's supper plate after they observed Resident # 21 reach over and remove food from Resident # 20's plate with his/her fingers and eat the food. Surveyor overheard the LNA state to Resident # 20: "it's OK s/he's hungry, we will get their plate." At approximately 5:45 PM during the same dining observation, Resident #22 was observed removing food from Resident # 14's dish. A Licensed Practical Nurse (LPN) seated at the next table stated "they're sharing again" and made no effort to intercede or evaluate the residents needs. Per interview on the morning of 12-16-09, the DNS stated that this was not acceptable practice.

F 441  
The nursing staff have been educated on the policy. The Charge Nurse assigned to each dining room will monitor compliance. Date of Completion: 1-25-10.

*Reopen per TC on 1-14-10 Admin. To read: "DNS will assure compliance's report findings at CQI meeting for 3 months. POC accepted with addendum. Don't forget, RN course surveyor."*