



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

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

April 19, 2011

Francis Cheney, Administrator
Pines Rehab & Health Ctr
601 Red Village Road
Lyndonville, VT 05851

Provider ID #:475044

Dear Mr. Cheney:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 23, 2011**.

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,

A handwritten signature in black ink that reads "Pamela M. Cota, RN". The signature is written in a cursive style.

Pamela M. Cota, RN
Licensing Chief

PC:jl

Enclosure



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

PRINTED: 04/05/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/23/2011
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NAME OF PROVIDER OR SUPPLIER PINES REHAB & HEALTH CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 601 RED VILLAGE ROAD LYNDONVILLE, VT 05851
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an annual recertification survey and four complaint investigations from 3/21/11 - 3/23/11. Regulatory deficiencies were cited as a result.	F 000	RECEIVED Division of APR 1 9 11 Licensing and Protection	
F 155 SS=G	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to assure staff honored 1 applicable resident's right to refuse treatment (Resident #66). Findings include: Per review of written statements, interview, and record review, LPN #1 failed to honor Resident #66's right to refuse disrobing and bathing on 3/11/11. Per review of written incident reports dated 3/11/11, two Licensed Nurse Assistants (LNA) summoned the Licensed Practical Nurse (LPN #1) on duty when Resident #66 resisted their effort to take him/her for a scheduled bath. The LNA's documented their witness of LPN #1 then wheeling Resident #66 backward toward the tub room while s/he screamed. Furthermore, per written incident report dated 3/11/11, and confirmed during an interview on 3/22/11 at 2:15 PM, LPN #2 (who came to the tub room from a nearby unit to investigate the screaming) confirmed that LPN #1 continued his/her attempts	F 155	<i>Please refer to attachments for details</i>	4/17/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* (X6) DATE: *4-13-11*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date 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 155	Continued From page 1 to pull down the pants of Resident #66 while the resident was "screaming for her to stop", the resident also begged for help, saying s/he was bring attacked, and stated "look what they're doing to me." LPN #2 further wrote in his/her statement and confirmed during the interview on 3/22/11 at 2:15 PM that Resident #66 calmed down enough to have a bath when LPN #2 used reassuring approaches as outlined in the plan of care for alteration in psychosocial/mood/behavior. Per record review on 3/23/11, the written plan of care for Resident #66 specified staff approaches for alteration in psychosocial/mood/behavior including: Allow "R" (Resident) to express frustrations, anxiety and allow "R" space; validate feelings with TLC (Tender Loving Care); and Reassure. In an interview on 3/23/11 at 12:56 PM, the Director of Nursing (DON) confirmed that the actions of the nurse on 3/11/11 were not consistent with the written approaches on the plan of care for alteration in psychosocial/mood/behavior, as s/he wheeled the resident backwards and attempted disrobing while the resident screamed and resisted.	F 155	<i>please refer to attachments for details</i>	<i>4/17/11</i>
F 221 SS=D	See also F241, F282. 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 221	<i>please refer to attachments for details</i>	<i>4/17/11</i>

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F 221	<p>Continued From page 2</p> <p>review, the facility failed to assure 1 of 2 residents was free from physical restraints not required to treat the resident's medical symptoms. (Resident #6) Findings include:</p> <p>1. Per observations and staff interviews during the afternoon of 3/22/11, while Resident #6 was in bed, a wedge device was placed under the mattress of Resident #6, on the open side of the bed, to prevent the resident from falling out of bed. Per observation at 1:43 PM on 3/22/11, Resident #6's bed is against the wall, leaving one side open for exiting the bed. At this time, the wedge device was in place under the mattress and out of the resident's reach, which raised the edge of the open side of the bed at least 6 inches, restricting the resident's ability to roll to that side of the bed or exit the bed. Per interview and observation of the wedge device with an LNA (Licensed Nursing Assistant) at 2:10 PM, the LNA stated that the wedge device was used so that the resident does not roll out of bed. Per observation at 2:17 PM the same day, Resident #6 was observed rocking his/her body to try to get over the hump created by the wedge device, while asking to get up.</p> <p>Per review of Nurses' Notes, the resident was found on the floor beside his/her bed on 3/14/11. Per record review, there was no care plan that directed staff to use the wedge, and no assessment to determine if this was an appropriate measure to use, nor an assessment for the device as a potential restraint. Per observation at 3:56 PM on 3/22/11, accompanied by the DNS (Director of Nursing Services), the wedge remained in place under the mattress on the open side of the bed, while the resident was lying in bed. The DNS confirmed this at the time</p>	F 221	<i>please refer to attachments for details</i>	<i>4/17/11</i>

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F 221	Continued From page 3 of observation. At 4:05 PM on 3/22/11, the Unit Manager confirmed that the care plan did not list using a wedge device as a safety measure.	F 221	<i>please refer to attachments for details</i>	<i>4/17/11</i>
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of written statements, the facility failed to provide care for 6 applicable residents in the total sample in a manner that maintains or enhances each resident's dignity and respect. (Residents #14, #15, #48, #29, #35, and #66) Findings include: 1. Per observation on 3/22/11 at 1:34 PM, a staff member wheeled Resident #14 backwards in a wheelchair from the living room on C-wing down the hallway to his/her room. The staff member did not explain this to the resident at the time, and the resident also had 3 visitors standing in the hallway that were observing this process. The staff member confirmed the above observation at 1:55 PM the same day. 2. Per observation on 3/21/11, Resident #15 had a clothing protector placed on him/her at 11:42 AM, 55 minutes prior to being assisted with his/her meal at 12:37 PM. In addition, the resident also waited 55 minutes to be served his/her meal while other residents were eating/being assisted. At 11:57 AM (40 minutes prior to being assisted with his/her meal),	F 241		<i>please refer to attachments for details</i>

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F 241	Continued From page 4 Resident #15 stated, "I'm hungry", to which staff responded verbally to the resident that it was almost time to eat. The resident, who requires staff assistance to eat/drink, was not provided with any food or drink after making this statement, until s/he was assisted with the meal at 12:37 PM. 3. Per observation on 3/21/11 from 3:42 PM to 3:48 PM, a staff member placed clothing protectors (garments made of cloth that fasten around the residents' necks and protect their clothing during meals) on Residents #48, #29, and #35 at least 45 minutes prior to the meal and without speaking to the residents to ask if they desired a clothing protector or explaining what s/he was doing. This observation was confirmed by the same staff member at 3:50 PM the same day. 4. Per review of 3 written witness statements, a nurse on the evening of 3/11/11 (LPN #1) wheeled Resident #66 down the hall backward from the resident's room to the tub room while s/he screamed. Furthermore, per written incident report dated 3/11/11, and confirmed during an interview on 3/22/11 at 2:15 PM, LPN #2 (who came to the tub room from a nearby unit to investigate the screaming) confirmed that LPN #1 continued his/her attempts to pull down the pants of Resident #66 while the resident was "screaming for her to stop", the resident also begged for help, saying s/he was being attacked, and stated "look what they're doing to me." See also F155, F282.	F 241	<i>Please refer to attachments for details</i>	4/17/11
F 272	483.20, 483.20(b) COMPREHENSIVE	F 272	<i>Please refer to attachments for details</i>	4/17/11

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F 272 SS=D	Continued From page 5 ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility staff failed to conduct a comprehensive assessment regarding skin condition for 1 resident in the Stage 2 Sample.	F 272	<i>please refer to attachments for details</i>	4/17/11	

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F 272	Continued From page 6 (Resident #44) Findings include: 1. Per record review, a wound consult on 3/8/11 revealed a stage 3 pressure ulcer (an open sore that involves full thickness skin loss) that measured 2 centimeters (cm) by 1 cm on Resident #44's coccyx, and 2 unstageable pressure areas on the resident's bilateral heels. Prior to the 3/8/11 wound consult, nursing staff were documenting completion of a daily skin assessment on the Treatment Record, as indicated by initialing the corresponding box on the Treatment Record every day. Resident #44 is totally dependent on staff for care and is unable to communicate his/her needs. Per record review, there was no documentation prior to 3/8/11 regarding any skin integrity issues on Resident #44's coccyx or left heel. Documentation was present in the record regarding the right heel. During an interview on 3/23/11 at 11:15 AM, the Unit Manager was not able to explain why there was no previous documentation as a result of the daily skin assessments about any skin integrity issues regarding the coccyx and the left heel, despite the daily skin assessment being signed off as completed.	F 272	<i>please refer to attachments for details</i>	<i>4/17/11</i>
F 279 SS=D	See also F314. 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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 plan for each resident that includes measurable objectives and timetables to meet a resident's	F 279	<i>please refer to attachments for details</i>	<i>4/17/11</i>

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F 279	<p>Continued From page 7</p> <p>medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a comprehensive plan of care for 2 residents in the stage 2 sample (Residents #14 and #29). Findings include:</p> <p>1. Per record review on 3/23/11, the plan of care for Resident # 14 did not address needs related to psychoactive medications. Resident # 14 is on a scheduled anti-psychotic medication. The care plan did not contain measurable goals and interventions to fully address the Resident's needs. The Social Services Director, who is responsible for development of behavioral care plans, confirmed during a 9:25 AM interview on 3/23/11 that the care plan did not address the Resident's needs related to anti-psychotic medication.</p>	F 279	<p><i>Please refer to attachments for details</i></p>	4/17/11	

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F 279	Continued From page 8 2. Per observations throughout the 3 days of survey, Resident # 29 has a severe contracture that effects his/her neck and head, which was observed to be unsupported at times. Per record review, the care plan does not address this contracture in terms of supports needed or any Range of Motion services that may assist with preventing further contraction of the neck. During an interview on 3/23/11 at 11:00 AM, the Unit Manager confirmed that the care plan does not address any needed supports or services to address the neck contracture.	F 279	<i>Please refer to attachments for details</i>	<i>4/17/11</i>
F 280 SS=D	See also F318. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	<i>Please refer to attachments for details</i>	<i>4/17/11</i>

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F 280	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to revise the care plan for 1 resident in the stage 2 sample (Resident # 14). Findings include: Per observation on 3/22/11 at 3:20 P.M., Resident # 14 had a blue fall mat on the floor next to the bed and a bed alarm in place. Per record review on 3/22/11, the care plan for risk of accidents/falls did not include the mat or alarm. On 3/22/11 at 3:45 P.M., a Licensed Nursing Assistant stated that s/he would look on the care plan to determine what the Resident's needs were and that "they shouldn't have things that are not on the care plan". The Unit Coordinator confirmed during a 3:50 P.M. interview on 3/22/11 that the care plan had not been revised to include the mat and alarm.	F 280	<i>please refer to attachments for details</i>	4/17/11
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, staff failed to implement care plan strategies as written related to repositioning needs and alteration in psychosocial/mood/behavior for 2 residents in the Stage 2 Sample (Residents #29 and #66). Findings include:	F 282	<i>please refer to attachment for details</i>	4/17/11

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F 282	<p>Continued From page 10</p> <p>1. Per continuous observation on 3/22/11, Resident # 29, who is totally dependent on staff for bed mobility, remained in the same position in bed, lying on his/her back from 1:22 PM to 3:33 PM. During this timeframe, the resident's head was not supported due to a severe neck contracture. The resident was repositioned at 3:33 PM, after remaining in the same position for 2 hours and 11 minutes, when it was brought to the attention of staff by the surveyor. Per record review, the care plan around Potential for Alteration in Skin Integrity directs staff to reposition Resident # 29 every 2 hours.</p> <p>See also F279, F318.</p> <p>2. Per review of an incident that occurred on 3/11/11, LPN #1 failed to implement the written care plan strategies related to psychosocial/mood/behavior challenges for Resident #66. Per review of written incident statements dated 3/11/11, 2 Licensed Nurse Assistants (LNAs) witnessed the evening shift nurse (LPN #1) wheeling Resident #66 down the hall backwards toward the tub room while the resident screamed. Furthermore, per written incident report dated 3/11/11, and confirmed during an interview on 3/22/11 at 2:15 PM, LPN #2 (who came to the tub room from a nearby unit to investigate the screaming) confirmed that LPN #1 continued his/her attempts to pull down the pants of Resident #66 while the resident was "screaming for her to stop", the resident also begged for help, saying s/he was being attacked, and stated "look what they're doing to me." LPN #2 further wrote in his/her statement and confirmed during the interview on 3/22/11 at 2:15 PM that Resident #66 calmed down enough to have a bath when LPN #2 used reassuring</p>	F 282	<i>please refer to attachments for details</i>	<i>4/11/11</i>	

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NAME OF PROVIDER OR SUPPLIER PINES REHAB & HEALTH CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 601 RED VILLAGE ROAD LYNDONVILLE, VT 05851		
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F 282	Continued From page 11 approaches as outlined in the plan of care for alteration in psychosocial/mood/behavior. Per record review on 3/23/11, the written plan of care for Resident #66 specified staff approaches for alteration in psychosocial/mood/behavior including: Allow "R" (Resident) to express frustrations, anxiety and allow "R" space; validate feelings with TLC (Tender Loving Care); and Reassure. In an interview on 3/23/11 at 12:56 PM, the Director of Nursing (DON) confirmed that the actions LPN #1 on 3/11/11 were not consistent with the written approaches on the plan of care for alteration in psychosocial/mood/behavior, as s/he wheeled the resident backwards and attempted disrobing while the resident screamed and resisted.	F 282	<i>please refer to attachments for details</i>	4/17/11	
F 314 SS=G	See also F155, F241. 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that 1 of 2 residents with pressure sores received the necessary treatment and services to prevent pressure sores from	F 314	<i>please refer to attachments for details</i>	4/17/11	

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F 314	Continued From page 12 developing and to identify pressure sores at an early stage. (Resident #44) Findings include: 1. Per record review, a wound consult on 3/8/11 revealed a stage 3 pressure ulcer (an open sore that involves full thickness skin loss) that measured 2 centimeters (cm) by 1 cm on Resident #44's coccyx, and 2 unstageable pressure areas on the resident's bilateral heels. Prior to the 3/8/11 wound consult, nursing staff were documenting completion of a daily skin assessment on the Treatment Record, as indicated by initialing the corresponding box on the Treatment Record every day. Resident #44 is totally dependent on staff for care and is unable to communicate his/her needs. Per record review, there was no documentation prior to 3/8/11 regarding any skin integrity issues on Resident #44's coccyx or left heel. Documentation was present in the record regarding the right heel. During an interview on 3/23/11 at 11:15 AM, the Unit Manager was not able to explain why there was no previous documentation as a result of the daily skin assessments about any skin integrity issues regarding the coccyx and the left heel, despite the daily skin assessment being signed off as completed.	F 314	<i>please refer to attachments for details</i>	4/17/11	
F 318 SS=D	See also F272. 483.25(e)(2) INCREASE/PREVENT DECREASE 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.	F 318	<i>please refer to attachments for details</i>	4/17/11	

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F 318	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that a resident with limited Range of Motion (ROM) receives appropriate treatment and services to prevent further decrease in range of motion for 1 of 3 residents in the targeted sample (Resident #29). Findings include: 1. Per observations on 3/22/11 and 3/23/11, Resident #29 has a severe contracture that effects his/her neck and consequently his/her head positioning. Per observations on 3/22/11 at 12:38 PM and 3/23/11 at 9:03 AM, the resident's head/neck was unsupported while sitting in a wheelchair and was hanging to the left and to the front. Per observation from 1:22 PM to 3:33 PM on 3/22/11, the resident was lying in bed, on his/her back, with the resident's head unsupported. At this time, the resident's head was not in physical contact with any surfaces due to the neck contracture and lack of any supports. This observation was confirmed by the nurse at 3:30 PM on 3/22/11. Per record review, there is no care plan that addresses the need for head/neck support related to this contracture. Per record review, there is no written plan that addresses any Range of Motion services provided to the resident's head; however, a Physical Therapy screen dated 11/26/09, indicates the resident had pain and got agitated with Range of Motion attempts on that particular day. There were no re-assessments by Physical Therapy regarding the resident's needs	F 318	<i>Please refer to attachments for details</i>	<i>4/17/11</i>

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F 318	Continued From page 14 around this contracture. During an interview at 11:00 AM on 3/23/11, the Unit Manager confirmed that there is no care plan around supports or services needed regarding the neck contracture.	F 318	<i>please refer to attachments for details</i>	<i>4/17/11</i>
F 323 SS=D	See also F279, F282. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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 resident environment is as free of accident hazards as possible for 1 applicable resident. (Resident #35) Findings include: 1. Per observation and staff interview on 3/22/11, Resident # 35 had a wedge device placed under the mattress on the open side of his/her bed to prevent the resident from rolling out of bed. Per observation on 3/22/11 at 2:42 PM, the resident was lying in the bed, which was against the wall. On the open side of the bed, a large wedge device was placed under the mattress, raising the side of the bed at least 6 inches, and there was no mat on the floor beside the open side of the bed. Per staff interview on 3/22/11 at 2:56 PM, the LNA confirmed the wedge device placement	F 323	<i>please refer to attachments for details</i>	<i>4/17/11</i>

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F 323	Continued From page 15 as described above and stated that it is placed there because the resident "likes to roll out of bed", so they were told to put the wedge there so s/he doesn't. Per record review the care plan stated to use a wedge for safety. There are no falls out of bed listed in her active record's nursing notes to warrant the use of this device. With the placement of the wedge, if the resident were to maneuver over the hump created by the wedge, s/he would fall from a much greater height onto the floor. Per further record review, Resident # 35 does not have a medical condition that warrants the use of a device that restricts movement in the bed, and there was no formal assessment to determine appropriateness of this device. Per observation with the DNS and concurrent interview at 3:52 PM on 3/22/11, the DNS confirmed the wedge placement under the mattress of Resident # 35 and stated that the wedge prevents the resident from rolling out of bed. The DNS stated that this was not the intended use for this device, and that the wedges are supposed to be used for positioning residents.	F 323	<i>Please refer to attachments for details</i>	4/17/11	
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	F 353	<i>Please refer to attachments for details</i>	4/17/11	

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F 353	<p>Continued From page 16 care plans:</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 observation and interview, the facility failed to have sufficient nursing staff to provide nursing services to attain or maintain the highest practicable physical, mental and psychosocial well being of each resident, including, but not limited to, Resident #6. Findings include:</p> <p>1. Per continuous observation on 3/22/11, Resident #6 was observed to call for assistance at 2:17 PM. A staff person exited the room at that time and asked another LNA for assistance to get the resident out of bed. The other LNA stated that s/he was required to supervise the residents in the living room, so they did not assist the resident at that time. Per observation, Resident #6 was heard continuing to yell out. At 2:31 PM the same day, the surveyor entered the resident room, and the resident was observed rocking his body towards the open side of the bed, and stated "I wanna, wanna get up." At this time, the resident had a distressed look on his/her face. At 2:32 PM, a therapy staff member responded to the Resident's calling out, and also entered the room. The therapist came out and informed staff that the resident wanted to get up, to which the</p>	F 353	<i>Please refer to attachments for details</i>	<i>4/17/11</i>

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F 353	Continued From page 17 staff member responded that s/he was waiting for another staff member to be able to watch the living room. Staff responded to the resident at 2:37 PM, 20 minutes after the resident's initial request.	F 353	<i>please refer to attachments for details</i>	<i>4/17/11</i>
F 456 SS=F	2. Per staff interviews on 3/23/11, Nursing Home staff are occasionally asked to distribute medications to residents in a separately licensed facility during their shifts at the Nursing Home. Per interviews with the A Wing Nurse, C Wing Unit Manager, and the DNS (Director of Nursing Services) at 12:40 PM, 12:49 PM, and 2:22 PM, respectively, all stated that the nurse assigned to the "A wing" of the Nursing Home is responsible for administering medications, during their shift in the Nursing Home, to residents in a separately licensed facility if a medication trained staff person in the other facility is not available. 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to assure that the laundry equipment was kept clean to assure safe operating condition. Findings include: Per observation on 3/23/11 at 8:50 AM, during the environmental tour of the facility, the clothes dryer ventilation pipes had a layer of dust and lint collected on them. The Maintenance Supervisor stated that they were usually cleaned about every	F 456	<i>please refer to attachments for details</i>	<i>4/17/11</i>

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F 456	Continued From page 18 two weeks, and were last cleaned about two weeks ago. On 3/23/11 at 8:55 AM, the Maintenance Supervisor confirmed the observation of dust and lint on the dryer ventilation pipes, and stated that the schedule would be changed to clean them more frequently.	F 456	<i>please refer to attachments for details</i>	4/17/11
F9999	FINAL OBSERVATIONS 3.14 Transfer and Discharge (d) Notice before transfer or discharge. Before a facility transfers or discharges a resident, the facility must: (1) notify the resident and, if known, a family member, including a reciprocal beneficiary, or legal representative of the resident, of the proposed transfer or discharge and reasons for the move. The notice shall be in writing and in a language and manner they understand, and shall be given at least 72 hours before a transfer within the facility and 30 days before the discharge from the facility. (2) record the reasons in the resident ' s clinical record; and (3) include in the notice the items described in subsection 3.14(e) below. (e) Contents of the notice. The written notice specified in this subsection shall be on a form provided by the licensing agency or one that is substantially similar and must include the following: (1) the reason for transfer or discharge; (2) the effective date of transfer or discharge;	F9999	<i>please refer to attachments for details</i>	4/17/11

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F9999	Continued From page 19 (3) the location to which the resident is being transferred or discharged; (4) a statement in large print or large point type that the resident has the right to appeal the facility 's decision to transfer or discharge to the State, with the appropriate information regarding how to do so as set forth in 3.14 (h) below; (5) the name, address and telephone number of the State Long Term Care Ombudsman; (6) a statement that the resident may remain in place pending the appeal; (7) for nursing facility residents with developmental disabilities, the mailing address and telephone number of the Developmental Disability Law Project and that of the Vermont Department of Developmental and Mental Health Services, Division of Developmental Services; and/or (8) for nursing facility residents who are mentally ill, the mailing address and telephone number of Vermont Protection and Advocacy, Inc. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to provide required information regarding resident transfer and discharge rights for 1 applicable resident.(Resident # 1). Findings include: Per record review on 3/23 11, the facility Notice of Discharge or Transfer form did not contain the	F9999	<i>please refer to attachments for Details</i>	<i>4/17/11</i>	

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F9999	Continued From page 20 name and address for the Ombudsman, a statement that the resident may remain in place pending the appeal or the mailing address and telephone number for Vermont Protection and Advocacy Inc.. This was confirmed by the Facility Administrator on 3/23/11 at 8:10 A.M.	F9999	<i>please refer to attachment for details</i>	<i>4/17/11</i>	

The Pines Rehabilitation and Health Center

Plan of Correction

Survey Completed on 03/23/2011

F155 483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES

The facility failed to assure staff honored one resident's right to refuse disrobing and bathing.

I. Action taken to correct deficiency:

1. LPN #1 was suspended and a self report was made to The Division of Licensing and Protection on 3/12/2011. She was also educated by DON on more appropriate approaches to use when handling a resident with dementia.
2. An in-service was provided to all nursing staff (including LPN #1) on Bathing Without a Battle. "Creating a better bathing experience for persons with Alzheimer's Disease and related disorders."
3. An in-service was provided to staff on Resident's Rights and Dignity with examples of better approaches to use on 4/07/2011.

II. Corrective actions monitored so that deficiency does not recur:

1. Administrative staff will be monitoring assigned areas frequently throughout their shift for deficient practice and reporting to their Supervisor for immediate correction.
2. Random interviews with residents and families weekly.
3. Residents with known behavior problems will be randomly selected to observe staff's approaches used during care on each shift times six weeks then sporadic checks to ensure compliance.

All residents have the potential to be affected. Completion date 4/17/2011.

Diana LaFountain RN/DON is responsible for the correction of this deficiency.

F155 POC Accepted 4/15/11 R.Tremblay RN / AMCok RN

F221 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS

The facility failed to assure 1 of 2 residents was free from physical restraints when a positioning wedge was placed under the mattress instead of on top of the mattress for res #6.

I. Action taken to correct deficiency:

1. Wedge removed from under the mattress.
2. Staff educated on correct placement and use of wedges and on other possible measures that may be construed as a restraint and on comprehensive assessment of wedge use.
3. Direction added to care plan to use wedges for positioning ONLY, and only on top of mattress not as a safety measure.

II Corrective Actions monitored so that deficient practice does not recur:

1. Unit Coordinator's will do random checks on each shift weekly times 6 weeks, then reduce to monthly checks if still in continued compliance as part of ongoing QA.

All residents have the potential to be affected. Completion date 4/17/2011.

Diana LaFountain RN/DON is responsible for correction of this deficiency.

F221 PDC Accepted 4/15/11 R.Tremblay RN / P. Motu RN

F241 483.15(a) Dignity and Respect of Individuality

The facility failed to provide care for 6 applicable residents in the total sample in a manner that maintains or enhances each resident's dignity and respect. (residents #14, #15, #48, #29, #35, and #66).

I. Action taken to correct deficiency:

1. The LNA that wheeled resident #14 backwards in his wheelchair without explanation of why he was doing so was educated by the unit coordinator with a better approach.
2. The LPN #1 that wheeled resident #66 backwards in wheelchair and removed clothing for a bath was educated by the DON on a better approach.
3. The staff that put cloth protectors on residents #15, #48, #29, and resident #35 between 45- 50 minutes early and without explanation of why they were using cloth protectors were educated on dignified procedures.
4. The dining room was moved to another area so that residents like #15 who was sitting in living room waiting for the next "assisted feeding" will not have to watch the other residents eat.

5. All staff given an in-service on 4/7/2011 on residents rights and dignity, by the administrator and DON.

II. **Corrective actions monitored so that deficient practice does not recur**

1. Unit coordinators and DON will do random checks on each shift weekly times 6 weeks, then monthly checks to assure continued compliance as part of QA>

All residents have the potential to be affected. Completion date 4/17/2011.

Diana LaFountain RN/DON is responsible for the correction of this deficiency.

F241 POC Accepted 4/15/11 R. Tremblay RN / AMcota RN

F272 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS

The facility staff failed to conduct a comprehensive assessment regarding skin condition for one resident.

I. **Action taken to correct deficiency:**

1. The LN's that documented completion of a daily skin assessment prior to 3/8/2011 were educated on the proper procedure and timely documentation changes of skin integrity regarding resident #44 coccyx and left heel, on 4/7/2011.
2. An in-service was given by KCI on 4/18/11 on comprehensive skin assessment.
3. A follow up webinar was provided by KCI also on comprehensive skin assessment and documentation.

II. **Corrective actions monitored so that deficient practice does not recur:**

1. Unit Coordinators will do a weekly comprehensive skin check on all residents and document in skin/wound QI log.
2. Ongoing in house education will be provided to LN's on comprehensive wound assessment and documentation, and for LNA's on preventive measures and reporting.

All residents have the potential to be affected. Completion date 4/17/2011.

Diana LaFountain RN/DON is responsible for the correction of this deficiency.

F272 POC Accepted 4/15/11 R. Tremblay RN / AMcota RN

F279 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CAREPLANS

The facility failed to develop a comprehensive plan of care for two residents (#14 and #29).

1. Resident #14 POC for psychoactive medication did not contain measurable goals and interventions to address resident's needs.
2. Resident #29 has a severe contracture that effects his neck. Care plan did not reflect contracture in terms of support needed or range of motion services.

I. Action taken to correct deficiency:

1. Resident #14's care plan was revised on 3/23/2011 to incorporate measurable goals with interventions to address needs in regards to use of psychoactive medications.
2. Resident #29's care plan was revised to address support needed for neck contracture.
3. MD did evaluation on resident #29 on 4/8/2011 to determine if range of motion was appropriate and determined that neither PROM or PT was appropriate for this resident. The dictated note was added to the medical record, as well as a note from the Physical Therapist on 4/12/2011.

II. Corrective actions monitored so that deficient practice does not recur:

1. Care plan team will review all care plans to assure that revisions have been made.
2. Nursing staff and care plan team will be educated on the importance of communication to assure timely revisions of care plans by DON/MDS coordinator.
3. Continue weekly care plan review of residents following care plan schedule for ongoing adjustments and compliance.

All residents have the potential to be affected. Completion date 4/17/2011.

Diana LaFountain RN/DON is responsible for the correction of this deficiency.

F279 POC Accepted 4/15/11 R.Tremblay RN / DMCotRN

F280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE- REVISE CARE PLAN

The facility failed to revise the care plan for one resident (#14) in stage II sample to include a blue fall mat and alarm that was being used.

I. Action taken to correct deficiency:

1. Blue fall mat and alarm were added to the residents care plan on 3/23/2011

II. Corrective actions monitored so that deficient practice does not recur:

1. Care plan team will review all care plans to assure that revisions have been made.
2. Nursing staff and care plan team will be educated on the importance of communication to assure timely revisions of care plans by DON/MDS Coordinator.
3. Continued weekly Care plan review of residents following care plan schedule for ongoing adjustments and compliance.

All residents have the potential to be affected. Completion date 4/17/2011.

Diana LaFountain RN/DON is responsible for correction of this deficiency.

F280 POC Accepted 4/15/11 R.Tremblay RN / AMcota RN

F282 483.20(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

The facility staff failed to implement care plan strategies as written related to repositioning needs and alteration in psychosocial, mood, and behavior for two residents in stage 2 sample (#29 and #66).

I. Action taken to correct deficiency:

1. Resident #29 was repositioned within a "reasonable" time frame. Staff reminders to read care plans weekly for changes, and new staff or if change in area assignment need to read prior to start of shift.
2. LPN #1 that failed to implement the written care plan strategies regarding to psychosocial, mood, and behavior challenges for resident #66 has been suspended, and educated by the DON on a better approach to handling challenging behaviors.
3. In-service given on time management by DON on 3/13/2011 to assure that residents are repositioned and toileted etc. in a timely manner.

II. Corrective actions monitored so that deficient practice does not recur:

1. Unit Coordinators will monitor the care for random residents to assure that the plan of correction is followed consistently on an ongoing basis.

All residents have the potential to be affected. Completion date 4/17/2011.

Diana LaFountain RN/DON is responsible for correcting this deficiency.

F282 POC Accepted 4/15/11 R.Tremblay RN / AMcota RN

F314 483.25(c) TREATMENT/SERVICES TO PREVENT/HEAL PRESSURE SORES

The facility failed to ensure that 1 of 2 residents with pressure sores received the necessary treatment and service to prevent pressure sores from developing and to identify pressure sores at an early stage.

I. Action taken to correct deficiency:

1. The LN's that document completion of a daily skin assessment prior to 3/8/2011 were educated on the proper procedure and timely documentation and reporting of changes in skin integrity on 4/7/2011 by DON.
2. Labs were drawn on 3/9/2011 for Albumin and 3/16/2011 for Pre-Albumin.
3. Special PUP boots were added for feet on 3/8/2011.
4. Wound specialist is following resident #44

II. Corrective actions monitored so that deficient practice does not recur:

1. Unit Coordinators will do a weekly comprehensive skin check on all residents and document in skin/wound QI log to assure continuance compliance.
2. Ongoing in house education will be provided to LN's on comprehensive wound assess and documentation and LNA's on importance of preventive measures and repositioning.
3. Engage wound specialist and dietician for high risk residents for preventative measures at admission and with change of status.

All residents have the potential to be affected. Completion date 4/17/2011.

Diana LaFountain RN/DON is responsible for correction of this deficiency.

F314 POC Accepted 4/15/11 R. Tremblay RN / J. Motar RN

F318 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION

The facility failed to ensure that a resident with limited range of motion receives appropriate treatment and services to prevent further decrease in range of motion for 1 of 3 residents in sample. (res. #29).

I. Action taken to correct deficiency:

1. Care plan revised on 3/23/2011 to address the need for head and neck support regarding to contracture.

2. An MD evaluation done on 4/8/2011 in conjunction with physical therapy to address the feasibility of providing range of motion to a permanent contracture that was in place prior to admission and for a resident on comfort care.

II. Corrective actions monitored so that deficient practice does not recur

1. All residents POC will be reviewed by care plan team to see if any other residents with limited range of motion are receiving appropriate treatment and necessary services to prevent further decrease in range of motion and adjust care plan as needed.
2. Identified residents will be evaluated by therapy staff at direction of MD for appropriate treatment.

All residents have the potential to be affected. Completion date 4/17/2011.

Diana LaFountain RN/DON is responsible for correction of this deficiency.

F318 POC Accepted 4/15/11 R.Tremblay RN / P.Mcota RN

F323 483.25(h) FREE OF ACCIDENT HAZARDS /SUPERVISION/DEVICES

The facility failed to ensure the resident's environment is as free of accident hazards as possible for (1) resident (Res. #35).

I. Action taken to correct deficiency:

1. Wedge removed from under mattress on 3/23/2011.
2. Mat put on floor beside open side of bed on 3/23/2011.
3. Staff educated on correct placement and use of wedges and on other possible measures that may be construed as a restraint, and on comprehensive assess of wedge use.
4. Direction added to care plan to use wedge for positioning only and on top of mattress as a PREVENTATIVE measure for skin issues.

II. Corrective actions monitored so that deficient does not recur:

1. Care plan team will review all residents currently at risk for falls to ensure POC is up to date or needs revision and adjustment accordingly.
2. Care plan team will continue to monitor all residents on an ongoing basis following the care plan schedule.

All residents have the potential to be affected. Completion date 4/17/2011.

Diana LaFountain RN/DON is responsible for correcting this deficiency.

F323 POC Accepted 4/15/11 R.Tremblay RN / P.Mcota RN

F353 483.30(a) SUFFICIENT 24 HOUR NURSING STAFF PER CARE PLANS

The Facility failed to have sufficient nursing staff to provide nursing services to attain or maintain the highest practical, physical, mental and psychosocial, well being of each resident including but not limited to resident #6.

I. Action taken to correct deficiency:

1. Resident #6 was assisted within 20 minutes of request.
2. The LN that worked that evening made an inappropriate judgment to remove an LNA from the assigned area. She was re-educated on the routine of each staff member and the collaborative effort of team work. As for that time of day the floor had a CN, 2 full LNA's, a floater, and an activity person for 18 residents which is more than sufficient staff if staff remain in assigned areas.
3. An in-service was given on time management.
4. LNA's and LN's have been provided with a time-line of their assignment to better manage their time to enable them to be more available to residents.
5. Staff educated on 4/7/2011 on timeliness of call bells.
6. There is no corrective action for the Nursing Home staff passing Medications to residents in a separately licensed facility during their shifts at the nursing home because it isn't be done. It was set up for A-Wing nurse to assist there if an EMERGENCY occurred. This is not happening and there has been sufficient staff trained to cover the 'separately licensed facility, as evidence by staffing reports.

II. Corrective actions monitored so that deficient practice does not recur:

1. Random Resident interviews by Social Services and Activities each week to ensure call bells and needs are answered within a 'reasonable' amount of time.
2. All staff informed that Nursing Home Staff will no longer be expected to cover Medication Pass in the separately licensed facility in any situation.

All residents have the potential to be affected. Completion date 4/17/2011.

Diana LaFountain RN/DON is responsible for correction of this deficiency.

F353 POC Accepted 4/15/11 R.TremblayRN/AMCotRN

F456 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITIONS

The facility failed to assure that the laundry equipment was kept clean to assure safe operating conditions AEB the clothes dryer ventilation pipes had a layer of dust on them.

I. Action taken to correct deficiency:

1. On 3/23/2011 the maintenance supervisor changed the cleaning schedule of the vent pipes from every two weeks to every week.
2. The vent pipes were cleaned on 3/23/2011.

II. Corrective actions monitored so that deficient does not recur:

1. A safety cleaning tag added to pipe and dated and signed weekly for ongoing compliance.

All residents have the potential to be affected. Completion date 4/17/2011.

Francis E. Cheney Jr. Administrator is responsible for correcting this deficiency.

F456 POC Accepted 4/15/11 R.Tremblay RN/CPMcostar RN

F9999 FINAL OBSERVATION 3.14 TRANSFERS AND DISCHARGES

The facility failed to provide required information re: resident transfer and discharge for 1 applicable resident (res. 1).

Per record review on 3/23/2011 the facility notice of discharge or transfer form did not contain the name and address for the Ombudsman, a statement that the resident may remain in place pending the appeal or the mailing address and telephone number for Vermont Protection and Advocacy Inc.

I. Action taken to correct this deficiency:

There is nothing that can be done for resident #1 as she has been discharged.

III. Corrective actions monitored so that deficient practice does not recur:

1. An updated discharge transfer form was put into place on 9/17/2010 that included the name and address for the Ombudsman, a statement that the resident may remain in place pending the appeal and the mailing address and telephone number for Vermont Protection and Advocacy Inc.

All residents have the potential to be affected. Completion date 4/17/2011.

Francis E. Cheney Jr. is responsible for correction of this deficiency.

F9999 POC Accepted 4/15/11 R.Tremblay RN/PMcotRN

Francis Elfe 4/13/11

Diana LaFontaine RN/DON 4.13.11