



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

October 31, 2011

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

Dear Mr. Cheney:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 22, 2011**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

A handwritten signature in black ink that reads "Pamela M. Cota RN".

Pamela M. Cota, RN  
Licensing Chief

PC:jl



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

OCT 18 2011

PRINTED: 10/06/2011  
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 09/22/2011
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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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F 000	INITIAL COMMENTS  An unannounced on-site complaint investigation was completed by the Division of Licensing and Protection on 9/22/11. The following are regulatory violations.	F 000		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES  The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide an activity program to meet the interests and well-being of 1 applicable resident. (Resident #1) Findings include:  1. Per record review on 09/22/11, Resident #1 was admitted on 9/14/11 with the physician 's report dated 9/4/11 stating " DX [diagnosis] dementia w/ combativeness/hallucinations, responds better to French, naps 1-3 hours/day " . Per observation on 09/22/11 from 10:00 AM - 12 Noon, Resident #1 was in a recliner with feet up and was not engaged in any activity, although an activity was listed on the calendar. When staff approached the resident for medication administration at 11:15 AM the resident did not respond and tried to strike out. When family came in for lunch they spoke to the resident in French, to which s/he responded. Per interview with family at that time, they stated that although	F 248	<i>please refer to attachments for details</i>	<i>10/10/11</i>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Francis O. [Signature]</i>	TITLE <i>Administrator</i>	(X6) DATE <i>10-13-11</i>
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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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NAME OF PROVIDER OR SUPPLIER  <b>PINES REHAB &amp; HEALTH CTR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>601 RED VILLAGE ROAD</b> <b>LYNDONVILLE, VT 05851</b>		
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F 248	Continued From page 1 Resident #1 knew and spoke English, s/he responded better to French. Per record review, there was no activity assessment for preferences, choices, goals or approaches to met the resident's needs. Per interview with LNA staff at 2:00 PM, they stated that it's " too bad we don't know french because we can't understand [the resident] and s/he I think reverted to speaking French ... it would be nice to use some French phrases " . Per interview at 2:30 PM, the Social Service Director (SSD) stated that the new Activity Director was hired 7 weeks ago and didn't have time to complete an activity assessment. The SSD confirmed that there was no activity evaluation/assessment to monitor or implement activities according to the needs of this resident.	F 248	<i>please refer to attachments for details</i>	10/16/11	
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 record review and interview, the facility failed to provide services in accordance with the written plan of care for 1 applicable resident. (Resident #1) Findings include:  1. Per observation on 09/22/11 at 1:00 PM, Resident #1 was coughing while being fed by a family member in the room. The fluids on the bedside tray were water, juice and a milk product. Per review of the care plan, as recommended by the speech therapist on 09/19/11, liquids are to	F 282	<i>please refer to attachment for details</i>	10/16/11	

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F 282	Continued From page 2 be thickened to nectar thick consistency. Per interview and confirmed with nursing staff at 1:09 PM, the water and juice were not nectar thick liquids, and were removed immediately.	F 282		
F 314 SS=G	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 record review and interview, the facility failed to provide necessary treatment and services to promote healing and prevent new sores from developing for 1 applicable resident. (Resident #2) Findings include:  Per record review on 09/22/11, Resident #2 developed a pressure ulcer and did not receive necessary monitoring, assessment and/or treatment to promote healing and/or prevent worsening. A nursing note dated 8/30/11 2 PM -10 PM shift states, " resident ' s daughter report that the buttocks has a red spot on it. Daughter put baza cream on her and put [resident] to bed, I was not able to verify but told daughter I would document and pass on information ". The nursing note of 08/31/11 states the physician made a visit, however, there was no physician ' s	F 314	<i>please refer to attachments for details</i>	<i>10/16/11</i>

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F 314	Continued From page 3 order or note to explain the treatment or wound measurements at that time. A nursing note on 09/01/11 contained no information regarding the pressure ulcer. A nursing note dated 09/06/11 states " noted to have stage 2 wound, MD changed order from duoderm to be pectin & baza cream b.i.d [twice daily]."  Per review of the Pressure Ulcer flow sheet with a start date of 09/06/11, it directs staff to measure the wound weekly and apply cream b.i.d. (twice daily). The pressure ulcer was first measured on 09/06/11 as 1.3 cm (centimeters) x.0.5 cm and had increased in size when measured again on 09/19/11 as 1.3 cm x 1 cm. The pressure ulcer was not measured as directed on 9/12/11. In addition, the pectin & baza cream that was ordered to be applied twice a day was documented as being applied only once on 9/6, 9/7, 9/11, and 9/19/11.  Per review of the Treatment Administration Record (TAR), it directs staff to assess the skin every day (QD), however, for the months of July and August 2011, the documentation indicates the skin assessment was completed only 4 days each month. In addition, the care plan noted in the chart was not updated to reflect the new pressure ulcer. Per interview on 09/22/11 at 3:00 PM the Director of Nursing Services (DNS) & the Clinical Manager confirmed the resident did not receive necessary care and services for the pressure ulcer.	F 314			
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329	<i>Please refer to attachments for details</i>	<i>10/16/11</i>	

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F 329	<p>Continued From page 4</p> <p>drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assure 1 applicable resident was free from unnecessary drugs. (Resident #1) Findings include:  Per record review, Resident #1 had a physician 's order dated 09/15/11 for haloperidol (an anti-psychotic medication) 2 mg (milligrams) now I.M. (intra-muscular) and may repeat in one hour. An additional physician's order on 09/16/11 states, Haldol (and anti-psychotic medication) 2 mg every 4 hours PRN (as needed) for agitation.</p>	F 329	<i>please refer to attachment for details</i>	10/16/11	

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F 329	Continued From page 5 The order was changed on 09/20/11 to haloperidol 2 mg p.o. (by mouth) or I.M. BID (twice a day) q 6 (every 6 hours) PRN agitation. Per the MAR (medication administration record), Haldol was given for agitation on 5 occasions from 09/15/11 until 09/22/11. Per record review, nursing notes did not indicate what non-pharmalogical interventions were tried prior to administration of the medication. Per interview on 09/22/11 at 1:20 PM, the Clinical Manager stated that a Behavior sheet to show what specific behaviors were being monitored and what interventions were tried prior to administration is used for residents with behavior. The Clinical Manager confirmed that the expectation would be to document and monitor all behaviors and interventions on a Behavior sheet which did not happen for Resident #1.	F 329	<i>please refer to attachments for details</i>	10/16/11	

The Pines Rehabilitation and Health Center

Plan of Correction

Survey Completed on 9/22/2011

**F248 483.15(f) (D) Activities Meet Interests and Needs of Each Residents**

SS=D

The facility failed to provide an activity program to meet the interest and well-being of 1 applicable resident (Res. #1). There was no activity assessment for preferences, choices, goals, or approaches to meet the resident's needs.

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

1. The activity director completed the activity assessment on 9/22/2011 and put it in the medical record.

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

1. Activities director was educated on the timely completion of activity assessments and care plans.

2. All records checked for complete activity assessments and care plans.

3. Activity Director started a QA check-off system to ensure continued compliance.

All residents have the potential to be affected. Completion date 10/16/2011.

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

*F248 POC accepted 10/20/11 SEMMONS RN/CPM/OTURN*

**F282 483.20(k) (3)(ii) Services by Qualified Persons and per Care Plan**

SS=D

The facility failed to provide services in accordance with written plan of care for 1 applicable resident (res. #1). A family member took a tray with fluids and thickening agent on it but did not thicken the fluids.

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

1. Nursing staff removed the tray immediately and thickened the fluids.

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

1. Staff reminded to check each tray card after taking it off the cart for specific instructions.

2. LN's to check trays quickly before being passed to assure compliance.

3. Dietary Director will provide LN's with list of residents on thickened fluids and will also make periodic checks to assure compliance.

4. Families will be instructed on the use of thickening agents if they so choose to feed their loved one.

All residents have the potential to be affected. Completion date is 10/16/2011.

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

F282 PDC accepted 10/20/11 SEMMONS RN / Pymota RN

**F314 483.25© Treatment and Services to Prevent and Heal Pressure Sores**

SS=G

The facility failed to provide necessary treatment and services to promote healing and prevent new sores from developing for 1 applicable resident (res. #2). Resident #2 developed a pressure ulcer and did not receive necessary monitoring, assessment and/or treatment to promote healing and/or prevent worsening.

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

1. A nurses meeting was scheduled and held on day of survey visit (9/22/11) to address this issue. See in-service record.

2. That pressure sore on resident #2 is healed off as of 10/10/2011.

3. Care Plan updated to reflect changes.

4. From this date forward skin assessments either daily or weekly will be removed from the treatment sheet. LNA's will check skin while performing daily care and on bath or shower day. LNA's will report red, rashy, or open areas to the LN for evaluation and documentation. Residents care plan will reflect the change

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

1. One LN assigned to monitor residents with problem areas and also to monitor the documentation as well on an ongoing basis.

2. All care plans, consults and MD orders will be checked for consistency on an ongoing basis as part of QA.

3. Wound consultant and MD will oversee this process

All residents have the potential to be affected. Completion date 10/16/2011.

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

F314 PDC accepted 10/20/11 SEMMONS RN / Pymota RN

**F329 483.25 (1) Drug Regimen is Free From Unnecessary Drugs**

SS=D

The facility failed to assure 1 applicable resident was free from unnecessary drugs, (res. # 1).

Haldol was given for agitation on 5 occasions from 9/15/11 until 9/22/2011. Nursing notes did not indicate what non-pharmacological interventions were tried prior to administration of the medication.

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

1. All nurses were given an in-service on 9/22/2011 that included correct documentation of PRN pharmacological medications.

2. Nothing else can be done for Resident #1 as he did not receive any more PRN psychotropic meds after 9/21/2011.

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

1. DON will get with every nurse individually and review their own documentation errors involving PRN psychotropic use for behaviors to increase their comprehension of needed documentation.

2. Nursing Supervisor will check documentation for all residents on PRN psychotropic medications weekly to assure continued compliance.

3. Pharmacy will do periodic checks as well when they do their monthly consults in- house.

All residents have the potential to be affected. Completion date 10/16/2011.

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

F329 POC accepted 10/20/11 SEMMERS RN / Pincot RN



Admin. 10/13/11