



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

March 1, 2010

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

Provider #: 475044

Dear Mr. Cheney:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 3, 2010**. Please post this document in a prominent place in your facility.

We will 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,

Suzanne Leavitt, RN, MS  
Licensing Chief

Enclosure



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESAH  
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # <b>475044</b>	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING: _____	DATE SURVEY COMPLETE: <b>2/3/2010</b>
NAME OF PROVIDER OR SUPPLIER <b>PINES REHAB &amp; HEALTH CTR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>601 RED VILLAGE ROAD LYNDONVILLE, VT</b>	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
<b>F 514</b>	<p><b>483.75(I)(1) CLINICAL RECORDS</b></p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to assure records were complete and accurate for 1 of 15 residents in the targeted sample. (Resident # 10) Findings include:</p> <p>1. Per review, Resident # 10's record demonstrated discrepancies of medication allergies that were listed on the admission (face) sheet, the readmission assessment, the pharmacy generated M.D. orders and the Medication Administration Record (MAR). The admission face sheet listed; ASA, Ibuprofen, PVK, Rocephin, Sulfa, Oxycodone, Tegretol; the readmission assessment listed, PVK, Oxycodone with ASA, Tegretol, Ibupdofen and the pharmacy generated M.D. orders listed: Carbomazopine, Ibuprofen, Penicillin, Ceftriaxone, Oxycodone, Bactrim. Per interview at 4 PM on 2-2-10, the Nurse Unit Manager confirmed the discrepancies in the medication allergies listed.</p>		

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

The above isolated deficiencies pose no actual harm to the residents

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2010  
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  02/03/2010
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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.	F 000		
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified</p>	F 225	<p><i>Please refer to attachment for details</i></p>	<p><i>2/16/10</i></p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cheng</i>	TITLE <i>Owner/Administrator</i> (X6) DATE <i>2-19-10</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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F 225	Continued From page 1 appropriate corrective action must be taken.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to conduct background checks and screening for new employees. The facility further failed to have in place a process for tracking background checks of potential hires. The findings include:  Per review of employee new hire records on 02/02/2010 at 3:00 pm, it was noted that there was no evidence of Abuse Registry, or Criminal background checks for 1 of 5 records reviewed. It was confirmed by the DNS during interview on 02/02/2010 at 5:10 pm that requests for all the above screening had been sent out manually but the facility does not retain a copy of the release of information that is signed by the potential employee.	F 225		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS  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,	F 280	<i>Please refer to attachments for details</i>	<i>2/22/10</i>

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F 280	Continued From page 2  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.  This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to revise the care plan for 2 of 15 Residents in the targeted sample. (Resident # 7 and Resident #10) Findings include:  1. Per record review, the Care Plan for Resident # 10 was not revised to reflect a 3000 ml per day fluid restriction following a readmission assessment conducted on 1-11-2010. This was confirmed during an interview with the Nurse Unit Manager on 2-2-10 at 4:10 P.M.  2. Per record review, the care plan for Resident #7 was not revised to reflect the correct Foley catheter size. The current Physician's order directed staff to use a 24 Fr. however the current care plan states to use a 18 Fr.. Per interview on 02/03/10 at 2:30 PM the Supervisor confirmed the care plan was not revised to reflect the correct Foley size.	F 280			
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by:	F 281	<i>Please refer to attachment for Details</i>	<i>2/25/10</i>	

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F 281	Continued From page 3 Based on observation and staff interview the facility failed to meet the professional standards of quality with regard to the proper administration of medications (Resident #15). Findings include:  Per observation during a medication pass on 02/01/2010 at 12:10 pm, the nurse administering insulin drew up an incorrect dose for Resident # 15. He/she would have given the incorrect dose had the surveyor not intervened to have the nurse recheck the ordered amount for that particular time of day. The correct dose was confirmed by the nurse at the time of the medication pass and Resident # 15 did receive the correct amount. During interview with the Unit Manager in the morning of 02/03/2010, she confirmed that the facility policy is to recheck the dose of insulin 3 times prior to administering it to the resident.  Ref: Nursing 2010 Drug Handbook, Lippincott, Williams and Wilkins, pgs 13-19.	F 281	
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION  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 and interview, the facility failed to ensure that the resident environment remained as free of accident hazards as is possible for all residents.	F 323	<i>Please refer to attachments for Detail</i>  2/2/10

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F 323	Continued From page 4	F 323		
F 386 SS=D	<p>1. Per observation during two days of survey, the door that leads to the cellar on A wing, had a combination lock that would not consistently lock, leaving the door unsecured. Per interview with the staff nurse during the initial tour, confirmed that there were several residents that wander. Per interview on 02/02/10 at 2:00 PM, the Maintenance Director confirmed that the combination lock "did not reset itself, if the handle isn't pushed down far enough". The Administrator later that day, removed the combination lock and replaced it, to secure the door.</p> <p>483.40(b) PHYSICIAN VISITS</p> <p>The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to assure all physician orders were signed and accurately reflected the care and treatment provided for 1 of 15 residents in the targeted sample. ( Resident # 10). Findings include:  Per record review, from 1-11-10 until 1-26-10, ( a period of 15 days) the facility failed to have signed physicians order for the use of a C-PAP machine, utilized by Resident # 10, nightly. An order including C-PAP was signed on 1-26-10. Per</p>	F 386	<p>Please refer to attachments for Details</p>	2/22/10

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F 386	Continued From page 5 interview on 2-2-10 at 4:10 PM, the Nurse Unit Manager confirmed there was no physician's signed order for the C-PAP during that 15 day timeframe.	F 386		
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	<i>Please refer to attachments for details</i>	2/26/10

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F 431	Continued From page 6  This REQUIREMENT is not met as evidenced by: Based on observation and interview, facility staff failed to assure all biologicals were secured. Findings include:  Per observation during the first 2 days of survey, the B Unit clean utility room door and the cupboards within the room, containing sharps, syringes, bottles of Hydrogen Peroxide, Santyl ointment, Hydrocortisone ointment, Nystop Topical Powder, DuoDerm and Normal Saline were unlocked and unsecured. Per interview on the afternoon of 2-2-10, the Nurse Unit Coordinator confirmed sharps, syringes and biologicals should be secured at all times.	F 431	
F 441 SS=E	483.65(a) INFECTION CONTROL  The facility must establish and maintain an infection control program designed to provide a 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 interview the facility failed to provide a safe and sanitary environment and assure the prevention of transmission of infection for 2 of 15 residents in the targeted sample. (Residents #10 & #15) Findings include:	F 441	Please refer to attachments for details  2/25/10

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F 441	<p>Continued From page 7</p> <ol style="list-style-type: none"> <li>1. Per observation during a medication pass on the morning of 2-3-10 at approximately 8:15 AM, the nurse failed to don gloves prior to administering a subcutaneous injection to Resident # 10. Per interview after the observation, the nurse confirmed that gloves were not worn during the injection administration.</li> <li>2. Per observation during a medication pass on the morning of 2-3-10 at approximately 8:15 AM, the nurse failed to sanitize the glucometer after obtaining a finger stick for a blood glucose sample for Resident # 10 and prior to returning the glucometer into the storage case. Per interview after the procedure, the nurse confirmed the glucometer, used for multiple residents in the facility, had not been sanitized after it had been used and prior to returning to its storage case.</li> <li>3. Per observation during a med pass on 02/01/2010 at 12:10 pm, the nurse administering an injection to Resident # 15 did not wear gloves during this procedure.</li> <li>4. Per observation on the afternoon of 2-2-10 at approximately 2:15 PM, B Units crash cart was found in the clean utility room and contained used and contaminated suction tubing and a suction catheter on the top shelf of the cart. Per interview on the afternoon of the observation, the Nurse Coordinator stated the cart had been in a resident's room and had not been sanitized and resupplied prior to being placed back in the clean utility room.</li> <li>5. Per observation on the first two days of survey, a mop pail and mop containing cleaning solution were stored in the Resident tub room, adjacent to</li> </ol>	F 441		

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F 441	<p>Continued From page 8</p> <p>the tub, on one unit. On the second day of the observation, a Physical Therapy (P.T.) ball was stored on top of the same mop pail. On the afternoon of 2-2-09, at approximately 2:30 PM, surveyor observed an Activity staff person remove the ball and initiate a game using the ball with a resident, without first sanitizing it. Surveyor intervened and discussed concern with the staff person who stopped the activity until the P.T. ball was sanitized.</p> <p>6. Per observation during the 3 days of survey, the inner aspect of a sink, found in a sink closet on Unit B, was observed to be covered with a build up of a large amount of grayish gelatinous substance with mold growing over the gelatinous substance. Per interview on the morning of the initial tour, the charge nurse was unaware of the condition of the sink and stated she did not think the sink was ever used.</p> <p>7. Per observation on 2-1-10 and 2-2-10, the bathroom shared by residents in rooms 24 and 25, identified by staff as able to use the bathroom facilities, contained an unlabeled toilet hat used to obtain specimens. Per interview on the afternoon of 2-2-10, the charge nurse confirmed the "hat" was unlabeled and removed it from the bathroom.</p> <p>8. Per observation on 2-1-10 at 10 a.m., the bathroom shared by residents in rooms 7A and 7B and rooms 10A&amp;B and room 12, identified by staff as being able to use the facilities, contained an unlabeled toilet hat in each bathroom. Per interview during this time, the charge nurse disposed of the hats confirming that they should have been labeled.</p> <p>F.465 483.70(h) OTHER ENVIRONMENTAL SS=D CONDITIONS</p>	F 441	<p><i>Please refer to attachment for details</i></p>	2/22/10

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F 465	Continued From page 9  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a sanitary and safe environment for all residents. Findings include:  1. Based on observation during all days of survey the metal radiator cover had sharp exposed edges in the B wing tub room, toilet area. Per interview during the General Environmental tour with the Director of Maintenance on 02/03/10 at 10:00 AM confirmed that the radiator cover posed a safety risk for residents.	F 465		
F 516 SS=B	483.75(l)(3), 483.20(f)(5) CLINICAL RECORDS  A facility may not release information that is resident-identifiable to the public.  The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.  The facility must safeguard clinical record information against loss, destruction, or unauthorized use.  This REQUIREMENT is not met as evidenced by:	F 516	<i>Please refer to attachment for details</i>	<i>2/24/10</i>

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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 LYNDONVILLE, VT 05851</b>		
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F 516	Continued From page 10 Based on observation and interview, the facility failed to maintain safety and confidentiality of clinical records for Residents on A wing. Findings include:  1. Per observation on 02/01/10 between 8:35 AM and 9:30 AM, and on 02/02/10 between 3:30 PM and 4:22 PM several LNA chart books, which had resident names, vital signs, and personal health information was left unattended in a public dining area. Per interview at 4:30 PM on 02/02/10, the Unit Manager confirmed that the LNA chart books, which had identifiable resident information, were unattended in a public place.	F 516			
F9999	FINAL OBSERVATIONS  Per Vermont Licensing and Operating Rules for Nursing Homes December 15, 2001, 3.17 (e) " A facility shall report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the Vermont State Nurse Assistants Registry or the appropriate licensing authority and the licensing agency. Actions by a court of law which indicate unfitness for service include a charge of abuse, neglect or exploitation substantiated against an employee or conviction of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction within or outside the State of Vermont." (h) "The results of all investigation must be reported to the administrator or his or her designated representative and to the licensing agency in accordance with 33 V.S.A. Chapter 69, and if the alleged violation is verified, appropriate corrective action must taken."	F9999	<i>Please refer to attachments for Details</i>	<i>2/16/10</i>	

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

PRINTED: 02/12/2010  
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  02/03/2010
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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F9999	Continued From page 11  Based on observation and staff interview, the facility failed to obtain the required state waivers for an employee whose Vermont Criminal Information Center (VCIC) background check revealed 2 misdemeanor charges. Findings include:  Per record review of new hire employees on 02/02/2010 at 3:00 pm it was noted that a VCIC background check revealed 2 misdemeanor charges for 1 of 5 employee records reviewed. The expected waiver letter from the Vermont Division of Licensing and Protection (DLP) was not found in the record. This was confirmed during interview with the Administrator in the morning of 02/03/2010. He further indicated at that time that no request for a waiver had been initiated by the facility.	F9999		

The Pines Rehab & Health Center  
Plan of Correction  
Survey Completed on 2/3/2010

**F225 483.13(c)(1)(ii)-(iii)(c)(2)-(4) STAFF TREATMENT OF RESIDENTS**

The facility failed to conduct background checks and screening for new employees. The facility further failed to have in place a process for tracking background checks of potential hires.

I. Action taken to correct deficiency:

1. The background check was done on the new employee and the facility Received it on 2/5/10.
2. The facility will retain copies of the background check and screening information on all new hires.
3. The facilities process for tracking background checks of potential hire is : All employees requiring background checks are recorded in a background check log at the time the check is done and are held open until the background check is finalized. See attached

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

1. Will continue to monitor background checks in the background check log with date of background check and date received results of background checks.

All residents have the potential to be affected. Completion date 2/16/10. Mary Bassett office Manage is responsible for the correction of this deficiency.

POC complete 2-22-10  
J Emmons [Signature]

**F280 483.20(d)(3),483.10(k)(2) COMPREHENSIVE CARE PLANS**

The facility failed to revise the care plan for 2 of 15 residents. (Resident #7 and Resident #10).

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

1. Resident #10's care plan was revised to reflect a 3000ml per day fluid restriction on 2/2/10.
2. Resident #7's care plan was revised to reflect the correct foley catheter size on 2/2/10.

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

1. Copies of MD order changes will be given to MDS team everyday to keep care plans current.
2. The DON will review 3 care plans a week to ensure revisions reflect current orders, this will be an ongoing process as part of QA.

All residents have the potential to be affected. Completion date: 2/22/10. Diana LaFountain, RN/DON is responsible for the correction of this deficiency.

*POC complete 2-22-10 S. Smalls*

**F281 483.20(k)(3)(i) COMPREHENSIVE CARE PLANS**

The facility failed to meet the professional standards of quality with regards to the proper administration of medications for resident #15. A nurse drew up an incorrect dose of insulin and was intervened by surveyors prior to administration. The nurse failed to adhere to the facility policy of rechecking the dose of insulin three times prior to administering it to a resident.

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

1. Resident # 15 did receive the correct dose of insulin.
2. The nurse administering the medication was:
  - A. Counseled on proper medication administration.
  - B. Was given a copy of safe drug administration with best practice on prevention. (Nursing 2010 Drug Handbook, Lippincott, Williams and Wilkins, pp 13-19.
  - C. Was required to review an educational video 'Principles of Medication administration- MED-PASS, inc. 2000.'

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

- 1. All LN's will be given a refresher inservice on proper medication administration on 2/25/10.
- 2. The education nurse will continue to do med-pass checks with each nurse as ongoing part of QA.
- 3. The Pines is working with NVRH to come up with a skills and medication administration test for all LN's upon hire and annually to ensure safe practice of all. (This is part of our ongoing QA).

All residents have the potential to be affected. Completion date: 2/25/10. Diana LaFountain RN/DON is responsible for correction of this deficiency.

*Doc aunts 2-22-10*  
*B Emma 18*

**F 323 483.25(h) ACCIDENTS AND SUPERVISION**

The facility failed to ensure that the resident environment remained as free of accidental hazards as is possible for all residents. The door to the cellar on A-Wing, had a combination lock that would not consistently lock, leaving the door unsecured.

I. Action taken to correct deficiency:

- 1. Combination door lock was replaced on 2/2/10 by maintenance.

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

- 1. Door locks will be checked weekly by maintenance to make sure they are working properly.

All residents have the potential to be affected. Completion date 2/2/10 Raymond Lindahl Jr. is responsible for the correction of this deficiency.

*Doc aunts 2-22-10*  
*fe / SR*

**F 386 483.40(b) PHYSICIANS VISITS****I. Action taken to correct deficiency:**

1. There is nothing that can be done about resident #10's order for C-PAP. She continued to get her C-PAP and the order was signed.

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

1. Fax copy of orders to Corner Medical for MD to sign until MD can come in and sign the originals.
2. Supervisors will review new orders weekly ongoing to ensure all orders are signed.

All residents have the potential to be affected. Completion date 2/22/10. Diana LaFountain RN/DON is responsible for the correction of this deficiency.

*Doc unnt 2-22-10 [Signature]*

**F 431 483.60(b),(d)(e) PHARMACY SERVICES**

The facility staff failed to assure all biologicals were secure. The clean utility room on B Unit's door and cupboard were unlocked containing syringes, normal saline, hydrogen peroxide, santyl ointment, hydrocortisone ointment, topical powders and duoderm dressing.

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

1. New self locking door knobs will be installed on 2/26/10 on all utility room doors for increased security.
2. All staff given an inservice on 2/3/10 that included drug and biological storage safety.
3. LN's only to have keys and will be held accountable for doors found open.

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

1. Supervisor to check doors everyday on their daily walk through checks.
2. LN's on evenings and nights will ensure doors remain locked.

All residents have the potential be affected. Completion date 2/26/10.  
Diana LaFountain, RN/DON is responsible for correction of this deficiency.

*Account 2-22-10 [Signature]*

**F 441 483.65(a) INFECTION CONTROL**

The facility failed to provide a safe and sanitary environment and assure the prevention of transmission of infection for 2 of 15 residents (resident #10 and resident #15). The nurse failed to don gloves prior to an injection to resident #10 and #15 and failed to sanitize the glucometer between resident use. A crash cart wasn't cleaned prior to being put away unlabeled specimen containers left in residents rooms, mop pail left in tub room with ball on it activity attempted use of ball without sanitizing and unused sink in a closet found to have mold on it.

I. Action taken to correct deficiency:

1. LN's that failed to don gloves with injections or clean glucometer between uses was counseled on safe and best practice on 2/3/10.
2. All LN's provided an inservice on 2/25/10 that included safe and best practice for administering injections and sanitizing glucometers between residents.
3. Policies and procedures were reviewed for med administration glucometer use, crash cart use and care of specimen containers and their storage, and the storage of the mop and bucket at night.
4. All nurses given copy of Safe Drug Administration best practices from Nursing 2010 rug handbook 30<sup>th</sup> Edition Lippincott, Williams, and Wilkins pp 13-19.
5. The activity game ball is stored in A-Wing closet and will only be available during activity time. Prior to usage the game ball will be sanitized and re-sanitized prior to storing.
6. The mop pail system for cleaning floors was eliminated in January 2010. The floor cleaning new system for spot cleaning will be finalized by 2/28/10.
7. The sink in question was not in use at the time of survey and was scheduled for removal. Sink was cleaned during survey on 2/2/10 and the sink was scheduled for an earlier removal.

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

1. IC nurse will do unannounced med administration observation weekly times four weeks with the nurses involved and then once a week on an ongoing basis with all nurses to assure continued compliance.
2. All equipment for spot cleaning floors will be stored in A&B wing dirty utility rooms between the hours of 2:15pm and 6:45am.

3. The sink was removed on 2/16/10.
4. All closets shall be added to maintenance directors weekly site checks.

All residents have the potential to be affected. Completed date 2/25/10  
Diana LaFountain RN/DON is responsible for the correction of the nursing portion of this deficiency, and Francis Cheney Jr. is responsible for the environmental portion of this deficiency.

*POC aunt 2-22-10 J. Cheney Jr.*

#### **F 465 483.70(h) OTHER ENVIRONMENTAL CONDITIONS**

The facility failed to provide a sanitary and safe environment for all residents. The metal radiator cover had sharp exposed edges in the B-Wing tub room, toilet area.

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

1. The radiator cover was replaced on 2/2/10.

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

1. Developing a check list for housekeeping to check each room while cleaning and to provide maintenance with any needed repairs daily.
2. Maintenance will meet with housekeeping individually about list.

All residents have the potential to be affected Completion date: 2/22/10.  
Francis Cheney Jr. is responsible for correcting this deficiency.

*POC aunt 2-22-10 J. Cheney Jr.*

#### **F 516 483.75(1)(3), 483.20(f)(5) CLINICAL RECORDS**

The facility failed to maintain safety and confidentiality of clinical records for residents on A-Wing. Two LNA chart books, which had residents names and personal health information was left unattended in a public dining room.

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

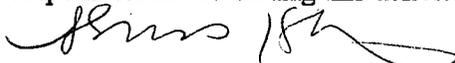
1. LNA's documentation books were removed from the dining room table and placed back in the A-Wing nurse station on 2/2/10.
2. LNA's were counseled at an inservice on 2/3/10 about confidentiality of resident information. LN's will be counseled on 2/24/10 during LN inservice.
3. LNA's will no longer be able to do their charting in public area. All charting will be done in nurse station.

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

1. Unit supervisors will check public areas daily to ensure continued compliance

All residents have the potential to be affected.

Completion date 2/24/10. Diana LaFountain is responsible for correcting this deficiency.

*Ac count 2-22-10* 

**F9999 FINAL OBSERVATIONS**

The facility failed to obtain the required state waivers for an employee whose Vermont Criminal Center background check revealed two misdemeanor charges.

I. Action taken to correct the deficiency:

1. The employee in question was removed from the work schedule from 2/2/10 to 2/15/10.
2. The waiver was applied for on 2/4/10 and received written approval to hire on 2/10/10. Copies attached.

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

1. The Pines review all policies concerning background checks and background investigation for completeness. See copies.
2. All employees requiring background checks are recorded in a background check log at the time the check is done and are held open until the background check is finalized. See attached.

All residents have the potential to be affected. Completion date 2/16/10.  
Mary Bassett is responsible for correction of this deficiency.

*Ac count 2-22-10*





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  
Fax (802)-241-2358

February 10, 2010

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

Dear Mr. Cheney:

I am writing in response to your letter of February 4, 2010 requesting a variance to Section 3.17 of the State of Vermont Licensing and Operating Rules for Nursing Homes to employ [REDACTED] despite [REDACTED]. Based on the material submitted I will grant the variance. This variance may be reviewed and revised at any point.

Please contact me at 802-241-2345 if you have any questions.

Sincerely,

Frances L. Keeler, RN, MSN, DBA  
Director

cc: file



## POLICY

### CRIMINAL BACKGROUND CHECKS

**Purpose:** To perform criminal background checks on individuals who work or intend to work at The Pines Rehab & Health Center;

Background checks will be done on:

- Established workers (every other year on their anniversary date)
- Potential workers
- Volunteers

This will identify those individuals who could pose a potential problem to the vulnerable people who reside at The Pines Rehab & Health Center. If there are any issues that arise as a result of the check, the name of the individual and any violation(s) will be submitted to the Division of Disability and Aging Services, Department of Disabilities, Aging & Independent Living to be reviewed.

The background checks will be submitted to:

1. Department of Children & Families (DCF) child abuse registry
2. Department of Disabilities, Aging & Independent Living (DAIL), Division of Licensing and Protection adult abuse registry
3. Vermont Criminal Information Center (VCIC)
4. Office of Inspector General (OIG)

Areas that will be reviewed for potential problems:

- a) A substantiated record of abuse, neglect, or exploitation of a child or vulnerable adult
- b) An individual has been excluded from participation in Medicare or Medicaid services, programs, or facilities by the federal Department of Health and Human Services' Office of the Inspector General; and/or
- c) A criminal conviction for an offense involving bodily injury, abuse of a vulnerable person, a felony drug offense, or a property/money crime involving violation of a position of trust, including but not limited to:

Aggravated assault, Aggravated stalking, Aggravated sexual assault, Assault and robbery, Manslaughter, Assault upon law enforcement, Cruelty to children, Arson, Extortion, Abuse, neglect, or exploitation of a vulnerable adult or child, Hate motivated crime, Kidnapping, Lewd and lascivious conduct, Simple assault, Sexual

assault, Murder, Domestic assault, Stalking, Embezzlement, Recklessly endangering another person while driving.

If a background check reveals an offense:

The background check will be submitted for a variance to the Deputy Commissioner, Division of Disability and Aging, Department of Disabilities, Aging and Independent Living along with:

1. A letter from the facility administrator requesting a variance that describes the offense(s) and the reasons why the facility wishes to keep current staff member or one seeking to be employed. This letter must also include the duties and hours/shifts of the employee or prospective employee.
2. A copy of the criminal background check that contains the description of the offense and when it occurred.
3. A letter from the employee or prospective employee that describes the offense and the reason why the individual wishes to stay employed or to be employed.

If a background check reveals a non-restricted conviction or motor vehicle violation, The Pines Rehab & Health Center may, at their discretion, hire or contract with the potential worker, or continue employment of a current employee.

A variance is granted to the facility, not the individual.

Variances of this policy may be granted only under exceptional circumstances:

The following factors will be considered in the decision of a variance-

- A. Age of the individual at the time of the crime or substantiation,
- B. Nature and seriousness of the crime (e.g., were there circumstantial reasons; was it related to a specific relationships, etc)
- C. The person's involvement with the criminal justice system and/or child abuse, neglect or exploitation systems since occurrence
- D. The amount of time which has passed since substantiation or conviction
- E. Willingness of the individual to pursue expungement of any child or adult abuse substantiation
- F. Disclosure to the person receiving services, their surrogate, and legal guardian (if there is one)

Written documentation of the decision to grant a waiver will be made stating the rationale and any conditions by The Department of Licensing & Protection.

Administrator: \_\_\_\_\_ Date: \_\_\_\_\_

## BACKGROUND INVESTIGATIONS

### POLICY STATEMENT

It is the policy of this facility to conduct background investigations on all persons being offered employment, being contracted with to provide resident care, and all volunteers who work alone with a resident of this facility. Subsequent to the initial background check, the facility also conducts periodic random background checks of currently employed persons.

### POLICY

- 1) Background investigations will include checks into former employer references, the State of Vermont Child Abuse Registry, the State of Vermont Adult Abuse Registry, the Dept of Health and Human Services Office of Inspector General exclusion list, and criminal records. Additionally, for those individuals who are responsible for the transportation of residents, motor vehicles records will be investigated.
- 2) All individuals seeking employment will be informed that background investigations are required and that any offer of employment is contingent on the satisfactory completion of these investigations.
- 3) Should background investigations disclose information that would prohibit them from employment as defined in the policy of this manual entitled "Hiring Practices", the applicant may not be employed, or if already employed may be terminated.
- 4) A person may be employed or contracted prior to the receipt of satisfactory background checks for a maximum of 60 (sixty) days.
- 5) Random background checks will occur bi-annually and sampling will be approximately 10% of total staff members employed.
- 6) Applicants for employment, will not be charged for the cost of background investigations.
- 7) Applicants will be permitted to review the results of their background investigations.
- 8) Inquiries concerning background investigations should be referred to the facility's Office Manager or Administrator.