

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

January 5, 2016

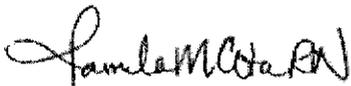
Mr. Francis Cheney, Administrator
Pines Rehab & Health Ctr
601 Red Village Road
Lyndonville, VT 05851-9068

Dear Mr. Cheney:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 9, 2015**. Please post this document in a prominent place in your facility.

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

Sincerely,



Pamela M. Cota, RN
Licensing Chief



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

PRINTED: 12/22/2015
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 12/09/2015
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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
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F 000 INITIAL COMMENTS

F 000

An unannounced onsite recertification survey was completed by the Division of Licensing and Protection from 12/7-9/15. The following regulatory violations were cited:

F 159
SS=C

483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS

F 159

Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.

The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

See POC Completion Date 1/3/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jeanne LaFontaine RN/DNS</i>	TITLE 12.30.15	(X6) DATE
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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 159 Continued From page 1

The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

This REQUIREMENT is not met as evidenced by:
Based on interviews with resident families and facility staff, and review of personal funds accounts, the facility failed to provide written quarterly statements to residents or legal representatives for 49 of 49 residents who have a personal funds account with the facility. The specifics are as follows:

Per review of the facility checking accounting system used for resident personal funds accounts, there is no evidence to reflect that quarterly statements were issued to either residents or their legal representatives for the last year.

This is confirmed by the Director of Social Services during Interviews on 12/08/2015 and 12/09/2015. S/he reports that residents or their legal guardians are notified verbally when money is needed to be added to the individual accounts but that s/he has not sent out written statements during the past year. Confirmation that no written

F 159

Diana LaFontaine RN/DNS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 159	Continued From page 2 statements were sent to residents was also obtained during a family interview during stage 1 of the survey process on 12/07/2015. Family reported never receiving a statement that indicates how much money is in the personal funds account but that s/he is told when money needs to be added for incidentals.	F 159		
F 279 SS=D	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 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to develop a written plan of care for 1 of 3 residents (# 78) in the sample of those at risk for wandering. The	F 279	<i>See POC Completion Date 1/3/16</i>	

Deana Lafontaine RN/DNS 12.30.15

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F 279 Continued From page 3
specifics are as follows: F 279

Per medical record review, Resident # 78 was assessed on the admission MDS (Minimum Data Set) that was dated 07/29/2015 as being at risk for wandering. Resident # 78 was admitted on 07/22/2015 with alcohol dependency, generalized weakness, electrolyte imbalance and traumatic brain injury. Documentation indicates that while s/he is "drying out" that there is a risk for wandering. Notes further indicate that Resident #78 left the facility through the therapy office door during the 'detox' period, was seen and followed by the therapy staff and brought back into the building. There is no written care plan to alert staff that wandering was identified as a problem on admission.

Per interview with the Nurse Supervisor at 1:30 PM on 12/08/2015, s/he confirms that when this client was admitted s/he was detoxing and was at risk for wandering. Staff further confirm that the expectation would be that a care plan would be in place for wandering and that there is not a care plan that was developed for wandering for Resident #78.

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN F 282

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 and staff interview, the

See POC Completion Date 1/3/16

Quiana LaFontaine, RN/DNS 12.30.15

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F 282	<p>Continued From page 4</p> <p>facility failed to provide services by qualified persons in accordance with each resident's written plan of care for 3 of 16 applicable residents (Residents # 20, 22, and 65). Findings include:</p> <ol style="list-style-type: none"> 1. Per continuous observation on 12/7/15 between 1:18 PM and 4:18 PM, staff did not turn, toilet, or reposition Resident # 22. The Minimum Data Set (MDS) dated 9/9/15 stated that Resident # 22 was totally dependent on staff for all activities of daily living (ADLs). A physician's note dated 10/26/15 stated that for the last 2 years h/she has been pretty much unable to move on his/her own. A care plan for limited mobility stated to turn and redistribute weight every 2 hours. A care plan for urinary incontinence stated to toilet the resident every 2 hours. Per interview with the Unit nurse 12/7/15 at 4:25 PM, Resident # 22 should be turned, toileted and repositioned every 2 hours. 2. Per record review on 12/8/15, Resident #20 has a care plan that includes the use of a fall mat placed next to the bed when the resident is in bed. Per observation on 12/8/15 between 1:05 PM and 2:30 PM, the resident was observed in the bed with no fall mat on the floor. There was a fall mat in the room up against the closet available for use. Per interview on 12/8/15 at 2:30 PM, the nurse confirmed that the resident's care plan stated that a fall mat was to be placed by the bed, and that it was not in place today. 3. Per record review on 12/8/15, Resident #65 has dementia, and sits and walks in a stooped over position. Per an Occupational Therapy evaluation completed on 10/7/15, the resident was given a high back reclining wheelchair to 	F 282	<p><i>See POC Completion Date 1/3/16</i></p>	
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Diana LaFountain RN/DNS 12.30.15

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

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PRINTED: 12/22/2015
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OMB NO. 0938-0391

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F 282	Continued From page 5 improve the position of the body when eating. Dietary also included the recommendation of the chair for positioning when eating. The plan of care was updated with this recommendation also, to be seated at meals in this wheelchair. Per observation on 12/7/15 at the noon meal, Resident #65 was observed sitting in the wheelchair positioned with their head up, and being fed by staff. The resident was able to look around the room and engage in eye contact with other residents and staff. Per observation on 12/8/15 at the noon meal, Resident #65 was observed sitting in a regular chair, stooped over so that their head was hanging down near their knees. The staff were feeding the resident in this position. Per interview on 12/8/15 at 12:20 PM, the LNA (Licensed Nursing Asslstant) in the dining room stated that the nursing students had seated the resident in a regular chair, and although the LNA told them that the resident was to be placed in the wheelchair, they did not transfer the resident, nor did any of the other staff. Per interview on 12/8/15 at 12:30 PM, the nurse confirmed that the plan of care for this resident stated that they were to be in the wheelchair for meals for proper positioning, and that the care plan was not followed for Resident #65.	F 282			
F 309	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	See POC Completion Date 1/3/16		

Diana LaFontaine RN/DNS 12.30.15

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

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F 309	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for 2 of 16 applicable residents (Residents # 22 and 65). Findings include: 1. Per continuous observation on 12/7/15 between 1:18 PM and 4:18 PM, staff did not turn, toilet or reposition Resident # 22. The Minimum Data Set (MDS) dated 9/9/15 stated that Resident # 22 was totally dependent on staff for all activities of daily living (ADLs). A physician's note dated 10/26/15 stated that for the last 2 years h/she has been pretty much unable to move on his/her own. A care plan for limited mobility stated to turn and redistribute weight every 2 hours. A care plan for urinary incontinence stated to toilet the resident every 2 hours. Per interview with the Unit nurse 12/7/15 at 4:25 PM, resident # 22 should be turned, toileted and repositioned every 2 hours. 2. Per record review on 12/8/15, Resident #65 has dementia, and sits and walks in a stooped over position. Per an Occupational Therapy evaluation completed on 10/7/15, the resident was given a high back reclining wheelchair to improve the position of the body when eating. Dietary also included the recommendation of the chair for positioning when eating. The plan of care was updated with this recommendation also.	F 309		

*See POC
Completion Date
1/3/16*

Diana LaFountain RN/DNS 12.30.15

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F 309 Continued From page 7
to be seated at meals in this wheelchair. Per observation on 12/7/15 at the noon meal, Resident #65 was observed sitting in the wheelchair positioned with their head up, and being fed by staff. The resident was able to look around the room and engage in eye contact with other residents and staff. Per observation on 12/8/15 at the noon meal, Resident #65 was observed sitting in a regular chair, stooped over so that their head was hanging down near their knees. The staff were feeding the resident in this position. Per interview on 12/8/15 at 12:20 PM, the LNA (Licensed Nursing Assistant) in the dining room stated that the nursing students had seated the resident in a regular chair, and although the LNA told them that the resident was to be placed in the wheelchair, they did not transfer the resident, nor did any of the other staff. Per interview on 12/8/15 at 12:30 PM, the nurse confirmed that the plan of care for this resident stated that they were to be in the wheelchair for meals for proper positioning, and that this was not done at today's noon meal.

F 309

F 371 483.35(i) FOOD PROCURE, SS=E STORE/PREPARE/SERVE - SANITARY

F 371

- The facility must -
- (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
 - (2) Store, prepare, distribute and serve food under sanitary conditions

*See POC
Completion
Date 1/3/16*

This REQUIREMENT is not met as evidenced

Diana LaFountain RN/DNS 12.30.15

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

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F 371	<p>Continued From page 8</p> <p>by: Based on observation and staff interview, the facility failed to prepare, distribute and serve food under sanitary conditions. Findings include:</p> <p>During the initial kitchen tour with the Dietary Manager (DM) on 12/7/15 at 9:41 AM, the exhaust hood over the main kitchen stove was heavily soiled with grease and loosely hanging particles of dust and debris. The DM confirmed this observation at the time of the observation.</p>	F 371	<p><i>See POC Completion Date 1/8/16</i></p>	

Diane LaFontaine RN/DNS 12.30.15

The Pines Rehabilitation and Health Center

Plan of Correction

Survey Completed on 12/9/2015

F159 483.10©(2)-(5) Facility Management of Personal Funds

The facility failed to provide written quarterly statements to residents or legal representatives for 49 of 49 residents who have a personal funds account with the facility.

I. Action taken to correct the deficiency:

1) The written quarterly statements for the 49 residents will be sent out January 8th 2016 (after the end of the last quarter).

II. Measures put in place to ensure deficient practice does not recur:

1) All residents who have a personal funds account with the facility will continue to receive written quarterly statements. The statements will be sent out by the 8th of the month following the end of the quarter.

2) The administrator will countersign statements sent out to ensure deficient practice does not recur.

All residents have the potential to be affected.

Completion date: January 8th 2016

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

F159 POE accepted 1/4/16 JHosmerRN/PMC

F279 483.20(d);483.20(k)(1) Develop Comprehensive Care Plans

The facility failed to develop a written plan of care for 1 of 3 residents (#78) in the sample of those at risk of wandering.

I. Action taken to correct deficiency:

1) Nothing can be done resident #78 as this person was discharged on 08-19-2015.

II. Measures put in place to ensure deficient practice does not recur:

1) Chart and MDS review was done on all residents at risk for wandering to ensure a care plan is in place or that a note is in place in the record to indicate why a care plan is not needed. This will be checked quarterly on an ongoing basis to ensure deficient practice does not recur.

All residents have the potential to be affected.

Completion date: 01/03/2015

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

F279 POC accepted 1/4/16 JHosmer RN/pmc

F282 483.20(k)(3)(ii) Services by qualified Persons/per Care Plan

The facility failed to provide services by qualified persons in accordance with each residents written plan of care for 3 of 16 applicable residents (#20, 22, and 65).

I. Action taken to correct the deficiency:

1) Resident #22 was checked and changed on change of shift rounds by 6-2 and 2-10 LNA's at 2pm per the LNA's. The care plan stated that resident #22 needed to be checked and changed every 2 hours. Staff did reposition the resident when told to by direct supervision on 12/7/15.

2) Resident #20's fall mat was placed by the bed on 12/7/15 by LNA's when instructed to do so by the charge nurse.

3) Nothing can be done for resident #65 for the lunch time feeding on 12/7/15 as he was done eating.

II. Measures put in place to ensure deficient practice does not recur:

1) A Reposition and check and change sheet that needs to be signed off every 2 hours was added to LNA documentation book for resident #22, (it will be on daily clipboard, checked by LN's and placed in chart every day on an ongoing basis.

2) Resident #20 has a turn and reposition sheet in place. A fall mat check was added to that sheet and is checked by LN's every day and placed in record on an ongoing basis.

3) Lyndon Institute's LNA instructor was counseled on the importance of reading residents care plans and LNA assignment sheets when caring for residents at this facility. The instructor was shown the care plan for resident #65 in regard to transferring to a high back wheel chair for feeding. LNA's were counseled on the importance of following a care plan despite students being in the building and that if a student did not follow the care plan it was their responsibility to report this to their charge nurse for appropriate action. LN's will check every shift when being fed to ensure resident #65 is always in a high back chair for meals on an ongoing basis.

All residents have the potential to be affected.

Completion date: January 3rd, 2016

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

F282 POC accepted 1/4/16 JHosmer RN/pmc

F309 483.25 Provide Care and Services for Highest Well-being

The facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care for 2 of 16 applicable residents (#22 and #65).

I. Action taken to correct deficiency:

1) Resident #22 was checked and changed on change of shift rounds by 6-2 and 2-10 LNA's at 2pm per the LNA's. The care plan stated that resident #22 needed to be checked and changed every 2 hours. Staff did reposition the resident when told to by direct supervision on 12/7/15.

2) Nothing can be done for resident #65 for the lunch time feeding on 12/7/15 as he was finished eating.

II. Measures put in place to ensure deficient practice does not recur:

1) A Reposition and check and change sheet that needs to be signed off every 2 hours was added to LNA documentation for resident #22 (it will be on daily clipboard and checked by LN's before placing in chart every day) on an ongoing basis.

2) Lyndon Institute's LNA instructor was counseled on the importance of reading resident care plans and LNA assignment sheets when caring for this facilities residents. The instructor was shown the care plan for resident #65 in regard to transferring to high back wheelchair for feeding. LNA's were counseled on the importance of following a care plan despite students being in the building, and that if students did not follow the care plan it was still their responsibility to report this to their charge nurse for appropriate action. LN's will check every shift when being fed to ensure resident #65 is always in a high back chair for meals on an ongoing basis.

All residents have the potential to be affected.

Completion date: January 3rd, 2016

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

F309 POC accepted 1/4/16 JHosmer RN/pml

F371 483.35(j) Food Procure, Store and Prepare Serve- Sanitary

The facility failed to prepare, distribute and serve food under sanitary conditions.

I. Action taken to correct the deficiency:

1) The exhaust hood over the main kitchen stove was cleaned 12/7/2015.

II. Measure put in place to ensure deficient practice does not recur:

1) Exhaust hood will be cleaned every week and will be checked by dietary manager weekly to ensure this is being done on an ongoing basis.

Completion date: January 3rd 2016

Cathy Lacourse Dietary Manager is responsible for the correction of this deficiency.

F371 POC accepted 1/4/16 JHosmer RN/PMC

Diana LaFountain RN/DNS

12.30.15