

Division of Licensing and Protection  
103 South Main Street, Ladd Hall  
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

February 6, 2014

Mr. J. Michael Rivers, Administrator  
Pine Heights At Brattleboro Center For Nursing & R  
187 Oak Grove Avenue  
Brattleboro, VT 05301-6642

Dear Mr. Rivers:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 8, 2014**. 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

PC:jl

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

PRINTED: 01/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

RECEIVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____  Division of <b>FEB -3 14</b>  Licensing and Protection	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/08/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PINE HEIGHTS AT BRATTLEBORO CENTER FOR NURSING &amp; R</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>187 OAK GROVE AVENUE BRATTLEBORO, VT 05301</b>
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F 000	INITIAL COMMENTS	F 000		
F 250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide medically related social services for 1 resident identified (Resident #83) to attain or maintain the highest practicable physical, mental and psychosocial well-being. The findings include;</p> <p>1. Per review of a facility self reported incident on 1/8/14, Resident #83 was admitted to the facility on 12/11/12 with diagnoses that include, dementia, depression and behavioral concerns. Per review of the investigation on 10/29/13, Resident #83 reported to staff that during care a facility employee had "tossed me around and hurt me." Resident #83 indicated it was not an accident that the employee "doesn't like me and beat me about", "the employee got discouraged and beat me up and shoved me."</p> <p>Per review of the nurse notes for Resident #83,</p>	F 250	<p>1. Social Service Director has met with the resident and the resident remains medically and psychosocially stable at this time.</p> <p>2. All residents who feel they have been abused could be affected by this alleged deficient practice. Residents that experience a change in mood/behavior and/or make an allegation of abuse will be assessed by nursing and social service and care plans will be implemented by both disciplines.</p> <p>3. Education has been provided to the Social Service Director by the Corporate Regional Nurse. Education included review of regulatory compliance with federal regulations regarding Social Service assessments and care plan implementation with a residents change in condition and meeting the needs of residents. A checklist has been completed for abuse investigations, notifying Social Service an investigation is taking place. The Social Service Director will follow up with those</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Mike Rivers</i>	TITLE  <i>Administrator</i>	(X6) DATE  <i>1/30/14</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 250	<p>Continued From page 1</p> <p>after the incident on 10/29/13, Resident #83's behavior declined. Resident #83 became more weepy than prior to 10/29/13, and was unable to articulate reason for the weepiness. After 10/29/13, Resident #83 did voice concern on 11/3/13 that he/she "feared being dropped on the floor by an aide when being turned." The notes indicate that Resident #83 was needing more physical assistance, and on 11/5/13, Resident #83 was refusing care from numerous caregivers. On 11/6/13 the nurse notes indicate that Resident #83 had a very flat affect. The notes also reflect on 11/8/13 Resident #83 was weepy at comfort care orders and when staff asked resident why he/she was crying Resident #83 responded "I don't know".</p> <p>Per review of the Social Service notes, the Social Service Worker (SSW) interviewed Resident #83 on 10/29/13 regarding the interaction between the facility staff member and Resident #83. Per review of the SS notes, there was no evidence that the SSW assessed the change in status with Resident #83 and the increase in weepiness, refusal of care, voiced fears of staff and the resident's inability to articulate what was wrong when questioned by staff.</p> <p>Per review of the medical record there was evidence that Resident #83 was also experiencing a decline in physical condition and that this was causing weepiness and potential distress to Resident #83 when comfort care changes were placed for Resident #83. There was no evidence that the SSW assessed and collaborated with medical, nursing, the resident and family to discuss and recommend possible interventions and services to assist Resident #83.</p>	F 250	<p>residents weekly x 4 weeks to assess for any changes, physical or mental.</p> <p>4. Social Service notes will be brought to morning meeting to discuss how the resident is doing and ensure compliance with assessments care plans. The abuse investigation process is being discussed in QA monthly and being revised.</p> <p>5. Complete by 2/8/14.</p> <p>6. DNS responsible.</p> <p><i>FASO PCC accepted 2/4/14 BBOR/HRN/PMC</i></p>	

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F 250	<p>Continued From page 2</p> <p>Per interview with the Director of Nursing Services on 1/8/14, he/she reviewed the medical record and confirmed that after the 10/29/13 incident with Resident #83 and a facility staff member, there was a decline in the resident's behavior after the 10/29/13 incident and that further behavior changes were noted after changes in resident care. The DNS confirmed that there was no evidence that after 10/29/13, Social Services assessed Resident #83 regarding the decline in mental and physical status and collaboration with medical, nursing, the resident and family to identify the cause of the changes in mental and physical status from 10/29 to 11/21/13.</p> <p>Per review of the facility policy titled " Abuse" under Care Plan Process, immediately after the incident occurs, an interim care conference will be held to develop interventions to ensure that the resident does not experience any physical harm, pain or mental anguish. The policy also indicates that "The facility Social Worker is to provide counseling and support to a resident involved. Documentation of Psychosocial interventions must be in the medical record. Social Services will document in the medical record weekly for two weeks or more if appropriate. The documentation must include the effectiveness of approaches stated in the Interim Care plan.</p>	F 250		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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</p>	F 280	<p>1. Resident #83's Mood and Behavior care plan has been updated and reviewed and reflect his current status. His physical and psychosocial condition is stable at this time.</p>	

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F 280	<p>Continued From page 3 changes in care and treatment.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to review and revise the comprehensive care plan for 1 resident identified (Resident #83) after a noted decline in resident's physical and mental status. The findings include:</p> <p>1. Per review of the facility self report on 1/8/14, Resident #83 was admitted to the facility on 12/11/12 with diagnoses that include, dementia, depression and behavioral concerns. Per review of the investigation on 10/29/13, Resident #83 reported to staff that during care a facility employee had "tossed me around and hurt me." Resident #83 indicated it was not an accident that the employee "doesn't like me and beat me about", "the employee got discouraged and beat me up and shoved me."</p>	F 280	<p>2. All residents involved in an abuse investigation could be affected by this alleged deficient practice.</p> <p>3. A checklist has been completed for abuse investigations, notifying Social Service an investigation is taking place. At this time an interim care plan will be established and interventions put into place. Current care plans will also be updated by the team at this time. Care plans to address resident's behavior regarding abuse allegation will be reviewed at morning report to ensure compliance with follow up and monitoring of resident's behavior. Interventions and goals will be revised as needed.</p> <p>4. Every abuse investigation will be brought to the monthly QA meeting to discuss the process and to ensure care plan updates have been made and monitored.</p> <p>5. Complete by 2/8/14.</p> <p>6. DNS responsible.</p> <p><i>F280 POC accepted 2/4/14 BBORERW/PMC</i></p>	

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F 280	<p>Continued From page 4</p> <p>Per review of the nurse notes for Resident #83, after the incident on 10/29/13, Resident #83 behavior declined. Resident #83 became more weepy than prior to 10/29/13, was unable to articulate reason for the weepiness. After 10/29/13, Resident #83 did voice concern on 11/3/13 that he/she "feared being dropped on the floor by an aide when being turned." The notes indicate that Resident #83 was needing more physical assistance, on 11/5/13, Resident #83 was refusing care from numerous caregivers. On 11/6/13 the nurse notes indicate that Resident #83 had a very flat affect. The notes also reflect on 11/8/13 Resident #83 was weepy at comfort care orders and when staff asked resident why he/she was crying Resident #83 responded "I don't know".</p> <p>Per review of the medical record there was evidence that Resident #83 was also experiencing a decline in physical condition and that this was causing weepiness and potential distress to Resident #83 when comfort care changes were placed for Resident #83.</p> <p>Per interview with the Director of Nursing Services (DNS) on 1/8/14, he/she reviewed the medical record and confirmed that after the 10/29/13 incident with Resident #83 and a facility staff member, there was a decline in the resident's behavior after the 10/29/13 incident and that further behavior changes were noted after changes were made in resident care. The DNS reviewed the comprehensive care plan for Resident #83 specifically the care plans titled, Mood and Behaviors and confirmed that after the 10/29/13 incident there was no evidence that the care plan was revised to address the residents changes in mental</p>	F 280		

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F 280	Continued From page 5 and physical status and reflect interventions and approaches to reflect current resident status and assist the resident and staff on addressing these changes.  Per review of the facility policy titled " Abuse" under Care Plan Process, immediately after the incident occurs, an interim care conference will be held to develop interventions to ensure that the resident does not experience any physical harm, pain or mental anguish." The policy also indicates that "The documentation must include the effectiveness of approaches stated in the Interim Care plan."	F 280			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interviews, the facility failed to ensure that 1 of 5 sampled residents (Resident #61) was free of any significant medication errors. The findings include:  Per record review, Resident #61 admitted with diagnoses to include, Hypoglycemia, Diabetes Type II, and Morbid Obesity. Physician Orders dated 08/01/13 through 8/31/13 state: Lantus 100 units/milliliters vial (Insulin) to Inject 26 Units (U) Daily at 8 PM.  Per medical record review, nurses notes on 08/30/13 12:55 AM document , "At 10:15 PM	F 333	Past noncompliance: no plan of correction required. <i>✓AME</i>		

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F 333	<p>Continued From page 6</p> <p>patient received 100 units Lantus in error." Signed by Registered Nurse (RN) who made the error. Per interview with the Unit Manger, Director of Nurses (DNS) and Physician, confirmation was made on 01/07/13 at 4 PM that the RN administered 100 Units of Lantus Insulin instead of the 26 Units as ordered to Resident #61. Family was notified, and the resident was transferred to the acute hospital for observation and treatment. Resident returned to the facility on 08/30/13 at 2:30 PM with no negative outcomes documented.</p> <p>Per interview with the DNS on 08/30/13 through 09/06/13 education and competencies were conducted with all nurses who administer medications. DNS confirms on 01/08/13 at 10 AM that medication competencies will be conducted annually.</p>	F 333		