

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

July 26, 2016

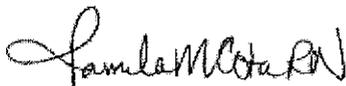
Mr. Francis Cheney, Administrator
Pines Rehab & Health Ctr
601 Red Village Road
Lyndonville, VT 05851-9068

Dear Mr. Cheney:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on June 22, 2016. 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: 07/05/2016
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 06/22/2016
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

An unannounced onsite complaint investigation was conducted by the Division of Licensing and Division on 6/22/16. The findings include the following:

F 221 483.13(a) RIGHT TO BE FREE FROM
SS=E PHYSICAL RESTRAINTS

F 221

The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

See POC attached

This REQUIREMENT is not met as evidenced by:

Based on record review, observation and staff interview, the facility failed to ensure that 1 of 3 sampled residents was free from a physical restraint (for Resident #3). The physical restraint is adjacent to the resident's body, the restraint can not be removed by the resident and restricts the resident's freedom of movement. This was previously cited on 2/25/15. The findings include the following:

During an environmental tour at approximately 2:15 PM, in the presence of the Director of Nurses (DNS), Resident #3 was observed sitting in a wheelchair in the living room on "A wing". The resident was incontinent of urine and was restrained with a belt restraint. The surveyor voiced that the resident is restrained and the DNS immediately responded "[S/he] can remove it". Resident #3 was asked by the surveyor if s/he could remove the belt restraint. After three (3) attempts the resident responded "No, no I can't", in a very weak soft voice. The DNS then

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

C. Diana LaFontaine, RN, BSN, LNHA 7-19-16

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 221 Continued From page 1 F 221

requested the resident to remove the belt restraint. Again, the resident was unable to disconnect the buckle closure. A Licensed Nurses Aide (LNA) whom was asked to provide incontinent care to the resident also requested the buckle to be disconnected. After approximately 5-6 attempts (in total), the resident was unable to complete the task of releasing the restraint.

Resident #3 was admitted on 9/9/15 with diagnosis to include Progressive Supra Nuclear Palsy with out sitting balance, Dementia, Pituitary Disorder, Parkinson's Disease and Cognitive Deficits. On admission physician orders stated, "sit belt to fit wheelchair". Physician orders for the following 9 months state, "sit belt to fit wheelchair". The physician order does not describe the type of restraint to be used or the parameters of use.

Informed Choice form dated 9/17/15, is not fully completed. The consent is intended to inform/educate the resident/families/guardians on the risks vs. the benefits of the physical restraint. There is no evidence in the medical record identifying that the information was provided to the family. Resident #3's representative signed the form on 9/18/15, nine (9) days after admission and six (6) days after the therapist identified that the resident has a seat belt on while up in the wheelchair. Nurse notes identify that the resident had a safety belt in place since 9/9/15.

Per interview with the DNS, confirmation was made that the family feels the need to restrain the resident in the wheelchair to avoid falls, there is no plan in place directing the staff to release the

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belt restraint at any specific times when up in wheelchair, and there has been no further assessment/evaluation by physical therapy to determine the need for continued use of the waist restraint. There is no focus on preventing adverse effects of the physical restraint use such as, but not limited to adverse outcomes such as functional decline, agitation, diminished sense of dignity, depression and the development of pressure ulcers. Confirmation is also made that there has been no communication with the family regarding a process for systemic and/or gradual restraint reduction as appropriate.

(see F279)

F 250 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE F 250

The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

All POE attached

This REQUIREMENT is not met as evidenced by:
Based on observation and confirmed by staff interview the facility failed to ensure that medically-related social services were provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being of for 1 of 3 sampled residents (Resident #1). This was previously cited on 8/25/15. The finding include the following:

Per Licensing and Protection intake information Resident #1's family had numerous unresolved

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F 250 Continued From page 3 F 250

complaints. Examples are, but not limited to Admission, Transfer and Discharge Rights, Quality of Care/Treatment, missing personal belongings, environmental concerns and assessments.

Per review of the Medical Record, there is no evidence that any discussions took place between Resident #1, his/her family and administrative staff to include the Social Service Director/ Medicaid Resident Financial Manager and/or the Admission/Discharge Coordinator.

Per discussion with both the Social Service Director/ Medicaid Resident Financial Manager and/or the Admission/Discharge Coordinator there were numerous meetings, telephone conversations and visits with the complainant, regarding the above listed complaints.

Confirmation was also made that staff did not document any of the discussions, plans for resolution of problems or initiatives that took place. Therefore, there is no evidence that Social Services provided necessary assistance in the resolution of complaints made.

(see F 514)

F 253 483.15(h)(2) HOUSEKEEPING & F 253
SS=E MAINTENANCE SERVICES

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:

see POC attached

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F 253 Continued From page 4 F 253

Based on observation and confirmed by the Director of Nurses (DNS) the facility failed to provide housekeeping services to maintain multi purpose rooms, halls and resident care areas in a sanitary, clean, and homelike environment. This citation was previously cited on 2/25/15. The findings include the following:

Per facility tour in the company of the DNS at 2 PM, the living room on "A wing" was found to have multiple cloth chairs/couches with numerous dark brown dried stains. The ramp leading to resident rooms, adjacent to the "A/B Wing" nurses station, was found to be heavily soiled with built up grease and grime was visible.

On all three units, furniture was found scratched and had missing and/or chipped pieces of the wood laminate covering. The furniture is in need of cosmetic repairs. The facility floors in resident rooms (linoleum) are worn as observed by tears and have a built up dirt and grime.

At 2:30 PM the DNS confirmed the above observations.

F 278 483.20(g) - (j) ASSESSMENT F 278
SS=D ACCURACY/COORDINATION/CERTIFIED

See POC attached

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

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F 278 Continued From page 5

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility failed to assure that the Minimum Data Set (MDS) assessment was accurately coded for 1 of 3 sampled residents (Resident #3). The finding include the following:

MDS Assessment completed and signed by the Registered Nurse/Director of Nurses on 3/21/16 for Resident #3, does not accurately code Resident #3 as being restrained by a physical restraint at any time during the day or night for 7 day look back period.

Confirmed by the DNS that the assessment does not identify that the resident has been restrained daily.

F 278

F 279 483.20(d), 483.20(k)(1) DEVELOP

F 279

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F 279 Continued From page 6
SS=E COMPREHENSIVE CARE PLANS

F 279

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 record review and staff interview the facility failed to develop comprehensive care plans for 2 of 3 sampled residents (Resident #1 and #3), to meet each resident's medical and nursing needs. This was previously cited on 8/25/15.

The findings include the following:

1. Per record review Resident #1 has a deep brain stimulator implanted into his/her brain. This is a device, inserted into the resident's brain and is attached to a wire that connects to a battery back located under the skin at the resident's

See POC attached

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F 279 Continued From page 7
collar bone.

F 279

Per interview with the Physical Therapist s/he identifies that due to the implantation of the stimulator, Resident #1's "movements were fluid and balanced. The stimulator minimized the Parkinson's Disease's spastic movements." The therapist voiced that s/he had discussions with staff how the stimulator improved Resident #1's abilities as compared to other residents who do not have a brain stimulator implanted. Staff were aware that they do not have to manage the stimulator, just monitor for changes in the resident's condition that could indicate the battery needed changing or adjustments were necessary with wiring.

Per Interdisciplinary Care Plan dated 2/25/16, identifies that Resident #1 has Parkinson's Disease. There is no notation that the resident has a Brain Stimulator implant or any observations or monitoring necessary to ensure functioning.

Per interview with the Director of Nurses confirmation is made that the the care plan does not include the brain stimulator; therefore, staff would not be aware of any changes that could identify that the equipment was not functioning properly or that follow up was necessary.

2. Resident #3 was admitted on 9/9/15 with diagnosis to include Progressive Supra Nuclear Palsy with out sitting balance, Dementia, Pituitary Disorder, Parkinson's Disease and Cognitive Deficits. On admission physician orders stated, "sit belt to fit wheelchair". Physician orders for the following 9 months state, "sit belt to fit wheelchair". The physician order does not

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F 279 Continued From page 8 F 279

describe the type of restraint to be used or the parameters of use.

Per Care Plan dated 9/9/15 and signed by a Registered Nurse, identifies a problem of Progressive Supra Nuclear Palsy need for restraint in wheelchair. Per Care Plan dated 9/17/15 and signed by the DNS identifies poor sitting balance related to nuclear palsy, need for safety belt. Care plans do not focus on preventing adverse effects of the physical restraint use such as, but not limited to adverse outcomes such as functional decline, agitation, diminished sense of dignity, depression and the development of pressure ulcers. Care plans does not identify a process for systemic and/or gradual restraint reduction as appropriate.

Per interview with the DNS confirmation was made that the care plan identifies a physical restraint for resident safety, that the family feels the need to restrain the resident in the wheelchair to avoid falls, there is no plan in place directing the staff to release the belt restraint at any specific times when up in wheelchair and there has been no further assessment/evaluation by physical therapy to determine the need for continued use of the waist restraint. Confirmation is made by the DNS that there has been no communication with the family regarding the reduction to the use of the restraint.

(see F221)

F 514 483.75(l)(1) RES F 514
SS=B RECORDS-COMPLETE/ACCURATE/ACCESSIB
LE

The facility must maintain clinical records on each

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resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

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.

See POC attached

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to ensure that medical records are complete and contain accurate documentation for 2 of 3 sampled residents (Resident #1 and #3). The findings include the following:

1. Per Licensing and Protection intake information, Resident #1's family had numerous unresolved complaints. Examples are, but not limited to Admission, Transfer and Discharge Rights, Quality of Care/Treatment, missing personal belongings, environmental concerns and assessments. Per Medical Record record review, there is no evidence that any discussions took place between Resident #1, his/her family and administrative staff to include the Social Service Director/ Medicaid Resident Financial Manager and/or the Admission/Discharge Coordinator.

Per discussion with both the Social Service Director/ Medicaid Resident Financial Manager and/or the Admission/Discharge Coordinator there were numerous meeting, telephone conversations and visits with the complainant,

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regarding the above listed complaints. Confirmation was also made, that neither of the professional staff members documented any of the discussions, plans for resolution of problems or initiatives that took place. Therefor there is no evidence that Social Services provided necessary services to assist in the resolution of complaints made.

2. Per medical record review for Resident #3 physician orders dated and signed on 9/9/15 identify "Sit belt to fit wheel chair that patient received specify". Physician orders dated and signed for the month of June identify "Sit belt to fit wheeichair". The physician order does not describe the type of restraint to be used and the parameters of use.

Per interview with the Director of Nurses confirmation is made that the physician orders do not clarify the use/need of the belt restraint and/or instructions for the management of, nor is there documentation identifying any plan or discussion for discontinuation or gradual reduction of the use of the restraint.

3. Minimum Data Set Assessment completed and signed by the Registered Nurse/Director of Nurses on 3/21/16 for Resident #3, does not accurately code Resident #3 as being restrained by a physical restraint at any time during the day or night for 7 day look back period.

Confirmed by the DNS that the assessment does not identify that the resident has been restrained daily.

(see F250 & F278)

The Pines Rehabilitation and Health Center
Plan of Correction
Complaint Survey Completed on June 22, 2016

F221 483.13(a) Rights to be Free from Physical Restraints

The Facility failed to ensure that 1 of 3 sampled residents was free from a physical restraint.

I. Action taken to correct the deficiency:

1. The physicians order was re-written to be more "specific". The order did describe the type of belt- it was a seat belt. See copy of new order.
2. The informed choice was completed. The alternatives in #9 of the form were stated in #7 of the form. See copy of form.
3. The evidence that the family received the information of risks vs benefits- is his signature. The copy goes with the family. A new Informed Consent Form has been signed and copy enclosed.
4. There are specific times the belt is released and it is care planned under toileting, and obviously Resident #1 does not use her seat belt in bed. A new 'Posture Belt Release Demonstration Form has been put in place. See enclosed form.
5. PT. did do another safety seat belt screen on 7/10/2016 to show that it is medically necessary and NOT for discipline or convenience. See enclosed copy.
6. Met with Resident #3's husband about the safety seat belt on 6/24/2016 and he wants to keep it to maintain what quality of life she has left.
7. There is a focus on the adverse effect for seat belt use such as functional decline, agitation, depression and development of pressure ulcers in OTHER areas of her care plan- but was added again to her seat belt/restraint care plan.

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

1. Will care plan all posture seat belts as a potential restraint even if resident can take it off at the time belt put in place.
2. Will have PT do quarterly evaluations of belt use (following MDS process).

3. Will use new posture belt release demonstration form for all residents in need of posture belt to monitor change in ability to self-release belt and to trigger PT screen and restraint screen.

4. Will have MD be more specific on all potential restraint orders.

All residents have the potential to be affected.

Completion date: July 19, 2016

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

F221 POC accepted 7/26/16 M. Bertrand RN/PMC

F250 483.15(g)(1) Provision of Medically Related Social Services

The facility failed to ensure that medically – related Social Services were provided to attain or maintain the highest practical , physical, mental, and psychsocial well being of 1 of 3 sampled residents (Resident 1).

I. Action taken to correct the deficiency:

1. Resident #1 is no longer a resident here so nothing can be done at this time to prove that Social Services met with resident #1's family member and had several phone conversations.

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

1. Initiate complaint/concern log and the notes will be kept on computer unless there is a formal grievance.

2. If formal grievance requested- family will be advised to come in and fill out paper work to start process.

3. Appropriate department heads will be notified.

4. Social Services will track action taken and resolution.

5. Concerns only- if family chooses not to file a formal grievance and just wants an issue addressed then it will be in the log.

6. Log will contain information on concerns and grievances.

7. Will discuss family issues and possible solutions and expected outcomes.

8. Family will be kept apprised of progress and notified of resolution.

9. Concerns will be directed to Social Services (unless it can be immediately rectified).

All residents have the potential to be affected.

Completion date: July 19, 2016

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

F250 POC accepted 7/26/16 M.Bertrand/PMC

F253 483.15(h)(2) Housekeeping and Maintenance Services

The facility failed to provide housekeeping services to maintain multipurpose rooms, halls and resident care areas in a sanitary, clean and homelike environment.

I. Action taken to correct the deficiency:

1. The furniture (couch, high back chair) with stains (2 chairs out of 10) were shampooed and stains removed.

2. The ramp leading to resident rooms and the outside doors has received heavy traffic bringing in mud. The ramp was shampooed.

3. The scratched furniture has been re-stained to provide cosmetic repairs.

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

1. Extra housekeeping/maintenance staff added for the heavy duty cleaning and repairs re; rug shampooing, staining, painting, window cleaning etc.

2. Furniture will be ordered on a time schedule to replace items that cannot be repaired.

3. Maintenance will make a weekly walk through of building to ensure multipurpose rooms, halls, resident care area and furniture are clean and not in need of repair. A log will be kept of items found and time frame for resolution of problem.

All residents have the potential to be affected.

Completion date; July 19, 2016

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

F253 POC accepted 7/26/16 M.Bertrand/PMC

F278 483.20(g)(j) Assessment Accuracy/Coordinator/Certified

The facility failed to assure that the MDS assessment was accurately coded for 1 of 3 sampled residents. (Resident #3).

I. Action taken to correct deficiency:

1. The MDS completed and signed by the DNS on 3/21/2016 for resident #3 was accurate at that time. She did have a seat belt however the regulation states that it is only a restraint if the "wearer" cannot remove it. She was able to remove it at least through 5/19/2016 when MD documented in progress note that she released it.

2. A new "Posture Belt Release Documentation Form" has been put in place to track when someone is no longer able to release the belt. This will trigger a PT screen and a restraint screen to assure adequacy of MDS coding.

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

1. The MDS nurse will use these assessments on an ongoing basis to develop review and revise the resident's comprehensive care plan

All residents have the potential to be affected.

Completion date: July 19, 2016

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

F278 POC accepted 7/26/16 M. Bertrand RN/rmc

F279 Comprehensive Care Plans

The facility failed to develop comprehensive care plans for 2 of 3 sampled residents (residents #1 and #3).

I. Action taken to correct deficiency:

1. There was no mention in the problem list or anywhere in the record of resident #1 having a deep brain stimulator. In talking to PT after the complaint survey she stated that the resident "told her" that he had one. The only note in the record stated that a CT scan of the brain was done and it showed a shunt in the brain. (See enclosed copy)

2. A telephone call was made to the medical director who also stated that it wasn't in the record. She did on 7/12/2016 look into DHMC's records and found where he did have one implanted in 2011 however as long as there was a care plan for Parkinson's there would be not be any reason to have this on a care plan. See Medical Directors letter enclosed.

3. Nothing else could be done for resident #1 as he is no longer a resident here.

4. Resident #3's physicians order was re-written to clarify use. The order did describe type of belt- it was a SEAT belt but there were no parameters. See copy of new order.

5. Resident #3's seat belt care plan was re-written to address possible adverse outcomes (even though they are addressed in other areas of care plan).

6. The care plan does state that the resident is to go to the toilet q2 hrs so the belt comes off at that time; however, it was also added to the seat belt care plan.

7. PT di another therapy screen on 7/10/2016 to show that it is medically necessary and not for discipline or convenience. See enclosed copy.

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

1. Will care plan all posture seat belts as a potential restraint even if a resident can take it off at the time the belt was put in place. This will be done on an ongoing basis.

2. Chart audits will be done when change in status is noted and also on a routine basis following quarterly care plan schedule on an ongoing basis.

All resident have the potential to be affected

Completion date: July 19, 2016

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

F279 POC accepted 7/26/16 M.Bertrand/ame

F514 483.75(l)(1) Resident Records-Complete/Accurate/Accessibility

The facility failed to ensure that medical records are complete and contain accurate documentation for 2 of 3 sampled residents.

I. Action taken to correct deficiency:

1. Resident #1 has been discharged and there is nothing that can be done at this point to show evidence that Social Services provide necessary services to assist in resolution of complaints made.

2. The physicians order for resident #3 DOES describe the type of seating device or "restraint"- it is a seat belt. The order was re-written to include parameters of use. See enclosed copy.

3. Other measures were tried and documented. See copy of restraint form that demonstrates other methods tried, however; there will be NO discontinuation or reduction of use per MD, therapy, and family. This is medically necessary to IMPROVE quality of life. See letter from MD and therapy screen.

4. There was no coding of the seat belt as a restraint for Resident #3 on the MDS Assessment dated 3/21/2016 as she had demonstrated the ability to take off the seat belt to the MDS nurse during quarterly assessment and the last document time that she took it off herself was in MD progress note dated 5/19/2016. So at that time it was NOT considered a restraint as she could release it.

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

1. Initiate complaint/concerns log that will show evidence that Social Services provided necessary services to assist in resolution of complaints/concerns made to facility. This will be kept on an ongoing basis.

2. Will care plan ALL posture seat belts as a potential restraint even if a resident can take it off at the time the belt was put in place. This will be done on an ongoing basis.

All residents have the potential to be affected.

Completion date: July 19, 2016

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

FS14 POC accepted 7/26/16 MBeArand RN/PMU

Diana LaFountain, RN, BSN, LNHA
7.19.16