

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 23, 2012

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 **February 1, 2012**. 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, MS
Licensing Chief

PC:jl



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

Division of

FEB 21 12

PRINTED: 02/08/2012
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 _____	Licensing and Protection (X3) DATE SURVEY COMPLETED 02/01/2012
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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
F 000	INITIAL COMMENTS	F 000		
F 248 SS=D	<p>An unannounced, on-site recertification survey was conducted by the Division of Licensing and Protection from 01/30/2012 to 02/01/2012. The following regulatory issues were identified:</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and review of the Activity calendar, the facility failed to provide for an ongoing program of activities to meet the intrests and well-being of 3 of 16 residents. (Residents #8, #47, and #64) Findings include:</p> <p>Per review of the activities program on 02/01/2012 at 12:40 PM, there are rarely activities scheduled for evenings or weekends</p> <p>1. Resident #8 indicated during Stage 1 interview on 01/31/2012 at 11:38 AM, that there are no activities offered on evenings or weekends. This is confirmed during interview with the Nursing supervisor on 02/01/2012. S/he indicates that there are a few scheduled group activities during evenings and weekends, and that the activity staff alters their schedules to attend but most planned activities are scheduled during the week and on the day shift. S/he further confirms that nursing</p>	F 248	<p>Please refer to attachments for details</p>	2-28-12 Dc

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Francis Cherry TITLE: Administrator (X6) DATE: 2-17-12

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 248	Continued From page 1 staff will occasionally put in a movie for residents to watch but that activities are usually the responsibility of the activity department. Per observation of the activity calendar during the 3 days of survey, all Saturdays and Sundays for the month of January are blank, as are the evening hours. 2. Resident #47 indicated during interview on 01/31/2012 at 9:30 AM that the facility does not offer activities on evenings and weekends. Per interview with Nursing supervisor on 02/01/2012 s/he confirms that there are no to minimal activities offered to residents on the weekends or during the evening hours. The activity calendar reflects that nothing is scheduled for the residents on evenings or weekends. 3. Per Stage 1 interview on 1/30/12 at 4:20 PM, Resident #64 stated that the facility does not provide any organized activities in the evenings or on weekends, and sometimes it's "boring". This surveyor also observed a lack of scheduled activities listed on the monthly calendar.	F 248		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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	F 280	<i>Please refer to attachments for details</i>	<i>2-28-12 DL</i>

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F 280	<p>Continued From page 2</p> <p>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, observation and interview, the facility failed to ensure that care plans were revised to reflect residents' actual falls and include new interventions to minimize fall risk. This affected two (#5, #21) of three resident care plans reviewed for falls. Findings include:</p> <p>1. Review of the clinical record for Resident #21 on 02/01/12, revealed diagnoses of non organic psychosis, depression and dementia with agitation. The nurses notes dated 01/28/12 at 8:00 P.M. indicated that the Resident had been observed on the floor beside the bed with a cut above the right eye. The fall risk assessment completed 11/02/11 revealed a score of 17, with a score of 10 or higher indicating a high risk. The quarterly minimum data set assessment for the period ending 10/31/11, indicated Resident #21 had impaired short term memory and moderately impaired decision making skills, and required extensive assistance from one staff for toileting, hygiene, and mobility off of the unit. The plan of care for At Risk for Accidents/Falls/Injury, initiated on 4/26/10 revealed that Resident #21 had confusion, gait problems, and used narcotic pain</p>	F 280		
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F 280	<p>Continued From page 3</p> <p>medications. The goal was to not sustain serious injury. The interventions included to maintain a clear pathway, keep needed items in reach, medications, labs and treatments per physician orders, fall assessment quarterly, keep wheel chair in reach as the resident uses it to push when ambulating, non skid foot wear on when out of bed, Physical Therapy evaluation as needed and glasses clean and applied daily as the resident allows. The plan of care did not reflect Resident #21 had an actual fall or changes to the interventions after the fall with injury on 01/28/12.</p> <p>Observation of Resident #21 on 1/31/12 at 4:05 P.M. revealed s/he was seated on the side of the bed. The room was at the end of the hall and Resident #21 preferred the door closed. Personal items and the wheelchair were in reach. The curtain was pulled to obstruct the view from the door. Resident #21 wore non skid socks on both feet. A Band-Aid was intact to the right temple above the eye. Bruising was noted to the right eye and right side of the face.</p> <p>During interview of the C unit Licensed Nursing Assistant (LNA) on 01/31/12 at 2:30 P.M. and the Licensed Practical Nurse (LPN), C unit charge nurse, on 01/31/12 at 4:00 P.M., both verified that Resident #21 was far from the common area and the activity on the unit and prefers the door closed. Both indicated Resident #21 used the call bell rarely and staff were in the room only about every two hours to offer assistance with toileting that was often refused. Both were unaware of any change to the plan of care or interventions since the fall on 01/28/12. During interview on 02/01/12 at 1:35 P.M., the Director of Nursing Services (DNS) stated that the facility</p>	F 280			

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F 280	<p>Continued From page 4</p> <p>does not update the care plan to reflect actual resident falls. The DNS verified that the plan of care for At Risk for Accidents/Falls/Injury for Resident #21 did not indicate any actual falls had occurred and the interventions had not been reviewed and revised after the fall on 01/28/12.</p> <p>2. Per record review on 1/31/12, Resident #5 has a diagnosis of advanced dementia with generalized weakness and is unable to walk independently. Per review of the resident's record, the last fall risk assessment was completed on 10/24/11 as a quarterly update, and the resident was considered a high risk of falls as they were in other quarterly assessments completed earlier in the year. The resident had actual falls on 10/28/11 in their room, 11/29/11 also in the resident's room, 1/2/12 in the common area, and also on 1/20/12 in the common area. Per interview on 2/1/12 at 10:45 AM, the LNA working on C wing stated that the resident was able to move very quickly to a standing position, however was not strong enough to maintain an upright position and would fall. The LNA also said that the resident wears a rise alarm at all times; however, the Resident knew how to turn off the alarm and would do so frequently. Per review of the resident's plan of care, there was no mention of the actual falls that had occurred in the last few months, and no evidence of review of the current interventions in place to see if they were meeting the needs of the resident, and no mention of the fact that the resident was turning off the rise alarm that is meant to alert staff that they are getting up. Per interview on 2/1/12 at 1:35 PM, the Director of Nursing stated that the care plans are not revised in relation to goals being met or not, and not updated to reflect actual falls when</p>	F 280		
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F 280	Continued From page 5 they occur.	F 280		
F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p><i>Please refer to attachments for details</i></p>	<p><i>2/28/12 DL</i></p>

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F 441	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure sanitary storage of activity supplies and medical equipment on one (unit C) of three units. This had the potential to affect 16 Residents who reside on the C unit in the facility. Findings include:</p> <p>During observations in the common area on C unit on 1/31/12 at 3:15 P.M., activity supplies including books, puzzles, building blocks, nuts and bolts and stuffed balls, were observed to be stored on a shelf in the common bathroom, just off of the living room. One Resident was observed to exit the bathroom independently. Observation of the bathroom immediately after the Resident exited revealed that large amounts of toilet tissue had been wound up and put behind the toilet and remained attached to the roll across the room. A soft, stuffed soccer ball was observed on the top shelf of the storage rack with a streak of a light brown material across it approximately three inches long. On 2/1/12 at 11:30 A.M. the shelf was noted to have medical equipment including a blood pressure cuff, stethoscope, and clip on alarm stored on the second shelf.</p> <p>Interview of the Licensed Nurse Aid (LNA) supervising the common area on 1/31/12 at 3:15 P.M. revealed that two Residents of the current census of 16 toilet themselves independently in the common bathroom. The LNA was not able to state if they washed their hands appropriately</p>	F 441		
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F 441	Continued From page 7 after toileting. The LNA verified that the unit housed Residents with cognitive impairments. The LNA indicated that one Resident was known to rummage through the items on the shelf as if looking for something. The LNA also stated that the activity supplies were available for use by evening and weekend nursing staff to use as needed with Residents when activity staff were not available on the unit. The LNA verified that the items were loose on the shelves, that the blocks were in a bag that could be zipped closed but were not, and could not identify the material noted to soil the stuffed soccer ball. During interview on 02/01/12 at 11:00 A.M., the Licensed Practical Nurse (LPN) C unit Charge nurse verified that the medical equipment stored in the common bathroom was used on all the Residents on the unit and stated it might not be the best practice to keep them in the bathroom.	F 441		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475044	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 2/1/2012
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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
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 156

483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible

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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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 156	<p>Continued From Page 1 for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide evidence that 1 of 3 residents in the applicable sample, or their representative, was informed that the effective date of coverage for skilled nursing services would end (Resident #74). Findings include:</p> <p>1. Per record review and interview, the facility failed to provide evidence that Resident #74, or the responsible party, was informed in writing that coverage for skilled nursing services would end on the effective date. The Social Services/Admissions Coordinator confirmed in an interview at 8:40 AM on 2/1/12 that the facility is unable to provide evidence that a Notice of Medicare Provider Non-Coverage was issued for Resident #74.</p> <p><i>Refer to attachments for details 2.17.12</i></p>		

The Pines Rehabilitation and Health Center
Plan of Correction
Survey Completed on 02/01/2012

F248 483.15(f) (1) Activities Meet Interest and Needs of Each Resident

The facility failed to provide for an ongoing program of activities to meet the interests and well-being of three of sixteen residents (Residents #8, #47, and #64) due to rarely having activities scheduled for the evenings and weekends.

I. Action taken to correct deficiency:

1. The February activity calendar was adjusted to reflect activities on nights and weekends. All ongoing calendars will reflect activities on nights and weekends.
2. Residents #8, #47, and #64 were interviewed to reveal what activities they would like on nights and weekends. Resident #8 doesn't want activities on nights or weekends "It's my time to rest." Resident #47 would like more crafts available. Resident #64 doesn't want in-house activities on nights or weekends she wants to be out of the facility. Out of facility activity options were discussed with resident #64 and with her family to get her out of the building as much as possible.
3. Continuing with resident interviewing and resident council to address residents interests, needs and well-being on an ongoing basis.

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

1. Activities staff will interview three to five residents a week for a month, then three to five residents a month, then sporadically each week to ensure that their interests are being met on an ongoing basis. (This is in addition to scheduled interviews).

All residents have the potential to be affected.
Completion date 02/28/2012

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

*Accepted: J. Coleman, RD
2/22/2012*

F280 483.20(d) (3), 483.10 (k)(2) Right to participate Planning Care- Revise Care Plan

The facility failed to ensure that care plans were revised to reflect residents actual falls and include new interventions to minimize fall risks for residents #5, and #21.

I. Action taken to correct deficiency:

1. Resident #21's fall of 1/28/2012 was added to the care plan on the morning of 1/29/2012 with new interventions to minimize fall risk.
2. Resident #5's care plan was updated on 2/1/2012 to reflect date of falls and update interventions.
3. An in-service on fall protocol, reports, interventions and care plans was provided on 2/28/2012.
4. LN's will add actual falls on care plans as well as new interventions on their shifts as they occur.

II. Corrective Actions Monitored so that deficient practice does not recur:

1. Fall reports and care plans will be reviews by supervisor every morning Monday thru Friday to ensure actual falls and updated interventions have been added to care plans on an ongoing basis.

All residents have the potential to be affected. Completion date 2/28/12.
Diana LaFountain RN/DON is responsible for the correction of the deficiency.

*Accepted POC: J. Coleman, RN
02/22/2012*

F441 483.65 Infection Control, Prevent Spread, Linens

The facility failed to ensure sanitary storage of activity supplies and medical equipment in one of three units.

I. Action taken to correct deficiency:

1. The shelf that held activity supplies and medical equipment was taken out of the bathroom 2/2/12.
2. All stuffed animals /balls etc that were on the shelf was disposed of. The rest of the activity supplies were cleaned and moved to a different location.
3. Activities supplies were moved to an area where wandering residents cannot rummage through them unattended.
4. Medical equipment was moved to another storage area.
5. All staff informed of new storage areas and cleaning of equipment after use.
6. Sign in and out sheet for activity supplies to aid in return of equipment to storage area.

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

1. The activity staff will check proper storage of activity equipment daily for a month, then weekly for a month, then sporadically on an ongoing basis to ensure continued compliance.
2. LNA's will check proper storage of medical equipment every shift on an ongoing basis. LN's will check on LNA's every shift for a month, then weekly for a month, then sporadically to ensure continued compliance.

All residents have the potential to be affected.
Completion date 2/28/2012

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

Accepted POC: *J. Coleman, RN*
02/22/2012

F156 483.10 (b)(5)-(10), 483.10 (b)(1) Notice or Rights, Rules , Services, Changes

The facility failed to provide evidence that one of three residents in the applicable sample, on their representation was informed that the effective date of coverage for skilled nursing services would end (Resident #74).

I. Action taken to correct deficiency:

1. On 2/15/2011 the Social Service /Admissions Coordinator call resident #74 to verify that she received the "End of Medicare" notice
2. The facility will maintain the facilities copy of the "End of Medicare" notices in a separate file in the office verses in the individual residents files, so that all notices are accessible in one area.

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

1. The administrator will review Medicare file weekly to ensure that all "End of Medicare" notices have been sent and copies have been filed.

All Medicare residents have the potential to be affected.
Completion date 2/28/2012.

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

Accepted POC: *J. Coleman, RN*
02/22/2012