VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

September 14, 2018

Ms.. Diane Sullivan, Administrator
Pine Heights At Brattleboro Center For Nursing & Rehab
187 Oak Grove Avenue
Brattleboro, VT 05301-6642

Dear Ms.. Sullivan:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 14, 2018**. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475023	A. BUILDING _____ B. WING _____	C 08/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE HEIGHTS AT BRATTLEBORO CENTER FOR NURSING & R	187 OAK GROVE AVENUE BRATTLEBORO, VT 05301

(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 An unannounced on-site investigation of a facility self-reported incident was conducted on 8-14-18 by the Division of Licensing and Protection. There were no regulatory violations identified for the self-report; however, there was a regulatory violation identified.	F 000	This plan of correction is the facility's credible allegation of compliance. The filing of this plan does not constitute an admission that the deficiencies alleged did in fact exist. This plan is filed and executed as evidence of the facility's desire to comply with the provisions of federal and state law, and to continue to provide quality care and services.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656	**F656 Comprehensive Care Plans** The facility develops and implements a comprehensive person-centered care plan for each resident. Floor mats were implemented per Resident #3's plan of care on 8/14/18. Resident fall care plans were reviewed and audited for intervention compliance by the DNS and/or his designee. Nursing staff received education regarding "Comprehensive Person Centered Care Plans" and the importance in implementing the interventions, by the DNS and/or his designee. Care Plan "fall interventions", for all new falls, will be reviewed and audited weekly by the Standards of Care Committee. A monthly audit of fall interventions and their implementation will be completed by the DNS and his designees. Audit findings will be reported monthly to the QAPI Committee until 3 consecutive months of 100% compliance is achieved. Audits will then be performed semi-annually to ensure continued compliance. Audit results and QAPI findings will be reviewed and monitored by the Administrator monthly. Completion Date: September 21, 2018	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane L. Sullivan — TITLE: Administrator — (X6) DATE: 9/12/18

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.

F656 POC accepted 9/14/18 DWideawakeRN/PMC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475023	A. BUILDING _____ B. WING _____	C 08/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE HEIGHTS AT BRATTLEBORO CENTER FOR NURSING & R	187 OAK GROVE AVENUE BRATTLEBORO, VT 05301

(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 656	Continued From page 1 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to follow a care plan for fall prevention for 1 of 3 residents in the applicable sample (Resident #3). Findings include: Per record review Resident #3 had an unwitnessed fall on 7/19/18. The care plan was updated on 7/19/18 to use "Floor mats on both sides of bed". Per observation on 8/14/18 at 2:04 PM, Resident #3 did not have floor mats on either side of his/her bed. Per interview on 8/14/18 at 2:07 PM with a Licensed Nursing Assistant (LNA), s/he confirmed that there were no floor mats on either side of Resident #3's bed. A Licensed Practical Nurse (LPN) also confirmed this, and stated that s/he was not aware that Resident #3's care plan had been updated with this intervention.	F 656		