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

August 5, 2022

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 **July 13, 2022.** 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

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 07/13/2022

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
E 000	Initial Comments The Division of Licensing and Protection conducted an annual emergency preparedness survey on 7/13/2022. The facility was found in substantial compliance with emergency preparedness regulations.	E 000	This plan of correction is the facility's credible allegation of compliance. The filing of this plan does not constitue 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 000	INITIAL COMMENTS An unannounced on site recertification survey and staff vaccine requirement review were conducted by the Division of Licensing and Protection on 07/11/22 through 07/13/22. The following regulatory finding was identified:	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote	F 686	F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer The facility performs comprehensive assessments of each resident. On 7/12/2022 resident #76's skin was audited and the pressure ulcers were assessed, the resident's treatments were reconciled. A comprehensive audit of all residents with an alteration in skin condition was completed to ensure that there were no other residents affected. Nursing staff received education regarding "Treatment/Services to Prevent/Heal Pressure Ulcers" and specifically, the order transcription process when a pressure ulcer is discovered. (Continued)	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (Beauregard David) TITLE Administrator (X6) DATE 8/3/2022

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 686	Continued From page 1 healing, prevent infection and prevent new ulcers from developing for 1 of 3 residents in a standard survey sample. Per record review for Resident #76, admitted in late June, 2022, the resident had unstageable pressure ulcers to the right and left buttocks on the admission assessment. Interview with unit LPN on 7/12/22 at 10:25 AM, the LPN was unaware of resident #76 having any open skin areas. On 7/12/22 at 10:30 AM, the Unit Manager and Director of Nursing (DON) confirmed the resident did currently have open areas on both right and left buttocks and that these areas were being treated. They were unable to locate any provider orders to treat the pressure ulcers or documentation that the ulcers had been receiving any treatment. On 7/12/22 at 3:45 PM, the DON reported a verbal order for treatment had been previously received; however, it had not been documented in the electronic health record nor had it been put on either the Medication Administration Record (MAR) or the Treatment Administration Record (TAR). Therefore, there was no documentation to substantiate the receipt of an order for treatment or record of treatment having been completed.	F 686	Admission skin assessments will be audited within 24 hours by the DNS or her designee to ensure all necessary documentation components are complete, including, a transcribed physician's order for treatment. The results of these audits will be reviewed by the DNS or her designee weekly at Standards of Care meeting. Audit results will be presented monthly at the QAPI Committee meetings until 3 consecutive months of 100% compliance have been achieved. Monthly QAPI audit results will be reviewed and monitored by the administrator. Completion date: 8/9/2022 and ongoing F686 POC accepted 8/4/22 HFox RN/mc	