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

October 9, 2024

Mr. David Beauregard, Administrator
Pine Heights at Brattleboro Center for Nursing & Rehabilitation
187 Oak Grove Avenue
Brattleboro, VT 05301-6642

Dear Mr. Beauregard:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **September 11, 2024.** 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,

PamelaMCotaRN
Pamela M. Cota, RN, BS
Assistant Division Director
State Survey Agency Director

Enclosure

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 09/11/2024

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

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E 000	Initial Comments The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey on 09/11/24. There were no regulatory violations identified.	E 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 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey and investigated one facility reported incident (ACTS # 23230) from 9/8/24 through 9/11/24 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following deficiencies were identified:	F 000		
F 585 SS=C	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available	F 585	Grievances On September 18, 2024 the Facility installed wall holders for grievance forms and envelopes on each nursing unit with posted signage containing information about the Facility's grievance Officer. The grievance officer or his designee completes regular rounds to collect any grievances in the mailboxes for follow-up. On September 20, 2024 each resident/patient was provided with a letter concerning the Facility's grievance/concern process, as well as a copy of the Facility's grievance Process.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 10/8/2024

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 585	Continued From page 1 to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to	F 585	On September 23, 2024 the Grievance Officer attended resident council meeting to review the grievance policy with council members and address any questions, comments, or concerns. The Grievance Officer or his designee will review grievances and their resolution daily (Monday-Friday) as part of the interdisciplinary meeting process. The Grievance Officer or his designee will review grievances monthly at QAPI meeting to identify trends and report findings. Monthly QAPI results will be monitored by the Administrator. Completion Date: 10/17/2024 and ongoing **Tag F 585 POC accepted on 10/8/24 by C. Howard/P. Cota**	

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F 585	Continued From page 2 prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interviews, observation, and record reviews, the facility failed to support the resident's right to file grievances anonymously for 5 out of 5 residents in the sample (Resident's #5, #26, #55, #53 and #67). This has the potential to affect all	F 585		

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F 585	Continued From page 3 residents in the facility. Findings Include: Per interview at Resident Council (RC) on 9/11/2024 at 10:30 AM, 5 out of 5 residents revealed they did not know how to file a grievance anonymously, or at all, and had no access to forms to be able to file anonymously or independently. All five residents revealed if they had known and understood their rights to file a grievance, they would have done so. Per observation of all units at the facility at 11:45 AM, there was no evidence of grievance forms on any unit for a resident, or his/her representative, to submit a grievance independently or anonymously. Per interview on 9/11/2024 at approximately 12:00 PM with the Administrator, s/he confirmed that there were no forms available for individuals to file a grievance independently or anonymously on any units. The Administrator confirmed during interview there was not a process or form available for the residents or responsible party to file a grievance independently or anonymously. Per facility policy titled "Grievance/Concern Policy", it states the following: "The residents/responsible party can bring forward their concerns verbally and or by written grievance process. Grievance/Concerns forms are available on the nursing units and in the front lobby where applicable." There is no evidence that forms were made available or that residents/representatives had access to file a grievance independently or anonymously.	F 585		

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F 677	Continued From page 4	F 677		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based upon observation, interview, and record review, the facility failed to provide Activities of Daily Living [ADL] care and assistance to maintain good nutrition for 1 dependent resident [Res.#39] of 3 sampled residents dependent on ADL assistance. Findings include: Per review of Res.#39's Care Plan, the resident is identified as having as having "Dysphagia" [Dysphagia is a medical term for difficulty swallowing. Difficulty swallowing can lead to: Malnutrition, weight loss and dehydration.]*, "has risk for weight loss and malnutrition due to variable meal intake and dysphagia as well as cognitive impairment", "at risk for dehydration", "has impaired cognitive function/dementia or impaired thought processes", "has an ADL [Activities of Daily Living] self-care performance deficit related to dementia", and "has impaired visual function related to left eye blindness". Care Plan interventions to counteract Res.#39's nutritional risks include "EATING: Continual supervision, May need more cues/assist"," Provide feeding/dining assistance as needed. Set up for meals", "Ensure the resident has access to Beverage of choice", and "Ensure all meals and fluid intake occur under staff supervision". A meal observation was conducted on 9/9/24 at	F 677	ADL Care Provided for Dependent Residents A therapy screen was completed for resident #39 to evaluate resident #39's self-feeding. Nursing staff have completed competencies related to "Eating & Swallowing". Nursing staff were provided education regarding cueing and monitoring as it relates to the resident's care plan; as well as the need to reevaluate resident preferences if their acceptance of food and fluid is suboptimal. Dining observations/audits will be completed for at least one meal per day (5 Days/week) per unit (at least 15 observations/week) by the DNS or her designee. Audit results 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 three consecutive months of 100% compliance have been achieved.	

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F 677	Continued From page 5 11:45 AM. During the lunch meal observation, Res.#39 was observed seated in a wheelchair with h/her eyes closed at a table with 4 other residents. At 11:45 AM, a meal platter and a drink were placed in front of Res.#39, along with platters in front of the other 4 residents, including a resident seated next to Res.#39. Per observation, a staff Licensed Nursing Assistant [LNA] sat down next to the resident seated next to Res.#39, and the LNA began to feed that resident. Res.#39 was positioned in front of h/her meal and drink and made no attempt to feed h/herself or was cued or assisted by staff for approximately 10 minutes, while the other residents at the table ate their meal and the resident seated next to Res.#39 was being fed by the LNA. At 11:55 AM, another resident, Res.#34, approached the table in their wheelchair, took the drink from in front of Res.#39, drank from it, then wheeled away from the table carrying the drink with them. The LNA seated at the table said nothing to Res.#34 and did nothing to intervene. Res. #39 remained seated at the table in front of h/her meal for another 11 minutes without cueing or assistance, when a second LNA came over to the table and replaced the drink that the other resident had taken. Res.#39 was not offered the drink or cued to drink. At 12:10 PM, 25 minutes after the meal platter was placed in front of Res.#39, after the LNA had finished feeding the resident seated next to Res.#39 and the other residents at the table had finished their meals, the LNA moved their chair next to Res.#39 and offered h/her a bite of the meal. Res.#39 took a spoonful of the food and shook h/her head. The LNA did not question the resident as to why they disliked it, if they wanted an alternative, or if the meal needed reheating after sitting uncovered for 25 minutes.	F 677	Monthly QAPI audit results will be reviewed and monitored by the Administrator. Completion Date: 10/17/2024 and on going **Tag F 677 POC accepted on 10/8/24 by C. Howard/P. Cota**	

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F 677	Continued From page 6 An interview was conducted with the facility's Director of Nursing [DON] on 9/10/24 at 9:30 AM. The DON confirmed that Res.#39 was identified as at risk for weight loss, malnutrition and dehydration, and diagnosed with impaired cognition and dementia along with difficulty swallowing. The DON confirmed Res.#39 is dependent on staff for cueing and assistance with meals, and agreed that based on the observation on 9/9/24 at 11:45 AM, Res.#39 was not offered either while the other residents at the table ate and/or were being fed, another resident took Res.#39's drink with no staff intervention, and after being offered their meal after 25 minutes and declining it, was not offered to re-heat the meal or an alternative.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide services that included supervision, monitoring, and ADL (Activities of Daily Living) care necessary to prevent a fall from a wheelchair for 1 of 10 residents in the applicable sample (Resident #19). Findings include:	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 7 Per record review Resident #19 was found on the floor of her/his room at 1:45 AM on 8/7/24. Review of Resident #19's care plan reveals that s/he is totally dependent on two staff with a mechanical lift for transfers to and from a wheelchair. The care plan also indicates that s/he has an ADL self-care performance deficit, with interventions that include, ensure resident is assisted to bed by 11 PM unless resident requests otherwise, intentional rounding every 1 hour for repositioning, and monitor positioning while in room. A Health Status Note written on 8/7/2024 states that the Resident was found on the floor next to her/his wheelchair in her/his room at 1:45 AM. The note further states that the call light was out of reach and the mechanical lift was in the room. Another Health Status Note written on 8/7/24 at 3:45 PM states that it appears that the Resident slid out of her/his wheelchair and was on the floor before being found by staff. Review of the facility incident summary written by the Administrator dated 8/7/2024 reveals that Resident #19 was assisted from the dining room to her/his room and was not assisted to bed or reevaluated until s/he was found on the floor by staff at approximately 1:45 AM. The summary also states that the Resident was to be turned and repositioned every 2 hours. Per interview with the facility Administrator on 9/11/24 at 11:36 AM the facility internal investigation of the incident determined that a staff member brought the Resident to her/his room sometime after the evening meal. The Licensed Nursing Assistant (LNA) who was assigned to Resident #19's care had signed	F 689		

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F 689	Continued From page 8 documentation that s/he had performed safety checks however, s/he had not. The evening and night shift staff had not done walking rounds at change of shift as is expected. During the onsite survey, it was determined that the facility had implemented actions to correct the noncompliance prior to the start of the re-certification survey, which included evaluation of Resident #19, staff education regarding safety checks, repositioning, intentional walking rounds, and increased monitoring of assistance provided to the residents. The facility was able to demonstrate monitoring of the corrective action and sustained compliance.	F 689		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812	Food Procurement, Store/Prepare/Serve-Sanitary The fan above the clean dish drying area in the Facility's kitchen was removed by Facility Staff and cleaned on 9/11/2024. The fan above the clean dish drying area in the Facility's kitchen was removed. Completion Date: 10/4/2024 **Tag F 812 POC accepted on 10/8/24 by C. Howard/P. Cota**	

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F 812	Continued From page 9 by: Based upon observation and interview, the facility failed to meet food service safety requirements. Findings include: 1.) Per observation on 9/8/24 at 9:30 PM and again on 9/11/24 at 9:45 AM, a fan located above the clean dish drying area in the facility's kitchen was noted to have a notable covering of dark gray dust-like material on the fan blades and the outer surface of the fan guard/grill. On 9/11/24 at 9:45 AM, the fan was noted to be circulating air directly above a tray of clean flatware. The dirt on the fan guard was noted to include a strand of dark, stringlike material extended from the guard while the fan was operating. The observation on 9/11/24 was conducted with the facility's Dietary Manager, who confirmed the fan blowing on the clean flatware represented an unsanitary condition, and stated that Maintenance had been notified about the fan needing cleaning the day before, on 9/10/24, but the cleaning had not been done. 2.) Per observation on 9/9/24 at 12:31 PM, a bag of white bread slices was noted to have visible green mold on it in the facility's 2nd floor kitchenette. Per interview on 9/11/24 at 9:45 AM the Dietary Manager confirmed the bread in the 2nd floor kitchenette was moldy and stated that the facility did not have a process for monitoring and dating bread to ensure it was not used beyond its expiration date.	F 812	On 9/9/2024 a facility-wide audit was conducted to ensure there were no expired or inedible food or liquids present. The Facility has developed a system for monitoring and dating bread to ensure it is not used beyond it's expiration date. The Food Service Director or her designee will complete daily (Monday-Friday) audits of all food storage areas to ensure all items are discarded as appropriate. Audit results will be presented monthly at the QAPI Committee meetings until three consecutive months of 100% compliance have been achieved. Monthly QAPI audit results will be reviewed and monitored by the Administrator. Completion Date: 10/17/2024 and Ongoing	