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

February 13, 2018

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 **January 10, 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
	475044	A. BUILDING _____ B. WING _____	C 01/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINES REHAB & HEALTH CTR	601 RED VILLAGE ROAD LYNDONVILLE, VT 05851

(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 complaint investigation was conducted on 01/10/18 by the Division of Licensing and Protection. The following are regulatory violations identified.	F 000		
F 550 SS=B	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without	F 550	Please see attached	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kranus E Thomas Jr | TITLE: Administrator | (X6) DATE: 2-8-18

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475044	A. BUILDING _____ B. WING _____	C 01/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINES REHAB & HEALTH CTR	601 RED VILLAGE ROAD LYNDONVILLE, VT 05851

(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 550	Continued From page 1	F 550		

interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to treat residents in a manner that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. This has the potential to effect 31 of 49 residents in the facility, wearing identifying wrist bracelets. Findings include:

Per observation on 01/10/18 at 10:00 AM several green wrist bands, with residents' names, were noted at the nursing station. When asked what the green wrist bands are, two nursing staff stated "[the resident's] are either on psychotropics, have behaviors or falls". They further stated that the four wrist bands "either fell off or they [the residents] took them off." When asked why the residents would take them off, a staff person responded "they probably don't like them".

During interview at 10:15 AM the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) identified nearly half of all residents in the facility wear these wrist bands. They stated that the wrist bands "...helps staff quickly know who may be aggressive...they're on psychotropics". During interviews throughout the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475044	A. BUILDING _____ B. WING _____	C 01/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINES REHAB & HEALTH CTR	601 RED VILLAGE ROAD LYNDONVILLE, VT 05851

(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 550	Continued From page 2 day, several residents stated, "I guess I have to wear it for safety", Resident #4 acknowledged that [he/she] "didn't want to wear it" and then shrugged when asked if this was known to the facility. Staff acknowledged that Resident #5's band "keeps falling off but I don't think [s/he] likes to wear it". During interview in the afternoon, a staff nurse stated that "the wrist bands quickly identify who are on psych meds and have the potential to have behaviors". When asked if all residents on psychoactive medications have behaviors and how can the wrist bands help if they're are not visible, the nurse stated "I don't have an answer for that, good question". Per record review for 31 residents designated to wear the wrist bands, 15 residents did not have care plans, interventions or monitoring for aggressive behaviors. The facility identified these residents as needing to wear colored wrist bands to help staff quickly identify potential problems related to difficult/aggressive behaviors. Per interview with 5 nurses on two different Units and two shifts, acknowledged that not all the residents wearing the bracelets have aggressive behaviors. There were 'permission slips' for the "I.D. Bracelet" in most of the charts reviewed. Some also had letters explaining to family or guardians, in regards to psychoactive medication use. The is no indication on the permission slips, the resident's preferences or choice in wearing theses identifying wrist bands. During the exit interview the DNS said this measure was in response to a recent audit from the State pertaining to safety issues..	F 550		
F 658	Services Provided Meet Professional Standards	F 658	Please see attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475044	A. BUILDING _____ B. WING _____	C 01/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINES REHAB & HEALTH CTR	601 RED VILLAGE ROAD LYNDONVILLE, VT 05851

(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 658 SS=E	Continued From page 3 CFR(s): 483.21(b)(3)(i)	F 658		

§483.21(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Based upon observations, record review and interviews the facility failed to meet professional standards of care for medication administration, documentation/transcription of orders and verifications of medications for 3 applicable residents in the sample. (Residents #1, #2 & #3) Findings include:

1. During review of Resident #1's medication administration record (MAR) and medical chart, information was incorrectly transcribed, omitted and/or written over as to make the entry illegible The physician order dated 01/05/18 states Risperidone 4 mg tablet, give 6 mg p.o. [by mouth] at bedtime. Risperidone was written on the MAR as 6 mg tab p.o. at bedtime. [A 6 mg tablet is not available; dosage comes in only 0.25 mg, .0.5 mg, 1 mg, 2 mg, 3 mg and 4 mg tablets] The medications were not available from 01/06 -09/2018, but is available in the Emergency back up kit. However, the Risperidone dosage in the back up kit is a 0.5 mg tablet A total of 10 tablets were dispensed for the five days, indicating a daily dose of 1 mg versus 6 mg, as ordered.

Furthermore, two examples of improper documentation was noted as follows:
a) Staff failed to document the Fentanyl Patch placement on two occasions during the last 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475044	A. BUILDING _____ B. WING _____	C 01/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINES REHAB & HEALTH CTR	601 RED VILLAGE ROAD LYNDONVILLE, VT 05851

(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 658	Continued From page 4	F 658		

days.

b) A notation on the MAR on 01/06/18 at 8 PM indicated that Dronobinol was not given, however another set of initials were written over this, making it illegible. The staff nurse during interview was unable to determine whether the medication was or was not given as ordered and confirmed "its not clear to me".

2. During review of the medication cart on B Wing, Resident #2's over the counter (QTC) Vitamin B-6 was incorrectly labeled. The Physician order states Vitamin B6 50mcg 2 tabs qd [100mcg every day]. The MAR states Vit B6 50mcg give 2 tabs (100mcg). However, there are two Vitamin B-6 bottles in the med cart, but they have two different doses on the label. One bottle is labeled as Vit B6 50mcg, but a hand written piece of tape states "give four tabs" [200mcg]. The other bottle's label is Vit B6 100mcg , but this also has a hand written label that states "give 2 tabs" [200mcg]. The nurse who was present at the medication cart said the dose was written on the label by a staff nurse at some point in time, to help other nursing staff "since there are two different doses on the bottles that were brought in from home". However, this staff nurse was not aware of the total dose discrepancy until the nurse surveyor pointed it out.

3. Resident #3's MAR had entry documentation that was illegible. In addition, there were several omissions of medication administrations that were not documental nor the reason for not given. The physician order dated 12/29/17 was for Trazadone 12 mg., p.o. at Noon & Dinner, and Trazadone 25 mg at h.s.[hour of sleep]. Per the MAR on December 29th and 30th, Noon and Dinner was marked [circled in green ink] as 'Not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475044	A. BUILDING _____ B. WING _____	C 01/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINES REHAB & HEALTH CTR	601 RED VILLAGE ROAD LYNDONVILLE, VT 05851

(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 658	Continued From page 5	F 658		

Given'. There was no documentation, circled or otherwise noted on the 31st for the Noon & Dinner time frame.
On the 2018 January 1st and 2nd Noon & Dinner and h.s. are circled in green as not given. However on 01/01/18 the dinner and h.s dose has written over in black ink, an illegible initial. The evening nurse on 01/10/18 at 5:00 PM confirmed that the medication was not given on 12/29 &30 as well as on January 1st & 2nd and marked in green as the medication was not available. This was further confirmed by the nurse note on the reverse of the MAR as not available. This nurse was very surprised to see that this was written in and marked as given, in black ink. The nurse was unable to decipher the initials.

4. During review of the Controlled Medication Accounting Record during shift count, three bottles of Controlled medications, Methadone 20 mg tablets, Oxycodone 5 mg tablets, and Lyrica 50 mg tablets were noted. Per observation these medications were from the resident's pharmacy, in dark yellow plastic bottles. The pills were not easily visible nor could be accurately accounted for without directly opening the lids. The lids were taped with white cloth tape [as used for dressing changes] and had a number written on it.. The nurse surveyor asked how staff reconciled the counts. The staff nurse, at that time stated "well its taped so that's the number of pills". The nurse confirmed that the bottles are not opened but "we go by what is written on the top" [of the taped lid] for verification].

Per review of the facility's policy and procedures, Narcotic Count Procedure # 1) ...must count and justify accuracy, verify the count of actual

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475044	A. BUILDING _____ B. WING _____	C 01/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINES REHAB & HEALTH CTR	601 RED VILLAGE ROAD LYNDONVILLE, VT 05851

(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 658	Continued From page 6 narcotics. During the afternoon interview, the DON was not aware of the above errors but acknowledged that a review will need to be done, as these are not acceptable practices. Ref: Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/ Lippincott Williams & Wilkins, pg. 17. Ref: Geriatric Dosage Handbook (12th Edition) Lexi-comp, page 1393. Ref: Pharmacy Services for Nursing Facilities, American Society of Consultant Pharmacists Med-Pass, Inc.	F 658		
F 755 SS=C	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755	Please see attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475044	A. BUILDING _____ B. WING _____	C 01/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINES REHAB & HEALTH CTR	601 RED VILLAGE ROAD LYNDONVILLE, VT 05851

(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 755	Continued From page 7	F 755		

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based upon record review and interviews the facility failed to assure the pharmaceutical services met the residents needs either through timely acquisition, or administration. This has the potential to affect all residents, notably new admissions.

An anonymous concern was reported to the Division of Licensing and Protection regarding untimely delivery of newly admitted residents' medications, the use of resident's medications brought in from home or borrowing other resident's medications. Please see examples of related concerns related to missed dosing of medication in F658; lack of verification of home medications in F755; and missed administration due to medications not available in F842.

During interview on 01/10/18 at 9:45 AM the DON (Director of Nursing) acknowledged that if a drug is not available and there is no medication in the [emergency] back up box, staff can call the pharmacy and the pharmacist will direct staff to take from one resident to give to the other. "We can borrow from another resident identified as having the same drug dose and enough supply left." The DON further started that the pharmacy will compensate the resident whose medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475044	A. BUILDING _____ B. WING _____	C 01/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINES REHAB & HEALTH CTR	601 RED VILLAGE ROAD LYNDONVILLE, VT 05851

(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 755	Continued From page 8	F 755		

was borrowed from. Nursing staff acknowledged that 'common' meds are at times borrowed. Five nursing staff interviewed confirmed that it "can take several days for a medications to arrive from the pharmacy, otherwise hopefully there is back ups, if not, we ask family to bring in their own."

Per Facility Policy -' IC5 Emergency Pharmacy Service and Emergency Kits, D- meds are not borrowed from other residents it is either obtained either from the emergency Kit or from provider pharmacy'. Also per Facility Policy 'Medication Order/Received IC12: medications brought to the facility by a resident /family A) is allowed only when the medication name, dose form and strength have been verified by consulting a tablet identification reference, E.G. Physician Desk Reference or call the dispensing pharmacy for a physical description of the medications".

Only two of the five nurse interviewed were able to articulate the process of assuring home medication verifications. One nurse stated they read the label, and two nurses stated the DON and ADON will do that [verify]. Per Interview on the afternoon of 01/10/18, the Administrator (ADM) stated the issue is mostly when a resident gets admitted after hours and the physician has not written the order to send to the pharmacy and there are no backups. The ADM confirmed pharmaceutical services did not always meet the residents' needs through timely acquisition.

F 761 SS=D Label/Store Drugs and Biologicals
CFR(s): 483.45(g)(h)(1)(2)

F 761 Please See attached

§483.45(g) Labeling of Drugs and Biologicals
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475044	A. BUILDING _____ B. WING _____	C 01/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINES REHAB & HEALTH CTR	601 RED VILLAGE ROAD LYNDONVILLE, VT 05851

(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 761	Continued From page 9	F 761		

professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review and interview, the facility failed to store/count controlled medication not being used for one of three residents in the sample (Resident #1) Findings include:

During observation on 01/10/18 at 11:26 AM of the medication cart on the A Wing, three prescription bottles from Resident #1's own pharmacy was noted. The three bottles had the pharmacy label on the front identifying Methadone, Oxycodone and Lyrica. The top of the bottle had white cloth tape [as used for dressings] taped over with a number on each lid. During interview at that time the staff nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475044	A. BUILDING _____ B. WING _____	C 01/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINES REHAB & HEALTH CTR	601 RED VILLAGE ROAD LYNDONVILLE, VT 05851

(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 761	Continued From page 10 explained that the resident brought this medication from home as these were not delivered from the facility's pharmacy at the time the resident was admitted (January 2018). The nurse stated the counts are done but acknowledged that the bottles 'are sealed so we know that the number on top is the number we go by for the count'. Another staff nurse standing nearby, did not dispute this practice of just looking at the bottle. Per review of the Facility's Protocol for counting controlled drugs, staff are to account for each medication accurately to readily detect missing medication. Narcotic Count Procedure # 1) ...must count and justify accuracy, verify the count of actual narcotics. Per interview at 4:36 PM, the evening staff nurse stated that although staff are supposed to open each bottle, each time, staff do not always do that because there is tape over the bottle. This nurse stated that 'anyone can just re-tape it so you should really look at all of them [pills]. The DNS at 6:15 P.M. confirmed unless readily visible [medication cards] the medications must be visible and each accounted for.	F 761		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842	Please See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475044	A. BUILDING _____ B. WING _____	C 01/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINES REHAB & HEALTH CTR	601 RED VILLAGE ROAD LYNDONVILLE, VT 05851

(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 842	Continued From page 11	F 842		

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475044	A. BUILDING _____ B. WING _____	C 01/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINES REHAB & HEALTH CTR	601 RED VILLAGE ROAD LYNDONVILLE, VT 05851

(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 842	Continued From page 12	F 842		

there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and confirmed by staff interview the facility failed to ensure that 3 of 5 applicable sampled resident's health record were accurately documented by the nursing staff (Residents #1, #2, #3). The findings include the following:

1. During review of Resident #1's medication administration record (MAR) and medical chart, information was incorrectly transcribed, omitted and/or written over as to make the entry illegible The physician order dated 01/05/18 states Risperidone 4 mg tablet, give 6 mg p.o. [by mouth] at bedtime. Risperidone was written on the MAR as 6 mg tab p.o. at bedtime. [A 6 mg tablet is not available; dosage comes in only 0.25 mg, .0.5 mg, 1 mg, 2 mg, 3 mg and 4 mg tablets] The medications were not available from 01/06 -09/2018, but is available in the Emergency back up kit. However, the Risperidone dosage in the back up kit is a 0.5 mg tablet. A total of 10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475044	A. BUILDING _____ B. WING _____	C 01/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINES REHAB & HEALTH CTR	601 RED VILLAGE ROAD LYNDONVILLE, VT 05851

(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 842	Continued From page 13	F 842		

tablets were dispensed for the five days, indicating a daily dose of 1 mg versus 6 mg, as ordered.

Furthermore, two examples of improper documentation was noted as follows:

a) Staff failed to document the Fentanyl Patch placement on two occasions during the last 6 days.

b) A notation on the MAR on 01/06/18 at 8 PM indicated that Dronobinol was not given, however another set of initials were written over this, making it illegible. The staff nurse during interview was unable to determine whether the medication was or was not given as ordered and confirmed "its not clear to me".

2. During review of the medication cart on B Wing, Resident #2's over the counter (OTC) Vitamin B-6 was incorrectly labeled. The Physician order states Vitamin B6 50mcg 2 tabs qd [100mcg every day]. The MAR states Vit B6 50mcg give 2 tabs (100mcg). However, there are two Vitamin B-6 bottles in the med cart, but they have two different doses on the label. One bottle is labeled as Vit B6 50mcg, but a hand written piece of tape states "give four tabs" [200mcg]. The other bottle's label is Vit B6 100mcg , but this also has a hand written label that states "give 2 tabs" [200mcg]. The nurse who was present at the medication cart said the dose was written on the label by a staff nurse at some point in time, to help other nursing staff "since there are two different doses on the bottles that were brought in from home". However, this staff nurse was not aware of the total dose discrepancy until the nurse surveyor pointed it out.

3. Resident #3's MAR had entry documentation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475044	A. BUILDING _____ B. WING _____	C 01/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINES REHAB & HEALTH CTR	601 RED VILLAGE ROAD LYNDONVILLE, VT 05851

(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 842	Continued From page 14	F 842		

that was illegible. In addition, there were several omissions of medication administrations that were not documental nor the reason for not given. The physician order dated 12/29/17 was for Trazadone 12 mg., p.o. at Noon & Dinner, and Trazadone 25 mg at h.s.[hour of sleep]. Per the MAR on December 29th and 30th, Noon and Dinner was marked [circled in green ink] as 'Not Given'. There was no documentation, circled or otherwise noted on the 31st for the Noon & Dinner time frame.
On the 2018 January 1st and 2nd Noon & Dinner and h.s. are circled in green as not given. However on 01/01/18 the dinner and h.s dose has written over in black ink, an illegible initial. The evening nurse on 01/10/18 at 5:00 PM confirmed that the medication was not given on 12/29 &30 as well as on January 1st & 2nd and marked in green as the medication was not available. This was further confirmed by the nurse note on the reverse of the MAR as not available. This nurse was very surprised to see that this was written in and marked as given, in black ink. The nurse was unable to decipher the initials.

4. During review of medication reconciliation for two Residents, # 1 & #2, had brought in their own medication from home. However, there is no evidence through documentation, that staff verified the pills through positive identification. The DNS confirmed that staff are to positively look at the pills, to ascertain if what is in the bottles are stated item & clearly marked. The DNS acknowledged that there is way to positively state that identification was performed as expected.

ALSO SEE F658, F761, F658.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475044	A. BUILDING _____ B. WING _____	C 01/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINES REHAB & HEALTH CTR	601 RED VILLAGE ROAD LYNDONVILLE, VT 05851

(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

The Pines Rehab & Health

Plan of Correction

Complaint Survey Completed on 01/10/2018

F550 **Resident Rights/Exercise of Rights CFR(s):483.10(a)(1)(2)(b)(1)(2)**

According to the state the facility failed to treat residents in a manner that promotes maintenance or enhancement of his or her quality of life with the potential to effect 31 of 49 residents wearing identifying wrist bracelets that the state APPROVED of at the last survey and now DISAPPROVES of- see exhibit #1.

I. **Action Taken to Correct the Deficiency:**
   1. All bracelets were removed.

II. **Measures Put in Place so That Deficient Practice Does Not Recur:**
   1. Will continue to use person centered care plan to identify potential triggers for residents with a history of behaviors.
   2. Staff will receive ongoing dementia training.

All residents have the potential to be affected.

Completion date: 02/12/2018.

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

POC accepted 02/09/18 for F550 [illegible] RN

F658 **Services Provided Meet Professional Standards CFR(s):483.21 (b)(3)(i)**

The facility failed to meet professional standards of care for medication administration, documentation/transcription of orders and verifications of medications for 3 residents in sample (Resident #1, #2, #3).

I. **Action Taken to Correct the Deficiency:**
   1. The Risperdone 6mg tab p.o. @ HS order for Resident #1 was changed to read: Risperdone 6mg p.o. @ HS.
      a.) The nurse that failed to document the Fentanyl Patch placement site on the MAR was educated on proper documentation.
      b.) The notation on the MAR on 01/06/2018 indicating Dronobilol was not given with another set of initials on top of those initials is legible but no explanation on the back of the MAR. Both nurses were educated on proper documentation.
   2. Resident #2's OTC Vitamin B-6 that was incorrectly labeled was removed.
   3. Resident #3's MAR that had illegible documentation was reviewed by all LN's on that day and were educated on proper documentation.
   4. Three bottles of controlled substances with taped tops were removed.
   5. Inservice to be provided by Consultant Pharmacist and DNS on 02/12/2018 on med administration and documentation.

II. **Measures Put in Place so That Deficient Practice Does Not Recur:**

1. The supervisor will check the MAR's randomly for correct documentation, errors, omissions, etc. weekly X8 weeks, then monthly as part of QA.

POC accepted 02/09/18 F-658 Susan L. Emmons RN

All residents have the potential to be affected.

Completion date: 02/12/2018

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

F755 **Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)**

The facility failed to assure the pharmaceutical services met the residents needs either through timely acquisition or administration.

I. **Action Taken to Correct the Deficiency:**
   1. Meeting held with consultant pharmacist on 01/11/2018 to address a more timely medication delivery- esp. for newly admitted residents.
   2. If families want to use meds from home, they will only be given after they have been verified by a consulting tablet reference or by calling pharmacy for verification and documenting the verification.
   3. Inservice will be provided on 02/12/2018 by the Consultant Pharmacist on ordering meds, home med verification, emergency after hours medication needs, and back-up meds.

II. **Measures Put in Place so That Deficient Practice Does Not Recur:**
   1. Admitting nurse will review admission packet with Supervisor upon entering the building to ensure all needed meds have arrived in building on an ongoing basis.

POC accepted for F 755 02/09/18 Susan L Emmons RN

All residents have the potential to be affected.

Completion date: 02/12/2018.

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

F761 **Label/Store Drugs & Biologicals CFR(s): 483.45(g)(h)(1)(2)**

The facility failed to count controlled medication not being used for one of three residents (Resident #1).

I. **Action Taken to Correct the Deficiency:**
   1. The unused tape-sealed controlled medication for Resident #1 was opened and counted and then removed by DNS.
   2. LN staff inservice will be provided by the Pharmacy Consultant on 02/12/2018 on narcotic count procedure, ordering meds, home med verification, etc.

II. **Measures Put in Place so That Deficient Practice Does Not Recur:**
   1. Weekly med cart checks by the Supervisor to ensure that multi-dose bottles are not sealed with tape and are counted.

POC accepted for F-761 02/09/18 Susan L Emmons RN

All residents have the potential to be affected.

Completion date: 02/12/2018

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

F842 Resident Records- Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)

The facility failed to ensure that 3 of 5 residents' health records were accurately documented by the nursing staff (for Resident's #1, #2, #3).

I. Action Taken to Correct the Deficiency:

1. The Risperdone 6mg tab p.o. @ HS order for Resident #1 was changed to read: Risperdone 6mg p.o. @ HS.
2. The staff that failed to document on the MAR the site of placement of the Fentanyl patch, was educated on proper documentation.
3. The notation on the MAR on 01/06/2018 indicating Dronobinol not given with another set of initials ABOVE those initials is legible, but no explanation on back of MAR.
4. Resident #2's OTC Vitamin B-6 that was incorrectly labeled was removed.
5. Resident #3's MAR that had illegible documentation was reviewed by all LN's on that day and were educated on proper documentation. In addition, an inservice will be provided to all LN's on 02/12/2018 by the Consultant Pharmacist and the DNS on med administration, and documentation.
6. LN staff will be educated on correct procedure and documentation of med reconciliation for home meds on 02/12/2018 by the Consultant Pharmacist and DNS.

II. Measures Put in Place so That Deficient Practice Does Not Recur:

1. The Supervisor will check the MAR's randomly for correct documentation, errors, omissions, etc. weekly X8 weeks, then monthly as part of QA.

All residents have the potential to be affected.

POC accepted for F.842
02/09/18 Susan J. Emmons RN

Completion date: 02/12/2018.

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

Francis E Cheney 2/8/18

Pharmacy remote dispense

Manager69 David Simpson <DavidSimpson@hdrxservices.Com>

Wed 2/7/2018 9:21 AM

To: dianapines@yahoo.com <dianapines@yahoo.com>;

Cc: Dale Atwood <Daleaa@Hotmail.com>; Jodi Wheeler <JodiWheeler@hdrxservices.Com>; Witt Hinton <WittHinton@hdrxservices.Com>;

Diana,
When the facility is need of a medication prior to the night delivery there are two options that we can use.

1. After faxing in the orders for the new admit to the pharmacy a call must be made to the pharmacy. It is best to speak to a pharmacist and discuss what is needed before the delivery. The pharmacist will then call the local Kinney Drug to get the order put up for the patient.
   (If it is a controlled substance that is needed, the prescriber should call this in directly to the local Kinney).
2. If the local Kinney doesn't have the med or if we determine that we need to send it to you, we will run a special STAT run to bring the med (same as after hours, Sundays or holidays).

Please let me know if you need anything further.

Thanks,
David

David Simpson
Site Manager, HealthDirect

HEALTHDIRECT
PHARMACY SERVICES

600 Blair Park, Suite 195, Williston, VT 05495
P 800-861-1903 | F 800-861-1904 | C 315-663-1494
www.hdrxservices.com

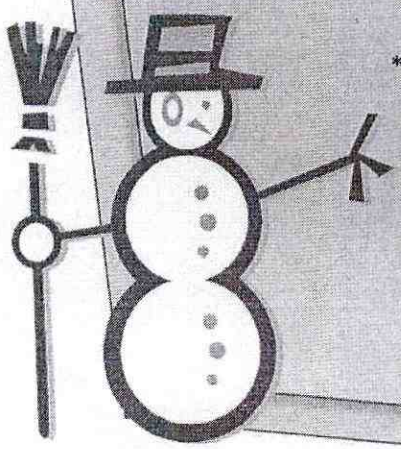
DOCUMENTATION & MED ADMIN INSERVICE

DATE: FEBRUARY 12, 2018

Time: 2 pm
To be held in the classroom

This inservice will cover documentation on the MAR, TAR, nurses notes, fall reports, and care plan updates. Also addressed will be the legal ramifications of poor documentation. It will also cover medication administration, ordering meds, home med verification, emergency afterhour medication needs, and back-up meds.

Inservice will be provided by Diana LaFountain, RN, BSN and Witt Hinton, RPH



****THIS IS A MANDATORY INSERVICE FOR ALL LN'S****