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

November 2, 2018

Ms. Diana Lafountain, Administrator
Pines Rehab & Health Ctr
601 Red Village Road
Lyndonville, VT 05851-9068

Dear Ms. Lafountain:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 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

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
	475044	A. BUILDING _____ B. WING _____	C 10/10/2018

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
E 000	Initial Comments An unannounced onsite recertification survey with Emergency Preparedness review was completed by the Division of Licensing and Protection from 10/8 - 10/10/18. The facility was found in substantial compliance with regulations related to Emergency Preparedness.	E 000	See POC attached	
F 000	INITIAL COMMENTS An unannounced onsite recertification survey concurrent with one complaint and one self-reported incident investigation was conducted by the Division of Licensing and Protection from 10/8 - 10/10/18. The following are regulatory findings.	F 000	See POC attached	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) 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 resident's option, formulate an advance directive. (ii) This includes a written description of the	F 578	See POC attached	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Diana Lafountain RN, BSN, LNHA		10.29.18

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.

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F 578	Continued From page 1	F 578		

facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, regarding Advanced Directive choices for one resident of 19 sampled (Resident #33), the facility failed to establish mechanisms for documenting and communicating the resident's choices to the interdisciplinary team and to staff responsible for the resident's care. Findings include:

Per medical record review, upon initial admission Resident #33 and/or the legal representative designated an Advanced Directive choice of full resuscitation and hospital transfer. At the top of page one of the comprehensive care plan was written "Code status: Full Code". The physician visited with Resident #33 and the legal representative on 7/25/18, and he/she documented in a progress note, signed 7/29/18, that they had filled out a new Advanced Directive

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F 578	Continued From page 2 form designating choices of DNR (Do Not Resuscitate), no transfer [to hospital], yes to antibiotics and IV (intravenous fluids). When interviewed on 10/9/18, the nurse on duty could not specify a mechanism to communicate the code status of residents. He/she confirmed that there is no list in the Medication Administration Record, nor in the nurses' station, nor a consistent method of flagging the medical record. In an emergency, the nurse offered that he/she would have had to find the physician's progress note of 7/19/18 to accurately identify code or transfer to hospital status for Resident #33. During interview on 10/9/18 at 1:22 PM, the Registered Nurse Supervisor confirmed that there was no clear mechanism for communicating code or transfer status of residents, and that the existing code status documentation for Resident #33 had not been updated after a change.	F 578		
F 606 SS=D	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.	F 606	See POC attached	

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F 606	Continued From page 3	F 606		

§483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.
This REQUIREMENT is not met as evidenced by:
Based on review of personnel records, background checks and staff interviews between 10/08-10/2018, the facility failed to assure that 1 of 5 employees reviewed was not hired after a background check of the Adult Abuse Registry revealed a charge of exploitation. The specifics are detailed below:

Per review of personnel files, including background checks and confirmed by the facility Administrator, Employee A's application for employment as an LNA (Licensed Nursing Assistant) is dated 1/9/2018. The background check is dated as having been done on 1/3/2018 and revealed that the LNA was on the adult abuse registry for exploitation for an incident that occurred in 2006. The allegation of fraud and exploitation was substantiated at that time. The State Board of Nursing revoked Employee A's license to practice as an LNA in 2008. The LNA requested to have his/ her license reinstated in January 2018. The State Board of Nursing stipulated that the license be reinstated after successful completion of an approved nurses aid training program and subsequent supervision of the employee by the facility. The facility staff was directed to send the supervision documents to the State Board on a regular schedule. Only 1 was sent before the employee was terminated. The current license expires 11/30/2018. This LNA was hired by the facility, completed facility LNA

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F 606	Continued From page 4 training in Feb. 2018, and worked from April 2018 to May 21, 2018. The administrator confirmed during interview, that they had hired an LNA who was on the adult abuse registry for exploitation.	F 606		
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)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656	See Poc attached	

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F 656	Continued From page 5	F 656		

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 medical record review, observations, staff and resident interviews, the facility failed to develop a care plan addressing all the identified needs of 1 of 18 residents (Resident # 10). The specifics are detailed below:

Per medical record review, Resident #10 was admitted on 10/23/2017 with unspecified psychosis, disorientation and dementia without behaviors. The MDS (Minimum Data Set) of 7/28/2018 identifies wandering that does not impact others. During the Resident Council meeting held during the survey period, several residents in attendance, complained about Resident #10's intrusive behaviors, including coming into their rooms uninvited. Resident #10 is observed during all days of survey, either lying in a recliner in the large activity room, walking independently around the unit or walking attended by staff. There is no care plan developed that addresses wandering or dementia for this resident, or what interventions are likely to work better than others, only to say that s/he does it and staff is to try to redirect him/ her. There are no specific cues for the staff to be consistent with Resident #10. This is confirmed by the Director of Nursing (DNS), during interview on 10/09/18 at 3:25 PM.

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The Pines Rehab & Health

Plan of Correction

Re-certification Survey completed on 10/10/2018

F 578 Request/Refuse/Discontinue Treatment; Formulate Adv. Dir. CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)

The facility failed to establish mechanisms for documenting and communicating the residents' choices to the interdisciplinary team and to staff responsible for the resident's care for one resident out of 19 sampled (Resident # 33).

I. Action Taken to Correct the Deficiency:
1. The code status on the care-plan was updated to: DNR/DNI on 10/09/18.
2. There is a mechanism in place to quickly identify code status. Blue charts are DNR/DNI, Red charts are Full Code- this has been in place for years.
3. An in-service will be provided to the nurses on Advanced Directives, communication and documentation on 11/02/18.

II. Measures Put in Place so That Deficient Practice Does Not Recur:
1. Add Advanced Directive mechanisms for documenting and communicating the residents' choices to the orientation packets for new hires.
2. The Supervisor will check all new charts to ensure that any changes in Advanced Directives are also changed on the care plan.

All residents have the potential to be affected.

Completion date: 11/02/18

Stephanie Burgess, RN/DNS is responsible for the correction of this deficiency.

F578 POC accepted 11/1/18 KCampos RN/PMC

F 606 Not Employ/Engage Staff w/Adverse Actions CFR(s): 483.12(a)(3)(4)

The facility failed to assure that one of five employees reviewed was not hired after a background check of the Adult Abuse Registry revealed a charge of exploitation.

I. Action Taken to Correct the Deficiency:
1. This employee was terminated in May 2018 after talking to Division of Licensing & Protection.

II. Measures Put in Place so That Deficient Practice Does Not Recur:
1. No one will be put in the class or hired with misappropriation on their background check despite approval by the Vermont Board of Nursing.
2. Office manager reviewed employee files to ensure ongoing compliance.

All residents have the potential to be affected.

Completion date: ~~May 2018.~~ Per telephone call with the Administrator on 11/1/18, the completion date for this citation is 11/02/18.

Diana LaFountain, RN/Administrator is responsible for the correction of this deficiency.
F606 POC accepted 11/1/18 KCampos RN/PMC
F 656 Development/Implement Comprehensive Care Plans CFR(s): 483.21(b)(1)

The facility failed to develop a care plan addressing all the identified needs of 1 of 18 residents (Resident # 10)- specifically interventions for wandering.

I. **Action Taken to Correct the Deficiency:**
   1. On 10/09/18 the DNS re-wrote the care plan for wandering that gave specific cues for the staff to be consistent with Resident # 10.

II. **Measures Put in Place so That Deficient Practice Does Not Recur:**
   1. SS reviewed all dementia/behavior care plans to ensure they were resident specific.
   2. Annual in-services on dementia with wandering.
   3. Continue to review care plans quarterly and with any changes on an ongoing basis to ensure compliance.

All residents have the potential to be affected.

Completion date: 11/02/18

Stephanie Burgess, RN/DNS is responsible for the correction of this deficiency.

* F656 POC accepted 11/1/18 KCampos RN/PMC

Diana LaFountain RN, BSN, LNHA 10.29.18

Mandatory LN In-service

Advanced Directives, communication and documentation

Mechanisms for documenting and communicating the residents' choices, Advanced Directives, COLSTS

Where: Upstairs Classroom

When: November 02, 2018

Time: 2:30 pm