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

May 2, 2019

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 **April 17, 2019.** 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 _____	04/17/2019

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 Emergency Preparedness review was completed by the Division of Licensing and Protection on 4/17/19. The facility was found in substantial compliance with Emergency Preparedness requirements.	E 000		
F 000	INITIAL COMMENTS An unannounced, onsite recertification survey was conducted by the Division of Licensing and Protection from 4/14/19 - 4/17/19. The following regulatory violations were identified.	F 000		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted 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	F 761	F761 1. No residents were negatively affected by this alleged deficient practice 2. Residents requiring medications have the potential to be affected by the alleged deficient practice 3. Re-education will be done with licensed nurses regarding drug labeling and discarding requirements according to accepted principles 4. Audits will be completed by the Director of Nursing or designee weekly x1 month and then monthly x3 months to monitor effectiveness of the plan 5. The results of the audits will be reported to the QAA committee x3 months at which time the committee will determine further frequency of the audits. 6. Corrective action will be completed by May 3, 2019	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Diana Lafountain RN, BSN, LNHA		4.26.19

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 761	Continued From page 1 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles to include the expiration date and that those medications that reached their expiration date were discarded. Findings include: Per observation in the Medication Storage Refrigerator on 04/16/19 at 10:28 AM, two multi-dose vials of Tubersol (a Purified Protein Derivative used for Tuberculosis testing) were opened for use and both contained a small amount of clear liquid. One was not labeled with either the date opened, or the discard date and the other vial had a date written on the label of 2/18. According to the manufacturer, a vial of Tubersol which has been entered [pierced with a needle] and in use for 30 days should be discarded due to possible oxidation and degradation which may affect potency. The Registered Nurse confirmed the above findings at the time of the observation and stated s/he was unaware that the Tubersol should be discarded after 30 days from the dated opened. Reference: http://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/UCM114924.pdf	F 761	F761 POC accepted 5/1/19 LLorcurn/Pme	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 842	Continued From page 2	F 842		

§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.

§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.

F842

1. Resident #48 was not negatively affected by this alleged deficient practice and received medication via the right route
2. Residents requiring medication via feeding tube and who are NPO have the potential to be affected by the alleged deficient practice
3. Re-education will be done with licensed nurses regarding documentation of the correct route of administration for medications
4. Audits will be completed weekly x1 month and then monthly x3 months to monitor effectiveness of the plan
5. Results of the audits will be reported to the QAA committee x3 months at which time the committee will determine further frequency of the audits
6. Corrective action will be completed by May 3, 2019

F842 POC accepted 5/1/19 LoveRN/pmc

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F 842	Continued From page 3	F 842		

§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 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 record review and staff interview, the facility failed to maintain medical records in accordance with accepted professional standards of practice regarding accurate documentation for 1 of 19 residents reviewed (Resident #48). Findings include:

Per record review, Resident #48 has physician orders to receive all medications and nutrition through a G-tube and nothing by mouth (NPO) due to being a high risk of aspiration. Per review of the Medication Administration Record (MAR),

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F 842	Continued From page 4	F 842		

there was an order hand written in March and April 2019 for "APAP (Acetaminophen) 650 mg. PO (by mouth) PRN q 4 hrs for pain/fever." This order was pulled from the signed physician standing orders for this resident. The medication was signed off as being given on 3/6, 3/8, and 3/20/19. Per review of the April 2019 MAR, the medication was signed off as being given on 4/1, 4/3, and 4/8/19. On the back of the MAR, the nurse documented that it was given PO on all these entries. Per interview on 4/17/19 at 9:20 AM, the nurse who wrote the entry and gave all the doses listed confirmed they had pulled the order from the Physician Standing Orders when the resident needed it for treating a fever. They knew that the resident takes nothing by mouth, and did not give Resident #48 any oral medication. They stated that wrote the order on the MAR like that because it is listed as a PO order, and they did not change the route when writing it in the MAR. Per interview on 4/17/19 at 9:50 AM, the Director of Nursing also confirmed that the nurse had documented the medication administration incorrectly, and that because there was an NPO order from the doctor in place, it would have been acceptable for the nurse to change the route to administer by Gtube when transcribing the standing order to the MAR.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475044	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED 4/17/2019

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 640	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to transmit a timely resident assessment for discharge of 2 of 19 residents in the applicable sample (Residents #1 and 2). Findings include: During staff interview and review of the Minimum Data Set (MDS) on 4/17/19 at 9:45 AM, the MDS Coordinator and MDS Consultant provided no evidence of a discharge MDS assessment for either Resident #1 or #2. At 11:30 AM, the MDS Consultant provided the Centers for Medicare and Medicaid Services (CMS) Submission Report, MDS 3.0 NH (Nursing Home) Final Validation for Residents #1 and 2. The MDS validation report showed a target date of 12/11/18 for Resident #1, and a target date of 12/12/18 for Resident

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 640	Continued From Page 1 #2. The discharge assessments were due within 14 days of the target dates [which represent the discharge dates]. It was confirmed by the MDS Consultant at this time that the discharge summaries for Residents #1 and 2 were not submitted within the required 14 day window.