

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 25, 2019

Mr. Chad Dingman, Administrator Pines Rehab & Health Ctr 601 Red Village Road Lyndonville, VT 05851-9068

Dear Mr. Dingman:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **October 2**, **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

Pamila M CotaRN

Licensing Chief

PRINTED: 10/10/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
	FCORRECTION	IDENTIFICATION NUMBER:	A BUILDING		COMPLETED
		n n			
	¥ .	475044	B, WING	a	10/02/2019
NAME OF F	PROVIDER OR SUPPLIER		.S	TREET ADDRESS; CITY, STATE, ZIP CODE	
•		_	6	01 RED VILLAGE ROAD	
PINES RI	EHAB & HEALTH CT	K.	L,	YNDONVILLE, VT 05851	-
(X4) ID.	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PRÉFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPROPERTY OF THE APPROPROPERTY OF THE APPROPROPORTY OF THE APPROPROPERTY OF THE APPROPROPERTY OF THE APPROPROPER	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	SINIE
744	<u> </u>	<u> </u>	 		
- 200	in the contract of the		E OOO	4 -	£
F 000	Initial Comments		E 000		-
= 1		27			= E
	An unannounced of				
	Preparedness revie	ew was completed by the			i
	Division of Licensin	ng and Protection on 10/2/19. und to be in substantial			1 1
		mergency Preparedness			
	requirements.	merdency i repareditess			
F 000	INITIAL COMMEN	TS:	F 000		
1, 0,00			1 400		* "
ï		ensife magdification auniqu			
		onsite recertification survey the Division of Licensing and			120 m
	Protection on 9/30				
		latory deficiencies were	4	190 and 190 an	
	identified.			***************************************	
F 656	THE R. LEW. LANSING.	it Comprehensive Care Plan	F 656		
SS=D				F 656	
				1 D:1+#281	
Ti.		ehensive Care Plans	Ì	1. Resident #28 now has a c	3m3
		facility must develop and	1	to address needs related to	
1 5		rehensive person-centered resident, consistent with the	1	elopement risk and exit se	eking
		forth at §483.10(c)(2) and		behavior.	36 365
		includes measurable		2. Residents residing in the	facility
8 - 2 -		eframes to meet a resident's		that have exit seeking beh	avior
		and mental and psychosocial		and who are at risk for eld	
,		ntified in the comprehensive	(1)	have the potential to be at	_
	assessment. The	comprehensive care plan must		by the alleged deficient pr	
	describe the follow	(Ing -	-		2"
	or maintain the rec	at are to be furnished to attain sident's highest practicable		3. Other residents with exit	
		and psychosocial well-being as	¥.	behavior and who are at r	
		33.24, §483.25 or §483.40; and	\$ 5	elopement have been revi	The state of the s
		at would otherwise be required	1	and care plans revised as	
£.		83.25 or §483.40 but are not	1	to ensure needs are address	ssed.
	provided due to the	e resident's exercise of rights		4	
1		luding the right to refuse	1		
	treatment under §2	483.70(c)(6).		8 8	
	` _	d services or specialized		The state of the s	
LABORATOR	PROVIDERECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE:

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WJKU11

Facility ID: 475044

If continuation sheet Page 1 of 19

ACTION AND ADDRESS OF THE PARTY	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	lG'	COMPLETED	
		475044	B. WING_	*	10/02/2019	
PINES REHAB & HEALTH CTR (X4):ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR-LSC IDENTIFYING INFORMATION)		JD PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 601 RED VILLAGE ROAD LYNDONVILLE, VT 05851 PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D.BE. COMPLETION		
F 656	provide as a result recommendations. findings of the PAS rationale in the resi (iv)In consultation vesident's represent (A) The resident's desired outcomes. (B) The resident's future discharge. F whether the resident community was as local contact agence entities, for this pur (C) Discharge plan plan, as appropriate requirements set for section. This REQUIREMED by: Based on staff interfacility failed to development and exit # 28 was admitted work and nursing nactively exit seeking 10/2/19 at 9:00 AM Supervisor (CNS) scare plan to address elopement or exit seeking services address resident # 28 was admitted work and nursing nactively exit seeking 10/2/19 at 9:00 AM Supervisor (CNS) scare plan to address elopement or exit seeking the services address elopement or exit seeking 10/2/19 at 9:00 AM Supervisor (CNS) scare plan to address elopement or exit seeking 10/2/19 at 9:00 AM Supervisor (CNS) scare plan to address elopement or exit seeking 10/2/19 at 9:00 AM Supervisor (CNS) scare plan to address elopement or exit seeking 10/2/19 at 9:00 AM Supervisor (CNS) scare plan to address elopement or exit seeking 10/2/19 at 9:00 AM Supervisor (CNS) scare plan to address elopement or exit seeking 10/2/19 at 9:00 AM Supervisor (CNS) scare plan to address elopement or exit seeking 10/2/19 at 9:00 AM Supervisor (CNS) scare plan to address elopement or exit seeking 10/2/19 at 9:00 AM Supervisor (CNS) scare plan to address elopement or exit seeking 10/2/19 at 9:00 AM Supervisor (CNS) scare plan to address elopement or exit seeking 10/2/19 at 9:00 AM Supervisor (CNS) scare plan to address elopement or exit seeking 10/2/19 at 9:00 AM Supervisor (CNS) scare plan to address elopement or exit seeking 10/2/19 at 9:00 AM Supervisor (CNS) scare plan to address elopement or exit seeking 10/2/19 at 9:00 AM Supervisor (CNS) scare plan to address elopement or exit seeking 10/2/19 at 9:00 AM Supervisor (CNS) scare plan to address elopement or exit seeking 10/2/19 at 9:00 AM Supervisor (CNS) scare plan to address elopement or exit seeking	es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. vith the resident and the tative(s)- goals for admission and preference and potential for acilities must document of sessed and any referrals to sies and/or other appropriate	F 65	4. Education will be provided licensed nurses regarding to requirement to ensure need addressed in the resident complan. 5. Audits will be done weekly the Director of Nursing or designee to monitor effection of the plan. 6. Results of the audits will be reported to the QAA command a months at which time the committee will determine the action needed. 7. Corrective action to be completed by 11/1/19. FIGURE POC accept	the ds are are y by iveness e nittee x e further	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM	PLETED		
	* × 5	475044	B. WING				1.0/0	02/2019
NAME OF F	PROVIDER OR SUPPLIER		*			DORESS, CITY, STATE, ZIP CODE	e	
PINES R	EHAB & HEALTH CT	ŧ.			**** **********************************	/ILLAGE ROAD		
			L)	YNDON	VILLE, VT 05851			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG			PROVIDER'S PLAN OF CORRECT EACH CORRECTIME ACTION SHOU OSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5)- COMPLETION DATE:
F 657	· · Confinite Facility				¥.			
1	Continued From pa	3504	2	557		*		
	Care Plan Timing a		Ft	557				
55=F	CFR(s): 483.21(b)(2)(1)-(11)		2	F 657			
	\$483.21(b) Compre	hensive Care Plans						
•		mprehensive care plan must			1.	Residents #4, 27, and 30) have	
	be-					had their care plans revi	cod to	
		7 days after completion of				reflect current needs.	scu to	
	the comprehensive				2.	Residents residing in the	C	
		interdisciplinary team, that				have the noteral 14.1	acility	ļ.,
	includes but is not (A) The attending p					have the potential to be	affected	
*		rse with responsibility for the	1.0		2	by the alleged deficient	practice.	
	resident.	rec war recoponalisms, for the			3.	The process for interdisc	iplinary	
	A CONTRACTOR OF THE PARTY OF TH	th responsibility for the				participation in the devel	lopment	
	resident.					and revision of care plan	s has	
		od and nutrition services staff.				been reviewed and revise	ed to	
		acticable, the participation of				ensure all necessary depart	rtments	
		e resident's representative(s). st be included in a resident's				have input into the care p	Jan	
		e participation of the resident			4.	Education will be provide	ded to the	-
. 7		epresentative is determined			1211	interdisciplinary team re		
		he development of the				the requirements for inp		
	resident's care plan	14		N				
		ite staff or professionals in			-	the care plan for each re		
		mined by the resident's needs			5.	Education has also been		
	or as requested by	the resident. Evised by the inferdisciplinary				to licensed nurses regard		
		sessment, including both the				requirement for the care		
,	comprehensive and		1	3		be updated with change	in needs	
	assessments.					for the residents.		1
		NT is not met as evidenced			6.	Audits will be done wee	kly by	7. 10.
	by:	- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1				the Director of Nursing of		
		eview and staff interview, the ure that all the required			0	designee to monitor effe		
		erdisciplinary team (IDT) were				of the plan.		
		ig the comprehensive care		1		energy and the Proposition		
L		sidents sampled (Residents #		9				
	4, 5, 6, 14, 19, 23,	27, 30, 34, 43, and 45). In	i					
	addition, 3 of 19 re	sidents sampled did not have				N 1		

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X3) DATE SURVEY	
AND PLAN C	F CORRECTION	JDENTIFICATION NUMBER:	A BUILDING		10/02/2019
6	PROVIDER OR SUPPLIER EHAB & HEALTH CT		. 60	REET ADDRESS, CITY STATE, ZIP CO IT RED VILLAGE ROAD YNDONVILLE, VT 05851	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE:PRECEDED BY FULL SC:IDENTIFYING:INFORMATION).	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 657	care plans revised (Resident #4, 27, at 1. Resident #5 had 7/9/19. The Social documentation list there was no LNA, documented. 2. Resident #6 had 5/14/19. The Social the dietary staff and the meeting. There indicate that the alprovided input into 3. Resident # 14 h 9/30/19. The Social attendance does in dietary staff, or an There was no doc services to indicate the team had provinceting. 4. Resident #45 had 7/3/19. Social Services to indicate they are that indicated they of the care plan. 5. Resident #23 has 8/1/19. Social Services include the preservice in the care plan.	to reflect their current status, and 30). Findings include: I a care plan meeting held on Service care plan meeting is the disciplines attending, and Dietary staff, or MD/NP input I a care plan meeting held on all Services note indicated that de MD/NP were not present at the was no documentation to be sent members of the team had the care plan meeting and a care plan meeting held on all Services note documenting not show that activities staff, LNA were at the meeting umentation provided by social at that the absent members of ided input to the care plan meeting on vices note indicated that there NP, or dietary staff who plan meeting, or documentation had any input in development and a care plan meeting on vices documentation did not not one of NP/MD, dietary staff, or neeting, or documentation that		 Results of the audits we reported to the QAA or 3 months at which time committee will determ action needed. Corrective action will completed by 11/1/19. FLST POC at Karen Campos 	ommittee x e the ine further be

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	LE CONSTRUCTION	COMPLETED			
AND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A BUILDING	·		COM	PLETED
		475044	B. WING			1070	2/2019
NAME OF	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, S	STATE, ZIP CODE:		
Diviso B	ENADO O DEALTO O	TD	9	601 RED VILLAGE ROAL	Ď.		
PINES REHAB & HEALTH CTR		1	LYNDONVILLE, VT 0	5851			
(X4) ID		TATEMENT OF DEFICIENCIES	l ID		PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG		CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	PREFIX		TIVE ACTION SHOUL CED TO THE APPRO		DATE DATE
IAG	NESSE NON S	(200.DENT) ANTONIA CAMPANIA (i ,		EFICIENCY)		
		40.5.40	[140 9 100	247 41	
F 657	Continued From	page 4	F-657	7			
		10/1/19 at 3:50 PM, the Director	l				
		s confirmed that not all the					
		eam members were present at			R		
		etings, or that the facility had a					
	members who did	menting the input of team					
	Members wito an	a not attend.	Ì		8		
	6. Per review of	the of the social service notes					N N
		who had a care plan meeting					
* * *	dated 08/28/19 a	t approximately 1 PM, does not			g*		
		nce of all members of the		*			
		feam (IDT). The members who are the attending					
		practitioner, a nurse's aide with					
		for the resident and a member	ľ				
		utrition services. The Director of					
		ifirmed during interview on					THE PARTY OF THE P
6		/19 that the full IDT has not nded the care plan meetings, nor					
		rave a process for documenting					
	the input of team	members who did not attend.					
	Alexandran		-				
		of the person-centered care d on 03/04/19, identifies that					
		eives Seroquel 12.5 mg	ŀ				
	(milligrams) by m	outh twice a day and 25 mg at			- 1		
		edication was discontinued by					7
		09/02/19. This was confirmed					de secondo
		0/03/19 at 2 PM via telephone it the care plan does not reflect					or promise
	the resident's cur						
			§ =				
		the person-centered care plan		1			
		ast updated on 03/01/19 resident receives insulin daily.	(*)				
s.		longer ordered. The plan also		·			E
-		resident has pain related to				+	ř.
E .	kidney stones.	The resident required surgical	4		No.		
y.	intervention to ex	tract the stones on 03/14/19.		4			1

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION		SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING_	80 S S	COM	PLETED
		475044	B. WING			10/	02/2019
NAME OF F	PROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE	75	
DINITO D	CHAD A BEAUTICH	3		18.00	RED VILLAGE ROAD		
PINES REHAB & HEALTH CTR			LY	NDONVILLE, VT 05851			
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE, PRECEDED BY FULL SC. IDENTIFYING INFORMATION)	ID- PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPRO	DULD BE	(X5) COMPLETION DATE
F.657	identifies the interv made by the DNS	age 5 ce in the care plan that ention. Confirmation was on 10/02/19 at 8:30 AM, that not reflect the resident's	L. Construction of the Con	357		· ·	No. 1
	Plan Meeting Reco a care plan meetin identify the present Interdisciplinary Te were not present a physician/nurse po the responsibility for the food and nutrit Nurse (DNS) confi 10/1/19 and 10/2/1 consistently attend does the facility ha	e of the Interdisciplinary Care ord for Resident #27, who had g dated 08/22/19, does not ce of all members of the am (IDT). The members who are the attending actitioner, a nurse's aide with or the resident, a member of ion services. The Director of rmed during interview on 9 that the full IDT have not led the care plan meetings, nor we a process for documenting nembers who did not attend.					
A THE COURSE OF	mandated assessing that the Resident of transfer between by 2 staff who physically ambulation in his/breview of the persoupdated on 06/20/lis at risk for falls/in Confirmation was that the person-ce	the Minimum Data Set (MDS) ment dated 09/25/19, identifies f27 is totally dependent on staffen bed/chair/standing position sically assist. The resident of 2 staff members for her room and/or corridor. Per con-centered-care plan, last 18 identifies that Resident #27, highly and walks all day long, made by the DNS on 10/02/19 intered care plan does not 27's current status.					
	for Resident #19, v-dated 07/30/19 at	ne of the social service notes who had a care plan meeting approximately 1:38 PM, does ce all members of the	A TANK THE RESIDENCE OF THE PARTY OF THE PAR				

YEAR THE WILLIAM VILLE PAPER 1 MAY A COLUMN AS A COLUM		(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	A. BUILDING.		- 000	INCELED.
		475044	P MAINC	B YANG			va 6 6 6 1 6
		475044	B. WING		DEST ADDRESS CITY STATE ZID CORE	1 10/	02/2019
NAME OF P	NAME OF PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 1 RED VILLAGE ROAD	2 00	
PINES REHAB & HEALTH CTR		}		NDONVILLE, VT 05851			
				1	PROVIDER'S PLAN OF CORRECT	TION	(85)
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	X ·	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPR DEFICIENCY)	COPRIATE	DATE
							1 2 0
F 657	Continued From pa	aige 6	Fe	557			*
, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	The second secon	am (IDT). The members who	į , ,	, .			
.	were not present a		i t				7
	physician/nurse pra	actitioner, a nurse's aide with		- }			
		or the resident and a member					-
		trition services. The Director of	II.	į.	4	*	
		rmed during interview on 9 that the full IDT have not					
		ed the care plan meetings, nor	ŀ	ŀ			
	does the facility ha	ve a process for documenting		ľ	*		
	the input of team n	nembers who did not attend.		- 1			
	40: Dooldont #04 b	nad a care plan meeting on			*		
		al Services note documenting		ľ			
		es that only social services.					
		les staff were present, none of					
	the other required						
		am (IDT) contributed to or					
	attended the meet	ing as required.					
	11. Resident #43 h	nad a care plan meeting on		il agent			
	9/26/19. The Soci	al Services note documenting	The state of the s				
		es that only social services,		ŀ			
•	the other required	les staff were present, none of					
		am (IDT) contributed to or		ŀ			-
	attended the meet		ľ		* •		
				i			
		0/1/19 at approximately 2:09		1	•		
		f Clinical Services confirmed rdisciplinary team members	j	\$			
i.		e care plan meetings as					
	required, and there	e is no process in place to	1	į			3
	consistently get in	out from those team members		- 1			1
EZOO	who did not attend		a	726	•		
F 730	CFR(s): 483.35(d)	n Review-12 hr/yr In-Service	F.	730			
ا با –قد	5, 1 (lo). ±00,00(d)	V. I					* 1
	§483.35(d)(7) Reg	ular in-service education.					
	14				1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING _		COMPLETED
		475044	B. WING.		10/02/2019
	ROVIDER OR SUPPLIER		60	reet address, city, state, zip codj 1 red village road 'ndonville, vt 05851	€.
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES X MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API	IOULD BE COMPLETION
F 730	of every nurse aid months, and must education based of reviews. In-service requirements of § This REQUIREMINATION of § Thi	complete a performance reviewed at least once every 12 to provide regular in-service on the outcome of these are training must comply with the		1. Employee #4 will recerequired mandatory in 2. Other employees of the will be reviewed to enterquirement for in-service and is aware required education to to employees each year. 3. Facility administration reviewed and is aware required education to to employees each year. 4. The tracking logs for in-servicing have been and are now current. 5. The Director of Nursit designee will review to logs monthly to ensure compliance with requiservicing. 6. The Director of Nursit review the findings would committee x 3 mandates with time the committee the committee that the committ	n-services. The facility asure the revice hours In has the of the revised the revised the tracking received t
F 759 SS=D	I to the second second	on Error Rts 5 Pront or More)(1)	F 759	completed by 11/1/19	1
	§483.45(f) Medic The facility must §483.45(f)(1) Me		Company and the Company of the Compa	Karen Cam	pos RN

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	8	COMPLETED
*		475044	B. WING		10/02/2019
NAME OF P	ROVIDER OR SUPPLIE	R	ST	REET ADDRESS, CITY, STATE, ZIP-CO	DE
(AMME-OIL)	NO VIDELL OIL DOX / Ele	**	60	1 RED VILLAGE ROAD	
PINES REHAB & HEALTH CTR		L	YNDONVILLE, VT 05851	51	
	CLIMINA	STATEMENT OF DEFICIENCIES.	ID.	PROVIDER'S PLAN OF CORE	RECTION (X5)
(X4) ID PREFIX TAG	(EACH DEFICIE)	ICY MUST BE PRECEDED BY FULL R-LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION DATE.
F 759	Continued From	page 8	F 759		
	percent or greate	ėr,		F 759	
	This REQUIREN	IENT is not met as evidenced		1 735	
	by:			1. Resident #10 had no	o negative
	Based on obser	vation, interview and record	ļ	affects as a result of	,
	review the facility	failed to ensure that it's		deficient practice.	
	medication error	rate was no greater than 5% tion administration observation,		2. Residents with phys	nicion orders
A	for Resident #10	The error rate was calculated	and an area of the second		
		findings include the following:	-1	for medications have	AC NO. INC.
	GE 10.0470. THO	tindings more to the same is		potential to be affect	
	1. During a med	cation administration observation	-	alleged deficient pr	actice.
	on 10/01/19 at 7	:46 AM with a Licenses Practical	,	In-servicing and me	edication pass
_ ×	Nurse (LPN), s/f	ne was observed to administer		audits will be done	for licensed
	(13) thirteen ora	medications to Resident #10.		nurses to ensure or	ders are
	Fibercon was or	dered to be administered before		followed as written	
		aid was to be administered with	^		
		dent confirmed at the time the	1	4. On-going medication	
	medication was	administered, that s/he had eakfast. The LPN confirmed at 8	ľ	will be completed b	The state of the s
e.	AM that the med	lications were not administered	1	of Nursing or desig	
	as directed.	10400110, 11010 1101 041		3 months to monito	or
8 9	do anostoa			effectiveness of the	plan.
- *	2. During a med	dication administration	i	5. Reports of the audi	ts will be
		10/01/19 at 7:46 AM with a		reported to the QA.	
	Licenses Praction	cal Nurse (LPN), s/he was		3 months at which	
	observed to adr	ninister (13) thirteen oral	1	committee will dete	
	medications to	Resident #10. The nurse surveyo Medication Administration Record	ľ		eritime further
1	reconciled the N	physician's orders and identified	1	action needed.	2
	that the residen	t was to receive Fluticasone nasa	į .	6. Corrective action v	
		anti-inflammatory), at 8 AM. At	•	completed by 11/1/	/19.
		of the reconciliation,	i i		_ (
	Resident #10 co	onfirmed that s/he had not	V	1759 POC	accepted 10/24/19
	received the na	sal spray. The LPN confirmed at	į.	1 10/1000	may be a fall of
	9:11 AM that the	e nasal spray has not been		2 0	10/29/19
	Security of the second security of the second second	Resident #10 as ordered.		Karen Camp	UZPal
F 800		leets Needs of Each Resident	F 800		ρυ .
SS=C	CFR(s): 483.60			1	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MUI TIPLE	E.CONSTRUCTION.	(X3) DATE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
£		475044	B. WING:	F	10/02/2019
	PROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP GODE 01 RED VILLAGE ROAD	
PINES RI	EHAB & HEALTH CT	R.	Ľ	YNDONVILLE, VT 05851	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES: Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLETION
F 800	Continued From pa	age 9	F 800		
	nourishing, palatal meets his or her didictary needs, taking preferences of each This REQUIREME by: Based on staff and review, the facility with a nourishing, that meets his or his dictary needs, taking meets his or her dictary needs his or her dicta	rovide each resident with a ble, well-balanced diet that ally nutritional and special ng into consideration the		 No residents were neg affected by the alleged practice. Residents receiving management facility have the potent affected by the alleged practice. The steam table has be repaired and hot meals served at the facility. 	I deficient eals in the tial to be I deficient een
	were served cold r 8/7/19 - 8/25/19. If PM, Resident # 1: only cold food in A 10/2/19 at 9:25 AM h/she recalls a per meals were served not all right". Two if during the interview the cold meals. Per food temperatures	eriod in August 2019, residents heals on 26 occasions between Per interview on 9/30/19 at 3:49 stated that h/she was served ugust. Per interview on M, Resident # 44 stated that iod in August where only cold 1. The resident stated "that's family members in the room w also stated that they recalled er review of facility menus with confirm that cold meals were sions as described above.		F 880 Polac Karen Camps	cepted 10/24/19 22 PN
F 801 SS=F	there was a 3 wee residents were ser The Head Cook st broken and was th provide hot meals	AM, the Head Cook confirmed k period in August 2019 that wed cold food at most meals, ated that the steam table had eat staff were unaware how to without the steam table. (1)(2)	F 801		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA		(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING_		COMPLETED
	= ^	475044	B. WING		* *	10/02/2019
N'AME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
		3		60	01 RED VILLAGE ROAD	
PINES R	PINES REHAB & HEALTH CTR.			Ľ	YNDONVILLE, VT 05851	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES FMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S FLAN OF CORRECTIVE ACTION SHO (EACH:CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLETION
F 801	Continued From pa	age 10	F	801	F 801	
A CANADA	appropriate competed the functions of taking into conside individual plans of and diagnoses of the inaccordance with required at §483.70. This includes: §483.60(a)(1) A qualified at full-time, part-time, qualified dietitian on the individual profession (i) Holds a bachelota regionally accreed United States (or a with completion of a program in nutritian appropriate nat recognized for this (ii) Has completed supervised dietetic supervision of a reprofessional. (iii) Is licensed or contrition professional will be deemed to or she is recognized the Commission of successor organized supervision of successor organized for licensum the Commission of successor organized for grant and the commission of successor organized for the commission of successor organized for the commission organiz	nploy sufficient staff with the tencies and skills sets to carry the food and nutrition service, ration resident assessments, care and the number, acuity ne facility's resident population the facility assessment (a)(e) alified dietitian or other nutrition professional either or on a consultant basis. A rother clinically qualified nal is one who- n's or higher degree granted by lited college or university in the in equivalent foreign degree) the academic requirements of ion or dietetics accredited by ional accreditation organization			1. No residents were negatifected by the alleged practice. 2. Residents receiving material facility have the potent affected by the alleged practice. 3. The dietary services in building now has over Certified Dietary Manthere is a second manain training to become 4. The facility contracts Registered Dietician the facility one day per well. FOR POL	d deficient eals in the tial to be I deficient the sight by a ager and ager that is certified. with a nat is at the

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION.	(X3) DATE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	A, BUILDI	ING	COMPLETED
		475044	B. WING		10/02/2019
NAME OF F	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP COD	Ė
				601 RED VILLAGE ROAD	·
PINES R	EHAB & HEALTH C	1K		LYNDONVILLE, VT 05851	4 5
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES	. ID	PROVIDER'S PLAN OF CORRE	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFI		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	INDIANAEL .
			<u>:</u>	. !	
E 004	Castlemad From	nogo 41	; 1 F8	201	(6)
F 801	1	TO PROPERTY AND ADDRESS OF THE PARTY AND ADDRE	FC	5U	£3 3
8		hired or contracted with prior to	4		W
		0.16, meets these requirements	į		
		ears after November 28, 2016 or			
	as required by st	ate law.			
	5392 60(a)(2) H	qualified dietitian or other	1		
f		d nutrition professional is not			
		e, the facility must designate a			
r r		as the director of food and	31		
	nutrition services		1		
		ons prior to November 28, 2016,			
		ing requirements no later than 5	1		
		mber 28, 2016, or no later than 1	Ì		unante u
		nber 28, 2016 for designations			
F.	after November 2	28, 2016, is:	-		instance
		tary manager; or			
		od service manager; or			100
		ational certification for food			The state of the s
		ment and safety from a national		Ton	1000
	certifying body; c				name property and a second
	D) Has an assoc	iate's or higher degree in food			
	service manager	ment or in hospitality, if the			manage of the state of the stat
		ludes food service or restaurant om an accredited institution of	į	***	
there .	higher learning;		ž.		and the state of t
No.		have established standards for		in the state of th	ion i
f .		hagers or dietary managers,		The second secon	* 1
		uirements for food service	1		8
ACT AND ADDRESS OF THE PARTY OF		tary managers, and			of the state of th
2	(iii) Receives free	quently scheduled consultations	3		
		dietitian or other clinically			¥.
	qualified nutrition				a a
	This REQUIREM	MENT is not met as evidenced			8
	by:				
		nterview and record review, the	3		
	facility failed to e	mploy sufficient staff with the			
3	appropriate com	petencies and skills sets to carry			
		of the food and nutrition service.			i
80.	this has the note	ntial to affect all residents of the		An and a second	

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVE	
	F CORRECTION	IDENTIFICATION NUMBER:	A BUILDING_		- QOM	'LE I:EU
		475044	B. WING		10/0	02/2019
NAME OF PROVIDER OR SUPPLIER PINES REHAB & HEALTH CTR		STREET ADDRESS, CITY STATE ZIP CODE 601 RED VILLAGE ROAD LYNDONVILLE, VT 05851				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH-CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 801	Per interview on 97 Cook (HC) stated Registered Dieticla The HC stated tha Nursing Assistant) approximately 2 m confirmed that h/s role of Dietary/kitc 11:01 AM, the faci there is not a full tithat there is not a meets regulatory r Sufficient Dietary CFR(s): 483.60(a) \$483.60(a) \$483.60(a) \$150 CFR(s): 483.60(a) \$150 CF	doubte: (30/19 at 10:45 AM, the Head that there is no full time an or Food Service Director. It his he was an LNA (Licensed and had been the HC for conths. The Head cook also he had no formal training in the hen manager. On 10/01/19 at lity Administrator confirmed line Registered Dietician and Dietary Director in place that requirements. Support Personnel ((3)(b) gemploy sufficient staff with the etencies and skills sets to carry of the food and nutrition service, eration resident assessments, care and the number, aculty the facility's resident population in the facility assessment.	established and the second sec	F 802 1. No residents were a affected related to the deficient practice. 2. Residents residing have the potential the by the alleged defices. 3. The dietary services.	in the facility o be affected cient practice. s in the	
	personnel to safel	oport staff. provide sufficient support y and effectively carry out the od and nutrition service.	Commence County Commence	facility now has ov Certified Dietary N second manager is become certified.	Sanager and a in training to	
	Services staff mus interdisciplinary te (2)(ii).	nber of the Food and Nutrition st participate on the earn as required in § 483.21(b)	a section	4. Training and education provided to dietary regarding proper for and temperature of	staff ood storage	

CTATEMENT	OF DEELGIENGIES	(X1): PROVIDER/SUPPLIER/CLIA	(X2):MUL	TIPLE C	ONSTRUCTION		SURVEY
-STATEMENT OF DEFICIENCIES		IDENTIFICATION NUMBER:	A. BUILDING			COM	PLETED:
	3						
		475044	B. WING			10/0	2/2019
NAME OF P	ROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CODE	E .	
MANULOIT	MONDEL ON GOLLER			601	RED VILLAGE ROAD		
PINES RE	HAB & REALTH CT	TR .	ul.	LYN	IDONVILLE, VT 05851		
<u> </u>					PROVIDER'S PLAN OF CORRE	CTION	. (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION
F 802	interview and recomploy sufficient competencies and functions of the folians the potential facility. Findings in Per interview on Scook (HC) stated Registered Dietic The HC stated the Nursing Assistant approximately 2 reconfirmed that have folians properly reand qualified staff. On 10/1/19, a diethat hashe did not job properly. Duri other nursing fact the kitchen, Reviews	ation, staff and resident ord review, the facility failed to staff with the appropriate d skills sets to carry out the rood and nutrition service. This to affect all residents of the nelude: 0/30/19 at 10:45 AM, the Head that there is no full time ian or Food Service Director at h/she was an LNA (Licensed) and had been the HC for nonths. The Head cook also she had no formal training in the chen manager. The HC stated and food temperatures were not corded due to lack of training		802	 Facility administration continue to review dail in the dietary department ensure enough staff to needs of the residents. Weekly audits will be by the administrator or to monitor compliance. Results of the audits we reported to the QAA committee will determ action needed. Corrective action to be completed by 11/1/19. FBZ PDC actions to the complete of the complete	y staffing ent to meet the completed designee will be committee x e the ine further	The state of the s
F 812. SS=F	observed doing of the Administrator confirmed during staff is due to not overseeing the d Food Procureme	Maintenance Director was lishes. On 10/2/19 at 11:30 AM, and Director of Operations interview the lack of qualified n-qualified management department. nt, Store/Prepare/Serve-Sanitary)(1)(2)		812			manual Catholic Community (See S. 1997)
	SARS EDG) Food	safety requirements.		6.1		4	B
	2:402'00(I) I ood :	ozneg reguijernemo.	15	1			1

STATEMENT	OF DEFIGIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING.		COMPLETED
SOLI	v =		-		1
		475044	B. WING	K.	10/02/2019
			I ST	REET ADDRESS, CITY, STATE, ZIP C	
NAME OF F	ROVIDER OR SUPPLIER		1 2	1 RED VILLAGE ROAD	
DIMES R	EHAB & HEALTH CT	Ŕ		AND	+)
LIMES IN		13	L	VNDONVILLE, VT 05851	
(X4) ID PREFIX TAG	TEACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL USG IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION EAPPROPRIATE DATE
			;		
E 040	0	3:4	F 812		
F.812	Continued From p	age. 14	F-0.12		
	The facility must -			F 812	a
				1 27	tivrolv
ê U	§483.60(i)(1) - Pro	ocure food from sources		1. No residents were	3
		dered satisfactory by federal,		affected by the alle	eged deficient
	state or local auth			practice.	
	(i) This may includ	le food items obtained directly	1	2. Residents residing	in the facility
inc.	from local produce	ers, subject to applicable State		have the potential	
	and local laws or i	egulations,		A	
	(ii) This provision	does not prohibit or prevent	17	by the alleged def	
	racilities from usin	g produce grown in facility o compliance with applicable		 All identified area 	
	gardens, subject i	food-handling practices.		cleaning have been	n cleaned.
	Sale growing and	does not preclude residents		4. Policies have been	
	from concuming f	oods not procured by the facility	,	address food stora	×-
	mour consuming r	bods hat procured by the racing			
	8483 60(i)(2) - Str	ore, prepare, distribute and		requirements to re	
	serve food in acco	ordance with professional		temperatures of re	
	standards for food		1	freezers, and food	, and
		ENT is not met as evidenced	The state of the s	requirements to m	ionitor levels of
	by:			sanitizers.	
		ation and staff interview, the			provided to
	facility failed to sto	ore, prepare, distribute and		5. Education will be	
1		ordance with professional		dietary staff regar	ding the above
		d service safety. This has the		policies.	
		all residents of the facility.		Audits will be con	mpleted weekly
	Findings include:	" s		by the administra	
	2	Spanning of the sale of the sa		to monitor effecti	
		dichen tour with the Head Cook			VOLICOS OF LIFE
		at 10:45 AM., the following		plan.	
1 (4)	observations were	e made:	ž.	7. Results of the aud	
6	1 Thora ware ==	dichwacher temporatures	3	reported to the Qa	AA committee x
	recorded in Septe	dishwasher temperatures		3 months at which	h time the
	2 There are no re	ecorded 3 bay sink sanitizer		committee will de	
		ng observed in use.			Stormine rai anoi
	3 Two wall moun	ted air conditioning units were	. 1	action needed.	W
	soiled with dust a		3	8. Corrective action	
	4 A wall mounted	d knife storage unit containing		completed by 11/	1/19.
	knives that are us	sed daily was soiled with dust)		

STATEMENT	OF DEFICIENCIES.	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION	COMPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COMPLETED
#/##0000000000 } Shi	0 2220000 Managor Schimer 10	200	1		
-			D MINIC		10/02/2019
		475044	B. WING		
NAME OF P	ROVIDER OR SUPPLIE	₹.		STREET ADDRESS, CITY, STATE, ZIP COD	E
111102 91 1				601 RED VILLAGE ROAD	
PINES RE	HAB & HEALTH C	TR		LYNDONVILLE, VT 05851	
				Company of the Compan	ALLEY OF THE
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH	ECTION (X5) ROULD BE COMPLETION
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE AP	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	- 5.
i l			<u> </u>		
	3			-	***
F 812	Continued From	nade 15	F 8	12	
1 012		page 10			
	and grease.	The state of the s			1
Í	An upright free	zer in the kitchen had no 🔪	1	F 077 DXP 001	WAL &
	recorded tempera	atures since 9/4/19.	1	· or roca	suppled /
	6. A freezer used	for ice cream had no recorded	7	F 872 Poc ac	10/24/19
ž.	temperatures.	Section Control of the Control of th			, (1, 1), 1
	7 In the walk-in r	efrigerator, there were 2 plastic	J		
	hade identified as	s cooked chicken that were	1	Karen Cam.	on RNI
N. Control of the Con	unishaled The c	hicken was being thawed on the	1	1 4 4	
	uniabeled, the c	was food on shelves underneath	1)		
Second 2	top sneil. There	Was 1000 on stiertes undernoam	1/ : -		
	the chicken. The	HC was unable to identify when			
		thawed, placed in the refrigerato	II:]		
	or expires.				- I
	8. There were 3	freezers in the basement. The			
	vegetable freeze	r had no recorded temperatures		r.	
:	in September 20	19. The meat freezer and freeze	er V		
ŀ	in the dry storage	e area had no recorded	1	E	ļ.
i.	temperatures.	χ.	l _{ogy}	* .	
	a The wire shell	ing in the reach-in refrigerator	`		
	were rusted and	soiled			
	Were rusted and	r used for milk in the kitchen had			
1					
	no recorded tem	peratures.			ì
li .	11. There are no	recorded food temperatures for			
	September 2019). In August 2019, there were 8	1		4
k	meal occasions	with no recorded temperatures.			
					8.
#	The Head cook	confirmed the above			and the second s
and a	observations du	ring the initial tour. Additionally,)		1
	the Head Cook	was unsure if there are related			
	kitchen policies.	THE RESIDENCE TO M. M. CO.			
F 880			F	880	
11.			89		1
SS≡E	Or 1 (19): 200.00(→ が パンーソン・ハゲーソハル	¥	8	# **
	§483.80 Infectio	n Central		*	
	3403.00 111160110	n control)
li .	ine tacility mus	t establish and maintain an			
	intection preven	tion and control program			
į.	designed to prov	vide a safe, sanitary and			
T.	comfortable env	ironment and to help prevent the	9:	e rai	assert.
	development an	d transmission of communicable	3	3	i
ľ.	1				

CENTERS ON MEDICAL COMPANY DROWNER (SH		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUP AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NUMBER:	A. BUILDING		COME	PLETED
			, , -, , -= , · · · · ·	- 1		
		475044	B. WING		10/0	2/2019
	PO NOCE OF CHARLIED	41,5047	S	TREET ADDRESS, CITY, STATE	, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			01 RED VILLAGE ROAD		267
PINES RI	EHAB & HEALTH CT	R "		YNDONVILLE, VT 05851	/	
				PROVIDER'S PLAN		(X5):
(X4) ID:	SUMMARY ST	ATEMENT OF DEFICIENCIES. Y MUST BE PRECEDED BY FULL	ID- PREFIX	(FACH-CORRECTIVE)	ACTION SHOULD BE	COMPLÉTION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED DEFICIE	TO THE APPROPRIATE	I DATE
IAO			i	DEFICI	EING (;)	1
F 880	Continued From p	age 16	F 880			
	diseases and infed					
	diseases and inice	300,10.		F 880		
	\$483.80(a) Infection	on prevention and control		1. No residents	were negatively	
	program			I. INO LESIGERES	e alleged deficient	
	The facility must e	stablish an infection prevention			e alleged deficient	
	and control progra	im (IPCP) that must include, at		practice.		
	a minimum, the fo	llowing elements:		2. Residents req	uiring blood	
	1		-	glucose moni	toring have the	
	§483.80(a)(1) A s	ystem for preventing, identifying,		potential to b	e affected by the	
	reporting, investig	ating, and controlling infections		alleged defic		
	and communicable	e diseases for all residents,		alleged delle.	one praesire.	
	statt, volunteers, v	visitors, and other individuals under a contractual			· ·	<u>.</u>
	providing services	ed upon the facility assessment		3. The policy for		1
	conducted accord	ling to §483.70(e) and following		disinfecting of	of blood glucose	1
	accepted national	I standards:			been reviewed and	
	accepted fiduoisa	otal autos			llow manufacture	
	\$483.80(a)(2) Wr	itten standards, policies, and			10W Managactare	
	procedures for the	e program, which must include,		guidelines.	1	
ki P S.	but are not limited	d to:		4. Education ha	- 10 markets	
	(i) A system of su	rveillance designed to identify			e above policy.	
	possible commun	icable diseases or		5. Audits will b	e completed weekly	
4		they can spread to other	•	by the Direct	tor of Nursing or	l.
	persons in the fac	cility;	0	designee to r	nonitor effectiveness	S
	(ii) When and to	whom possible incidents of sease or infections should be	÷ I	of the plan.		
	reported;	sease of Infections should be	100	6. Results of th	a andita will be	
	(iii) Standard and	transmission-based precaution	S	1000/21 People majoritativa paracel Freez		
	to be followed to	prevent spread of infections,			he QAA committee:	X .
F	(iv)When and ho	w isolation should be used for a		3 months at	which time the	
	resident, includin	g but not limited to:	ii (#i	committee w	vill determine further	C .
P 44 4	(A) The type and	duration of the isolation,		action neede	ed.	
	depending upon	the infectious agent or organism	1	7. Corrective a		1
	involved, and			completed b		-
	(B) A requiremen	t that the isolation should be the)			
		ossible for the resident under th	е	Com Do	man Mad	10/24/19
	circumstances.	and madernihich the facility		F880 Poe Karen	July Jes	11, 11, 1
	(v) The circumsta	ances under which the facility		Kanon	Campos R	N

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	11.5	
AND PLAN OF CORRECTION. IDENTIFICATION NUMBER:		A. BUILDING _		COMPLETED			
		475044	B. WING		10/02/2019		
NAME OF PROVIDER OR SUPPLIER PINES REHAB-& HEALTH CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 601 RED VILLAGE ROAD LYNDONVILLE, VT 05851				
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION		
F 880	Continued From p	page 17	F 880				
	must prohibit emp disease or infecte contact with resid contact will transr (vi)The hand hygi	ployees with a communicable diskin lesions from direct ents or their food, if direct nit the disease; and ene procedures to be followed in direct resident contact.	The state of the s		is a contract on the contract of the contract	g)	
	identified under th	ystem for recording incidents ne facility's IPCP and the taken by the facility.		: ^ .			
	§483.80(e) Linent Personnel must h transport linens s infection.	s. nandle, store, process, and o as to prevent the spread of		*			
	IPCP and update This REQUIREM by:	nduct an annual review of its their program, as necessary ENT is not met as evidenced	and the state of t			g	
A A A A A A A A A A A A A A A A A A A	interview, the fac carried out infect the development communicable di	vation and confirmed by staff illity failed to ensure that all staff ion control practices to prevent and transmission of seases and infection related to of resident equipment. Finding				É	
	8.28 AM the Lice observed wiping medical device for concentration of alcohol swab. Po observation, the	on on 10/1/19 at approximately need Practical Nurse (LPN) was down a shared glucometer (a or determining the approximate glucose in the blood) using an er interview at the time of the LPN confirmed that the					
		used for more than one resident is/her practice to wipe it down alcohol swab.		a sir			

	S DEFOIT LOTE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		COMPLETEL	
		47.5044	B. WING	8	10/02/20	1,9
NAME OF P	ROVIDER OR SUPPLIER		Si	REET ADDRESS, CITY, STATE, ZIP CODE	1 8	
				11 RED VILLAGE ROAD		21
PINES RE	EHAB & HEALTH CT	1	L D	YNDONVILLE, VT 05851		
(X4) ID PREFIX TAG	JEACH DEFICIENC	ATEMENT OF DEFICIENCIES: Y MUST BE PRECEDED BY FULL ESCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	DLD BE COMPONENTS DE	KS), LETION: ATE.
F 880	In reviewing the m	anufacturer's user instruction is that cleaning and disinfecting use a commercially available	F-880			
	In interview on 10 AM, The Director	/1/19 at approximately 10:00 of Clinical Services confirmed eahing and disinfecting the	and the conditions of building (1888), minute			
-		W I	The state of the s		and the second	-1
8						
				Y		-
			Accompanies de la Companie de la Com			
			matthillian race or m		balter en Eliferateriste pers	
			9			
	And make a constraint was a constraint of the co	×				
	The second secon		C IN		in the state of th	
	The second secon			1 *	5.1	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE		PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY				
NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs			A. BUILDING:	COMPLETE:				
		475044	B, WING	10/2/2019				
NAME OF PR	OVIDER OR SUPPLIER	STREET ADDRESS,	CITY, STATE, ZIP CODE					
		601 RED VILLA	GE ROAD	sa l				
PINES RE	HAB & HEALTH CTR	LYNDONVILLI	C, VT					
ID								
PREFIX	*							
TAG	SUMMARY STATEMENT OF DEFICIE							
F 623	Notice Requirements Before Transfer/ CFR(s): 483.15(c)(3)-(6)(8)	Discharge	*	9				
	§483.15(c)(3) Notice before transfer.							
	Before a facility transfers or discharge	s a resident, the faci	lity must-					
			of the transfer or discharge and the reas-	ons for the				
			tand. The facility must send a copy of t					
	a representative of the Office of the St							
		or discharge in the	resident's medical record in accordance	with				
	paragraph (c)(2) of this section; and							
	(iii) Include in the notice the items des	cribed in paragraph	(c)(5) of this section.	3 B				
	§483.15(c)(4) Timing of the notice.							
		c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge						
			least 30 days before the resident is tran					
	discharged.							
	(ii) Notice must be made as soon as pr	racticable before transfer or discharge when-						
	(A) The safety of individuals in the fac	cility would be endangered under paragraph (c)(1)(i)(C) of this section;						
		acility would be endangered, under paragraph (c)(1)(i)(D) of this ifficiently to allow a more immediate transfer or discharge, under						
	section; (C) The resident's health improves suf							
	paragraph (c)(1)(i)(B) of this section;	inclinity to allow a more infinitediate transfer of discharge, under						
		e is required by the	resident's urgent medical needs, under	naragranh				
	(c)(1)(i)(A) of this section; or	on; or						
	(E) A resident has not resided in the facility for 30 days.							
	§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must							
	include the following:	ine written notice s	beenied in paragraph (e)(3) or this sect	ion must				
	(i) The reason for transfer or discharg	ė;						
	(ii) The effective date of transfer or di	scharge;	v.					
	(iii) The location to which the resident	is transferred or dis	charged;					
	(iv) A statement of the resident's appear	il rights, including th	ne name, address (mailing and email), a	ind				
	telephone number of the entity which	eceives such reques	ts; and information on how to obtain ar	n appeal				
form and assistance in completing the f		form and submitting	the appeal hearing request;					
	(v) The name, address (mailing and en	nail) and telephone	number of the Office of the State Long-	Term Care				
	Ombudsman;			200 0 0				
	(vi) For nursing facility residents with	intellectual and dev	elopmental disabilities or related disab	ilities, the				
	of individuals with developmental disc	he number of the ag	ency responsible for the protection and	advocacy				
	Assistance and Bill of Rights Act of 20	sabilities established under Part C of the Developmental Disabilities 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and						
	(vii) For nursing facility residents with	a mental dicorder o	r related disabilities the mailing and a	, and mail addrass				
	and telephone number of the agency re	n a mental disorder or related disabilities, the mailing and email address esponsible for the protection and advocacy of individuals with a mental						

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

The above isolated deficiencies pose no actual harm to the residents

	ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY		
	ONLY A POTENTIAL FOR MINIMAL HARM	September September	A. BUILDING:	COMPLETE:		
FOR SNFs AND		475044	B. WING	10/2/2019		
	VIDER OR SUPPLIER AB & HEALTH CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 601 RED VILLAGE ROAD LYNDONVILLE, VT				
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIE	NCIES		, .		
F 623		s prior to effecting the	transfer or discharge, the facility must	update		
	§483.15(c)(8) Notice in advance of far. In the case of facility closure, the individual notification prior to the impending clo Care Ombudsman, residents of the factransfer and adequate relocation of the This REQUIREMENT is not met as experience.	cility closure vidual who is the admi sure to the State Surve ility, and the resident is residents, as required evidenced by: view, the facility failed	I to issue a written notice of transfer/di	r-Term the		
	evaluation. There was no notice of trai interview on 10/1/19 at 3:15 PM, the 5 weekend and that the notice was not is 2. Per record review, Resident #19, w Personality Disorder and Anxiety, had resident sustained a facial laceration a evidence in the medical record that a v representative as required. Per intervient PM, confirmation is made that a written intervience is the sustained as the sustained as the sustained as required.	nsfer provided to the resocial Services Directors with diagnoses to include an unwitnessed fall or on the Emperiter notice of transfew with the Social Service and there is no provided and there is no provide and the provided and the provi	was sent to the Emergency Department esident's legal representative as require or confirmed that this transfer happened to Parkinson's Diseat 107/06/19 at approximately 11 AM. Tergency Room for evaluation. There is ser was provided to the resident/resident vice Director on 10/01/19 at approximated as required. Confirmation was also sess in place ensuring that notices are presented to the provided as required.	ed. Per ed on a ise, The is no it's legal eately 3 so made		
F 625	Notice of Bed Hold Policy Before/Up CFR(s): 483.15(d)(1)(2)	on Trnsfr				
	§483.15(d) Notice of bed-hold policy	and return-				
	goes on therapeutic leave, the nursing representative that specifies-	facility must provide policy, if any, during very;	ty transfers a resident to a hospital or the written information to the resident or rewhich the resident is permitted to return \$447.40 of this chapter, if any;	esident		

AH "A" FORM

	OR MEDICARE & MEDICAID SERVICES OF ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER#	MULTIPLE CONSTRUCTION	"A" FO
	TH ONLY A POTENTIAL FOR MINIMAL HARM	T KO VIDEK II	A. BUILDING:	Description of the second seco
SNFs AND		475044	B. WING	COMPLETE: 10/2/2019
ME OF DRA	OVIDER OR SUPPLIER	STREET ADDRE	SS, CITY, STATE, ZIP CODE	
			LAGE ROAD	
NES REF	AAB & HEALTH CTR	LYNDONVII		* 1
EFIX				¥I
G	SUMMARY STATEMENT OF DEFICIE	ENCIES		
625	Continued From Page 2			
	(iii) The nursing facility's policies reg		eriods, which must be consistent	: with paragraph (e)
	(1) of this section, permitting a reside	nt to return; and		
	(iv) The information specified in para	graph (e)(1) of th	s section.	
8	§483.15(d)(2) Bed-hold notice upon t	rancfar At the tim	a of transfer of a resident for he	anitalination as
	therapeutic leave, a nursing facility m			
	which specifies the duration of the be	d-hold policy desc	cribed in paragraph (d)(1) of this	section .
	This REQUIREMENT is not met as	evidenced by:		
	Based on record review and staff inter	view, the facility	failed to issue a written notice of	f bed-hold policy to
	the resident and/or legal representativ	e upon transfer to	the hospital for 2 of 4 residents	(Residents #5, 19).
	Findings include:			*
	1 Per record raview Pacident # 5 has	l a fall a= 0/20/10	and the second of the second	5
	1. Per record review, Resident # 5 had evaluation. There was no notice of be	d-hold policy prov	, and was sent to the Emergency	Department for
	as required. Per interview on 10/1/19	at 3:15 PM the S	ocial Services Director confirme	d that this transfer
	happened on a weekend and that the b	ed-hold notice wa	is not issued.	a that this transier
OK.				
	2. Per record review, Resident #19 ha	nd an unwitnessed	fall on 07/06/19 at approximate	ly 11 AM. The
	resident sustained a facial laceration a	nd was sent to the	Emergency Room for evaluation	n. There is no
	evidence in the medical record that a	written notice of	ped-hold was provided to the res	ident/resident's legal
	representative as required. Per intervi PM, confirmation is made that a writte	ew with the Socia	Service Director on 10/01/19 a	t approximately 3
	that the transfer occurred on a weeken	d and there is no	provided as required. Confirmal	tion was also made.
	weekends, holidays and/or at time of l	eave.	process in prace challing that no	tices are provided on
	, i.			
			3	
	1			
				*
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