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

December 3, 2021

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 survey conducted on **November 3, 2021.** 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

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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 11/03/2021

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 conducted, in conjunction with the recertification survey, by the Division of Licensing & Protection on 11/3/2021. There were no regulatory deficiencies identified as a result of the review.	E 000		
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted a recertification survey from 11/1/2021 to 11/3/2021 in conjunction with a facility reported incident investigation, the following regulatory deficiencies were identified.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to provide adequate supervision of one resident in the applicable sample (Resident # 20). Finding include: Per record review Resident #20 has diagnoses that include intracranial injury, anoxic brain damage, major depressive disorder, and sexual dysfunction. Progress notes and resident care plans reflect that Resident #20 has a history of frequently exhibiting hypersexual behaviors	F 689	F689 1. No negative effects occurred as a result of this alleged deficient practice. Resident #20 no longer requires direct supervision when out of the room and the care plan has been updated. 2. Residents residing in the facility with another who requires supervision have the potential to be affected by the alleged deficient practice.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 11/23/21

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 689	Continued From page 1 toward staff and other residents. These behaviors include groping, biting, and soliciting sex from staff, exposing her/himself to others, and following residents around and entering their rooms. Per review of Resident #20's care plan a focused "Problem" was implemented on 6/13/2018 (prior to the incident) and last reviewed on 9/15/2021 "[Resident #20] is at risk of becoming sexually reactive in common areas" with a goal listed as " [Resident #20] will not display sexual behaviors or inappropriately expose self towards staff or others." Interventions include "Staff will redirect [Resident #20] to a private area when acting out sexually in appropriate" and " [Resident] requires supervision when out of [her/his] room." On 1/8/2020 a care plan was implemented that states "[Resident] has exhibited inappropriate behavior and yelling out during group activities and is distracting others." Interventions include "[Resident] will have direct supervision while in the dining room." On 10/8/2020 during the lunch meal Resident #20 was left unsupervised. When staff returned a resident who is of the opposite sex reported that Resident #20 had touched her/his breast. A Nurse's Progress Note written on 10/8/2020 at 12:59 PM states "Resident (#20) was moaning and pointing during the morning and at meals and was reported to have had inappropriate touching of [another] resident at about 12:20. Just prior to incident, two LNAs [Licensed Nursing Assistants] were in the dining room assisting with feeding and watching the room, then one resident began to vomit and was escorted to [her/his] room. Once [s/he] was [feeling] better, I asked the second LNA to help transfer the resident while I	F 689	3. Re-education has been provided to staff regarding the requirement to follow the plan of care for a resident requiring supervision. 4. Resident care plans have been audited to ensure appropriate levels of supervision required are accurate. 5. The Director of Nursing or designee will conduct audits weekly to monitor effectiveness of the plan. 6. 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. 7. Corrective action will be completed by December 3, 2021. **TAG F 689 POC Accepted on 12/03/21 by L. Lovell/P. Cota**	

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F 689	Continued From page 2	F 689		

watched the dining room. While I watched the dining room, nothing happened, but the [other resident] sitting next to [Resident #20] seemed uncomfortable and repeatedly looked at [her/him] out of the corner of [her/his] eye. The PCA (patient care attendant) in the room came over to the [other resident] and asked if [s/he] was ok and [s/he] reported that [her/his] breast had been touched by [Resident #20]. They were both done eating at this point and were assisted to their rooms. It seems the touching occurred during a transition of supervision. Incident reported to supervisor."

During direct observation on 11/1/2021 at approximately 2:15 PM, Resident #20 was sitting in the living room watching a movie with another resident. There were no staff members providing supervision to Resident #20. During observation on 11/02/21 at 8:52 AM Resident #20 was seen self-propelling her/his wheelchair throughout A wing unsupervised. Staff were observed walking by and entering other residents' rooms. On 11/03/21 at 11:16 AM Resident #20 was observed self-propelling down B-wing hall unsupervised by staff.

Per interview with the Director of Nursing and the Director of Clinical Services on 11/3/2021 at 11:42 AM Resident #20 is seen by psych services and has modified clothing to prevent exposure. S/he does "tool around and goes to visit other residents. When s/he has socially inappropriate behaviors staff offer trivia and other activities."

During interview on 11/3/2021 at approximately 2:00 PM the Director of Clinical Services confirmed that Resident #20's care plan does reflect the need for supervision however, S/he is

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F 689	Continued From page 3 not always supervised when out of her/his room.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents who require dialysis receive services, consistent with professional standards of practice, and the comprehensive, person-centered care plan for one of 12 residents (Resident #6). Findings include: 1. Per record review, Resident #6 receives dialysis treatment three days a week on Tuesdays, Thursdays, and Saturdays. Resident #6 has a fistula (an access point for dialysis treatment on the arm in which a vein and an artery are connected) in their left arm. Per review of Resident #6's care plan, there is a care plan focus for "Dialysis: Resident receives dialysis for ESRD (end stage renal disease)" that was initiated on 1/4/21. One of the interventions under this care plan focus is the intervention, "Monitor AV shunt (fistula) in left arm every shift for bruit (a rumbling sound you can hear through a stethoscope) and thrill (a vibration that can be felt through the skin)." Assessing a fistula for a bruit and thrill ensures that the fistula is working properly. Per review of Resident #6's TAR (treatment	F 698	F698 1. Resident #6 had no negative effects related to the alleged deficient practice. The Medication Administration Record has been updated to reflect the monitoring of the access point for dialysis. 2. Residents that have an access point for dialysis treatment have the potential to be affected by the alleged deficient practice. 3. Re-education has been provided to licensed nurses regarding the requirements for monitoring a dialysis access point. 4. The Director of Nursing or designee will conduct weekly audits 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 December 3, 2021.	

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F 698	Continued From page 4 administration record), there is no documented evidence that Resident #6's fistula is assessed every shift by staff. A search of the rest of Resident #6's record does not show any documentation of a fistula assessment done every shift. Per interview on 11/3/21 at approximately 9:00 AM, the nurse caring for Resident #6 confirmed that there was nowhere in the record that they could find for documenting a fistula assessment. They also stated that they were not aware that they should be assessing Resident #6's fistula. Per interview on 11/3/21 at approximately 10:00 AM, the Director of Clinical Services confirmed that there is no documented evidence of facility staff assessing Resident #6's fistula every shift.	F 698	**TAG F 698 POC Accepted on 12/03/21 by L. Lovell/P. Cota**	
F 730 SS=B	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide regular in-service education to 2 of 5 sampled Licensed Nursing Assistants (LNA). (# 1,3) Findings include: Review of facility education and inservice documents showed that 2 LNAs did not receive the 12 hours of annual inservice education as	F 730	F730 1. No residents were negatively affected by the alleged deficient practice. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. Facility administration is aware of the requirement to ensure Nurse Aids have at least 12 hours of in-service education yearly.	

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F 730	Continued From page 5 required by regulation. LNA # 1 received 10.25 hours and LNA #3 received 8.0 hours. At 1:16 PM on 11/3/21, the Director of Clinical Services confirmed that there is no evidence that staff # 1 and #3 had received the required 12 hours of annual training.	F 730	4. The number of hours missing for in-service education will be completed for all affected staff members. 5. The Director of Nursing or designee will conduct an audit monthly to monitor on-going compliance with the plan. 6. The results of the audits will be reported to the QAA committee x3 months at which time the committee will determine further frequency of audits. 7. Corrective action will be completed by December 3, 2021. **TAG F 730 POC Accepted on 12/03/21 by L. Lovell/P. Cota**	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a	F758	1. Resident #6 had no negative effect as a result of the alleged deficient practice. 2. Residents with orders for psychotropic medications have the potential to be affected by the alleged deficient practice.	

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F 758	Continued From page 6 diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure each resident's drug regimen is free from unnecessary psychotropic drugs for one of 12 residents (Resident #6) as evidenced by the resident being administered psychotropic drugs without adequate monitoring. Findings include: 1. Per record review, orders were placed for two psychotropic drugs for Resident #6 on 4/29/21. There is an order for "duloxetine (an antidepressant) 30 milligrams a day for anxiety and depression" and an order for "Aripiprazole (an antipsychotic medication) 5 milligrams a day for anxiety and depression." The record shows that the Aripiprazole was increased to 7.5 milligrams on 10/21/21 per resident request. Per review of Resident #6's care plan, there is a care plan focus for "depression" initiated on 8/11/21 that includes interventions for	F 758	3. An initial audit was completed to identify other residents receiving psychotropic medications to ensure appropriate monitoring is identified in the plan of care and appropriate monitoring for behaviors is present. 4. Education has been provided to licensed nurses regarding the requirement to monitor for side effects and behaviors for those receiving psychotropic medication. 5. The Director of Nursing or designee will conduct weekly audits to monitor effectiveness of the plan. 6. 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. 7. Corrective action will be completed by December 3, 2021. **TAG F 758 POC Accepted on 12/03/21 by L. Lovell/P. Cota**	

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F 758	Continued From page 7 "medications as ordered" and "AIMS (Abnormal Involuntary Movement Scale) testing per protocol." AIMS testing is used to monitor for side effects of antipsychotics. Per review of assessments in the record, Resident #6 has only received AIMS assessments on 10/12/21 and 10/26/21 since their admission in April of 2021 and the subsequent ordering of Aripiprazole. There is no evidence in the record of monitoring side effects of antidepressants. There is also no evidence in the record of regular behavior monitoring to help assess for effectiveness of either medication. Per interview on 11/3/21 at approximately 1:30 PM, the Director of Clinical Services confirmed that there is no evidence in the record of monitoring for the psychotropic medications, outside of the AIMS assessments.	F 758		