

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475023	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Pine Heights at Brattleboro Center for Nursing & R		STREET ADDRESS, CITY, STATE, ZIP CODE 187 Oak Grove Avenue Brattleboro, VT 05301	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0585</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>50336</p> <p>Based on interviews, observation, and record reviews, the facility failed to support the resident's right to file grievances anonymously for 5 out of 5 residents in the sample (Resident's #5, #26, #55, #53 and #67). This has the potential to affect all residents in the facility.</p> <p>Findings Include:</p> <p>Per interview at Resident Council (RC) on 9/11/2024 at 10:30 AM, 5 out of 5 residents revealed they did not know how to file a grievance anonymously, or at all, and had no access to forms to be able to file anonymously or independently. All five residents revealed if they had known and understood their rights to file a grievance, they would have done so.</p> <p>Per observation of all units at the facility at 11:45 AM, there was no evidence of grievance forms on any unit for a resident, or his/her representative, to submit a grievance independently or anonymously.</p> <p>Per interview on 9/11/2024 at approximately 12:00 PM with the Administrator, s/he confirmed that there were no forms available for individuals to file a grievance independently or anonymously on any units. The Administrator confirmed during interview there was not a process or form available for the residents or responsible party to file a grievance independently or anonymously.</p> <p>Per facility policy titled Grievance/Concern Policy, it states the following: The residents/responsible party can bring forward their concerns verbally and or by written grievance process. Grievance/Concerns forms are available on the nursing units and in the front lobby where applicable. There is no evidence that forms were made available or that residents/representatives had access to file a grievance independently or anonymously.</p>		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>29776</p> <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based upon observation, interview, and record review, the facility failed to provide Activities of Daily Living [ADL] care and assistance to maintain good nutrition for 1 dependent resident [Res.#39] of 3 sampled residents dependent on ADL assistance.</p> <p>Findings include:</p> <p>Per review of Res.#39's Care Plan, the resident is identified as having as having Dysphagia [Dysphagia is a medical term for difficulty swallowing. Difficulty swallowing can lead to: Malnutrition, weight loss and dehydration.]*, has risk for weight loss and malnutrition due to variable meal intake and dysphagia as well as cognitive impairment, at risk for dehydration, has impaired cognitive function/dementia or impaired thought processes, has an ADL [Activities of Daily Living] self-care performance deficit related to dementia, and has impaired visual function related to left eye blindness. Care Plan interventions to counteract Res.#39's nutritional risks include EATING: Continual supervision, May need more cues/assist, Provide feeding/dining assistance as needed. Set up for meals, Ensure the resident has access to Beverage of choice, and Ensure all meals and fluid intake occur under staff supervision.</p> <p>A meal observation was conducted on 9/9/24 at 11:45 AM. During the lunch meal observation, Res.#39 was observed seated in a wheelchair with h/her eyes closed at a table with 4 other residents. At 11:45 AM, a meal platter and a drink were placed in front of Res.#39, along with platters in front of the other 4 residents, including a resident seated next to Res.#39. Per observation, a staff Licensed Nursing Assistant [LNA] sat down next to the resident seated next to Res.#39, and the LNA began to feed that resident. Res.#39 was positioned in front of h/her meal and drink and made no attempt to feed h/herself or was cued or assisted by staff for approximately 10 minutes, while the other residents at the table ate their meal and the resident seated next to Res.#39 was being fed by the LNA. At 11:55 AM, another resident, Res.#34, approached the table in their wheelchair, took the drink from in front of Res.#39, drank from it, then wheeled away from the table carrying the drink with them. The LNA seated at the table said nothing to Res.#34 and did nothing to intervene. Res. #39 remained seated at the table in front of h/her meal for another 11 minutes without cueing or assistance, when a second LNA came over to the table and replaced the drink that the other resident had taken. Res.#39 was not offered the drink or cued to drink. At 12:10 PM, 25 minutes after the meal platter was placed in front of Res.#39, after the LNA had finished feeding the resident seated next to Res.#39 and the other residents at the table had finished their meals, the LNA moved their chair next to Res.#39 and offered h/her a bite of the meal. Res.#39 took a spoonful of the food and shook h/her head. The LNA did not question the resident as to why they disliked it, if they wanted an alternative, or if the meal needed reheating after sitting uncovered for 25 minutes.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the facility's Director of Nursing [DON] on 9/10/24 at 9:30 AM. The DON confirmed that Res.#39 was identified as at risk for weight loss, malnutrition and dehydration, and diagnosed with impaired cognition and dementia along with difficulty swallowing. The DON confirmed Res.#39 is dependent on staff for cueing and assistance with meals, and agreed that based on the observation on 9/9/24 at 11:45 AM, Res.#39 was not offered either while the other residents at the table ate and/or were being fed, another resident took Res.#39's drink with no staff intervention, and after being offered their meal after 25 minutes and declining it, was not offered to re-heat the meal or an alternative.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>40258</p> <p>Based on interview and record review the facility failed to provide services that included supervision, monitoring, and ADL (Activities of Daily Living) care necessary to prevent a fall from a wheelchair for 1 of 10 residents in the applicable sample (Resident #19). Findings include:</p> <p>Per record review Resident #19 was found on the floor of her/his room at 1:45 AM on 8/7/24. Review of Resident #19's care plan reveals that s/he is totally dependent on two staff with a mechanical lift for transfers to and from a wheelchair. The care plan also indicates that s/he has an ADL self-care performance deficit, with interventions that include, ensure resident is assisted to bed by 11 PM unless resident requests otherwise, intentional rounding every 1 hour for repositioning, and monitor positioning while in room.</p> <p>A Health Status Note written on 8/7/2024 states that the Resident was found on the floor next to her/his wheelchair in her/his room at 1:45 AM. The note further states that the call light was out of reach and the mechanical lift was in the room. Another Health Status Note written on 8/7/24 at 3:45 PM states that it appears that the Resident slid out of her/his wheelchair and was on the floor before being found by staff.</p> <p>Review of the facility incident summary written by the Administrator dated 8/7/2024 reveals that Resident #19 was assisted from the dining room to her/his room and was not assisted to bed or reevaluated until s/he was found on the floor by staff at approximately 1:45 AM. The summary also states that the Resident was to be turned and repositioned every 2 hours.</p> <p>Per interview with the facility Administrator on 9/11/24 at 11:36 AM the facility internal investigation of the incident determined that a staff member brought the Resident to her/his room sometime after the evening meal. The Licensed Nursing Assistant (LNA) who was assigned to Resident #19's care had signed documentation that s/he had performed safety checks however, s/he had not. The evening and night shift staff had not done walking rounds at change of shift as is expected.</p> <p>During the onsite survey, it was determined that the facility had implemented actions to correct the noncompliance prior to the start of the re-certification survey, which included evaluation of Resident #19, staff education regarding safety checks, repositioning, intentional walking rounds, and increased monitoring of assistance provided to the residents. The facility was able to demonstrate monitoring of the corrective action and sustained compliance.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>29776</p> <p>Based upon observation and interview, the facility failed to meet food service safety requirements.</p> <p>Findings include:</p> <p>1.) Per observation on 9/8/24 at 9:30 PM and again on 9/11/24 at 9:45 AM, a fan located above the clean dish drying area in the facility's kitchen was noted to have a notable covering of dark gray dust-like material on the fan blades and the outer surface of the fan guard/grill. On 9/11/24 at 9:45 AM, the fan was noted to be circulating air directly above a tray of clean flatware. The dirt on the fan guard was noted to include a strand of dark, stringlike material extended from the guard while the fan was operating. The observation on 9/11/24 was conducted with the facility's Dietary Manager, who confirmed the fan blowing on the clean flatware represented an unsanitary condition, and stated that Maintenance had been notified about the fan needing cleaning the day before, on 9/10/24, but the cleaning had not been done.</p> <p>2.) Per observation on 9/9/24 at 12:31 PM, a bag of white bread slices was noted to have visible green mold on it in the facility's 2nd floor kitchenette. Per interview on 9/11/24 at 9:45 AM the Dietary Manager confirmed the bread in the 2nd floor kitchenette was moldy and stated that the facility did not have a process for monitoring and dating bread to ensure it was not used beyond its expiration date.</p>