VERMONT

AGENCY OF HUMAN SERVICES
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

March 24, 2025

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

Dear Mr. Bergeron:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **February 26, 2025.** 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, BS
Assistant Division Director
State Survey Agency Director

Enclosure

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 02/26/2025

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 The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey on 2/26/25. There were no regulatory violations identified.	E 000		
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey and investigation of one complaint # 023534 from 2/24/2025 through 2/26/2025 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657	F657 1. Resident #20 has had the care plan updated to reflect new interventions and the lock has been evaluated to ensure it remains locked when resident #20 and roommate are not using it. 2. Residents with a past history of trauma have the potential to be affected by the alleged deficient practice.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Travis B. Bruyn	Administrator	3/17/25

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 657	Continued From page 1 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to revise a care plan for 1 of 21 sampled residents (Resident #20) related to past trauma. Findings include: During an interview, on 2/24/25 at 12:55 PM, Resident #20 and his/her roommate stated that more than one wandering resident had entered their room in the middle of the night via a shared bathroom several times over the course of a few months. Resident #20 and his/her roommate requested that a lock be put on the bathroom door to prevent anyone from accessing their room via the shared bathroom, which was done. Resident #20 became visibly upset, with noticeable anxiety and agitation. His/her voice became louder and s/he was clutching the arms of his/her wheel chair during the interview, stating "The staff always forget to lock it!" Resident #20 is hearing impaired, and said "I wouldn't hear someone come in if my back was to the bathroom door." During this interview, this surveyor observed Resident #20 check the bathroom door, which was unlocked at the time. Per record review, Resident #20 has a Care Plan for "Actual Psychosocial Well-being problem related to sexual abuse at a young age" dated 10/19/2023. There are no updates in the Care Plan regarding wandering residents entering	F 657	3. In-servicing will be provided to staff regarding the need for effective interventions for those experiencing past trauma. 4. Audits will be completed 3x weekly x1 month then weekly thereafter x3 months to monitor effectiveness of the plan. Audits will include an interview with resident #20. 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 complete by 4/12/2025 **Tag F 657 POC accepted on 3/24/25 by J. Schneckenburger/S. Stem**	

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F 657	Continued From page 2 his/her room, or regarding the need for the bathroom door to always locked from inside the resident's room. During an interview, on 2/26/25 at 1:20 PM, the Director of Nursing and the Clinical Lead both confirmed that Resident #20 should have interventions in his/her Care Plan relating to wandering residents and the need for the bathroom door to be locked at all times, and both confirmed that s/he does not have these interventions in place.	F 657		
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 interview and record review, the facility failed to ensure residents remained free of accident hazards related to falls and care plan interventions for 2 residents [Residents #55 & #3] of 25 sampled residents. Findings include: 1.) Per record review Resident #55 was admitted to the facility with diagnoses that include a history of falls, alcohol-induced dementia, lack of coordination, and muscle wasting. The resident's Care Plan identified the resident "at risk for falls due to a primary medical history of falls, alcohol abuse, and increased weakness."	F 689	F689 1. Residents #55 and #3 have had reviews done to the care plan to ensure interventions are in place to prevent further falls. 2. Residents at risk to fall in the facility have the potential to be affected by the alleged deficient practice.	

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F 689	Continued From page 3 Review of progress notes for the resident dated 2/1/25 reveal "At 2:10 PM: Nurse was summoned to resident's room after [s/he] was found on the floor beside [h/her] bathroom door ... Root cause of fall: Alone and unassisted- resident lacks safety awareness." Further review of progress notes reveal the next day, "2/2/25 at 04:45 AM: Resident was found on the floor, beside [h/her] bed in a sitting position. Resident was awake and alert." The following day, 2/3/25, Progress notes record at 12:00 AM "Resident was found on the floor, in a sitting position beside [h/her] bed while this nurse was making rounds. When resident was asked what had happened, resident was speaking in word salad [unintelligible, extremely disorganized speech]. Resident is confused at baseline." Review of the facility's 'Resident Centered Approaches to Managing Falls and Falls Risk' policy [revised March 2018] records "the staff will implement a resident centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls." The policy continues "If falling occurs despite initial interventions, staff will implement additional or different interventions ...if underlying causes cannot be readily identified or corrected, staff will try various interventions ...until falling is reduced or stopped." Review of Resident #55's Care Plan reveals no new interventions added to prevent further falls after falls on consecutive days 2/1/25 and 2/2/25. A third fall in 3 days [2/3/24] then resulted in	F 689	3. In-servicing will be provided to staff regarding the requirement to implement new interventions immediately after a fall to prevent further falls and those interventions will be added to the care plan. 4. Audits will be completed as needed with falls to ensure compliance with 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 4/12/2025. **Tag F 689 POC accepted on 3/24/25 by J. Schneckenburger/S. Stem**	

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F 689	Continued From page 4 interventions being added. 2.) Per record review Resident #3 was admitted to the facility with diagnoses that included paranoid schizophrenia, bipolar disorder, and borderline personality disorder. The resident's Care Plan identified the resident "at risk for falls due to a history of falls and muscle weakness." Review of progress notes for the resident dated 12/7/24 reveal "At 3:10 this morning this nurse was called into room by this resident's roommate via call light. On arrival [Resident #3] is seen laying on floor on the side of [h/her] bed. [Resident #3] stated had pain in chest area when asked why stated 'I fell on my chest facing down' ... Resident skin assessment completed and noted redness on mid chest area,. During the end of skin assessment noted tenderness tor right side of chest wall under axillary area. Area is tender to touch and has a slight skin color change. Resident states this area hurts. MD suggested resident to go to Hospital. When asked resident if [s/he] would like to go to hospital to get x-ray and seen by MD there [s/he] declined." Review of Resident #3's Care Plan reveals no new interventions added to prevent further falls after the fall on 12/7/24. An interview was conducted with the Director of Nursing [DON] on 2/26/25 at 10:33 AM. The DON stated the expectation is that after a fall interventions are added to a resident's the care plan "immediately" to prevent any additional falls. The DON confirmed Resident #55 fell on 2/1, 2/2, & 2/3/25 before new interventions were added into the care plan on 2/4, after resident had fallen twice with no new actions taken. The DON also confirmed no new interventions were added to	F 689		

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F 689	Continued From page 5 Resident #3's care plan interventions to prevent future falls after a fall on 12/7/24.	F 689		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that dinnerware was sanitized and failed to maintain a clean kitchen environment, which has the potential to impact all residents in the facility. Findings include: On 02/24/25, at 10:41 AM, it was observed that the shelf under steam table was covered in a greasy residue with crumbs and dust adhering to it. This shelf contained the clean steam table trays, which were stacked, opening side down, on	F 812	F812 1. No residents were negatively affected by the alleged deficient practice. 2. Residents residing in the facility and receiving facility meals have the potential to be affected by the alleged deficient practice. 3. The identified areas in the kitchen have been cleaned and in-servicing will be provided to dietary staff to ensure a clean dietary environment. 4. The identified temperatures of the dishwasher were due to a malfunctioning temperature gauge that has since been replaced and no further issues identified since the dates identified in this survey.	

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F 812	Continued From page 6 the soiled shelf. Crumbs were observed on the counter near and under the toaster, and there were brown stains on the counter at the window used to pass food and beverages to the dining room. The facility uses a high temperature dishwasher (which uses heat for sanitization rather than chemicals). Per regulatory requirements, the dishwasher must have a wash cycle temperature of 150 to 165 degrees Fahrenheit. A record review of the 12/2024 Dishwasher Temperature Log showed the following insufficient temperatures were recorded on the log by staff: 12/4/2024 148 degrees Fahrenheit (F), 12/5/2024 120 degrees F, 12/7/2024 140 degrees F, 12/8/2024 110 degrees F, 12/15/2024 125 degrees F, 12/16/2024 140 degrees F, 12/17/2024, 140 degrees F, and 12/21/2024 130 degrees F. During an interview, on 2/24/25 at 10:50 AM, the Certified Dietary Manager confirmed that the shelf under the steam table was not clean and that the counters were not clean. During an interview, on 2/26/25 at 10:16 AM, the Certified Dietary Manager confirmed wash cycle temperatures for the dishwasher were insufficient for sanitization on 12/4/2024, 12/5/2024, 12/7/2024, 12/8/2024, 12/15/2024, 12/16/2024, 12/17/2024, and 12/21/2024.	F 812	5. In-servicing will be done for staff to ensure compliance with the protocol to follow if dishwasher temperatures fall outside of acceptable range. 6. Weekly audits will be completed by the Certified Dietary Manager to ensure compliance with the plan. 7. 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. 8. Corrective action will be completed by 4/12/2025. **Tag F 812 POC accepted on 3/24/25 by J. Schneckenburger/S. Stem**	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880	F880 1. No residents were negatively affected by the alleged deficient practice.	

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F 880	Continued From page 7 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F 880	2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. A risk assessment to identify areas in the building that could grow and spread legionella in the facility water system will be developed and control measures put into place. 4. Facility administration, infection preventionist, and maintenance personnel are aware of the requirements. 5. Audits will be completed by the Infection Preventionist or designee monthly x3 months 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 4/12/2025.	

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F 880	Continued From page 8 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to implement an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections related to Legionella prevention. Findings include: Per record review of the facility's water management program, there was no risk assessment to identify areas in the building that could grow and spread Legionella in the facility water system. Per the facility's "Water Management for Legionella" policy [effective date: 1/1/23] states, "	F 880	**Tag F 880 POC accepted on 3/24/25 by J. Schneckenburger/S. Stem**	

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F 880	Continued From page 9 Kingdom kare locations will utilize water management practices to reduce the risk of growth of Legionella and other opportunities pathogens in building water systems ...Core elements of the water management plan are: ...describe the facilities water system using text and flow diagram, risk assessment with control methods and corrective actions, monitoring control measures ..." The facility's water management system policy did not include any testing protocols. An interview was conducted with the Infection Preventionist and Director of Maintenance on 2/26/25 at 10:50 AM. The Director of Maintenance and Infection Preventionist confirmed that the facility did not complete a risk assessment, including identifying areas in the building where Legionella could grow or reside.	F 880		