VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
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AGENCY OF HUMAN SERVICES

November 3, 2025

Mr. David Beauregard, Administrator
Pine Heights at Brattleboro Center for Nursing & Rehab
187 Oak Grove Avenue
Brattleboro, VT 05301

Provider ID #: 475023

Dear Mr. Beauregard:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **September 17, 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
Pamela M. Cota, RN, BS
Assistant Division Director
State Survey Agency Director

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475023	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Heights at Brattleboro Center for Nursing & Rehab	187 Oak Grove Avenue , Brattleboro, Vermont, 05301

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E0000	Initial Comments The Division of Licensing and Protection conducted an on-site, unannounced survey of the facility's emergency preparedness program on 9/17/25 during an annual recertification survey. There were no regulatory violations related to emergency preparedness as a result of this survey.	E0000	This plan of correction is the Center's credible allegation of compliance. The filing of this plan does not constitute an admission that the deficiencies alleged did, in fact, exist. This plan is filed and executed as evidence of the Center's desire to comply with the provisions of federal and state law, and to continue to provide quality care and services.	
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey from 9/15/25 to 9/17/25 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey.	F0000		
F0657 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.	F0657	Care Plan Timing and Revision Resident #38 was not negatively affected by this deficient practice. All residents could be affected. On 9/18/2025 the Director of Social Services attempted to contact resident #38's son to schedule a care plan meeting. On 10/2/2025 staff attempted to hold a bedside care plan meeting, however, the resident declined as there is an Annual meeting scheduled for the following week. On 10/3/2025 each Resident and Resident Representative received a letter, email, or text message outlining the updated Care Plan meeting process, and invited them to reach out to the Center to schedule an interim Care Plan meeting should they so choose.	

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 reverse for further 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
	ADMINISTRATOR	10/3/2025

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F0657 SS = D	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 interview and record review, the facility failed to ensure resident involvement in the care planning process for 1 of 20 residents (Resident #38). Findings include: Per interview on 9/15/2025 at 11:39 AM, Resident #38 reported that s/he is not involved in her/his care plan development or review. S/he stated that s/he feels that decisions involving her/his care are made without her/him and that s/he does not know when the facility reviews or revises her/his care plan. Review of a Care Conference/Care Plan meeting note dated 7/8/2025 reveals that a Nurse, Social Services, and Recreation was in attendance at the meeting. Section 2. of the form that states "Was the resident/responsible party invited to the resident care conference?" was left blank. Per interview with the facility Administrator on 9/17/2025 at 2:27 PM, residents and/or their responsible parties are only invited to the comprehensive care plan meetings which are done annually and with a significant change.	F0657	Members of the Interdisciplinary/Care Planning team were provided with education related to the Resident's Involvement in the Care Planning Process. The Center has developed a process by which each resident and their representative (if they so choose is invited to each Care Plan Meeting (Annual, Admission, Significant Change, and Quarterly). The Director of Social Services or her designee will audit the Care Planning process to ensure 1) the Resident was provided notice in writing (invitation) of the Care Plan Meeting 2) (if they so choose) their responsible party/representative will be provided notice in writing (invitation) of the upcoming care plan meeting. The resident and their representative may reschedule the meeting for a time that works best for them. The Director of Social Services or her designee will review the results of the audit monthly at QAPI meeting to identify trends and report findings until the Center achieves three consecutive months of 100% compliance. Monthly QAPI results will be monitored by the Administrator. Completion Date: 10/24/2025 and ongoing **Tag F0657 POC accepted on 11/3/25 by D. Hoffman/S. Stem**	
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to follow professional standards of practice related to care and maintenance of a PICC line for 1 of 1 resident (Resident #23). Findings include: Per record review, Resident # 23 has diagnoses that include acute osteomyelitis, left ankle and foot, and non-pressure chronic ulcer of the other part of the left foot. Resident #23 is receiving wound care and	F0658	Services Provided Meet Professional Standards Resident #23 suffered no ill effects from deficient practice. All residents with a CVAD could be affected. On 9/17/2025 the Medical Director reviewed the CVAD measurements and current status. The Medical Director declined X-Ray for confirmation of placement based on: positive blood return and flushing and an absence of pain, discomfort, or inflammation. Nursing staff received education/competency evaluation on CVAD's and the measurement requirements upon admission and with each dressing change thereafter, "Infusion Therapy Educational Program - Central Vascular Access Device (CVAD)"	

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F0658 SS = D	Continued from page 2 intravenous (IV) antibiotics through a PICC line. On 9/16/25 at 9:35 AM, a Licensed Practical Nurse (LPN) was observed preparing to administer an antibiotic via Resident #23's PICC line. She encountered resistance while trying to clear the catheter line to allow the antibiotic to pass through. This surveyor noticed that the line was very long and coiled, causing it to kink under the dressing, thus preventing the flow of liquid to flush the line. When the line was uncoiled, it measured 42 cm at the indicator marked on the line, indicating that the line could have potentially migrated out of position. An interview conducted minutes later with the Assistant Director of Nursing (ADON) revealed that, after assessing the line, it should have been measured during the admission assessment performed by nursing and each week thereafter. A review of Resident #23's medical record revealed that the resident was admitted to the facility on 9/3/25 with a PICC line inserted. There was no evidence in the record indicating the length of the line at the insertion site upon admission or any time after. A policy "Central Venous Access Device [CVAD] Catheter Dressing Change," dated January 2022 reads, " A VAD (Venous Access Device) assessment should occur before, during, and after medication administration, during dressing changes, with each site assessment of the VAD, presence of the following, at a minimum, should be included: erythema (redness) drainage, induration, tenderness warmth, swelling, external catheter length." Per the interview with the ADON on 9/16/2025 at 2:20 PM, the nurse admitting the resident should have measured the line, and the line should have been measured at the insertion site at least weekly during dressing changes. She confirmed that there were no measurements in the medical record that might support whether the line had migrated or not, and that it was safe to use. Caring for your PICC: What you need to know. CEUfast.com Blog. (n.d.). https://ceufast.com/blog/caring-for-your-picc-what-you-need-to-know#:~:text=Measuring%20The%20PICC,proper%20function%20of%20the%20PICC.	F0658	The DNS or her designee will audit each admission involving CVAD's for orders and measurements upon admission and with each dressing change thereafter. The DNS or her designee will review the results of the audits monthly at QAPI meeting to identify trends and report findings until the Center achieves three consecutive months at 100% compliance. Monthly QAPI results will be monitored by the Administrator. Completion Date 10/24/2025 and ongoing **Tag F0658 POC accepted on 11/3/25 by D. Hoffman/S. Stem**	
F0730 SS = E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(e)(7) §483.35(e)(7) Regular in-service education.	F0730	Nurse Aide Perform Review- 12 hr/yr In-Service No residents were negatively impacted by this deficient practice.	

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F0730 SS = E	Continued from page 3 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 interview and record review, the facility failed to complete annual evaluations for two of three Licensed Nursing Assistants sampled. Findings include: Per record review of three Licensed Nursing Assistants' (LNA) personnel files that had worked at the facility for over a year, there was no documentation of annual evaluations for 2 of the 3 LNAs to indicate what education or trainings were appropriate for each LNA. Per interview on 9/17/2025 at 12:19 PM, the facility Administrator confirmed that they do not conduct annual evaluations for any staff. Per interview on 9/17/2025 at 12:48 PM, the Director of Nursing confirmed that the facility does not conduct annual evaluations for Licensed Nursing Assistants.	F0730	Each LNA staff receives over 12 hours of in-service education in 12 months. Licensed Nursing Assistants and Leadership staff received in-service education on regulation F730 - Nurse Aide Performance Review - 12 hr/yr In-Service as well as the need for additional education based on the results of the annual performance evaluation. LNA staff received a performance appraisal and additional in-service education based on the results of the performance appraisal as needed. The Human Resources Manager or her designee will audit Annual performance appraisals for LNA staff monthly. The Human Resources Manager or her designee will review the results of the audit monthly at QAPI meeting to identify trends and report findings until the Center achieves three consecutive months of 100% compliance. Monthly QAPI results will be monitored by the Administrator. Completion Date 10/24/2025 and ongoing	
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of	F0761	Tag F0657 POC accepted on 11/3/25 by D. Hoffman/S. Stem Label/Store Drugs and Biologicals No residents were negatively impacted by this deficient practice. All residents receiving medications/treatments could be affected. The expired medications were removed and discarded. Nursing staff received education/in-servicing related to medication storage and expiration. The DNS or her designee will conduct audits of medication storage areas weekly. The DNS or her designee will review the results of these audits monthly at QAPI meeting to identify trends and report findings until the Center achieves three consecutive months at 100% compliance. Monthly QAPI results will be monitored by the Administrator. Completion date 10/24/2025 and ongoing.	

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F0761 SS = E	Continued from page 4 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure medications were stored in accordance with currently accepted professional principles for 2 of 4 medication carts. Findings include: Observation on 9/17/25 at 8:17 AM for one of the Third Floor Unit medication carts revealed that the Isopto Atropine Solution 1% bottle had expired on 4/2025. Per interview on 9/17/25 at 8:17 AM with the Licensed Practical Nurse (LPN) assigned to this medication cart, they confirmed that the above medication had expired. They stated the process for checking for outdated medications was a task completed by the night shift. Observation on 9/17/25 at 11:51 AM for one of the Fourth Floor Unit medication carts revealed that a tube of Glutose 15 had expired on 6/2025. Per interview on 9/17/25 at 11:51 AM with the LPN assigned to this medication cart, they confirmed that the above medication had expired. They stated the process for checking for outdated medications was a task completed by the night shift.	F0761	**Tag F0761 POC accepted on 11/3/25 by D. Hoffman/S. Stem**	
F0812 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	F0812	Food Procurement, Store/Prepare/Serve-Sanitary No residents were negatively affected by this deficient practice. All residents have the potential to be affected. The affected dishes were rewashed and stacked in a manner that allows them to air dry. The frozen food had not expired, however, it was discarded due to it's location in the freezer. Dietary staff received in-service education related to: Food storage in the cooler/freezer and ware washing/wet nesting. The Dietary Manager or her designee will conduct daily audits of the cooler/freezer to ensure food is stored in accordance with professional standards for food service safety.	

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F0812 SS = F	Continued from page 5 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 and interview, the facility failed to store, prepare, distribute and serve food in accordance with professional standards of food service safety. This has the potential to impact all residents. Findings include: During the initial tour of the kitchen with the Dietary Manager (DM) on 9/15/2025 at 9:49 AM a frozen turkey in a cardboard box was noted on the floor and an open bag of frozen fish was seen on the shelf. When asked about the frozen turkey on the floor, the DM stated that it was left over from last Thanksgiving, and that she had just not discarded it yet. The DM also confirmed that the bag of fish had been left open and that it should not have been. On 9/15/2025 at approximately 10:15 AM on return to the kitchen, it was noted that clean dishes were being put away and placed on food carts while wet. At this time the DM confirmed that the dishes were being put away wet and that they should not be.	F0812	Drying racks were implemented in order to eliminate wet nesting when dishes are put away or on food carts. The Dietary manager or her designee will conduct daily audits of clean dish storage areas to monitor for wet nesting. The Dietary Manager or her designee will review the results of these audits monthly at QAPI meeting to identify trends and report findings until the Center achieves three consecutive months at 100% compliance. Monthly QAPI results will be monitored by the Administrator. Completion date 10/24/2025 **Tag F0812 POC accepted on 11/3/25 by D. Hoffman/S. Stem**	
F0880 SS = D	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 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	F0880	Infection Prevention & Control Resident #11 was not negatively affected by this deficient practice. All residents have the potential to be affected. Nursing staff were provided in-service education regarding Enhanced Barrier Precautions and the required Personal Protective Equipment. The DNS or her designee will conduct four (4) audits of care provided in rooms that require Enhanced Barrier Precautions per unit, per week, to ensure adherence. The DNS or her designee will review the results of these audits monthly at QAPI meeting to identify trends and report findings until the Center achieves three consecutive months of 100% compliance.	

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F0880 SS = D	Continued from page 6 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 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.	F0880	Monthly QAPI results will be monitored by the Administrator. Completion date 10/24/2025 **Tag F0880 POC accepted on 11/3/25 by D. Hoffman/S. Stem**	

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F0880 SS = D	Continued from page 7 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 observations, policy review, and staff interviews, the facility failed to implement infection control policies and procedures when staff didn't don personal protective equipment to handle an indwelling device for a resident on enhanced barrier precautions for 1 of 7 residents (Resident #11). Findings include: Per observation on 9/16/2025 at 9:48 AM, a Licensed Practical Nurse (LPN) was observed picking up an indwelling catheter bag (collection bag for urine connected to a catheter, which is a thin, flexible tube that a healthcare provider inserts into the bladder to drain and collect urine) from the floor without wearing any personal protective equipment (PPE). Per interview on 09/17/2025 at 10:34 AM with the Infection Preventionist (IP), she confirmed that indwelling catheter bag handling, whether it is in a privacy pouch or not, requires gloves worn when handling, and Enhanced Barrier Precautions (EBP) should be utilized during care of the catheter. The facility policy "Urinary Catheterization policy" dated 1/2023/4-24 defines EBP as "the use of gown and gloves." Per interview on 9/17/2025 at 10:43 AM with the LPN observed on 9/16/2025 handling the indwelling catheter bag without PPE, she confirmed PPE should've been worn when handling the bag. She stated, "Should have, but that wasn't my focus," and "I carry gloves with me when I know I'll be providing care, so I didn't have gloves in my pocket." When asked about gloves being available in Resident rooms, she stated there may be some gloves in the bathroom, but she isn't sure., The Centers for Disease Control and Prevention describes the reasoning for EBP as reducing the opportunities of Multi-Drug Resistant Organisms (MDROs) to be transferred from one resident to another on staff hands and clothing.	F0880		