

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 22, 2016

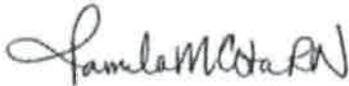
Ms. Melissa Greenfield, Administrator
Rutland Healthcare And Rehabilitation Center
46 Nichols Street
Rutland, VT 05701-3275

Dear Ms. Greenfield:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on February 17, 2016. 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/17/2016
NAME OF PROVIDER OR SUPPLIER RUTLAND HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 46 NICHOLS STREET RUTLAND, VT 05701	

(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
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS	F 000	The filing of this plan of correction does not constitute an admission of the allegations set forth in the statement of deficiencies. The plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law.	
F 282 SS=G	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide services in accordance with the plan of care for 1 of 4 residents who was identified as at risk for falls (Resident #4). Findings include:</p> <p>Per staff interview and record review, the facility failed to implement safety interventions for fall prevention per care plan and this failure resulted in resident injury. Per record review on 2/17/16, Resident #4 was identified as at risk for falls related to decreased safety awareness, noncompliance and a history of falls. Per review of Resident #4's 11/25/16 MDS (Minimum Data Set), s/he is listed as having severe impairment of cognitive skills for daily decision making; having short and long term memory problems; disorganized thinking; requires extensive assistance for transfers, dressing, walking and moving from seated to standing; and is not steady, only able to stabilize with staff assistance.</p>	F 282	<p>The care plan for resident #4 was revised to identify and implement interventions to prevent falls.</p> <p>No other residents were negatively impacted by the alleged deficient practice.</p> <p>An audit was conducted to review</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Greenfield TITLE: Administrator (X6) DATE: 3/7/2016

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/17/2016
NAME OF PROVIDER OR SUPPLIER RUTLAND HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 46 NICHOLS STREET RUTLAND, VT 05701	

(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
--------------------	--	---------------	---	----------------------

F 282

Continued From page 1

The resident had a care plan for fall risk that was revised on 10/12/15 to include the intervention that the "Resident is to be visual to staff at all times."

Per review of the facility's "Fall Log," "Event Summary" and the resident's medical record, the resident sustained at least 19 falls during the period from 11/1/15- 2/17/16. Of those 19 falls, 14 were reported as "unwitnessed" falls on 11/10, 12/5, 12/7, 12/8, 12/9, 12/10/15, 1/2, 1/14 (2 falls on this date), 1/21, 1/28, 1/29, 2/2 and 2/3/16. No injuries were reported for the falls except for the fall on 2/3/16.

Per nurse's progress notes, on 2/3/16, at 6 PM, Resident #4 was heard calling for help and found on his/her knees in the hallway. On 2/17/16 at 1:21 PM, the staff nurse, who was on duty at the time of the 2/3/16 fall, reported that the fall occurred around dinner time when 2 of the 3 staff members were assisting residents with care needs in rooms and one staff member was providing supervision in the dining room; Resident #4 was in the hallway and not within sight of staff when s/he fell. The resident's physician was notified and on 2/4/16 an x-ray of the knee revealed a nondisplaced incomplete left tibial tubercle fracture (fracture involving the lower leg). Per physician orders, the resident was evaluated in the Emergency Department on 2/4/16 and returned to the facility with a knee immobilizer for the fractured left tibia.

On 2/17/16 at 3:33 PM, the DNS (Director of Nursing) confirmed the above information and that the care plan for Resident #4 was not followed related to the resident being visual to staff at all times and that a fracture was sustained

F 282

The care plan interventions to prevent falls and revise care plans as appropriate.

Education regarding fall prevention interventions has been provided to Nursing staff.

DNS or designee will conduct weekly audits x3 to ensure compliance, and then monthly x3 with results to be reviewed at QA meeting for further review and recommendations.

Date of compliance:
3/12.16

F282 POC accepted 3/22/16 P.McArthur

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/17/2016
NAME OF PROVIDER OR SUPPLIER RUTLAND HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 46 NICHOLS STREET RUTLAND, VT 05701	

(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
F 282	Continued From page 2 from the unwitnessed fall on 2/3/16. (Refer F323 and F353)	F 282		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that the environment was free of accident hazards and that each resident received adequate supervision to prevent accidents for 1 of 4 residents in the sample. (Resident #4) Findings include: Per staff interview and record review, the facility failed to ensure adequate supervision to prevent accidents/falls per care plan and this failure resulted in resident injury. Per record review on 2/17/16, Resident #4 was identified as at risk for falls related to decreased safety awareness, noncompliance and a history of falls. Per review of Resident #4's 11/25/16 MDS (Minimum Data Set), s/he is listed as having severe impairment of cognitive skills for daily decision making; having short and long term memory problems; disorganized thinking; requires extensive assistance for transfers, dressing, walking and moving from seated to standing; and is not steady, only able to stabilize with staff assistance.	F 323	F-323 The level of supervision for resident #4 has been re-assessed and the care plan has been revised to reflect the interventions the resident needs to prevent falls and injury. No other residents were negatively impacted by the alleged deficient practice. An audit of fall prevention interventions has been conducted to ensure the plan of care has interventions in place to ensure the resident receives adequate supervision to prevent accidents as is possible.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/17/2016
NAME OF PROVIDER OR SUPPLIER RUTLAND HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 46 NICHOLS STREET RUTLAND, VT 05701	
(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)

F 323 Continued From page 3

The resident had a care plan for fall risk that was revised on 10/12/15 to include the intervention that the "Resident is to be visual to staff at all times."

Per review of the facility's "Fall Log," "Event Summary" and the resident's medical record, the resident sustained at least 19 falls during the period from 11/1/15- 2/17/16. Of those 19 falls, 14 were reported as "unwitnessed:" falls on 11/10, 12/5, 12/7, 12/8, 12/9, 12/10/15, 1/2, 1/14 (2 falls on this date), 1/21, 1/28, 1/29, 2/2 and 2/3/16. No injuries were reported for the falls except for the fall on 2/3/16.

Per nurse's progress notes, on 2/3/16, at 6 PM, Resident #4 was heard calling for help and found on his/her knees in the hallway. On 2/17/16 at 1:21 PM, the staff nurse, who was on duty at the time of the 2/3/16 fall, reported that the fall occurred around dinner time when 2 of the 3 staff members were assisting residents with care needs in rooms and one staff member was providing supervision in the dining room; the nurse verified that Resident #4 was in the hallway and not within sight of staff when s/he fell. The resident's physician was notified and on 2/4/16 an x-ray of the knee revealed a nondisplaced incomplete left tibial tubercle fracture (fracture involving the lower leg bone). Per physician orders, the resident was evaluated in the Emergency Department on 2/4/16 and returned to the facility with a knee immobilizer for the fractured left tibia.

On 2/17/16 commencing at 2:54 PM, the nurse and 2 LNAs (Licensed Nursing Assistants) who routinely provide care for Resident #4 reported that there are typically 13-14 residents on the

F 323 Staff will be educated on
Implementing Care plan interventions
to maintain supervision of the residents
and prevent accidents and falls as
is possible.
DNS or designee will
conduct weekly audits x3 to ensure
compliance and then monthly x3
with results to be reviewed at QA
meeting for further review and
recommendations.
Date of compliance:
3/12/16

F323 POC accepted 3/22/16 Pmuckup

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/17/2016
NAME OF PROVIDER OR SUPPLIER RUTLAND HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 46 NICHOLS STREET RUTLAND, VT 05701	
(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)

F 323

Continued From page 4
Dementia unit where Resident #4 resides. Most of the residents require some assistance with meals, personal care, toileting, supervision and or redirection. At times the nurse is giving medications or treatments and the 2 LNAs are providing care to other residents in their rooms and none of the staff are available to keep eyes on Resident #4. Per interview, Resident #4 is not to transfer or walk alone; however, when other residents on the unit require care, there is not always enough staff to keep eyes on Resident #4 as per care plan. The staff reported that in most of the falls, Resident #4 had attempted to transfer or ambulate independently without requesting assistance.

F 323

On 2/17/16 at 3:33 PM, the DNS (Director of Nursing) confirmed the above information related to falls and that staff have not been able to keep eyes on Resident #4 per care plan to prevent falls as other residents require care and the resident sustained a fracture from an unwitnessed fall on 2/3/16.

F 353
SS=G

483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS

F 353

The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident

F-353

Staffing has been reviewed by administration to ensure sufficient staffing to provide care to residents per care plans
The care plan for resident #4 was revised to identify and implement interventions

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/17/2016
NAME OF PROVIDER OR SUPPLIER RUTLAND HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 46 NICHOLS STREET RUTLAND, VT 05701	
(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)

F 353 | Continued From page 5
care plans:

Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.

Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interviews, the facility failed to assure sufficient staff to provide nursing and related services to maintain the highest practicable well-being of each resident according to residents' assessments and individual plans of care for 1 of 4 residents. (Resident #4) Findings include:

Per staff interview and record review, the facility failed to ensure sufficient nursing staff to implement safety interventions for fall prevention per care plan and this failure resulted in resident injury. Per record review on 2/17/16, Resident #4 was identified as at risk for falls related to decreased safety awareness, noncompliance and a history of falls. Per review of Resident #4's 11/25/16 MDS (Minimum Data Set), s/he is listed as having severe impairment of cognitive skills for daily decision making; having short and long term memory problems; disorganized thinking; requires extensive assistance for transfers, dressing, walking and moving from seated to standing; and is not steady, only able to stabilize with staff assistance. The resident had a care plan for fall risk that was revised on 10/12/15 to

F 353 | to prevent falls.

No other residents were negatively impacted by the alleged deficient practice.

An audit was conducted to review the care plan interventions for other residents to ensure they have interventions prevent falls. Revision of those care plans were made as appropriate.

Education regarding fall prevention interventions has been provided to Nursing staff.

DNS or designee will conduct weekly audits x3 to ensure compliance, and then monthly x3 with results to be reviewed at QA meeting for further review and

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/17/2016
NAME OF PROVIDER OR SUPPLIER RUTLAND HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 46 NICHOLS STREET RUTLAND, VT 05701	

(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
--------------------	--	---------------	---	----------------------

F 353 Continued From page 6
include the intervention that the "Resident is to be visual to staff at all times."

Per review of the facility's "Fall Log," "Event Summary" and the resident's medical record, the resident sustained at least 19 falls during the period from 11/1/15- 2/17/16. Of those 19 falls, 14 were reported as "unwitnessed:" falls on 11/10, 12/5, 12/7, 12/8, 12/9, 12/10/15, 1/2, 1/14 (2 falls on this date), 1/21, 1/28, 1/29, 2/2 and 2/3/16. No injuries were reported for the falls except for the fall on 2/3/16.

Per nurse's progress notes, on 2/3/16, at 6 PM, Resident #4 was heard calling for help and found on his/her knees in the hallway. On 2/17/16 at 1:21 PM, the staff nurse, who was on duty at the time of the 2/3/16 fall, reported that the fall occurred around dinner time when 2 of the 3 staff members were assisting residents with care needs in rooms and one staff member was providing supervision in the dining room; Resident #4 was in the hallway and not within sight of staff when s/he fell. The resident's physician was notified and on 2/4/16 an x-ray of the knee revealed a nondisplaced incomplete left tibial tubercle fracture (fracture involving the lower leg bone). Per physician orders, the resident was evaluated in the Emergency Department on 2/4/16 and returned to the facility with a knee immobilizer for the fractured left tibia.

On 2/17/16 commencing at 2:54 PM, the nurse and 2 LNAs (Licensed Nursing Assistants) who routinely provide care for Resident #4 reported that there are typically 13-14 residents on the Dementia unit where Resident #4 resides. Most of the residents require some assistance with meals, personal care, toileting, supervision and or

F 353 recommendations.

Date of compliance:

3/12/16

F353 POC accepted 3/22/16 MUSTARD

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/17/2016
NAME OF PROVIDER OR SUPPLIER RUTLAND HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 46 NICHOLS STREET RUTLAND, VT 05701	
(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			

F 353

Continued From page 7

redirection. At times the nurse is giving medications or treatments and the 2 LNAs are providing care to other residents in their rooms and none of the staff are available to keep eyes on Resident #4. Per interview, Resident #4 is not to transfer or walk alone; however, when other residents on the unit require care, there is not always enough staff to keep eyes on Resident #4 as per care plan. The staff reported that in most of the falls, Resident #4 had attempted to transfer or ambulate independently without requesting assistance.

On 2/17/16 at 3:33 PM, the DNS (Director of Nursing) confirmed the above information related to falls and that staff have not been able to keep eyes on Resident #4 per care plan to prevent falls as other residents require care and the resident sustained a fracture from an unwitnessed fall on 2/3/16.
(Refer F323 and F282)

F 353