

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

November 25, 2014

Mr. David Lamando, Administrator
Rutland Healthcare And Rehabilitation Center
46 Nichols Street
Rutland, VT 05701-3275

Dear Mr. Lamando:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 15, 2014**. 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: 11/03/2014
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 10/15/2014
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 248	<p>Continued From page 1</p> <p>that residents are escorted by staff when they go outside but was not able to verify this activity was met for Resident #1. The AD confirmed that the facility was unable to ensure Resident #1's interests were met.</p> <p>F 279 483.20(d), 483.20(k)(1) DEVELOP SS=D COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop a care plan to meet the needs for 1 of 2 residents in the sample (Resident #2). Findings include: Per record review on 10/15/14, the facility failed</p>		<p>compliant with offering activities that meet the interest of the residents.</p> <p>Results of the audit will be discussed at CQI for further evaluation and recommendations.</p> <p>Corrective action will be completed by December 5, 2014 <i>F248 POC accepted 11/21/14 SEMMONS/RN/PMC</i></p> <p>F-279 The care plan for Resident #2 has been reviewed and updated to include the use of psychotropic medication.</p> <p>Residents who require the use of psychotropic medication have the potential to be affected by this alleged deficient practice.</p> <p>A review will be conducted to identify all residents receiving these meds and ensure a care plan is in place.</p> <p>Nurses will be re-educated on the required documentation and monitoring of patients on these medications.</p>	

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 10/15/2014
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 279	Continued From page 2 to develop a care plan to address Resident #2's needs related to psychotropic medication use. Per review of the care plan for Resident #2 who was admitted on 03/28/14 had a care plan for to monitor behaviors, elopement risk, skin risks and to maintain safety and comfort. The resident was started on Seroquel [an anti-psychotic medication] on 05/31/14, however, the care plan does not address this use nor reflect the interventions or goals. The DON (director of nursing) confirmed during interview on 10/15/14 at 5:07 PM that there was no care plan for the use of psychotropic medication.	F 279	DNS or designee will ensure that audits will be done weekly X 4 weeks and then monthly x 3 to ensure that the center is compliant with ensuring that a care plan is in place for patients that require psychotropic medication.		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assure that professional standards of practice were met regarding obtaining clear physician orders for medication for one resident (Resident #1) in the sample. Findings include: 1. Per record review on 10/15/14, Resident #1 was re-admitted to the facility on 07/05/14 with a change in the dose for a cardiac medication (metoprolol) from 25 mg to 50 mg 1 tablet every day. There was no evidence that Nursing had assessed the resident's blood pressure and/or heart rate from 07/05/14 to 09/06/14. Additionally, on 07/10/14 the physician approved 'as needed' herbal medications as follows: a) 'bach rescue remedy' 4 drops under tongue or	F 281	Results of the audit will be discussed at CQI for further evaluation and Recommendations. Corrective action will be completed by December 5, 2014 <i>F279 POC accepted 11/21/14 Simmons RN/ml</i> F-281 Resident #1 no longer resides at the center. Residents who require the use of beta blockers, herbal medications, and lorazepam medication have the potential to be affected by this alleged deficient practice. A review will be conducted to identify all residents receiving these meds and ensure the proper documentation and monitoring is in place.		

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

PRINTED: 11/03/2014
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 10/15/2014
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 281	<p>Continued From page 3</p> <p>in a small glass of water when stressed two times a day</p> <p>b) 'end fatigue revitalizing sleep formula' 1 cap 30-60 minutes before bedtime</p> <p>c) 'ignatia' 2 pills/day to suck on empty stomach for feelings of grief or sadness</p> <p>The resident also had an order for as needed (PRN) Lorazepam 1 mg for agitation /anxiety twice daily. Per a handwritten message in the margin of the MAR states "try supplements first". Per review of the MAR [medication administration record] for the months of October, September and August 2014, staff were administering either one, two, three or four of the PRN medications at the same time. On one occasion staff administered Lorazepam for 'yelling/exit seeking' and on several occasions the medications were given without the dose and/or reason as noted on the PRN documentation.</p> <p>Per interview at 11:52 AM the DON stated that the PRN herbal medication was "confusing and does not indicate which to use when or if in fact can be used all together". The DON confirmed at that time the best practice would be to assess the blood pressure and heart rate prior to administering the beta-blocker and the failure of staff to obtain physician orders with parameters for the use of the PRN medications.</p> <p>*Reference: Lexi-Comp Drug Information Handbook for Nursing 8th Edition page 813-814</p> <p>*Reference: Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p>	F 281	<p>DNS or designee will ensure that audits will be done weekly X 4 weeks and then monthly x 3 to ensure that the center is compliant with completing documentation and monitoring for any resident that requires a medication.</p> <p>Results of the audit will be discussed at CQI for further evaluation and Recommendations.</p> <p>Corrective action will be completed by December 5, 2014</p> <p><i>FAB1 POC accepted 11/21/14 Semmons PA/PMC</i></p> <p>F-323 Resident #1 no longer resides at the center.</p> <p>All residents have the potential to be affected by this alleged deficient practice.</p> <p>Staff will be re-educated on providing supervision to prevent injury and accidents and the importance of monitoring the environment to reduce any possible hazards that could contribute to an accident, and how to document the supervision provided.</p>
F 323 SS=D		F 323	

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

PRINTED: 11/03/2014
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 10/15/2014
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 323	<p>Continued From page 4</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure 1 of 2 residents in the sample received adequate supervision or services to prevent accidents. (Resident #1) Findings include:</p> <ol style="list-style-type: none"> 1. Resident#1 had three falls within four days, from 10/07 - 10/11/14, sustaining a serious injury with the last fall. In addition, during the time period from October 2 - 14th, 2014, 8 out of 17 residents on this unit had 11 falls. Per observation on 10/15/14 at 10:25 AM, of Resident #1's room, which is situated around a corner from the nursing station, not in view, it is neat and free from clutter. However, the bed alarm was not audible from the nursing station. The charge nurse at that time confirmed that the alarm was not audible and was placed on the bed after the third fall. <p>Per the record review the Care plan directs staff to encourage the resident to attend activities, monitor for toileting needs, place all personal needs item when in bed, call bell and to keep a clutter free environment. Nursing added on 10/08/14 to provide verbal cues for proper pacing and energy conservation to the care plan, more</p>	F 323	<p>A review was conducted to identify any current environmental hazards and evaluate the supervision of the residents.</p> <p>DNS or designee will ensure that audits will be done weekly X 4 weeks and then monthly x 3 to ensure that the center is compliant with maintaining a hazard free environment and that adequate supervision of the residents is in place.</p> <p>Results of the audit will be discussed at CQI for further evaluation and Recommendations.</p> <p>Corrective action will be completed by December 5, 2014 <i>F323 POC accepted 11/21/14 Seminars Rel/ PML</i></p> <p>F-387 A physician visit was completed for resident #2.</p> <p>All residents have the potential to be affected by this alleged deficient practice.</p> <p>A review will be conducted to identify the dates due of all physician visits, and ensure the medical providers are aware of the scheduled visits.</p>	

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

PRINTED: 11/03/2014
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 10/15/2014
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 323	<p>Continued From page 5</p> <p>frequent checks through the night on 10/10/14 and a Bed alarm applied on 10/11/14. However, there is little indication that staff consistently provided supervision or services as evidenced by documentation. The resident had an increase in the dose of an anti-hypertensive medication metoprolol from 25 mg to 50 mg 1 tab every day upon re-admission on 07/05/14. The blood pressure and/or heart rate were not checked until 09/06/14 to assess how the resident was adjusting to the new dose. The DON confirmed at 11:52 AM that best practice would be to monitor the vital signs at least weekly if not daily, as a measure to assess blood pressure.</p> <p>Per interview with the Activity Director at 2:29 PM stated " I am new and several of my staff are new, so we have no records of how much she was engaged in activities". S/he further stated that "I am not sure how busy [Resident #1] was I did not keep track of activities".</p> <p>Per interview at 4:08 PM the DON stated "well we are now getting some outside help/review to see why there are these falls." S/he confirmed the resident did not get assessed per best practice or evidence of supervision for the resident's needs or activities.</p>	F 387	<p>The physician will be re-educated on the appropriate time frame required for visits.</p> <p>Administrator or designee will ensure that the audits will be done weekly X 4 weeks and then monthly x 3 to ensure that the center is compliant with ensuring proper timeliness and frequency of physician visits.</p> <p>Results of the audit will be discussed at CQI for further evaluation and Recommendations.</p> <p>Corrective action will be completed by December 5, 2014</p> <p><i>F387 POC accepted 11/21/14 SEMMUNSRAL/PML</i></p> <p>F-9999</p> <p>There were no specific residents cited under this tag.</p> <p>All residents on the dementia unit have the potential to be affected by this alleged deficient practice.</p> <p>An audit has been conducted for people that have direct contact with residents on the dementia unit to determine any further training needed.</p>	
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT			
	<p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was</p>			

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

PRINTED: 11/03/2014
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 10/15/2014
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 387	Continued From page 6 required. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview on 10/15/2014, the facility failed to assure that 1 of 2 residents (# 2) had physician visits made within the appropriate time frame. Findings include: 1. Per record review at 4:01 PM on 10/15/2014, Resident #2 was admitted on 03/28/14 and seen by the physician. There was no evidence that the physician saw the resident at least every 30 days for the first 90 days. The resident was next seen approximately three months later on 06/17/14 and 07/01/14 by the nurse practitioner, and on 07/23/14 by the physician. The resident was due to be seen by 09/23/14 has not had a another physician visit to date. Per interview with the DNS at this time, confirmed the resident was not seen for the first 30 days x 90 days and is over due at present.	F 387	The staff educator has reviewed the requirements for training people who have direct contact with residents on the dementia Unit. The staff educator will provide people with direct contact with residents who reside on the dementia the required education upon hire and quarterly on an ongoing basis. DNS or designee will ensure that audits will be done weekly X 4 weeks and then monthly x 3 to ensure that the center is compliant with providing the education required to people have direct contact with residents that reside on the dementia unit.		
F9999	FINAL OBSERVATIONS 2.7 Special Care Units (SCU) (d) Dementia units shall meet the following staffing and staff training requirements: (1) Dementia units must provide initial training in addition to general facility training to include eight hours of classroom orientation for all employees assigned to the unit and an additional eight hours of clinical orientation to all nursing employees assigned to the unit. The eight hours of classroom work must include: (i) A general overview of Alzheimer ' s disease and related dementia; (ii) Communication basics;	F9999	Results of the audit will be discussed at CQI for further evaluation and Recommendations. Corrective action will be completed by December 5, 2014 <i>F9999 POC accepted 11/21/14 Semmons RW/PMC</i>		

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

PRINTED: 11/03/2014
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 10/15/2014
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
F9999	<p>Continued From page 7</p> <p>(iii) Creating a therapeutic environment; (iv) Activity focused care; (v) Dealing with difficult behaviors; and (vi) Family issues</p> <p>(2) Ongoing in-service training shall be provided to all nursing and non-nursing staff, including volunteers, who have any direct contact with residents of the unit. Staff training shall occur at least quarterly. The facility will maintain records of all staff training provided and the qualifications of the presenter. Training over 12 months must include the above subjects.</p> <p>Based on record review and interviews the SCU did not meet the required training for all staff. Findings include:</p> <p>1. Per review of 5 sampled staff who were identified as working on the SCU, two newly hired staff did not have documentation of receiving the initial Dementia training and three staff who have worked greater than one year, have not received at quarterly trainings. Per interview on 10/15/14 at 3:55 PM the Staff Educator stated "I have not done the quarterly SCU education for all staff, especially staff [who worked] here greater than one year." S/he also acknowledged the two newly hired Activity Staff, who were hired "a month or so ago", did not receive the initial dementia training. The Staff Educator confirmed the above findings.</p>	F9999		