

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

May 18, 2016

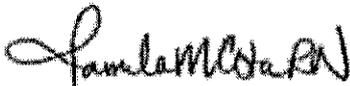
Ms. Melissa Greenfield, Administrator  
Rutland Healthcare And Rehabilitation Center  
46 Nichols Street  
Rutland, VT 05701-3275

Dear Ms. Greenfield:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on April 27, 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

MAY 17 2016

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 04/27/2016
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NAME OF PROVIDER OR SUPPLIER  RUTLAND HEALTHCARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 46 NICHOLS STREET RUTLAND, VT 05701
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(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
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F 000 INITIAL COMMENTS

F 225 SS=D .483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on 4/27/16. There were regulatory findings.

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance

F 000 Preparation and or execution of this plan of correction does not constitute the providers admission of/or agreement with the alleged violations or conclusions set forth in this statement of deficiencies. This plan of correction is prepared and/or executed as required by State and Federal law.

F 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4)

1. The identified incident was reported to state agency on 4/21/16 as identified
2. Facility administration has reviewed and understands the requirements for reporting altercations between residents to the state agency and the time frames in which to do so.
3. Audits will be completed as needed with reportable incidents to monitor effectiveness of the plan.
4. The results of the audits will be reported to the QAA committee x3 months for review and further action needed.
5. Corrective action will be completed by 5/27/16
6. The facility Executive Director will be responsible to monitor the plan.

F225 POC accepted 5/11/16 BB:ACR/ML

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Melissa Greenfield</i>	TITLE Executive Director	(X6) DATE 5/11/2016
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any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the 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

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F 225 Continued From page 1  
 with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:  
 Based on staff interview and record review, the facility failed to report an allegation of a resident to resident altercation to the State Agency until a week after the incident. Findings include:

Per review and investigation of an entity reported incident, there was an altercation between two residents that occurred on 4/8/16 and it was not reported to the State Agency until 4/21/16. Per interview with the Administrator, s/he confirmed at 2:10 PM that the incident had been filed late. At 6:10 PM per interview with the Director of Nursing Service, s/he was aware of the incident at the time it happened but stated that s/he was not fully aware if it needed to be reported because the facility's computer software for logging incidents did not "trigger" that it would require reporting. S/he further stated that it was not until "Corporate" reviewed the incident that it was reported.

F 279 : 483.20(d), 483.20(k)(1) DEVELOP  
 SS=D COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

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F 279

Continued From page 2

objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

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).

This REQUIREMENT is not met as evidenced by:  
Based on staff interview and record review, the facility failed to develop a plan of care for one resident, Resident #1, following a resident altercation. Findings include:

Per record review, Resident #1 was pulled from his/her wheelchair by another resident on 4/8/15. S/he fell to the floor and struck his/her head on the doorframe. Review of care plans presented that a care plan was not developed until 4/15/16 to indicate that Resident #1 was at Risk for behaviors that puts him/her at risk for abuse. Confirmation received at 5:15 PM by the Director of Nursing Service that the care plan was not developed until a week after the incident.

F 279

F279 483.20(d), 483.20(k)(1)

1. Resident #1 had no negative effects as a result of the alleged deficient practice.
2. Residents at risk for behaviors that put them at risk for abuse have the potential to be affected by the alleged deficient practice.
3. Resident #1's has a care plan in place that identifies resident as being at risk for abuse due to behaviors.
4. Education provided to staff regarding the requirements to develop care plans to identify potential risks for abuse and the time frame in which to do so.
5. Weekly audits will be completed to monitor effectiveness of the plan.
6. The results of the audits will be reported to the QAA committee x3 months for review and further action needed.
7. Corrective action will be completed by 5/27/16.
8. The Center Nurse Executive will be responsible to monitor the plan.

F279 PDC accepted 5/17/16 BB/AJR/PML