

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

February 17, 2016

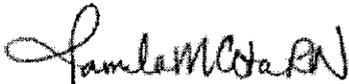
Ms. Melissa Greenfield, Administrator
Rutland Healthcare And Rehabilitation Center
46 Nichols Street
Rutland, VT 05701-3275

Dear Ms. Greenfield:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 13, 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: 01/21/2016
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 01/13/2016
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 An unannounced onsite recertification survey and investigation of two facility self reports and an anonymous complaint was conducted by the Division of Licensing and Protection on 1/11/16-1/13/16. There were regulatory findings related to the recertification survey and investigations. Findings include:	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 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview the facility failed to ensure that ventilation ducts located in resident care areas, are adequately maintained in a sanitary and orderly manner. The findings include the following: Per room to room tour on all three units with the Nursing Home Administrator (NHA), Maintenance Director, and Housekeeping Supervisor on 1/13/15, confirmation was made that vents in multiple resident shared bathrooms on all three units on the south side have accumulated dust and debris. The Maintenance Director confirms that there is no schedule or preventative maintenance program for cleaning of the bathroom vents.	F 253	There no residents were impacted. No other residents were negatively impacted by the alleged deficient practice. The vents were cleaned 1/18/16. Vents were inspected for cleanliness and any dirty vents were cleaned throughout the facility on 1/18/16. Cleaning of the vents added to daily housekeeping project list. Maintenance to add internal cleaning of vents to the monthly TELS checklist. Administrator or Housekeeping manage 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.	2.3.16
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280	FAS3 POC accepted 2/16/16 Dwideanicki Pdl /PML	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Melissa Greenfield

Administrator

2/4/2016

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.

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F 280	<p>Continued From page 1</p> <p>incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to revise/update and/or evaluate/review in a timely manner, the plan of care for 2 of 15 residents in the sample (Residents #69 & #123) Findings include:</p> <p>1. Resident #69's care plan was not revised or evaluated in a timely manner for independent smoking. A care plan [related to smoking on admission 05/19/15] states: educate [Resident #69] on the facility's smoking policy, reassess patient's ability to smoke independently with any change in condition, and to monitor patient's compliance to smoking policy. The facility's policy for smoking OPS137 states patients will be assessed on admission, quarterly and with</p>	F 280	<p>For resident #69 care plan and smoking assessment has been revised.</p> <p>For resident #123 the care plan was revised, the notes have been removed from resident room and added to LNA Communication book.</p> <p>No other residents were negatively impacted by the alleged deficient practice.</p> <p>Other residents have the potential to be affected by the alleged deficient practice. An audit has been conducted to ensure smoking assessments and care plan for smoking are up to date.</p> <p>Also that no notes are posted in resident rooms and care plans revised for changes in Psychosocial status.</p> <p>Nursing and social service staff will be educated on proper policy and procedure for completing assessment and revising care plan as appropriate.</p> <p>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.</p> <p><i>FABO POC accepted Helle Dwidarainia Rul / Pme</i></p>	2-10-16

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F 280	<p>Continued From page 2</p> <p>change in condition for the ability to smoke safely and if necessary will be supervised.</p> <p>The resident had an order for a Nicoderm patch on 12/02/15 but it was discontinued a week later on 12/10/15. There was no revision to the care plan regarding the use or discontinuation of the patch. A Social Service note dated 12/05/15 noted a discussion regarding "certain recent behaviors....talking in rude ways to fellow residents particularly on the smoking porch". On 12/17/15 at approximately 11:00 AM the resident had a fall while on the smoking porch. The facility's Accident/Incident tool states that staff found the resident "laying on the concrete floor flat on [his/her] back with wheelchair behind..." The resident stated "felt something snap". The resident reported pain as '8 out of 10' per the nursing note of 12/17/15 at 7:00 PM. Additionally, a nursing note of 01/05/2016 states "Resident fell on 12/17/2015 at which time began to have pain with lower back. Since the fall, resident has begun to decline". There was not a smoking evaluation after the 12/05/15 incident or after the fall on 12/17/15 nor a timely revision to the care plan. An unsigned evaluation was dated 01/04/16 and a revision dated 01/05/15, nearly a month later.</p> <p>Per interview on 01/13/16 at 1:02 PM the Unit Manager confirmed there were not timely evaluations or revisions regarding the smoking care plan.</p> <p>2. Resident #123's care plan [admitted on 05/15/15] was not revised to reflect concerns about family member behaviors or psychosocial needs and positioning. Staff expressed concerns that a family member 'was mean' to Resident #123 and a nursing note of 08/11/15 documented that the resident said that [a family member]</p>	F 280		

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F 280	Continued From page 3 made the resident "feel bad" and "I am just going to die". There is no revision to the care plan to address what interventions are in place to protect the resident or how the psychosocial needs will be met. In addition, personal medical information was observed posted in the resident's room, that included how staff should be positioning the resident, such as "always Head Of Bed 30-40 degrees, no side lying or prone, Never, +neck+back straight-line." However, per review of the LNA care plan, the above information was not documented in the chart. The information was also not in the nursing care plan. Per staff interviews with two Licensed Nursing Assistants (LNAs) on 01/12/16 at 2:30 PM, stated that they thought that [a family member] had posted the information and acknowledged they where supposed to follow it although this was not in the official care plan book. Per interview on 01/13/16 at 3:30 PM, the Unit Manager (UM) stated the family posted the information, because "I guess [s/he] wanted to make sure we did positioning correctly" but confirmed that this information was not revised in the care plan. The UM confirmed that there was no documentation in the care plan to reflect interventions needed to protect the resident from being [allegedly] treated unkindly, other psychosocial needs or positioning.	F 280			
F 323 SS=E	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	F 323			

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F 323	<p>Continued From page 4</p> <p>adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based observation and confirmed by staff interview the facility failed to ensure that the residents' environment remains free of accident hazards and each resident receives adequate supervision to prevent accidents. The findings include the following:</p> <p>Per observation during the initial tour and through out the three day survey, all five surveyors identified that the stairwell door (that is centrally located on the first floor), leading down to the basement and up to the second and third floors is not secure. The second and third floor doors do have a security system enabling staff, visitors and the public to access by utilizing a security code. The security is intended to keep residents safe from injury by not having access to the stairwell.</p> <p>Per interview with the Nursing Home Administrator (NHA) on 1/13/15, the unsecured first floor door was brought to his attention. NHA confirmed that he has made a capital expense requests to his Corporate Office on 2/6/15 and 5/18/15, of which they have both been denied due to budget constraints. The NHA has no documentation evidencing the denial, but confirms that the Regional Property Manager informed him via telephone, after both requests were denied.</p> <p>Per observation there are 3 doors that are</p>	F 323	<p>F-323 There were no residents impacted.</p> <p>The security system upgrades are being installed on the three first floor doors on 2/8/16.</p> <p><i>F323 POC accepted 2/16/16 DwideawakeRw/pme</i></p>	2.12.16

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F 323	Continued From page 5 unsecured on the first floor: The employee exit is locked from the outside, not allowing individuals in, the stairwell door is open unsecured at all times and lastly the doorway that exits to the outside at the north end of the building next to a conference room. Per interview with the Unit Manager (UM) and the Registered Nurse (RN) who oversee the first floor unit, confirmation is made that the resident population on the unit currently houses both long term and short stay rehabilitation residents. Eight (8) of the seventeen (17) residents residing on the unit have cognitive deficits. Two (2) have severe cognitive losses and six (6) have moderate cognitive losses. Of the eight residents, one (1) resident wanders, one (1) resident is able to wheel themselves in a wheelchair and one (1) resident ambulates independently. Per interview on 1/13/16 with the UM and the RN on the first floor unit, both confirm that they have concerns regarding residents eloping, taking the stairway up or down or exiting the employee exit. The exit door at the north end of the building is out of their direct view. The UM has had conversations with the NHA and the Director of Nurses (DNS), regarding their concerns pertaining to safety. Confirmation is made by UM and RN that staffing is not good especially on the weekends, therefore they are unable to monitor any of the three (3) unsecured exits.	F 323			
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371			

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F 371	<p>Continued From page 6</p> <p>considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to assure that food was served under sanitary conditions. Findings include:</p> <p>Per dining observation at the lunch meal on 1/11/2016, the Licensed Nurses Assistant (LNA) at 12:25 PM, failed to wash or sanitize hands after assisting another LNA with repositioning a resident in a room across the hall (Room 218).</p> <p>At 12:45 PM, for the second lunch seating, the same LNA removed an overbed table from room 218 to use for a resident (R#128) who was not in that room without cleaning or sanitizing it, and set the food tray on the table. In an interview on 1/11/2016 the LNA confirmed that s/he should have sanitized her hands and sanitized the table before using it for another resident.</p> <p>Based on observation, staff confirmation and policy review the facility failed to store food safely to prevent foodborne illness, for residents who have personal refrigerators in their rooms on second floor north. The findings include the following:</p> <p>Per observation during Stage 1 and Stage 2 of</p>	F 371	<p>A specific resident was not identified to have been affected by the alleged Deficient practice.</p> <p>No other residents were negatively impacted by the alleged deficient practice.</p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>An audit of all has been conducted to ensure nurses that nurses demonstrate proper hand Hygiene practice to reduce the spread of infection and prevent cross-contamination and basic sanitation of tables used for meals.</p> <p>The use of personal refrigerators will be audited to ensure daily temperature check and removal of any outdated food.</p> <p>Nursing staff will be re-educated on the policy & procedure of the proper hand hygiene and the proper monitoring of refrigerator temps in Resident rooms and disposal of any Outdated food items.</p>	<p>2-10-16</p> <p>2-10-16</p>

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F 371	Continued From page 7 the survey, on the second floor north unit multiple personal refrigerators located in resident rooms were identified with incomplete temperature logs. One of the refrigerators had outdated cottage cheese and yogurt. Per facility log titled "Refrigerator/Freezer and Temperature Log" (dated as revised 2/06), located on the side of each refrigerator, #3 identifies "Temperature Checks will be checked and recorded daily". Per interview on 1/12/15 at approximately 8:30 AM, with the Unit Manger and the Licensed Practical Nurse, confirmation is made that the temperature logs have not been consistently completed as per policy.	F 371	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. <i>F371 POC accepted Helene D. [Signature]</i>		
F 516 SS=B	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed through	F 516	A specific resident was not identified to have been affected by the alleged Deficient practice. LNA documentation books will be stored at the nurses station when not in use. An audit was conducted to ensure they have been removed from the dining area, and only stored at the nurses station when not in use. Nursing staff will be re-educated on the proper safeguarding of medical information. DNS or designee will conduct weekly audits x3 to ensure	2.1.16	

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F 516	Continued From page 8 staff interview the facility failed to safeguard resident clinical information against unauthorized use. The findings include the following: Per observation during the initial tour on 1/11/16 and again on the second day of the survey, resident personal health information (PHI) was located on the second floor north, in the day/dining room that is frequently left unattended by staff. Multiple notebooks containing resident PHI related to care needs, specific directions to staff on the managing and monitoring of falls, flow sheets evidencing food and fluid intake, evacuation logs, resident pictures and staff assignments were left on the table and/or sitting next to the toaster. Per interview with a Licensed Nurse Aide (LNA) on 1/12/16 confirmation was made that the log books are kept in the dining/day room for easy access for staff use. Confirmation was also made on 1/12/16 by the Director of Nurses, Nursing Home Administrator and Unit Manger that residents' PHI has been stored in the day/dining room which has public access and does not always have staff presence. Therefore making the log books available to anyone who had interest, but no authority.	F 516	compliance and then monthly x3 with results to be reviewed at QA meeting for further review and recommendations. <i>F516 POC accepted 2/16/16 DW/Deanne R/P/PM</i>		
F9999 SS=E	FINAL OBSERVATIONS Based on staff interviews and review of the facility provided Daily Nursing Staffing Patterns, the facility failed to provide the minimum of 2 hours of Licensed Nursing Assistant Care per Vermont State Regulations. Findings include: 1.) In Stage One of the survey, during a family interview for Resident # 72 a family member	F9999			

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F9999	Continued From page 9 stated to the surveyor that ' They never have enough staff usually the evening nurse has to assist in getting my {spouse} out of bed and to the dining room'. 2.) Per interview with a surveyor on 1/13/16 at 11:15 AM a Registered Nurse (RN) #1, said that they can't man the unsecured doors because there isn't enough staff and the weekends are the worst. 3.) Per interview with Licensed Nursing Assistant (LNA) #1 on 1/13/16 at 11:50 AM, said that s/he feels bad because s/he can't provide the type of care that his/her residents deserve. S/he further stated that there are residents with behaviors and sometimes when s/he has to spend individual time with them, s/he can't help the others that need him/her. S/he further stated that there is between 20 to 25 residents and only 2 LNAs to provide the care. LNA #2 stated that sometimes there are a lot of residents with behaviors and it is hard with only 2 LNAs to get the care completed. 4.) Per interview at 11:53 AM on 1/13/16 with a Licensed Practical Nurse there are some days that the LNAs can not always get to the residents in time and they become incontinent because even though the nurses will help the LNAs, they have their own jobs to do. S/he further stated that there have been times when there is only one LNA and it is difficult to get to the residents in time when they are ringing there bells and at times there have been residents that get red buttocks because they can't be taken care of timely. 5.) Per interview with LNA #3 on 1/13/16 at 1:05 PM, 'there are days that there is only one LNA on	F9999	Center management has reviewed regulatory requirements for staffing and understand those requirements. Center Management will continue to review staffing levels daily to ensure it meets the needs of the residents. As of 2/8 doors on the first floor will be secure Audits will be completed daily to ensure regulatory compliance. Audits will be reviewed at QAPI for further evaluation and recommendations. Oversight: DON <i>F9999 POC accepted 2/11/16 Dwideawake RN/pme</i>	2-12-16	

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OMB NO. 0938-0391

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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		
(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	Continued From page 10 the floor for 22 residents and even though the nurses will help it is sometimes difficult to get the work done." 6.) Per review of the Daily Nursing Facility Staffing Patterns on 1/13/16 at 1:50 PM that was presented by the facility for the months of October, November and December 2015, the minimum State requirements were not met in October for 13 of 31 days, and in November for 13 of 30 days. In December these requirements were not met for 18 of 31 days based on Licensed Nursing Assistant (LNA) hours and census.	F9999		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475039	MULTIPLE CONSTRUCTION A. BUILDING: _____ B WING: _____	DATE SURVEY COMPLETE: 1/13/2016
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NAME OF PROVIDER OR SUPPLIER RUTLAND HEALTHCARE AND REHABILITATION C	STREET ADDRESS, CITY, STATE, ZIP CODE 46 NICHOLS STREET RUTLAND, VT
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 241	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to promote care for 1 of 15 residents in the Stage 2 sample in a manner and in an environment that maintains each resident's dignity. (Resident #123) Findings include:</p> <ol style="list-style-type: none"> 1. Resident #123's personal medical information (diagnosis and or medical history, medication, rehabilitation status, cognitive level, and assistance level) was posted in full view of other residents or visitors. This resident's room is shared with other residents for showers and is near the nurse's station. <p>Per observation on 01/12/16 at 10:30 AM a yellow sign was posted on the closet door with the following information: "always HOB [head of bed] 30-40 degrees, no side lying or prone Never! +neck+back straight-line ratinidine (medication) experience HX [history] of reflux, Hx of stroke ?blood flow to posterior brain half rails in place down +High fall risk +dementia, confused +call bell in reach "</p> <p>Per interview on 01/12/16 at 2:30 PM, two Licensed Nursing Assistants (LNAs) stated 'I think the [family] put [the sign] up but I would not want that information if that was my [family]'. The LNAs acknowledged that the 'walking rounds book', for LNA care, did not have this information, which would be helpful. Per interview on 01/13/16 at 3:30 PM, the Unit Manager confirmed that although the family posted the information, steps should have been taken to protect the residents health information.</p> <p>Also see F-280</p>
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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 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

The above isolated deficiencies pose no actual harm to the residents