

Division of Licensing and Protection  
103 South Main Street, Ladd Hall  
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

January 18, 2013

Ms. Diane Sullivan, Administrator  
The Pines At Rutland Center For Nursing And Rehabilitation  
99 Allen Street  
Rutland, VT 05701

Provider #: 475018

Dear Ms. Sullivan:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **December 26, 2012**. 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

PC:ne

Enclosure



JAN 11 2013

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

PRINTED: 01/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/26/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  THE PINES AT RUTLAND CENTER FOR NURSING AND REHABI	STREET ADDRESS, CITY, STATE, ZIP CODE 99 ALLEN 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  F 204 SS=D	<p>INITIAL COMMENTS</p> <p>An unannounced on-site complaint investigation was conducted on 12/26/12 by the Division of Licensing and Protection. There was a regulatory deficiency identified.</p> <p>483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG</p> <p>A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that the appropriate services were provided upon discharge from the facility to ensure a safe and orderly discharge for one resident in the sample. The findings include:</p> <p>1. Per review of the medical record for Resident #1 on 12/26/12, the medical record indicated that Resident #1 was admitted to the facility on 10/19/12 status post a right hip fracture with no surgical intervention. Per the medical record the resident was admitted to participate in short term rehabilitation for transfers and to increase strength. The medical record indicates Resident #1 is to return home with spouse at completion of therapy.</p> <p>Per review of the clinical care plan meeting on 11/1/12, the notes by Social Services (SS) indicates that Resident #1 is anticipated to be discharged home on 11/12/12. The SS notes on 11/1/12 indicate that at the care plan meeting it was documented that Resident #1's spouse</p>	F 000  F 204	<p>This plan of correction is the facility'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 of correction is filed and executed as evidence of the facility's desire to comply with the provisions of federal and state law, and to continue to provide quality care and services.</p> <p><b>F204 Preparation for Safe, Orderly Transfer/Discharge</b> The facility continues to provide safe, orderly resident transfers/discharges from the facility. Resident #1's home care referral was completed on 11/14/13. Record reviews for prior 30 days of discharged residents were completed by the Director of Social Services, as well as phone calls to resident/family to ensure satisfaction with discharge services. Current short stay patient discharge plans were reviewed, for thoroughness and accuracy, by the Director of Social Services and the interdisciplinary team. The director of Social Services and the IDT received re-education on the discharge process policies and procedures by the Administrator.</p>	
----------------------------	---	--------------------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 1/7/13
--	------------------------	---------------------

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.

PMC

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

PRINTED: 01/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 12/26/2012
NAME OF PROVIDER OR SUPPLIER  THE PINES AT RUTLAND CENTER FOR NURSING AND REHABI		STREET ADDRESS, CITY, STATE, ZIP CODE 99 ALLEN 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 204	<p>Continued From page 1</p> <p>would not be able to "provide any physical assistance at home" and that SS would set up physical therapy and a home health aide through Visiting Nurses.</p> <p>Per review of the Occupational Therapy (OT) Discharge Summary dated 11/9/12, the summary indicates that Resident #1 is being discharged from Occupational therapy for reaching maximal level of self care activities. The discharge summary indicates that resident is to benefit from home health services upon discharge to promote safety and good transition to home during self care activities. The summary indicates that Occupational Therapy recommends home health services and physical therapy for home modification to increase functional independence.</p> <p>Per review of the discharge instructions, the discharge instructions indicate Resident #1 is to be discharged on 11/12/12 to home. Per the discharge instructions, they indicate that Resident #1 is to have "home health to follow".</p> <p>Per review of a fax dated 11/14/12 (two days after Resident #1 was discharged from the facility), the fax indicates that Resident #1 was discharged to home on 11/12/12 and the family would like him seen today (11/14/12) as he is not transferring. The fax also indicates that Resident #1 is in need of social work, physical therapy and a home care aide.</p> <p>Per interview with the Administrator on 12/26/12 at 11:18 AM, he/she indicated that the discharge summary is completed by staff and the discharge summary indicates what specific needs the resident had upon discharge along with all</p>	F 204	<p>A new discharge checklist was developed and implemented in order to ensure that all necessary care and services are included and completed for each patient discharge. A copy of the completed checklist will be provided to the Administrator for review and ongoing monitoring.</p> <p>All discharged residents will be contacted via telephone within 24 hours of discharge in order to verify that recommended services are being provided.</p> <p>Monthly audits of 25% of discharged residents charts will be reviewed by the Director of Social Services, and/or the Administrator, to ensure accuracy and timely discharge services.</p> <p>Audit results will be reported monthly to the Quality Assurance Committee to ensure continued compliance, and will be reviewed and monitored by the Administrator.</p> <p>Completion Date: 1/15/2013</p> <p>F204 POC accepted 1/18/13 McLuhann RN / AMC</p>	

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

PRINTED: 01/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/26/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE PINES AT RUTLAND CENTER FOR NURSING AND REHABI</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>99 ALLEN STREET RUTLAND, VT 05701</b>		
(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 204	<p>Continued From page 2</p> <p>pertinent instructions, medications and need the resident will have upon discharge along with documentation of the residents stay at the facility. The Administrator indicates the resident and family receive a copy of this on discharge and a copy is kept in the medical record and sent to the primary physician.</p> <p>Per interview with the Social Service Director (SSD) on 12/26/12 at 3:05 PM, he/she confirmed that all residents receive upon discharge, a discharge summary that details the residents stay and information regarding medications, follow up care and services to be provided upon discharge. The SSD confirmed that the discharge summary for Resident #1 that was given to the resident upon discharge indicated that Resident #1 was to receive home health follow up. Per interview with the SSD at 305 PM on 12/26/12, he/she confirmed upon review of the 11/1/12 SS care conference note, that SS was to set up physical therapy and a home health aide through VNA for discharge. Per interview with the SSD on 12/26/12 at 305 PM, he/she reviewed the occupational therapy discharge recommendations and confirmed that the recommendation from OT was "resident planned to discharge home with support of spouse and home health services. Recommend home health aide for completion of showers safely to decrease burden of care." The SSD also confirmed that the discharge summary also indicated that the resident is to benefit from home health services upon discharge to promote safety and good transition to home during self care activities. Per interview with the SSD on 12/26/12 at 305 PM, he/she confirmed that he/she did not request services from home health until 2 days after Resident #1 was discharged as</p>	F 204			

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

PRINTED: 01/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/26/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE PINES AT RUTLAND CENTER FOR NURSING AND REHABI</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>99 ALLEN STREET</b> <b>RUTLAND, VT 05701</b>		
(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 204	Continued From page 3 her fax dated 12/14/12 indicates. The SSD confirmed that these services should have been arranged for prior to discharge and was unable to indicate why they were not done until 2 days after discharge.	F 204		