

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

PRINTED: 08/24/2009  
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 08/07/2009
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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	AUG 31 2009
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F 000	INITIAL COMMENTS	F 000	<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 id 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>F280 Comprehensive Care Plans</b> A comprehensive care plan is developed for all residents of the facility, and is reviewed and revised periodically. Resident #1 had a comprehensive plan of care, with updates and revisions, which addressed all of his diagnoses, problems, and needs. Resident #1 had a Fall Risk Assessment completed on the date of his re-admission to the facility, 9/12/08. Resident #1's Fall Risk score was "7", which does not represent a high risk for falls. Accordingly, Resident #1's re-entry MDS dated 9/22/08 did not trigger for a "Fall" RAP or Care Plan. Resident #1 had not had any falls during his prior placement at the facility, or during his second placement beginning 9/12/08 through the event date/discharge date of 9/28/08. Resident #1 was consistently assessed to be alert and oriented, making his own decisions, including choosing not to comply with all of his physician orders and total plan of care. Residents' care plans were reviewed by the RN Nurse Managers, Assistant Director of Nursing, and Director of Nursing in order to ensure that residents</p>	
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS</p> <p>The resident has the right, unless adjudged 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 interview and record review, the facility failed to revise the care plan for Resident #1 to reflect the current needs. Findings include:  Per record review, Resident #1 had a history of unsafe behavior, including getting out of bed unassisted and disconnecting self from ventilator.</p>	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ (X6) DATE 8/26/09

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	Continued From page 1 A nurses' note, dated 9/16/08 states, "Does not ring for assist. Found OOB (out of bed) on other side of room, leaning over commode, with vent disconnected." A nurses' note, dated 9/23/08 states, "...getting OOB alone, not using call light, disconnecting TF (tube feeding) and vent..." Per review of the plan of care, there was no care plan that addressed falls or safety. On 9/28/08 at 12:57 AM, staff responded to a "thump" in the resident's room, and found the resident to be disconnected from the ventilator and on the floor across the room from the resident's bed. Resident #1 was not able to be revived, and subsequently expired at 1:24 AM. On 6/22/09 at 3:30 PM, the DNS confirmed the above information.	F 280	Nurses have received education related to Comprehensive Care Plans and care planning for residents' falls and safety needs, by the Staff Development Coordinator and Director of Nursing. Monthly audits of 20% of residents' medical records and care plans will be completed by the DNS, and/or her designee, in order to ensure compliance with the facility's policy and procedures. Audit findings will be reported to the Quality Assurance Committee monthly, and will be monitored by the Administrator.	
F 323 SS=G	483.25(h) ACCIDENTS AND SUPERVISION  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 interview and record review, the facility failed to provide adequate supervision and to prevent accidents for 1 applicable resident in the targeted sample (Resident #1). Findings include:  Per record review, the facility failed to provide adequate supervision for Resident #1, had a history of unsafe behavior, including getting out of bed unassisted and disconnecting self from ventilator. A nurses' note, dated 9/16/08 states,	F 323	Completion Date: August 29, 2009 <i>POC completed 9-3-09</i> <i>B. Cohn 1542 as m</i> <b>F323 Accidents and Supervision</b> The facility ensures that the residents' environment remains as free of accident hazards as is possible, and that each resident receives adequate supervision and assistance to prevent accidents. Resident #1 was consistently assessed to be alert and oriented, and sometimes chose to disregard/refuse to follow his plan of care and physician orders. The facility views Resident #1's choice to ambulate independently and disconnect himself from mechanical devices as his right and can only provide oriented residents with education and reminders related to their safety and decision making. As stated previously, Resident #1 was not assessed to be at risk for falls on either	

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F 323	<p>Continued From page 2</p> <p>"Does not ring for assist. Found OOB (out of bed) on other side of room, leaning over commode, with vent disconnected." A nurses' note, dated 9/23/08 states, "...getting OOB alone, not using call light, disconnecting TF (tube feeding) and vent..." Per review of the plan of care, there was no plan that addressed falls or safety measures. On 9/28/08 at 12:57 AM, staff responded to a "thump" in the resident's room, and found the resident to be disconnected from the ventilator and on the floor across the room from the resident's bed. Resident #1 was not able to be revived, and subsequently expired at 1:24 AM. On 6/22/09 at 3:30 PM, the DNS confirmed the above information from the medical record. Per interview on 2/10/09, with the nurse that responded to alleged fall on 9/28/08, it was confirmed that no bed or clip alarms were sounding at the time of the alleged fall.</p> <p><b>F9999 FINAL OBSERVATIONS</b></p> <p><b>2.9 Reports to the Licensing Agency</b> The following reports must be filed with the licensing agency: (a) At any time a fire occurs in the home, regardless of the size or damage, the licensing agency and the Department of Labor and Industry must be notified by the next business day. A written report must be submitted to both departments by the next business day. A copy of the report shall be kept on file in the facility. (b) Any untimely death that occurs as a result of an untoward event, such as an accident that results in hospitalization, equipment failure, use of restraint, etc., shall be reported to the licensing agency by the next business day, followed by a written report that details and summarizes the event. (c) Any unexplained or unaccounted for absence</p>	F 323	<p>alarms built into his ventilator (model LTV950) to alert Respiratory Therapy staff of disconnection to the ventilator. Ventilator alarms sound within approximately 20-30 seconds of disconnection, and are unable to be turned off. When the ventilator connection is re-established within that time frame, no alarm will sound. Lastly, it was determined by the primary care physician for Resident #1, that the un-witnessed event that occurred on 9/28/09 was related to the resident's disease process and was a "natural" death, not an accident/fall, and was stated, and registered, as such on the Vermont State Certificate of Death. Nursing staff have received education related to the F323 regulation and the facility's policy and procedures related to Accidents and Incidents, by the Staff Development Coordinator and the Director of Nursing. Monthly audits of 20% of residents' who are assessed to be at high risk for falls, or other safety concerns, will be completed by the DNS, or her designee, in order to ensure compliance with the regulation and facility's policy and procedures. Audit findings will be reported to the Quality Assurance Committee monthly, and will be monitored by the Administrator.</p> <p>Completion Date: August 29, 2009</p> <p><i>Dr. account 9-3-09</i></p>	
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F9999	Continued From page 3 of a resident for a period of more than 30 minutes shall be reported promptly to the licensing agency. A written report must be submitted by the close of the next business day. (d) Any breakdown or cessation to the facility's physical plant that has a potential for harm to the residents, such as a loss of water, power, heat or telephone communications, etc., for four hours or more, shall be reported within 24 hours to the licensing agency.  Based on interview and record review, the facility failed to notify the State Agency of an untimely death that occurred as a result of an untoward event for 1 resident (Resident #1). Findings include:  Per record review, on 9/28/08 at 12:57 AM, Resident #1 was found on the floor, disconnected from the ventilator, and on the other side of the room from his/her bed. Staff and EMS responded, but were unable to revive Resident #1, who subsequently expired at 1:24 AM on 9/28/08. The State Agency was not notified of this untimely death. On 6/22/09 at 3:30 PM, the DNS and Administrator confirmed that the State Agency was not notified.	F9999	F9999 The facility reports mandated events to the State Agency. The primary care physician for Resident #1 determined that the un-witnessed event on 9/28/09 was not an "untoward event" or an "untimely death", but rather part of the resident's disease process and a "natural" death. Therefore, since the physician reported the death to be "Natural", not accidental or an untoward event, the facility would have no reason to believe that they should be reporting an "untimely death". The Department Heads of the facility were provided with inservice education by the Administrator related to reporting requirements to the State Agency. Please note that the facility has since made reports to the State Agency related to other required reporting. All reports to the state will be reviewed by the Quality Assurance Committee monthly, and monitored by the Administrator for compliance. Completion Date: August 29, 2009 <i>Poc unntd 9-3-09</i> <i>P. Carter</i>		