

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
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September 9, 2015

Mr. Timothy Urich, Administrator
The Pines At Rutland Center For Nursing And Rehabilitation
99 Allen Street
Rutland, VT 05701-4501

Dear Mr. Urich:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 5, 2015**. 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

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 08/05/2015
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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
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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

The Division of Licensing and Protection conducted an unannounced onsite annual recertification survey from 8/3/15 to 8/5/15. The following regulatory deficiencies were cited as a result.

F 315 483.25(d) NO CATHETER, PREVENT UTI, SS=D RESTORE BLADDER

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:

Based upon staff interview and record review, the facility failed to assure that 1 of 2 residents with urinary catheters in the stage 2 sample of 18 (Resident #148) had medical justification for the continued use of a catheter and failed to assure appropriate monitoring. Findings include:

1. Per record review and interviews, staff did not demonstrate a valid medical justification for continued use of an indwelling catheter for Resident #148. Additionally, there is no documentation that the catheter will be discontinued as soon as clinically warranted. Per interview on 08/03/15 at 2:14 PM the Unit Manager stated the reason the Resident had a

F 000

Plan of Correction F315

Corrective Action: The catheter for Resident #148 has been removed per the attending physician's order.

F 315

Identify Other: All residents with an indwelling or supra pubic catheter will be assessed for clinical justification for placement and to ensure an appropriate diagnosis is in place. Any resident who does not have an appropriate diagnosis will have a physician assessment completed for evaluation of catheter removal.

Systemic Changes: All residents who are admitted with a catheter, or have one inserted while residing at the facility will have a physician assessment / level completed and in the absence of a qualifying clinical indicator, a goal for removal will be established.

Monitoring: A log of all residents with indwelling / supra pubic catheters will be maintained by the DNS. This document will be evaluated weekly and as needed in the event of a new catheter insertion. The document will, in addition, be evaluated in QA.

Completion Date: 9/4/15
Responsible Party: Director of Nursing

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

TITLE

(X6) DATE

[Signature] Administrator 8/31/15

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.

F315 POC accepted 9/4/15 Rtenney R/P/PMU

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F 315	<p>Continued From page 1</p> <p>catheter was because of BPH (benign prostatic hyperplasia). Later that same day the Unit Manager notified the nurse surveyor that the reason for the catheter was Hypernatremia. Per review of the resident's record, showed that the resident was hospitalized for dehydration and Hypernatremia, had a catheter inserted while at the hospital, and admitted on 07/01/15 to the nursing facility. The Care Plan of 07/01/15 notes use of the Foley (catheter) for Hypernatremia and directs staff to monitor I&Os (intake and output), urinary infections and to irrigate as necessary [PRN] and change the Foley every 6 weeks and/or PRN. There is no information related to the long or short term use of the Foley catheter or end date for discontinuation.</p> <p>Per review of the significant change and 5-day MDS assessment (Minimum Data Set) dated 7/08/15 and 07/16/15, respectively, noted that the resident had a (new) indwelling catheter and no genitourinary diagnosis for the catheter. Per interview on 08/05/15 at 10:55 AM the MDS personnel stated the catheter was inserted elsewhere and was for Hypernatremia. Per interview on 08/05/15 at 11:02 AM the physician stated "Hypernatremia is not a medical justification, when [s/he] went to the hospital they found [resident] to be dehydrated, so they hydrated [the resident] and tracked it by the Foley and IV fluids. So when [s/he] came back I thought that we can do that short term but it should be taken out....I am only giving fV fluids twice weekly and we want make sure [of] voiding". The DNS and physician at that time acknowledged that there was no evidence, either by case conference notes, physician/nursing notes, or care plan review, for a plan to remove the catheter.</p>	F 315		

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F 315	Continued From page 2 Per review of the Clinical Service Intake and Output policy and procedures notes (5th bullet) the nurse manager will assess the total intake and output daily for these resident to determine if the resident is meeting their hydration goals'. Procedure #4 - 'if a resident does not take any (by mouth) fluids during a given shift write 'zero' in the shift total column, never leave this column blank'. #9 - 'If the resident does not urinate during the shift write 'zero' in the appropriate column.' The Nursing I&O records for Aug. 1, 2, 3 and July 28, 29, 30, 20 were not found and missing information on one or more shifts during July 2, 4, 6, 7, 8, 9, 10, 12, 13, 14, 23, & 26th is noted. The LNAs ADL (activity of daily living sheet) also had inconsistent documentation of output (all shifts) for July 2, 4, 6, 8, 9, 12, 13, 14, 16, 19, 20, 21, 22, 25, 26, 29, 30, and Aug 1, 2, 4. The above information was confirmed by ADNS at that time. F 465: 483.70(h) SS=B SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a functional / comfortable environment on one of three units. Findings include: 1. Per the tour of a unit on 08/05/15 at 8:47 AM, with both maintenance men, the following was	F 315	Plan of Correction F465 <u>Corrective Action:</u> (1) The dresser in room 401 has been repaired to ensure that there are no chipped, rough, broken or worn edges. (2) The handles on the dresser in room 418 have all been replaced. (3) The armoire in room 420 has been repaired and the foam and duct tape has been removed from the toilet's plumbing. (4) The bedside stand in room 421 has been replaced. <u>Identify Other:</u> An audit of all resident room furniture will be conducted. A corrective action plan will be implemented to address all damaged furniture. <u>Systemic Changes:</u> Monthly room audits will be conduct in each resident room to ensure that damaged/worn resident room furniture is identified and corrective action taken. <u>Monitoring:</u> Results of these audits will be submitted to the Quality Assurance Committee monthly for three months. The need for submittal of audits beyond the three months will be determined by the committee. <u>Completion Date:</u> 10/1/15 <u>Responsible Party:</u> Director of Maintenance F465 PC accepted 9/1/15 Rtrumbldgr/jm

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F 465	<p>Continued From page 3 noted:</p> <p>Room 401's dresser was chipped, had rough, broken and worn edges; Room 418 (a) dresser's handles were missing; Room 420 was noted to have a tall armoire with the front laminate missing and torn while the bathroom's toilet had polyethylene foam and duct tape on the plumbing; Room 421 was noted to have orange blaze duct tape on the corner bedside stand.</p> <p>The Maintenance men stated that they were not aware of these specific items but that the facility was in the process of getting some new furniture for this unit but had not heard when. They confirmed the above findings.</p>	F 465		