

Division of Licensing and Protection

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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

June 13, 2016

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 **May 18, 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

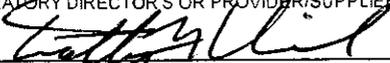
JUN - 7 2016

PRINTED: 05/23/2016
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 05/18/2016
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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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F 000	INITIAL COMMENTS	F 000		
F 252 SS=D	<p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a safe, clean, comfortable and homelike environment for 2 residents, Resident #61 and #133. Findings include:</p> <p>Per observation on 5/17/16 at 8:32 AM, in the room where Resident #133 and Resident #61 reside, there were 8 ventilator machines (a machine that helps one breathe) and 6 large oxygen tanks being stored. Per interview on 5/17/16 at 8:32 AM with a Licensed Practical Nurse (LPN), s/he stated that the room was a four bed room and was possibly going to be used for storage during renovations of the facility. Per interview on 5/17/16 at 2:21 PM with the Assistant Director of Nursing (ADNS), s/he confirmed that the ventilator and oxygen equipment should not have been stored in the Residents' room.</p>	F 252	<p>Plan of Correction F252</p> <p><u>Corrective Action:</u> The identified equipment has been relocated to non-resident care area.</p> <p><u>Identify Other:</u> All residents/patients could be affected by the practice.</p> <p><u>Systemic Changes:</u> Non-essential equipment will no longer be stored in any resident room within the facility. Environmental audits will be conducted weekly of each resident room to ensure compliance.</p> <p><u>Monitoring:</u> Weekly environmental audits will be conducted for a period of three months and the results will be submitted to the facility's QA Committee for review. Further auditing beyond the initial three months will be determined by the QA Committee.</p> <p><u>Completion Date:</u> 6/30/16 <u>Responsible Party:</u> Maintenance Director <i>F252 POC accepted 6/10/16 BB/ADNR/PML</i></p>	
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
 **ADMINISTRATOR** **6/2/16**

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 SS=D	<p>Continued From page 1 PARTICIPATE PLANNING CARE-REVISE CP</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 staff interview and record review, the facility failed to revise a care plan regarding wound treatment orders for Resident #133 and Advanced Directives for Resident #179. Findings include:</p> <p>1.) Per record review for Resident #133, the weekly wound/skin condition report noted the treatment to the Resident's wound on right buttocks area was to cleanse area, use Calmo (type of lotion/cream), and then Telfa (a non-adhering dressing). Per review of the care</p>	F 280	<p>Plan of Correction F280</p> <p><u>Corrective Action:</u> (1) Resident # 133's care plan has been revised to reflect current treatment regimen per physician's order. (2) Resident # 179's care plan has been revised to reflect current code status.</p> <p><u>Identify Other:</u> (1) All residents receiving wound care treatment have the potential to be impacted by this practice. (2) All residents with advanced Directives in place have the potential to be impacted by this practice.</p> <p><u>Systemic Changes:</u> (1) All residents that currently receive wound treatment will have their care plan audited to ensure compliance of prescribed treatment. Continued compliance will be managed by nursing administration through daily review of any treatment changes noted on the facility's 24-hour Nursing Report. (2) An audit will be performed on all residents' charts to ensure accuracy of advanced directives and that current status is reflected in the resident's care plan. Each resident's care plan for Advanced Directives will be reviewed every time a resident has a care conference or a completion of an MDS.</p>		

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F 280	Continued From page 2 plan for Resident #133, there was no documentation of the current treatment, but had treatments listed that had been discontinued and were no longer being used. Per interview on 5/17/16 at 4:38 PM with the ADNS, s/he confirmed that the Resident's plan of care was not updated to reflect the current wound care treatment. 2.) A review of the medical record for Resident #179 presented that his/her care plans included Advance Directives. The care plan was dated as reviewed on 3/16/16 and states that the resident is a Full Code and the staff are to honor his/her wishes. There is a Do Not Resuscitate (DNR) order that was signed by the physician and the legal guardian on 3/23/16. The ombudsman met with the resident and reviewed the advanced directive and co-signed with him/her to indicate that they wished to have a DNR order. Per interview with the Licensed Practical Nurse (LPN) at 3:45 PM on 5/17/16, the physician had signed a DNR order for Resident #179 on 3/23/16 after a family meeting. The assistant Director of Nursing Services confirmed at 3:51 PM that the care plan had not been updated and did not reflect the current code status.	F 280	<u>Monitoring:</u> (1) A monthly audit will be conducted for all residents that receive wound treatment to ensure their respective care plan reflects the currently prescribed treatment. These audits will continue for a period of 3 months and will be submitted to the facility's QA committee for review. After 3 months, the need and frequency of auditing will be determined by the committee. (2) Each resident's care plan for Advanced Directives will be reviewed each time a resident has a care conference or a completion of an MDS. This will be documented in a log and submitted monthly to the facility's QA Committee for a period of 3 months. After 3 months, the need and frequency of auditing will be determined by the committee. <u>Completion Date:</u> 6/30/16 <u>Responsible Party:</u> Director of Nursing <i>F280 POC accepted 6/10/16 BBurke/AN/PWL</i>	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN. The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by:	F 282	Plan of Correction F282 <u>Corrective Action:</u> At the time of observation, the two splint devices were immediately reapplied to resident #133. <u>Identify Other:</u> All residents that have orders and subsequent care plans that indicate the use of orthotics have the potential to be impacted by this practice.	

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F 282	Continued From page 3 Based on observation, staff interview and record review, the facility failed to follow the plan of care for 1 of 20 residents, Resident #133, in regards to the application of hand splints. Findings include: Per observation on 5/17/16 at 8:32 AM in Resident #133's room, 2 (two) splint devices were noted on the counter next to the sink in the room. Per review of the Resident's plan of care a wrist/hand orthotic (splint) wearing schedule was noted. "The patient is to wear orthotic at all times except for self-care and skin checks." Per interview on 5/17/16 at 4:37 PM with the ADNS, s/he confirmed the Resident was not wearing the hand splints and that the Resident was to have them on at all times except for self-care and skin checks.	F 282	<u>Systemic Changes:</u> (1) The care plans for all residents with the use of orthotics will be audited to ensure the compliance with therapy indications. (2) All nursing staff will be re-educated on the necessity of following a resident's care plan as it relates to the use of orthotics. <u>Monitoring:</u> Unannounced audits will be conducted once per week for three months for all residents that are care planned for the use of orthotics. The audits will be conducted to ensure that use of orthotics are in line with the specific resident's therapy indication and care plan. These audits will be submitted to the facility's QA Committee for review and the need for continued auditing past the three months will be determined.	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to insure that 1 of 2	F 328	<u>Completion Date:</u> 6/30/16 <u>Responsible Party:</u> Director of Nursing <i>F328 POC accepted 6/10/16 BBurke/RH/PMC</i> Plan of Correction F328 <u>Corrective Action:</u> For the affected resident (#177): 1) the physician's order for the rate of the resident's tube was confirmed and the enteral pump was adjusted to run at the proper amount. 2) the physician's order for the resident's water flushes was confirmed and the order was appropriately documented on the resident's MAR for the current month.	

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F 328	Continued From page 4 residents, Resident #177, received the proper care and treatment for enteral fluids via a gastrostomy tube. Findings include: 1.) Resident #177 was admitted to the facility with diagnoses that include anoxic brain injury, quadriplegia and dysphagia. The resident also has a tracheostomy and receives all nutrition via a gastrostomy tube (G-tube). Review of the medical record has orders from the physician to have enteral feeding of Osmolite continuous at 70 milliliters per hour (ml/hr). Review of the medication administration record (MAR) indicates that the resident is to receive 70 ml/hr and that is what the nursing staff had signed for. Observation of the enteral pump showed that it was set to run at 60 ml/hr and the bottle of Osmolite that was hanging and running through the pump and G-tube was labeled to run at 60 ml/hr. Confirmation received on 5/18/16 at 9:48 AM from the Registered Nurse (RN), that the Osmolite was ordered for 70 ml/hr and it was being given at 60 ml/hr. 2.) Review of the physician orders for Resident #177 presented that the order for 200 ml free water flushes were discontinued on 4/24/16 and a change was made to have 100 ml water flush every 3 hours via G-tube to ensure patency. The Licensed Practical Nurse confirmed on 5/18/16 at 11:36 AM that there is no evidence of water flushes being provided to the resident after review of the MAR. S/he pointed out that the 200 ml flushes were marked as changed, but there was no water flushes marked on the MAR. The RN confirmed at 11:38 AM that the physician had signed an order dated 4/24/16 for the 100 ml water flush to be done every 3 hours and that it	F 328	<u>Identify Other:</u> All residents with an order for tube feeding and water flushes have the potential to be affected by this practice. Therefore, a full house audit of all residents requiring tube feeding and water flushes will be conducted to verify the proper rate for tube feeding is being administered and that proper water flushes are indicated on the respective resident's current MAR. <u>Systemic Changes:</u> Weekly audits will be conducted for all residents requiring tube feeding and water flushes to ensure the proper rate for tube feeding is being administered and that proper water flushes are indicated on the respective resident's current MAR. <u>Monitoring:</u> These weekly audits will be conducted for a period of three months and the results submitted to the facility's QA Committee for review. The need for continued auditing will be determined by the committee. <u>Completion Date:</u> 6/30/16 <u>Responsible Party:</u> Director of Nursing <i>F328 FCC accepted 6/10/16 Barbara Rainone</i>	

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F 328	Continued From page 5 was written on the April 2016 MAR and signed that it had been administered, but there is no evidence that the order was carried forward on the May MAR and that there is no evidence that the flushes have been administered.	F 328			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store, prepare and distribute food under sanitary conditions. Findings include: 1. During the initial tour of the kitchen on 5/16/16 at 10:15 AM, a cartridge of pH testing paper (pHydriion lapers QT-10), located on the shelf above the sanitizing sink, was noted to have an expiration date of 5/15/12. Per interview on 5/17/16 at 12:51 PM with the Dietary Manager, s/he confirmed that the pH strips used to test the efficacy of the sanitizer had expired. Also while on tour, it was noted that the dishwasher room had two fans mounted on the west and south walls. The west wall fan was blowing toward clean dishes and the south side fan was blowing toward the center of the room. The fan on the	F 371	Plan of Correction F371 <u>Corrective Action:</u> (1) New pH testing papers were immediately procured and placed in use. The fans noted to have accumulation of dust were immediately cleaned. (2) The items noted to be unlabeled or not properly dated were immediately discarded. (3) The four expired items located in the dry storage area were immediately discarded. An audit of the entire dry storage area was completed to ensure no outdated food products are being stored. Any items found to be expired were immediately discarded. <u>Identify Other:</u> (1) All residents of the facility could be affected by the practice of using outdated pH testing strip and fans that are not properly cleaned in an area that stores clean dishes. (2) All residents of the facility could be affected by the practice of not properly labeling or dating food products. (3) All residents of the facility could be affected by the practice of using expired food products.		

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F 371	Continued From page 6 west wall was noted to have dust covering the fan propellers and the entire metal cage that encloses the propellers. Per interview on 5/16/16 at 10:15 AM with the Dietary Manager, s/he confirmed that the fan on the west wall was not clean and was blowing toward clean dishes. 2. Per observation on 5/17/16 at 9:00 AM of the second floor kitchenette, the resident refrigerator had an unlabeled and undated, 9 x 12 aluminum container with a fluffy white dessert appearing substance. Per interview on 5/17/16 at 9:10 AM with the second floor Unit Manager, s/he confirmed that the container had no use by date or label of contents. During observation on 5/17/16 at 9:26 AM of the fourth floor kitchenette, the resident refrigerator had a plate of brown dessert type substance and a plate of orange whipped dessert type substance located on the top shelf. Each plate was covered with saran wrap without use by dates or content labels. Per interview on 5/17/16 at 9:33 AM with a Licensed Practical Nurse (LPN), s/he confirmed that the two dessert type substances on the plates were without use by dates or content labels. 3. Per observation on 5/16/16 at 10:33 AM of the facility dry storage area, there was a box of Pancake Mix with an expiration date of 9/1/15; a box of Gold Medal Honey Bran Mix with an expiration date of 12/30/15; a box of Gluten Free Cake Mix with an expiration date of 5/2015; and a box of Gluten Free Baking Mix with an expiration date of 7/2015. Per interview on 5/15/16 at 10:33 AM with the Dietary Manager, s/he confirmed that the mixes were expired.	F 371	<u>Systemic Changes:</u> (1) A weekly audit of the pH testing papers will be conducted to ensure no expired products are being used. The fans noted in the clean dish area have been removed and will no longer be used. (2) A daily audit of all kitchenette refrigerators will be implemented to ensure proper labeling and dating of food and beverages. This will be added to and documented on the existing facility log for refrigerator temperatures. (3) A weekly audit of the entire dry storage area will be completed and any items found to be expired will be immediately discarded. <i>All dietary staff will receive education on the following: properly examining the expiration date on pH testing papers prior to each use, properly labeling and dating food products stored in the facility kitchenettes and properly inspecting expiration dates for products stored in the dry storage area.</i> <u>Monitoring:</u> All daily/weekly logs will be presented to the facility's QA Committee monthly for review for three months. Continued review of these audits past three months will be determined by the Committee. <u>Completion Date:</u> 6/30/16 <u>Responsible Party:</u> Food Service Director <i>F371 POC accepted 6/10/16 B. B. [Signature]</i>	