VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

August 2, 2018

Mr. Timothy Urich, Administrator
The Pines At Rutland Center For Nursing And Rehabi
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 **June 28, 2018**. 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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475018	A. BUILDING _____ B. WING _____	06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES AT RUTLAND CENTER FOR NURSING AND REHABI	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
E 000	Initial Comments During an unannounced on-site re-certification survey from 6/25/18 through 6/28/18, the Division of Licensing and Protection conducted a review of the facility's Emergency Preparedness Program. The facility was found to be in substantial compliance with Emergency Preparedness planning.	E 000		
F 000	INITIAL COMMENTS An unannounced on-site re-certification survey was conducted on 6/25/18 through 6/28/18 by the Division of Licensing and Protection. The following regulatory violations were identified:	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 580	Corrective Action: For resident #92, the resident's change in condition occurred 6/13/18 @ 2:00 a.m. and a message for her responible party was left with her at 6:35 a.m. Therefore, the resident's alternate contact was notified at this same time and indicated she would contact the resident's responsible party. On 6/13/18 @ approximately 9:00 a.m. the resident's responsible party did arrive at the facility and was updated on the resident's condition. For resident #372, the facility Social Worker did speak with patient and responsible party on 6/25/18 prior to the room change. The surveyor verbally confirmed with the patient that she was asked to move. Therefore, the facility Social Worker entered a late note on 6/27/18 referencing her conversation with the patient and her responsible party.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7/25/18

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475018	A. BUILDING _____ B. WING _____	06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES AT RUTLAND CENTER FOR NURSING AND REHABI	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 580	Continued From page 1 (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on family and staff interviews and record review, the facility failed to notify the resident's representative immediately at the time of a significant change in condition; and of a room change, for 2 residents in the applicable sample (Resident #92 and Resident #372). Findings include: 1. Per record review for Resident #92, progress	F 580	Identify Others: All residents could be affected by this practice. Systemic Change: All nursing and Social Work staff will be re-educated on the requirement of notification of change in condition and room changes. Monitoring: Compliance with notification in change and notification of room change will be monitored through the facilities EMR Dashboard daily. An audit of 5 medical records will be conducted per week on those residents with either a change in condition and/or room change to ensure compliance. These audits will be conducted for 12 weeks and the results will be submitted to the QA Committeee for review. Completion Date: 8/25/18 Responsible Party: Director of Nursing F580 POC accepted 8/1/18 DWildeswaterRN/PMC	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475018	A. BUILDING _____ B. WING _____	06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES AT RUTLAND CENTER FOR NURSING AND REHABI	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 580	Continued From page 2 notes identify the following: -6/12/18 at approximately 23:15 (11:15 PM), the resident complained of not being able to swallow and the resident's tongue was slightly swollen. Supervisor notified; -6/13/18 at approximately 02:20 (2:20 AM), the resident still complaining of not being able to swallow well and tongue more swollen. Hospice Nurse notified and will come into the facility to assess the resident; -6/13/18 at approximately 03:00 AM, Hospice Nurse assessed the resident and concluded the resident was having a reaction to the antibiotic, that began on 6/12/18. Nurse Practitioner (NP), contacted and orders received for treatment; -6/13/18 at approximately 03:45 AM, medications administered; -6/13/18 at approximately 04:30 AM, Hospice Nurse left the facility, but provided nursing staff with instructions if condition changes; -6/13/18 at approximately 07:00 AM, resident still complaining of trouble swallowing and tongue remains swollen; -6/13/18 at approximately 07:34 AM medication administered for anaphylaxis (a severe, potentially life-threatening allergic reaction); -6/13/18 at approximately 08:00 AM NP on site, assessed resident and injectable medications administered; -6/13/18 at approximately 11:34 AM progress notes identify family communication. Per family interview on 6/25/18 at 12:00 PM, on 6/27/18, and on 6/28/18 at approximately 12:30 PM, the notification of Resident # 92's allergic reaction/anaphylaxis did not occur until 6/13/18 at approximately 7:20 AM. Per interview on 6/27/18 with an Administrator from Hospice, s/he	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475018	A. BUILDING _____ B. WING _____	06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES AT RUTLAND CENTER FOR NURSING AND REHABI	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 580	Continued From page 3 confirmed that the hospice nurse was on site on 6/13/18; and did not notify the family of the resident's condition at the time of his/her assessment/visit. 2. Per record review Resident #372 was transferred from room 220 to room 214 on 6/26/18. There was no evidence in the medical record that the resident and/or resident's representative was notified of the room change prior to the room change taking place. Per interview on 6/27/18 at 8:24 AM with the social worker, s/he confirmed that the resident and/or resident's representative was not notified of the room change.	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance	F 584	Corrective Action: (1) The mechanical lift obstructing the door at the end of the hall has been moved. The wheelchairs and linen cart in that area have been removed. (2) All items (i.e. linen carts, medication carts, mechanical lifts, meal delivery carts & empty wheelchairs) were either removed from the area or placed on one side of the hall. Identify Others: All facility corridors can be affected by the same practice. Systemic Change: All staff with be re-educated on the requirement to ensure a safe and homelike environment for residents. Particularly for equiment that is placed in the facility corridors. Monitoring: An inspection of all facility corridors will be conducted 10 times per week for 12 weeks at various times to ensure compliance. The result of these audits will be submitted to the QA Committee for review.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475018	A. BUILDING _____ B. WING _____	06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES AT RUTLAND CENTER FOR NURSING AND REHABI	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 584	Continued From page 4 services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a safe and homelike environment for residents on the third and fourth floor. Findings include: 1. Per observation during the initial tour on 6/25/18 at approximately 9:24 AM the fire exit on the third floor, at the renovation site, was found to be partially obstructed. The door at the end of the hall marked "Danger Authorized Personnel Only", was found to be partially obstructed by a mechanical lift stored to the left of the exit. The handle of the lift, was directly obscuring the door handle. Also identified at this time, in the same location, wheelchairs and a laundry cart was also stored. The equipment was observed being used during the three days but after use was returned	F 584	Completion Date: 8/25/17 Responsible Party: Maintenance Director F584 POC accepted 8/1/18 DWidawaterN/RNE	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475018	A. BUILDING _____ B. WING _____	06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES AT RUTLAND CENTER FOR NURSING AND REHABI	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 584	Continued From page 5 to this location for storage. On 6/26/18 an inspector from the Division of Life Safety, confirmed the deficient practice to the surveyor at approximately 11 AM. The inspector immediately brought this to the attention of the facility administrator. On 6/27/18 at approximately 8:18 AM, the equipment was once again found to be stored obstructing the fire exit. The administrator was immediately notified by the surveyor. The administrator confirmed the equipment was blocking the fire exit. Per review of documentation provided by the Administrator, Memorandum dated 5/3/18 identified education provided to staff:, ["Mitigation Plan: As a result of the diminished corridor width and blocked stairwell egress there will be a daily inspection of the area outside of the construction area to ensure no equipment is left blocking the corridor."]. The administrator confirmed on 6/26/18 at approximately 3 PM, that staff observed the fire exit and corridor throughout the day/evening/night shifts. However, there were no no logs or documentation that identified the inspections were conducted. Education forms identify, sixty-three (63) employees were aware of the plan. 2. While doing observations on the fourth floor at 10:30 AM on 6/25/18, it was noted that the hallway contained linen carts, medication carts, mechanical lifts, meal delivery carts and empty wheelchairs on both sides of the hallway and in the middle of the hallway. There were mechanical lifts in front of the doorways of 2 resident rooms (421, 426). The Unit Manager stated that there was not enough space to store	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475018	A. BUILDING _____ B. WING _____	06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES AT RUTLAND CENTER FOR NURSING AND REHABI	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 584	Continued From page 6 equipment while not in use. S/he confirmed that the lifts should not be in front of the doors to resident rooms. During further observation at this time, another room (423) which housed 3 residents had 6 wheelchairs that were stored in an empty corner of the room. Per the nursing staff, one of the residents used 2 different types of the chairs that were stored in the room, one of the other residents used a wheelchair, and the third resident occasionally used a wheelchair; however, was not using it currently. Per observation on 6/26/18 at 8:53 AM, the doorway to another resident's room (426) was partially blocked with a mechanical lift. There were also meal carts, linen carts, wheelchairs, mechanical lifts, and medication carts on both sides of the hall and in the middle of the hall making it difficult to pass by without having to move them. These observations were confirmed with a Registered Nurse at 9:15 AM, after the Vermont State Fire Marshall voiced concerns about the hall clutter and his/her observation of the resident's room (426) being blocked.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656	Corrective Action: For resident #2, a care plan is now in place to address acceptable parameters of nutrition. Identify Others: All residents that receive dialysis have the potential to be affected by the same practice. Systemic Change: The facility's Dietitian will retain a daily census for all residents/patients that receive dialysis and ensure that a current plan of care is in place that addresses acceptable parameters of nutrition.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475018	A. BUILDING _____ B. WING _____	06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES AT RUTLAND CENTER FOR NURSING AND REHABI	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 656	Continued From page 7 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to develop a comprehensive care plan regarding nutrition for one resident in the applicable sample (Resident #2). Findings include: Per record review Resident #2 has a diagnosis of kidney failure with dependence on renal dialysis.	F 656	Monitoring: The facility Dietitian will submit this document to the DNS/ADNS weekly for 12 weeks who will then verify that the care plan has been implemented. In addition, a care plan audit of all residents receiving dialysis will be conducted weekly for 12 weeks to ensure compliance. The results of these audits will be submitted to the QA Committee for review. Completion Date: 8/25/18 Responsible Party: Director of Nursing F656 POC accepted 8/1/18 pwidenwaterfall/fme	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475018	A. BUILDING _____ B. WING _____	06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES AT RUTLAND CENTER FOR NURSING AND REHABI	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 656	Continued From page 8 There was no evidence in the medical record that a care plan was developed to address acceptable parameters of nutrition for a resident on dialysis. Per interview on 6/28/18 at 11:29 AM with the Registered Dietitian (RD), s/he confirmed that a care plan was not developed.	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to assure that services provided met professional standards regarding following physician's orders for 2 of 23 residents in the applicable sample (Resident #20 and Resident #27). Findings include: 1. Per record review for Resident #20, there were two physicians' orders dated 1/7/18 that state to, "document occurrence, intervention, and outcome. Target behavior: sad, weepy, isolates self, withdrawn every shift for monitoring of behavior interventions; and document occurrence, intervention, and outcome. Target behavior: restlessness, increased concern, agitation every shift for monitoring of behavioral interventions". Per review of Resident #20's progress notes and care plan, the resident had a potential to yell out and demand care and services related to vascular dementia (decline in thinking skills caused by a reduced blood flow to the brain). Per review of the nursing progress	F 658	Corrective Action: (1) For resident #20, a Behavior Monitoring Sheet is now in place. (2) For resident #27, the nurse that was identified to have not checked the placement of the gastro-intestinal tube has been re-educated on the requirement to follow the physician's order for placement. Identify Others: (1) All residents that currently require behavior monitoring have the potential to be affected by the same practice. (2) All residents that have a physician order for checking the placement of a feeding tube prior to each use have the potetial to be affected. Systemic Change: (1) All nursing staff will be re-educated on the policy and procedure for behavior monitoring. (2) All nursing staff will be re-educated on the policy for following a physician's order for checking placement of a feeding tube prior to each use. Monitoring: (1) A weekly audit of 5 residents with behavior monitoring in place will be conducted for 12 weeks to ensure compliance. The results of the audits will be submitted to the QA Committee for review. (2) Three feeding tube administration audits will be conducted with nurses weekly for 12 weeks to ensure compliance. The results of the audits will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475018	A. BUILDING _____ B. WING _____	06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES AT RUTLAND CENTER FOR NURSING AND REHABI	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 658	Continued From page 9 notes, on 5/8/18, the resident was "combative, refusing medications, yelling out, and swinging fists as staff". On 6/22/18, the resident was "yelling out, cussing at staff and swinging fist at staff". On 6/28/18, the resident was "yelling at another resident and staff requiring one to one staff interventions". There was no evidence of behavior monitoring in the medical record. Per observation on 6/25/2018, Resident #20 was isolated, withdrawn, and restless with increased concern and agitation. Per interview on 6/27/18 at approximately 10:00 AM, with the Unit Manager, s/he stated that any behavior monitoring was documented in the medical record and further confirmed that there was no behavior monitoring done for Resident #20. Per interview 6/27/2018 at approximately 10:15 AM with the Assistant Director of Nursing, s/he also confirmed that there was no behavior monitoring done for Resident #20. 2. Per observation on 6/26/18 at 8:30 am of a medication administration for Resident #27, the Licensed Practical Nurse (LPN), did not check placement of Resident #27's gastro-intestinal tube (tube in the stomach used to feed and/or give medications) prior to administering Resident #27's 9 AM medications. Per record review, Resident #27 had a physician's order dated 1/9/18 to "Check placement of feeding tube prior to each use". Per interview on 6/26/2018 at 9:30 AM with the LPN, s/he confirmed that s/he did not check placement of the gastro-intestinal tube prior to administering the medications. S/he stated that the gastro-intestinal tube was checked earlier in the shift as this was usual practice. Per interview on 6/26/2018 with the Unit Manager and the DNS, they stated that the usual practice	F 658	submitted to the QA Committee for review. Date of Completion: 8/25/18 Responsible Party: Director of Nursing F658 POC accepted 8/1/18 DWideawake RN/PMC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475018	A. BUILDING _____ B. WING _____	06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES AT RUTLAND CENTER FOR NURSING AND REHABI	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 658	Continued From page 10 was to check the gastro-intestinal tube once a day per the recommendation of the Wound Ostomy and Continence Nurse (WOCN). References: American Nurses Association (2015). Nursing: Scope and Standards of Practice (3rd ed.). Silver Spring, MD: ANA (pg. 61). Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins, (pg 17).	F 658		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions 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 confirmed by staff interview, the facility failed to provide necessary housekeeping and maintenance services to maintain a sanitary, orderly and comfortable interior for 3 of the 3 units. The findings include the following: Per facility tour on all three units, in the presence of the Maintenance Director and the Housekeeping/Laundry Supervisor on 6/27/18 at 8:14 AM the following was discovered: -Numerous resident bathrooms were found with dusty bathroom exhaust vents; -Two resident commodes located in resident bathrooms were identified to be soiled with dry brown matter; -One resident who spends much of her/his time	F 921	Corrective Action: All areas and equipment noted to be unsanitary and/or in disrepair will be cleaned and/or repaired/replaced. Identify Others: All areas of the facility have the potential to be affected by the same practice. Systemic Change: All housekeeping and maintenance staff will be re-educated on requirement and importance of providing a safe, functional, sanitary and comfortable environment for residents, staff and public. A weekly environmental audit of all areas and equipment identified will be completed for 12 weeks. Monitoring: The weekly audits will be submitted to the QA Committee for review. After the completion of the 12 week audits, these audits will be conducted once per month. Date of Completion: 8/25/18 Responsible Party: Maintenance Director F921 POC accepted 8/1/18 DWildawalaRN PMC	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475018	A. BUILDING _____ B. WING _____	06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES AT RUTLAND CENTER FOR NURSING AND REHABI	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 921	Continued From page 11 in bed, was found with a wall fan heavily caked with dust and grime and the ceiling tiles above the bed were spotted with brown matter; -One resident bathroom was found to have a ceiling tile peeling and discolored; -One resident bathroom had an exhaust fan/vent missing, the casing was caked with dust and had visible cobwebs. The vent area was not covered, and the space was vacant; -Numerous resident wheel chairs, bed side tables and equipment were found with accumulated dust and dried food splatters. A resident recliner was found with multiple tears and missing portions of the vinyl covering; -Two resident bathroom lights had bulbs that were not functioning; -In one resident room, the heating/air conditioning wall unit had a portion of the cover covered with cardboard that was taped in place with white surgical tape. The cardboard and tape were discolored. During the tour, both professionals confirmed that all of the above discovered conditions were in need of repairs and cleaning.	F 921		